This issue of *Healthcare Quarterly* features a feast of articles providing new information, insights and answers to an extra-wide array of questions: what to embrace, avoid or weigh to inculcate people-centred care, activate physician leadership in quality and safety or formulate policy positions pending landmark legislation. Why is meaningful informed consent in digital health so elusive? Where are the most innovative healthcare procurement strategies? How is research illuminating the economic and resource impacts of healthcare interventions and the extent of homelessness? What can go wrong (and right) when screening patients for behavioural risks?

In healthcare, so many critical outcomes depend on seemingly simple declarative actions that are often inadequately undertaken or overlooked: Inform and be informed. Teach and be taught. Ask and answer. Listen, learn and, if appropriate, leap. The efforts and outcomes described in the articles, whether celebratory or cautionary, could all benefit from that common counsel.

Health System Innovations

Healthcare discussions veer sooner or later – usually sooner – to questions of cost. But data derived from an econometric model described by Doyle (2022) show that healthcare innovations have significantly boosted the economy of Newfoundland and Labrador. The model calculated that the total direct, indirect and induced impacts of healthcare innovation in the province in 2019 and 2020 hiked the gross domestic product from $4.5 million to $12.2 million. Over the same period, total labour compensation rose from $4.3 to $11.1 million and the number of related jobs increased from 51 in 2019 to 134 in 2020. Factors facilitating this growth include pandemic-prompted manufacturing, better coordination among a bigger pool of vendors and support from Eastern Health and collaborative partnerships.

The careful implementation of value-based procurement in Denmark's health sector is finely detailed by Belotti Pedroso et al. (2022), who describe the innovative strategies the country introduced to align with organizational goals and achieve better patient and system outcomes, well beyond cost containment. The authors trace Denmark's journey from traditional procurement to category management (requiring up-to-date understanding of clinical processes and technologies in discrete subcategories) and long-term strategic innovation partnerships with suppliers to value-based procurement.

The authors advise any jurisdictions interested in following Denmark's lead to develop a robust learning process to secure and consolidate the new skills and additional knowledge that case management and value-based procurement require.

Examining Resource Allocations

In a meticulous article based on an original case-costing study, Cheng et al. (2022) quantify the actual as well as potential resource and capacity impacts of a project set up to mitigate an entrenched healthcare challenge: poor access to alternate level-of-care (ALC) for hospitalized patients who cannot be discharged without it. The authors framed their analysis around the significant and unnecessary system costs, increased hospital occupancy rates and poor patient flow that result from this ostensibly isolated issue.

In the Toronto-based provincially funded pilot project, ALC patients from Sunnybrook Health Sciences Centre were transferred to a "Reintegration Unit" set up in the community. They remained there, with specialized support from SPRINT Senior Care and LOFT Community Services available for patients requiring them, until transitioning to long-term care or returning home with supports. The Reintegration Unit brought about a $861,000 reduction in direct hospital costs in the first year, with 102 (3.5%) of the hospital's waiting-for-ALC patients transferred. When modelling optimized scenarios – increased transfers and all transfers happening on the day of ALC readiness – the authors identified the potential to avoid direct costs in the range of $2.3–$5.4 million and increase hospital capacity by 11%.

Policy Development Considerations

In one of the first publications examining pediatric hospital

policies and cannabis, Whelan et al. (2022) describe the proactive, prudent approach that the Children's Hospital of Eastern Ontario (CHEO) took in formulating two positions: one on cannabis for medical purposes in children and youth and the second on all illicit substances, including cannabis, for people under 18 years. Long before legalization, CHEO turned its head to the many-faceted (and sometimes frayed) issues connected to the use of medical and non-prescribed cannabis. A working group produced a literature view, evidence synthesis, iterative versions and recommendations before landing on final versions, approved with attendant policies and released on October 16, 2018, the day before the *Cannabis Act* (2018) became law. CHEO supports the individualized integration of medical cannabis for circumstances where the benefits appear to outweigh the risks and does not support the liberalized use of either prescribed or non-prescribed cannabis, given the negative effects on cognitive function and various adverse outcomes for youth under the age of 25.

Digital Consent and Privacy

Digital health innovations keep coming while evolving privacy policies lag and digital literacy levels remain low. Canadians are ill-equipped to provide informed consent to digital health service providers, assess privacy risks or detect inappropriate use of personal data. Shen et al. (2022) capture this consensus, systematically summarizing input from participants attending a series of pan-Canadian consent management workshops. Improving risk communication and enabling meaningful informed consent emerged as key imperatives. Recommendations for improvement included active engagement of patients, caregivers and the public; measures to promote transparency; public education to improve digital health; standards that align with care practices; and leadership and resources to drive this priority.

Quality Improvement

Tosoni et al. (2022) have produced a clearly written article with candid content enunciating what physicians said they need to make them more effective at stoking innovation in quality and keeping it burning. This article is based on interviews with 13 physician quality and safety (Q&S) leads at an academic hospital. Little information exists on the precise support needed to effectively execute this role, and the physician input is revealing. Formal physician Q&S leads were a minority (i.e., 15/40 departments or divisions), and among the leads in place, very few reported formal supports including funding or staff. The leads provided detailed suggestions on how their support could be improved: reward their work academically, hire skilled collaborators, provide the power and authority to advance initiatives and facilitate connections to break silos. The leads identified a strong potential source of support: decisive action by senior executives to address root causes of Q&S issues identified through the leads' work.

Preventing Workplace Violence

Corovic et al. (2022) share evaluation results for a program first described in *Healthcare Quarterly* (Corovic et al. 2021): the Hamilton Health Sciences (HHS) Behaviour Safety Risk (BSR) Communication and Care Planning program. Implemented at five HHS hospital sites, the program identifies, manages and cares for patients at risk of exhibiting unsafe behaviours.

The evaluation noted several limitations and showed mixed results. Over one-third of staff believed that the program directly resulted in an increased confidence in identifying (39%) and managing (30%) patient behaviour risk. Almost 65% of the patients and families interviewed said that the program had not been explained to them; 83% of those who completed the interview were not given a program patient and family brochure; and 71% were not wearing a BSR wristband to identify their risk level. The evaluations included staff surveys, focus groups and open forums, screening audits, patient interviews and assessment of effectiveness measures.

Partnering with Patients

The in-depth article by Scane et al. (2022) offers evidence and examples of the meaningful participation of patients and the primacy of patient-centred care at the University Health Network (UHN). The authors, including Patient Partners and leaders from several of the six units comprising the Patient Engagement portfolio, chart how that happened and to what end. Enablers include dedicated resources and public accountability, deliberate and organic growth, leadership from the top, strong commitment across workplaces and departments and built-in contributions from the 144 well-oriented UHN Patient Partners. Patient Partners are engaged in key areas and activities, sitting on senior governance bodies and human resources' hirings, collaborating on quality improvement initiatives, co-designing communication products and guiding health information system implementation.

Scane and her colleagues point to the Patient Declaration of Values as a key example of shared decision making. Developed through collaborative change management and released in 2019, the declaration is a foundational document that guides the delivery of patient care and sets patient experience expectations. It is UHN's public commitment to the value of meaningful patient collaboration and partnership, both in individual care and organizational decision making, and serves as an accountability framework to patients and families.

Quarterly Columns

An assessment of a research method's value in better quantifying homelessness in Ontario by Booth et al. (2022) speaks to data deficiencies and methodological weaknesses that impede an accurate capture of the number of homeless individuals, hobbling the targeted support they need. The Canadian Institute for Health Information's reporting of the COVID-19 pandemic's early impact on priority procedure waitlists (Reason et al. 2022) reflects the health system's overall resiliency and its variable vulnerabilities to the impacts of the pandemic, disadvantaging different groups at different times. Sharing reliable health service data during the pandemic can help shape health system responses.

– *The Editors*

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