"It is now time to set goals for better quality." So say Adalsteinn Brown and Terrence Sullivan in their short, impassioned opinion piece included in this issue of *Healthcare Quarterly*. Notwithstanding the laborious complexity of achieving an A-player healthcare system for Canada, the seven essays gathered here offer several insights and avenues necessary for such transformation.

Health Human Resources

If you do a quick search for "engagement" on the Longwoods site, you will find links to articles relating to all sorts of stakeholders – especially employees – in the healthcare sphere. In this issue, Graham Lowe extends this discussion by analyzing a huge sample: 10,000 staff members in 16 Ontario hospitals. The main premise of Lowe's article is that "high-performing organizations have healthy and engaged employees." Consequently, employee engagement is a "strategic goal" that can and should be measured.

Lowe's list of the top-10 work environment drivers of engagement make intuitive sense for anyone who has ever loved, loathed or been indifferent to their jobs. If healthcare (not just hospital) managers act on these and other of Lowe's careful findings, I am confident – even acknowledging Lowe's caveat to be wary of attributing causation – his key outcomes – retention, service quality, patient-centred care and safety – will improve.

Citizen Engagement

Lowe's "profile of the engaged employee" prefigures Lynn Nagle and Barbara Pitts' report on the outcomes of the Citizens' Reference Panel (CRP). This corporate-sponsored initiative in Ontario sought "to engage Ontarians in a dialogue about the future of healthcare," with a view to influencing government and organizational decision-makers as well as healthcare providers. A diverse group representative of Ontario's population, the CRP heard from experts, debated the issues and formulated actionable recommendations, which Nagle and Pitts distill into three "primary concerns": integrating providers and institutions, accelerating e-health solutions and improving access to care. As the authors note, these recommendations synch well with the provincial health ministry's policy directions, thus also highlighting the power of citizen engagement in policy validation.

Primary Care

When the CRP recommended improving access to care, primary care was one of the two main areas of emphasis (the other being community care; on which, see Collister et al. below). In British Columbia, the Enhancing Practice to Improve Care (EPIC) project sought ways to improve primary for people with chronic kidney disease (CKD). EPIC's principal investigator, David Attwell, and his co-authors present lessons learned from this project, with a focus on narrowing the gaps between patient care and outcomes. Drawing on over 2,000 case report forms and more than 500 patient surveys, Attwell et al. found that practice redesign is essential. While the methods might take time and be complex, the basic lesson is that "providers should practise *proactive* patient-centred care not *reactive* medicine."

Performance Measurement

In accord with Brown and Sullivan's call for better measurement, Pierre Emmanuel Paradis and his co-authors scrutinize the economic impact arising from the decision by most Canadian jurisdictions to not list varenicline – a smoking-cessation treatment – on their formularies. Taking a "societal perspective," Paradis et al.'s cost—benefit projection showed that, had reimbursement commenced when varenicline was approved in 2007, there would have been "significant net economic benefits, mainly due to increased productivity, reduced absenteeism and lower healthcare costs." The point here is less about this one drug and more about the need for policy-makers to think broadly – at the system and economy levels – when considering whether or not to list new medications.

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Chronic Disease Management

Most of us are accustomed to thinking of "e" with regard to diagnostics and data-sharing. But what about e-learning? That's the angle James Pringle and Neil Seeman take in their advocacy of an online graduate institute for chronic disease management and prevention. The authors make a strong business case for their proposal. They also analyze the limited effectiveness of recent efforts at including inter-professional education in university health-sciences programs. Ultimately, they argue, only a separate, fully online graduate institute not attached to any existing universities is the best solution. If I could choose just one question to pursue further with Pringle and Seeman, I would want to know much more about how *quality* would be ensured within their institute's curricula as well as its teaching and evaluation practices.

Quality Improvement

With our next paper, quality in fact takes centre stage – albeit, in a more traditional, care-delivery sense. John Puxty and his co-authors address the Bridges to Care initiative, a three-month pilot project involving six long-term care (LTC) facilities. As the authors note, quality is a major worry in the LTC sector. Thus, their project sought to understand the effectiveness of a quality improvement (QI) model for knowledge-to-practice

resource delivery on four measures: collaborative practice, staff satisfaction, knowledge translation and resident outcomes. Puxty et al. report that, not only did all the LTC homes report "improvements in sustainable collaborative resident-centred care processes," but these improvements led to better care outcomes. The authors' observation that strong staff engagement was critical to these successes resonates with Graham Lowe's earlier related claims.

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Care in the Community

These days, there is a great deal of talk, and even some policy shifting, around the migration of care into the community. With these changes, however, come some major budgetary challenges. Barbara Collister and her co-authors argue that, in order to succeed, it is "essential to address the critical role that front-line case managers have in resource allocation decisions." Looking at the Calgary Zone of Alberta Health Services, Collister et al. discuss the development and testing of service guidelines (SGs) that factor in client groups, service categories and spending limits. The end result: the use of the SGs "promotes consistent practice and decreases variation in resource allocation decisions." Those seem to me outcomes to which we might well aspire – not just in home care but *all* care.

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