In 1997, Anton Hart, Peggy Leatt and Dianne Foster Kent launched Longwoods Publishing's flagship journal, *Healthcare Quarterly*, with the vision of being a trusted knowledge centre where ideas, inventions and practices could be introduced, debated, translated and shared for the benefit of better care and service delivery. Healthcare in Canada and around the world has changed remarkably over the last 20 years. Through it all, the *Healthcare Quarterly* team has strived to continue the journal's mission to publish best practices, policies and innovations.

Quality Improvement

In addition to being filled with great reads on a variety of urgent topics, our twentieth-anniversary issue inaugurates a new feature on quality improvement initiatives. Our aim is to publish examples of programs and projects in which groups or organizations have created initiatives to improve the delivery of health services. In particular, we are eager to showcase front-line initiatives that have demonstrated quality improvement. Please take a look at our call for abstracts (p. 28) and consider joining the discussion.

Christina Krause sets the ball rolling with her succinct overview of the quality improvement terrain. She sheds light on the relative merits and challenges of "intrinsic" and "extrinsic" motivators, as well as touches on a few examples — such as British Columbia's steps to improve sepsis care — that speak to the following four case studies' demonstrations of "evidence-based change management" in the complex world of patient transfer and discharge.

Every hip-fracture patient requires rehabilitation. Receiving such care soon after surgery is vital to their outcomes. Charissa Levy and her co-authors examine the efforts of Toronto-area hospitals to achieve Ontario's six-day post-op window for starting inpatient rehabilitation. The early referral they address was founded on 10 partnerships between acute care and rehabilitation/complex continuing care hospitals. Levy et al. present interim results for six of those partnerships and lessons for other change initiatives.

Vincent Vuong et al. next look at patients moving from acute to long-term care (LTC). Specifically, the authors seek to understand how, in such cases, medication errors arise and might be prevented. Their charting of a new approach to the Medication Reconciliation (MedRec) process presents a good example of the major role Krause's "intrinsic motivators" can play. Certainly, there were crucial logistical details involved in bringing about improvements, such as greater patient safety and "real and potential cost savings," but the authors likewise note the importance of interprofessional listening/communication and pharmacist engagement with patients.

Our next case study looks at patient transfers that go in the other direction – from LTC to hospital. In their contribution, Jill Oliver and Paula Chadwick discuss a solution to the all-too-frequent problem of LTC residents being transferred against their desires (e.g., as expressed in a Power of Attorney document) to hospital for treatment. The "Individualized Summary" tool trialled by their project replaces the standard Level of Care form, more carefully recording – and endeavouring to honour – a resident's own "wishes, values and beliefs."

The final – often happiest – transition dealt with in this section addresses the departure from hospital back into the community. Unfortunately, however, at that critical moment the records for a high percentage of patients are not transferred to their primary care providers in a timely fashion, and an even more dismal percentage do not have a follow-up appointment within seven days. These problems can too often lead to hospital readmission. Documenting improvement efforts at the St. Thomas Elgin General Hospital in Ontario, Emily Sheridan et al. share insights into how one institution's attempt to tackle "inadequate, inefficient and ineffective" care transitions met with success, including much higher rates of records transfer, follow-up appointments and patient satisfaction.

Engaging Patients and Their Families

A thematic thread running throughout all the quality improvement articles is the quest to ensure patients' needs and desires are central to decisions affecting their care. One might argue that such engagement is both in itself a form of quality improvement and a spur to improve care quality. Terence Montague et al.'s discussion of the findings of the 2013–2014 and 2016 Health Care in Canada surveys regarding "patient centricity" in healthcare provides further illumination. By and large, these and other results are intuitive. For example, most crucial for both groups was "readily and timely accessed" care. A little surprising was the high level of overlapping support between the public and healthcare professionals, but this result certainly adds fuel to the engine as patient-centred care steams ahead.

Patricia Sullivan-Taylor and her co-authors engage with another facet of patient-centred care: "patient relations" measuring and reporting. They explain in detail Health Quality Ontario (HQO)'s plans and efforts – driven by provincial government legislation – to catch up with jurisdictions such as British Columbia and Scotland by creating patient relations indicators. As a result, a voluntary patient relations measurement and reporting pilot was launched in 2016 with 29 organizations. Results of this initiative will give HQO the data it needs to make recommendations to Ontario's health ministry.

Does patient-centred care entail installing a new model of care? Lisa Shiozaki and her co-authors would respond in the affirmative. As they point out, one of the main stumbling blocks to transforming aspirations into actions is a "lack of alignment" among team members, as each person "orbits around the patient on their discipline-specific trajectory." Taking us through a large community hospital's efforts to solve this familiar conundrum, Shiozaki et al. document the five main tactics involved in effecting "an organizational cultural transformation" predicated on collaboration, communication and interdisciplinary respect.

We end this section with an essay that draws together quality improvement and patient engagement. Exploring efforts at the Children's Hospital of Eastern Ontario (CHEO), Mireille Brosseau et al. point out that efforts in each area are often conducted in isolation from one another. Indeed, this was the case at CHEO, where evidence-based co-design was implemented on the patient engagement side and Lean principles on the quality improvement flank. How to integrate both approaches became the challenge, and Brosseau et al. report on the methods and outcomes of the hospital's approach to "bridging the divide."

Improving Equity

Brosseau et al. mention, in passing, the way families are sometimes "overwhelmed with the influx of information received during the days following an oncology diagnosis." Extending this concern to just about any disease, what happens when a patient or family member has limited English proficiency (LEP), rendering them, in Nirbhai Singh Pannu et al.'s words, the "most vulnerable" patients in Canada's health system? The specific subject Pannu and his co-authors tackle in this regard is hospital inpatient length of stay (LOS). Surprisingly, and contrary to other studies, research the team conducted at a large hospital in a culturally diverse part of Ontario found that "patients with LEP had a shorter LOS compared to the sample population of EP [English-proficient] patients by 0.36 days (8.6 hours)." The authors ruminate on causes for this finding, and they outline a number of "structural limitations" their study faced. Despite the latter, their thoughts on implications for hospital budgets and staffing, among other topics, are worth serious consideration.

Operational Reviews

By and large, this twentieth-anniversary issue of *Healthcare Quarterly* has steered clear of financial concerns. Yet, we all know that budgets are nearly as close to the top of system administrators' minds as patient well-being. And so, we close with Anne Trafford and Danielle Jane's scrutiny of operational reviews "to identify, implement and sustain efficiencies and cost savings" at Toronto's St. Michael's Hospital. In-year savings of $7.4 million resulted from "key projects," such as supply standardization and inventory management, improved utilization of the operating room through process redesign and creation of a Rapid Referral Clinic. Trafford and Jane offer five lessons for others contemplating similar journeys. In the context of this issue of our journal, however, one needs to be mentioned in closing: the vital importance of strategically aligning cost savings with quality.

– The Editors