Discerning a major theme in any issue of *Healthcare Quarterly* is challenging. Healthcare is, after all, such a diverse field, and we try our level best to represent that variety. The ICES Report in this issue on recent efforts to share data with Indigenous partners, however, strikes us as an example of the critical importance of collaboration within healthcare – a theme that's also addressed in a good many of the following articles.

Engaging Stakeholders

The mantra of patient- and family-centred care is steeped in an ethic of collaboration. Addressing Saskatchewan's recent lifting of restrictive visiting hours in its acute care hospitals, Malori Keller and her co-authors highlight the efforts of various stakeholders to develop – and then implement – the Open Family Presence Policy. Patients and families, provincial health system leaders and regional staff leads all had essential, collaborative roles to play in this shift.

Another instance of collaboration is documented by Sean Molloy et al. who describe a Symptom Management Summit for people with cancer. Patients and family members gathered with clinicians, administrators and health system leaders to undertake a co-design approach to improving symptom management. Besides research and patient data, a key driver of success was the "engagement of multiple stakeholders from across regions" – especially patient and family advisors.

Organizational Culture

In Ontario, most Francophones who live in a minority situation prefer to receive French-language health services (FLHS), yet are unable to do so. While an "active offer" of FLHS has been proposed as a solution, what are the means of realizing that goal? Elina Farmanova, Louise Bouchard and Luc Bonneville recommend a multi-faceted strategy that regards this active offer as part of organizational health literacy. Among the steps they outline are recruitment, creative scheduling and inclusion of Francophones in leadership and decision-making bodies. When one considers the connections between FLHS provision and a potential increase in patient safety, the system-wide "cultural change" required seems all the more justified.

Nearly everyone has felt shame at some time or other. But that emotion can be particularly stinging for healthcare providers who have made mistakes. Taking a "grounded theory" approach, Diane Aubin and Sharla King examined the "overwhelming and complex" psychology of such self-eroding traumatic shame (and its evil twin, silence). They propose replacing the oft-touted "just culture of safety" with a more resilient "empathetic culture of safety."

Another emotion many of us have experienced is disgruntlement with our co-workers – maybe they don't understand how complex our jobs are, or perhaps we see their work as less valuable. Melinda Piechnik and Linda Dempster studied the role job shadowing could play in ameliorating workplace discord. Their Walk in My Shoes project enabled registered nurses to shadow social workers at an acute care hospital. Surveys and interviews revealed significantly improved perceptions, and the authors advocate job shadowing – a tactic explored also by Farmanova et al. – as a way to improve multidisciplinary teamwork as well as improve staff morale and organizational culture.

The Cost of Care

There has been lots of discussion lately about bundled care, a funding approach that covers treatment costs across providers and institutions. Trillium Health Partners recently piloted bundled care for 90% of its cardiac patients. Core ingredients were clinical pathways, development of a Gain/Risk Sharing Model to foster improvement, an interdisciplinary cross-organizational team, a 24/7 telephone service and seamless electronic medical records. Patti Cochrane and Michelle DiEmanuele's summary of the quality, access, efficiency and patient-experience gains make for upbeat reading.

Little is known about the costs per patient for specific medical conditions in ambulatory care settings. Seeking clarity, Sanchita Gulati et al. share a case study involving "time-driven activity-based costing" (TDABC) in a pediatric outpatient eye clinic. Aimed at measuring "value," application of this model (a fundamental component of which was having a detailed process map) enabled the authors to identify opportunities to optimize resources and resource capacity. Additionally, TDABC generated quantitative data useful for evaluating process improvements and forecasting demand.

Ensuring Safer Care

Collaboration again looms large in our next piece: Irene Andress and her co-authors' evaluation of Michael Garron Hospital's Coordinated Care Team (CCT) model involving nurses, interprofessional practitioners (e.g., social workers) and unlicensed care providers in medicine, surgery, mental health and complex continuing care. Acknowledging criticism that the CCT model entails workforce "de-skilling," Andress et al. counter that it "enables nurses to work to their full scope of practice while better matching staff to patient need." The result, they say, is "a culture of high-quality and safe patient care" that is also "financially viable."

Antimicrobial resistance is truly frightening. Like many others, including Health Canada, Anna Lee and her co-authors therefore recommend antimicrobial stewardship programs (ASPs). But in hospitals, these programs require a resource that is all too scarce: staff time of infectious disease physicians, infection control practitioners and clinical pharmacists. Enter, therefore, prospective audit and feedback (PAF) rounds supported by automated, "user-friendly" surveillance software. Testing of such an ASP on a general internal medicine unit of an acute care hospital led to significantly less antibiotic use as well as cost savings.

Quality Improvement

E-tech and collaboration unite in our final article: José Pereira et al. report on a quality improvement project in Ottawa to improve referral and triage to palliative care units and hospices. Critical to the success of this project was establishing a Central Referral and Triage Office and leveraging available software technology. The team also created one standardized online referral form (replacing previous paper-based forms unique to each site). Results point to reduced referral and triage rates, while patients "are better assigned to the service that best meets their needs." The project also generated lessons that could easily be spread to other services, including the importance of close collaboration among partners, education and training, IT support and project management.

– The Editors