Legions of people with multiple roles are charged with bringing accessible, high-quality healthcare to Canadians every day. To fulfill this shared responsibility, all participants must contribute. Their success is tied to each other's, and the quality and sustainability of the system depend on their collective performance. The contingencies are diverse and daunting. High-performing health systems yield better care, lower costs, improved outcomes and better patient and provider experience (Bodenheimer and Sinsky 2014). They have no weak links.

They need it all: the right supply, mix and distribution of health professionals with the right education, training and mindset; the skills and support to build effective teams and visionary leaders who co-create compassionate cultures and inclusive partnerships that foster integrated patient-centred care; and the right resources, processes and tools to deliver solutions for current and future demands.

In this issue of *Healthcare Quarterly*, readers learn about efforts to address those prerequisites. It opens, appropriately enough, with a focus on effective primary care and an array of initiatives in Alberta, British Columbia and Ontario.

Effective Primary Care

Cunningham et al. (2020) examined patient–physician continuity of care and health service use in Alberta, specifically emergency department (ED) visits and in-patient hospitalizations among chronic disease patients without a family physician – a difficult-to-identify cohort given no provincial patient registry. Their study produced a continuity index and used regression modelling to yield results consistent with those of similar provincial studies: ED visits and unplanned hospitalization declined with increased continuity of care. The study showed that individuals without a regular primary care provider are typically healthy males younger than 55 using limited or no health services. The authors note that their data can target patient populations more precisely to serve those with the greatest need first.

Continuing with continuity of care – this time acute to primary care continuity for vulnerable patients with complex high needs transitioning from hospital to home – Lait and colleagues (2020) describe a unique new role in Alberta: a hospital-based primary care navigation nurse (PCNN). Funded by the Mosaic Primary Care Network and co-developed by the Peter Lougheed Centre, the position is deemed a bold innovation and a first for Alberta. The PCNN helps in-patients return to the community with the care and assistance they need, linking or reconnecting them to family physicians and arranging suitable supports. The early and ongoing emphasis on clear communication with hospital staff and the primary care network established trust, transparency and respectful relationships – foundations for the PCNN's successful introduction.

The primacy of communication in healthcare – and its problems, including poor coordination during outpatient referrals and little, if any, exchanges between primary and specialty care – have been well documented. But according to Wong and colleagues (2020), that literature is based largely on providers' perspectives, not patient and caregiver views. Their study, based on focus groups with a small sample of Albertans recently referred to specialists, starts to fill that gap. Tracking patient–doctor and doctor-to-doctor communication involving referrals, the study shares the reported impact on patient care: inadequate communication across the board and incomplete information hindering continuity of care, causing inappropriate referrals, delaying timely diagnosis and follow-up and leading to negative health consequences. It describes the communication patients and caregivers want: timely information about the status of referrals and a single point of contact for starters.

Although team-based care requires a mix of people working together, Price et al. (2020) astutely observe that "bringing providers together into a group practice does not make them a team." Enter team mapping. Developed in 2018 at the UBC Primary Care Innovation Support Unit, the method features short interventions using patient personas and paper prototyping circles of care. Twelve sessions have been held with groups of individuals visualizing and preparing for work within a primary care team. The program has gone to multiple communities and settings, facilitated teams at all stages and reached 188 participants, reporting 92% satisfaction. Although team mapping remains relatively new in British Columbia, the authors say signs suggest that it is a feasible and scalable tool to support team-based primary care.

The creation of 24 Ontario Health Teams reflects the drive to push beyond team-based care to create regional cross-sector systems of integrated care. In their article on the Rural Hastings Health Link, Linton et al. (2020) describe the evolution of an earlier model, led by primary care. The RH Health Link was created in 2013 by Gateway Community Health Centre working with local primary care teams and broader health and social sector partners.

The model is distinguished by four features: a structure supporting integrated system thinking with partners, system navigators embedded in primary care to address medical and social needs, a digital care-coordination tool and data management that promotes accountability. The results since 2014–2015 include an 85% decrease in clients' hospital utilization, a 90% decline in ED visits, an 80% reduction in inpatient stays and a 74% decrease in length of stay. This represents a cost saving of $7,384,797 (October 2013 to the end of 2018) – a 369% return on investment.

Workforce Planning

Headlines decrying the loss and lack of doctors are commonplace in small communities still offering local newspapers.

A study by Macneill et al. (2020) examines one such region – the Nova Scotia Health Authority's Eastern Zone – to assess its doctor shortages and recruitment and retention efforts. Among the barriers are a "one in one out" rule that prevents recruiters (if they exist) from searching until a physician retires, limitations on international medical graduates, random onboarding practices and poorly defined roles. Effective strategies include word of mouth, community involvement and collaborative practices.

Health Human Resources

Nelson et al. (2020) look at a dialogue-based model that develops leadership skills in post-graduate trainees who engage with established faculty members on priority policy and research issues of the day.

Quality Improvement

Cotton et al. (2020) describe how Southlake's Stronach Regional Cancer Centre used a new diagnostic assessment program developed by Cancer Care Ontario – and a carefully chosen Lean improvement event – to boost poor performance on wait times for lung cancer diagnosis. The centre reduced wait times (from consultation to diagnosis) for lung cancer patients by 60%, surpassing provincial targets; met increased service demand; and boosted patient experience.

Effective Teamwork

Strauss et al. (2020) share how creative thinking and trusted relationships, along with hard work, detailed planning and careful execution, can find new solutions for old problems. Faced with closing its only catheterization laboratory (cath lab) to replace equipment, Toronto's Michael Garron Hospital (MGH) pioneered a collaborative project that ensured no service disruption. The MGH leased a cath lab and patient recovery bay from Sunnybrook Health Sciences Centre, creating a separate entity staffed by MGH nurses and physicians and electronically connected to the home hospital. Despite complex arrangements across domains, the 12-week relocation was successful: the demand for safe, accessible service was met with minimal and manageable challenges.

Digital Health

The closing article by Huebner et al. (2020) presents a thoughtful new framework from the eHealth Centre of Excellence in Waterloo, Ontario, to meet ambitious objectives: assess and support a wholly redesigned digital health vendor procurement process, securing long-term partnerships and ongoing stakeholder engagement to generate better solutions targeted to meaningful outcomes.

CIHI's column on indicator results (substance use harm and hospital stays, ED visits related to mental health and/or addictions and extended hospital stays pending homecare) from the first tranche of shared health priorities reflects another system imperative: the need for evaluation and accountability measures to ensure maximum use of finite public funds (Paltser et al. 2020). ICES's article on the start of an innovative trial tapping big data to prevent heart disease and elevate cholesterol management is a reminder of how healthcare's future can be shaped by the intelligent use of tools and resources (Ferreira-Legere et al. 2020).

– The Editors

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