Lazar et al. (2013) examined the pace, scope and significance of Canadian health policy reforms over several decades and found a prevailing problem, which became the title of the book *Paradigm Freeze*. Some experts argue that the tendency to "move slow and not break anything" means little action unless a crisis hits. Will the COVID-19 pandemic be that crisis? Will it kickstart substantive health system change in Canada, or are the deficiencies, clearly displayed during the pandemic, too daunting? Can the healthcare community leverage recovery efforts to strengthen what works in the system, rebuild what is broken, introduce what is missing and integrate what has been fragmented?

This issue of *Healthcare Quarterly* does not underplay the obstacles that the pandemic and years of system status quo have cast in the way of health in all its forms. But as Snowdon et al. (2021a) point out, Canada has the "strategic assets" it needs to mobilize to protect all residents against COVID-19. Evidence from other authors shows stakeholders reframing relationships and roles to improve patient-centred and palliative care, expanding options to better manage chronic health conditions and using provider input for more targeted support and safer care for them and their patients.

Responding to the COVID-19 Pandemic

The first two articles focus on the discrete policy interventions to respond to COVID-19 that the authors deemed flawed or failed. Fancott et al. (2021), from the newly minted Healthcare Excellence Canada, assert that the restricted visitor access policies variously introduced across Canadian care facilities during COVID-19 failed to foresee and forestall the harmful consequences of that decision. The balanced, forward-looking article explains the perils of imposing highly restrictive blanket rules on family presence policies, particularly with the pandemic's burdening demands. The authors use these changes instituted during COVID-19 as a teachable moment (and as an opportunity to describe a program to safely reintegrate family/care partners into health settings), emphasizing the importance of distinguishing between visitors and essential family/care partners and their proven contribution to the quality and safety of care. They question the rationale for the restrictions, noting that poor adherence to infection control – not family presence in care – is the key source of spread of infectious diseases.

PhD students Just and Variath (2021) point to the results of their comparative analysis when reporting that the provinces with the heaviest loss of life failed to use their executive powers fast enough to protect long-term care (LTC) residents during COVID's first wave. They looked at jurisdictions with the highest percentages of deaths among LTC residents testing positive for COVID-19 – Quebec: 44.4%; British Columbia: 34%; Ontario: 30.9%; Alberta: 25%; and Nova Scotia: 22%. They compared how and when these provinces declared emergencies and made use of masks mandatory, decreed expanded testing, restricted visiting, mandated a single work site for staff or called the military to LTC facilities.

Snowdon et al. (2021b) weigh in with fresh, informed insights on two elements fundamental to containing and overcoming COVID-19. A national vaccination strategy that is rapid, precise and scalable will guide the country to its goal of vaccinating every Canadian by September 2021. But collaborative, inclusive leadership and an integrated workforce, with primary care and pharmacy included, must accompany it. Snowdon et al. return to a second enabler, one requiring remediation: a reliable supply chain capable of moving and tracking vaccines to increase vaccinations.

The next two articles provide a change of scene, moving to the hospital setting. Flynn et al. (2021) describe the supports that front-line workers say they would take – or leave – to help them through the pandemic. Lucchese et al. (2021) talk about how a change in protocol is reducing restraint use and security over-reliance during emergency Code White calls and introducing different clinicians to improve patient care and protection against disease transmission.

> **... Canada has** the "strategic assets" it needs to mobilize to protect all residents against COVID-19.

Innovations in Care

High-performing health systems know the health status and needs of the populations they serve, the cost of doing so and the importance of continuously improving patient experience. Zywiel et al. (2021) describe how an intriguing model – Good Life with osteoArthritis in Denmark (GLA:D) – that is aligned with those aims has been adopted and adapted in Canada to support the prevention, early diagnosis and effective management of hip and knee osteoarthritis.

Howard et al. (2021) describe the challenging process of engaging groups for assessing, refining and adopting tools to help providers, patients and families have good, ongoing conversations about advance care planning (ACP) and difficult end-of-life issues. This work matters: Canada has a serious shortage of health providers who possess the aptitude, knowledge and tools to reach the millions of patients and family members who would benefit from ACP and its earlier introduction to their lives.

Empowering Patients

In their article on "This Is ME," Sequeira et al. (2021) detail the design, implementation and evaluation of an initiative enabled by technological changes but driven completely by a commitment to make and keep a patient's humanity top of mind and to improve therapeutic relationships between patients and providers. In 2018, Toronto's Centre for Addiction and Mental Health announced a change to its electronic health record, creating a new landing page that tells a patient's story – their own narrative that includes personal interests, hobbies, coping strategies and more – not just their clinical history. The article shares uptake results, patient and provider perspectives and recommendations for improvement.

Quarterly Columns

Columns from ICES and the Canadian Institute of Health Information (CIHI) add more heft to this issue's discussions on patient-centred and palliative care and underscore the value of current, high-quality population health information referenced in other articles. ICES authors Seow and Winemaker (2021) call for nothing short of a revolution in how palliative care is understood, referenced and provided – and by whom. The authors – who have taken the cause to the podcast airwaves – call on patients and families to partner with specialists and family physicians to elevate the priority given to palliative care, improve its access and speed up its introduction. CIHI authors McKenzie et al. (2021) share results from CIHI's first pan-Canadian report on children and youth with medical complexity, highlighting this group's small share (1%) of the pediatric population and its extensive use of hospital and emergency department care.

– The Editors

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