It would be a vast understatement to say that our healthcare systems are facing extraordinary pressure. The COVID-19 pandemic has pushed our people and our systems to their limits. We observe with trepidation that the current state of healthcare has not looked more precarious at any time in recent memory. Patients and families are feeling it. Providers, clinicians and leaders in the system are feeling it. And all of us recognize that it will take incredible political will and system-wide commitment to make the changes that are needed to renew and strengthen our front-line teams, structures and capacity. As editors for *Healthcare Quarterly* (*HQ*), we see the opportunity to contribute to the daunting task ahead by shining a light on leading practices and lessons learned from implementing change across Canada and beyond. Our commitment is to continue to showcase healthcare leadership in all forms and share opportunities for post-pandemic recovery and the future of healthcare.

In this edition of *HQ* we highlight key themes related to equity and the social determinants of health, improving access to care, engaging with patients and families and supporting research. In addition to our regular contributions from our colleagues at ICES and Canadian Institute for Health Information (CIHI), we are also pleased to introduce a new column from Neil Seeman (2022), who has chosen to focus his first contribution on the critical topic of home care and elder care.

Greening Healthcare

Our first article in this issue of *HQ* offers a practical tool for those looking to green the hospital sector. Sergeant et al. (2022) present a brilliant and potentially impactful framework for helping hospitals reduce greenhouse gas (GHG) emissions. The tool covers a very diverse range of interventions from how one's organization makes investments to constructing a low-carbon building, from deprescribing to installing bike stations. For each intervention, they set out the likely savings/costs and GHG emission benefits. The authors illustrate their findings graphically with a low-hanging peach tree figure (see p. 20). Decision makers who have been wrestling with the question of how they and their organization can make a meaningful contribution to reducing GHG emissions will find that this tool is just what they need to tackle the task.

Support for Underserved Communities

Health equity and support for underserved communities is becoming a stronger focus of *HQ* as we recognize that achieving population health for all means bridging systemic gaps. There can be no doubt that the existing health inequities have worsened as a result of the COVID-19 pandemic. Bhatti et al. (2022) discuss how members of the Alliance for Health Communities developed hyper-local strategies aimed at increasing the uptake of vaccines across diverse communities. They did this by establishing and building on trusted relationships, creatively and collaboratively adapting to the needs of the community and sustaining trust through investments, resources and support. They share specific examples of strategies for outreach that are broadly applicable for those engaged in health promotional activities.

Learnings from the Pandemic

Continuing with the theme of the pandemic, Tam et al. (2022) shared their evaluation of a common policy for visitor restrictions across six hospitals in the Toronto Region. Using a qualitative approach that included interviews with both developers and implementers of the policy, the researchers used the Accountability for Reasonableness framework to assess the fairness of the policy. Given that restrictive visitor policies have been applied in various healthcare settings across Canada during the pandemic resulting in significant hardship for many patients and their families, the evaluation findings provide valuable learnings for developing more nuanced policies in the future.

Improving Access to Care

Too many of us die in acute care. It is not where most of us want to be for our last days. And it is often not a good use of

our limited acute care hospital resources, particularly at a time when hospitals are facing pressures to minimize the number of alternate level of care patients and free up acute care beds. Bottoms and colleagues (2022) from a large teaching hospital share the results of a retrospective survey of patients that explores how patients access the hospital's palliative care unit. They identify several barriers that delay accessing palliative care and discuss strategies for mitigating these barriers. Their work will be of great interest to *HQ* readers concerned with the quality of end-of life care and to those tasked with improving the use of hospital resources.

Examples abound of opportunities to improve the transition from hospital care to post-discharge care. Salvador et al. (2022) describe their work on an innovative approach to early postnatal care at home, a critical transition for the well-being of newborns and mothers. Even before the pandemic, public health units were focusing most of their postnatal care resources on high-risk cases. And with the pandemic, it was further stretched. Salvador et al.'s (2022) team developed a program that integrates physician and midwifery models to provide early postnatal care at home for low-risk maternal–newborn dyads. Salvador et al. (2022) show how their model provides individuals and families with care in a preferred setting, achieves a much more seamless transition from care in the hospital and frees up valuable hospital resources.

Engaging with Patients and Families

Over the past several years, we have seen a shift in hospitals from thinking of caregivers and family members as "visitors" to a greater focus on "family presence," and this includes recognition that caregivers and families are essential to the healing process. The challenge inherent in many hospitals and other healthcare spaces is that they are not necessarily able to accommodate the presence of caregivers and families for extended periods. Shivgulam et al. (2022) conducted a qualitative study to better understand the connection between family presence and welcoming spaces, such as dedicated family zones. The results of their study promote a patient-and-family-centred approach and an enhanced experience of care.

Research at Point of Care

The last 40 years have seen a big expansion of hospital-based health research and the emergence of academic health science centres. But to date, community-based healthcare organizations have lacked the resources and in-house expertise to engage in their own research programs. McKay et al. (2022) describe the work of a homecare delivery organization to create an embedded research unit and nurture a culture of evidence-based transformation, working with partners from academia and acute care. The article offers a road map for other community-based care organizations interested in pursuing a similar strategy.

An article from Horsburgh et al. (2022) describes an initiative to create a clinical demonstration unit (CDU) for dementia care. The absence to date of effective pharmacological treatments for dementia underlines the case for building capacity to improve learning about how best to care for those with dementia, including how to effectively manage the profound behavioural symptoms associated with dementia. Horsburgh et al. (2022) outline how their hospital-based geriatric dementia unit staff partnered with a nearby university to create the CDU and launch numerous impressive research projects. This article will be of relevance to those looking to establish CDUs not just for dementia care but also for other areas of care.

Quarterly Columns

ICES report

Saunders et al. (2022) from ICES give us an eye-opening analysis of injuries caused by air guns and BB guns, particularly injuries to children and youth. Many of these injuries result in long-term needs and disabilities, and they add to healthcare costs. The authors highlight the case for further regulation and greater public awareness.

CIHI survey

Husak et al. (2022) from CIHI explore the rapid increase in physicians using virtual care modalities since the onset of the pandemic – modalities including telephone, videoconferencing and online messaging. The authors analyze physician billing data in five Canadian provinces and review a related survey of seniors in Canada and 10 peer countries led by the Commonwealth Fund. The CIHI analyses show that the uptake of virtual delivery modalities for physician care did not vary as much as might have been expected across age groups, income groups and rural–urban settings. Interestingly, the Commonwealth Fund Survey found that Canadian seniors were much more likely to report having virtual appointments than seniors in the other countries that were surveyed: 71% versus an average of 39% for the 11 countries surveyed as a whole. While these findings may confirm our general perception of what occurred during the pandemic, readers might also revisit an insightful article "Virtual Care Following the Pandemic" from Powis et al. (2022) in the previous issue of *HQ*, in which the authors take us behind the numbers.

Quarterly reflections from Neil Seeman

This edition of *HQ* wraps up with a new addition to our journal as we welcome Neil Seeman as a regular columnist. Neil is a senior fellow at the University of Toronto's Institute of Healthcare Policy, Management and Evaluation and at the Fields Institute and Massey College. Neil is also known for his work as founder of RIWI, a data solutions company, and has

written extensively about healthcare. For his first *HQ* column, he has chosen to tackle the topic of home care as it relates to the crisis in elder care (Seeman 2022). He explores the challenges of the current system from the perspective of different stakeholders and discusses what should be included in a five-year integrated plan that would address the changes that are critically needed.

We hope you enjoy this edition of *HQ*. As always, we invite feedback, comments and ideas from our readers through the Longwoods site or social media. HQ

– Anne Wojtak and Neil Stuart

About the Editors

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