Emergency Preparedness Planner

A Newsletter for the Health System

Emergency Management Branch, Ministry of Health and Long-Term Care Summer 2011

A Busy Summer

This has been quite a summer for emergencies! It was the busiest forest fire season in Ontario in years, with more than 3,000 people evacuated from First Nation communities. Severe weather patterns brought us everything from intense heat to lightning storms to the F3 tornado in Goderich. There was a major *E. coli* outbreak in Europe, not to mention an earthquake felt across the eastern seaboard.

One of the minor casualties of all this was our publication schedule! Juggling the demands of various emergencies with our routine work is a challenge for all of us in the emergency preparedness world, so we hope you'll forgive our planned summer issue coming out with the new school year.

We're looking forward to a number of articles from our colleagues in the field over the next few issues about how they responded to this summer of emergencies, but in this issue, we'll be focussing on the role we played here at the Emergency Management Branch (EMB). We'll also be featuring some of our planned articles on important topics like planning networks and emergency preparedness for Long-Term Care Homes. And, as always, we'll be bringing you updates on exercises and other exciting activities in the health sector.

In this issue we're also introducing a new section. Fondly known as the 'So What?' Supplement, this section will look back at some of the stories we've featured in earlier issues and see what initiatives or

Ontario

longer-term changes came out of the lessons learned. In our inaugural 'So What?' Supplement, we're looking at discharge planning for the G20 and the lessons that were carried forward into the Toronto Central LHIN's Alternate Level of Care planning.

We hope you've made it through this eventful season without too many late nights, and that you'll enjoy our summer-into-autumn update!

~ Gerilynne Carroll, Director, Emergency Management Branch

Extreme Makeover: Long-Term Care Home Edition

Copernicus Lodge is a large seniors' complex serving mostly Toronto's Polish community. With 228 long-term care beds, special care units for Alzheimers and complex care, 200 self-care retirement apartments, supportive housing and various other programs, Copernicus Lodge's emergency planning has to be flexible and responsive to a variety of scenarios.

This past April they had the opportunity to put their plans to the test. During routine maintenance, a small damp spot was noticed on the ceiling of the 5th floor of the long-term care building. It proved to be a drip from the sprinkler system line. A certified company was called in to repair it and replace the part. Two days later, after several issues, the site of the repair failed significantly.

The time of day made the failure a perfect storm. It was dinner hour, and almost everyone was in the dining hall, so the problem wasn't spotted right away. The longer the sprinkler system leaked, the more the system registered low water pressure, and pumped more water to the problem area. At dinner time, there are limited maintenance staff on site, and they were working in the retirement part of the complex that day. By the time they reached the long-term care building, the system's alarm had been triggered, so the elevators weren't available to transport them up to the 5th floor, adding further delays to the response. When they finally got the water turned off, not only were the hallway and some residents' rooms on the 5th floor ankle deep in water, but water had already flooded the hallways and resident rooms on all of the floors below - the worst being the 1st floor where the water stopped and pooled.

Luckily the Copernicus Lodge emergency plan was in place, including an emergency measures committee, a fan-out protocol to reach management staff, pre-identified temporary evacuation sites with supplies and equipment already in place, and an agreement with an outside company who came in with machines to collect the water and begin drying things out.
Bed-ridden residents were moved into a dry common room while clean-up took place. There were no injuries and,

miraculously, there was no damage to residents' personal belongings or property – partly due to infection control policies that discourage leaving belongings on the floor. By 9:00 pm everyone was back in their rooms.

But this wasn't the end of the Copernicus dilemma. Despite the fans and dehumidifiers that were part of the response, water had collected in the walls, particularly on the first floor, where the water had pooled.

A company was called in to make sure that the electrical system was safe and the nurse call system was still working efficiently, but the home was concerned about the potential for issues like mold and implications for residents' health. Working with the insurance company, environmental testing had to take place, and contingency planning was put in place to evacuate immediately if the readings were poor. The home's emergency planners began to work with the local hospitals, the CCAC, City of Toronto divisions, the MOHLTC, and other partners to start lining up alternatives if an evacuation on this scale was needed.

Happily, the environmental readings came back fine, and the decision was made to tackle the repairs floor by floor. But it was clear that major renovations would require a longer-term plan. While the home's emergency plan identified short-term evacuation locations for residents, these are designated and equipped for no more than a three-day stay!

St. Joseph's Health Centre, next door to Copernicus, indicated they could clean out an old Intensive Care Unit and accept a group of residents if needed -- a generous offer of partnership. But luckily two more immediate options were quickly found.

A local Polish-speaking retirement home, Wawel Villa, was able to take six of the more resilient residents for the full duration of any repairs but, as a retirement home, they weren't licensed for long-term care stays. Copernicus contacted EMB, and EMB helped to connect them with Performance Improvement and Compliance Branch, the part of the ministry that has the ability to grant temporary licenses. Their compliance inspectors from the Toronto Area Service Office worked quickly to get arrangements in place.

A Korean nursing home nearby - the Rose of Sharon – had just received its license, so did not yet have a waiting list, and they were able to take other residents. To address the specific needs of Copernicus's Polish-speaking residents, Copernicus committed to one Polish-speaking staff person on hand 24/7, available for translation and support.

With some residents in the temporary beds at the retirement home for the full duration, it was possible to simply relocate some of the very frail residents to other rooms at Copernicus. The remaining residents could stay at Rose of Sharon during the repairs to their floor, generally about five to six weeks.

In addition, as vacancies arose in the home during this time, Copernicus Lodge did not admit new residents, but used these spaces to transfer internally during the repairs, further diminishing disruptions.

While this has impacted wait times, it meant that as of late August, six residents were in Wawel Villa and only six residents needed the Rose of Sharon beds - compared to the 19 who went to Rose of Sharon at the beginning of the response. Once all the existing residents are back in their own rooms, the home will be able to take a large number of admissions off their wait list at once to fill these vacancies. Repairs have been completed to the 1st, 4th and 5th floors, and are underway on the 3rd floor.

The Planner spoke to Tracy Kamino, Chief Executive Officer of the long-term care home within Copernicus Lodge, about the experience.

“I’m incredibly proud of our team!” Kamino commented. “Our internal processes were challenged, but the planning and training we had done paid off. I was amazed and proud of how we had people safely back in their beds within four hours of the event. And of course our partners were outstanding. St. Joseph's Health Center, Rose of Sharon, and Wawel Villa deserve tremendous thanks, and there were plenty of others, like the MOHLTC compliance inspectors, and the Toronto Transit Commission (TTC), who continued to help with Wheeltrans transport not just during the first wave of the response, but each time another floor had to be relocated. And those are just a couple of examples.”

The Planner asked about other impacts of the flood.

“Of course there were cost implications for the home,” said Kamino. They ended up staffing three locations – as well as providing support at Rose of Sharon. The temporary licenses for the retirement villa were granted to Copernicus, so Copernicus had to staff and perform care for those residents. There was also the loss of revenue from those individuals who were transferred to the Rose of Sharon beds.

The paperwork involved had an impact as well. The residents going to Rose of Sharon had to be discharged from Copernicus, then admitted to Rose of Sharon, with full assessments done and care plans developed. Then on return they had to be discharged from Rose of Sharon and readmitted to Copernicus with new assessments and care plans.

“We recognize the importance of this, but it was challenging and HR-intensive, particularly given the number of extra staff already involved,” commented Kamino.

“It was also very stressful for the families of our residents to have to sign discharge papers. We’re the only Polish long-term care home in Ontario, and many residents and their families waited years to get in. The residents and families have been very understanding and cooperative with us, which we’ve really appreciated, but it created a lot of anxiety. People

needed reassurance that their family member would definitely be returning to Copernicus."

The Planner asked about the impact on the residents.

"They're doing really well," said Kamino, "and I really credit our team – both here and at the other sites - for making people feel comfortable and reassured. We even had some residents comment that it was like going on a holiday and then coming home again. If anything I think it's given them a deeper appreciation for the community here. We work to make Copernicus a home-like environment, so it was nice to hear our residents say, 'Now I'm back home!' on their return."

And what recommendations does Copernicus Lodge have coming out of this experience?

"Make sure you have good insurance!" said Kamino. "We review our insurance coverage every year." But even more than that, it validated the planning they had done. "It went very smoothly, all things considered. We didn't have a specific flood plan, but our fan out and other evacuation planning and processes were easily and successfully used."

Did you know?

For the first time in Ontario's history, seniors living in retirement homes across Ontario will be protected under provincial legislation. Introduced by Ontario's Minister Responsible for Seniors, the new Retirement Homes Act received legislative approval on June 2, 2010, and the first regulations were filed this past spring.

Among other requirements, the new Retirement Homes Act:

- created a regulatory authority with the power to license homes and conduct inspections, investigations and enforcement;
- established residents rights, and
- established mandatory care and safety standards.

These standards include requirements for an infection prevention and control program, and for an emergency plan that responds to emergencies in the home or in the community.

The first phase of regulations lays out the requirements for the infection control program and the emergency plan in more detail. These requirements address consultation with relevant community agencies, availability of supplies and equipment, and expectations regarding evaluation and updating of plans and conducting evacuation drills. For more information see the Ontario Seniors' Secretariat.

Public Health Planners Build a Network

May 13 of this year marked the first meeting of the Public Health Emergency Planners planning group now open to all of Ontario's public health units.

In 2004, Connie Verhaeghe of Hamilton Public Health Services and Andre Luc Beauregard of Peel Public Health began regular meetings to link the emergency preparedness planning in their respective units. This networking expanded over the years to include various public health units from the GTA area, and became a quarterly event.

The shared knowledge was a valuable resource. "More and more we found other health units getting in touch," commented Verhaeghe, "wanting to know how their colleagues in other areas were handling issues, or had implemented programs." And so the ambitious plan was formed: open the group to all health units, right across the province.

Connie Verhaeghe and Pat Simone, of the Middlesex London Health Unit (MLHU), played a key role in organizing the larger group meeting. "We were very pleased with the turnout," commented Verhaeghe, "We had more than 22 people participate. Health units may face different issues and have different resources in their own areas, but getting the range of perspectives and experiences from across the province was really valuable. It's useful to hear about different ways of approaching things, and it builds confidence to have your planning approach validated if other health units have arrived at similar solutions."

The group will be meeting again in the fall, but in the meantime they have been very busy, sharing information and carrying out a series of surveys on everything from the roles different health units play in community heating and cooling centres to links with other healthcare partners. MLHU has provided a great deal of support for the ongoing survey activities. "We've managed to share an enormous amount of helpful information with each other through quick and simple questions!" said Pat Simone.

This group will certainly serve as an important source of information and way to share news with the field in future, and we look forward to working with them.

What's New at EMB and the Agency?

Some significant changes have taken place with the MOHLTC and the Ontario Agency for Health Protection and Promotion this summer.

First, the agency has adopted the new operating name Public Health Ontario (PHO). This new name and the tagline "Partners for health," are meant to better reflect their role as a hub organization that links public health practitioners, front line health workers and researchers to the best scientific knowledge from around the world. Plus it's easier to say!

Second, a number of public health scientific functions that previously resided in the ministry's Public Health Division (PHD) have been moved to PHO, along with the staff who carried out those functions.

This shift aligns work and staff resource with the respective mandates of the two organizations. It also builds on the current roles of both -- PHO has a mandate to ensure that the best scientific/technical advice and evidence are available for public health decision-making, while the ministry's role is stewardship, which focuses less on involvement in the actual delivery of health services and more on establishing overall direction and accountability for the health system.

PHO has assumed responsibility for surveillance, outbreak investigation, advice on outbreak control measures, scientific and technical advice and support on communicable disease and environmental health matters, and public health library services.

However, oversight and management of provincial communicable disease outbreaks and health hazards, as well as health emergency management, will remain within the ministry as part of a realigned PHD. Among these changes, many things remain the same. The ministry will retain other areas responsible for a variety of core government functions related to strategic direction, policy, standards, accountability and funding. And, of course, both the EMB and PHO continue to work together on supporting evidence-based emergency preparedness in Ontario.

E. coli O104:H4

This summer Ontario demonstrated its preparedness for the potential spread of Escherichia coli O104:H4, (*E. coli*) which was causing a widespread outbreak in Europe. Even before the only case related to this outbreak in Canada was confirmed, the MOHLTC was busy with a variety of preparedness activities, working with a variety of partners.

An Enhanced Surveillance Directive (ESD) was issued, requiring health units to report any *E. coli* cases with the outbreak strain and a history of recent travel to

Germany to the ministry within one business day. The ESD also provided directions for health units to submit stool samples directly to the Public Health Ontario (PHO) public health laboratories for testing.

At the laboratory, testing capability was rapidly expanded to include molecular testing and whole genome sequencing, the result of some dedicated emergency preparedness planning at the labs. Previously, routine testing of stool samples did not detect non-O157 *E. coli*, and this had been identified as a vulnerability in the system. Over the past two years, the lab has been working to address this, starting with instituting a simple ELISA test (a biochemical technique that can detect the presence of a given antibody or an antigen) for specimens submitted directly to the labs as part of outbreak investigation, and building to a sophisticated Polymerase Chain Reaction (PCR) testing and confirmatory process for non 0157 *E. coli* disease. PCR is a molecular biological technique that allows the detection of specific DNA or RNA even in samples containing only minute quantities. These new tools put the labs in an excellent position to respond to any outbreak in the province. Support was also given by the National Microbiology Laboratory in Winnipeg.

Given the potential for *E. coli* to cause kidney failure, the ministry also engaged the dialysis sector. They determined provincial capacity and, building on some of the strategies identified in the Ontario Health Plan for an Influenza Pandemic (OHPIP), put some contingency planning in place around how to respond to a potential increase in demand. This work proved useful once again during this summer's forest fire related evacuations, as there was concern about the number of individuals on dialysis among the vulnerable populations who were evacuated.

Ontario Radiation Health Response Planning Day

On Friday, July 15th, EMB hosted a one-day planning session for health system stakeholders to discuss the health system's response to radiological / nuclear (R/N) emergencies in Ontario. In total over 40 participants attended the planning event from across the health and nuclear power sectors. Different levels of government and several provincial ministries were represented. The day included presentations from all three levels of government and nuclear facilities.

The Radiation Protection Bureau of Health Canada and the Public Health Agency of Canada presented on the federal role during an R/N emergency. The provincial perspective was provided by Emergency Management Ontario, who spoke on the Provincial Nuclear Emergency Response Plan, and by the MOHLTC, who presented the draft Radiation Health Response Plan. The work of Ontario Power Generation (representing Darlington and Pickering Nuclear Generating stations) with the local health system was also shared, along with the Durham Region Health Department's plan for a nuclear emergency.

A key component of the day was the afternoon discussion. A number of critical aspects related to an R/N emergency response were covered, including the

integrated nature of roles and responsibilities in the health system during an R/N emergency, and the various resources available during a response. The informal nature of the discussion and the mixture of stakeholders from various areas allowed for exchanges of ideas, identification of gaps in planning, and a better understanding of the health system's role in an R/N emergency. The productive consultation provided an excellent step towards finalizing the MOHLTC's Radiation Health Response Plan.

Evacuations in Northwest Ontario

The weather this summer kept the emergency management sector busy across the province, with high temperatures and heat alerts in the south, an F3 tornado in Goderich, and forest fires across northwestern Ontario.

The Ministry of Health and Long-Term Care activated its Emergency Operations Centre in mid June to support the provincial response to the forest fires in the northwest. At the time of printing, there have been 1,100 forest fires in 2011 with 627,222 hectares burned - compared to the 10 year average of 968 fires annually and 70,677 hectares burned. Not only were there more fires and larger fires, but the location of the fires and the dense smoke they produced became a direct threat to a number of northern First Nation Communities.

Over the course of the summer, 10 First Nation communities were evacuated to 14 host communities as far south as Arthur and even into Winnipeg. The Ministry of Natural Resources is still leading fire fighting efforts in the region and will continue to monitor the situation until the end of forest fire season.

The main role of the ministry in this type of emergency is coordination: helping to ensure that the health system has the information, resources and connections that are needed to support the local response. This summer, the ministry's focus was on coordinating health sector response activities among Health Canada's First Nations and Inuit Health Branch (who provide health care services in remote and isolated First Nation communities), local public health units, and Local Health Integration Networks and their service providers.

EMB also oversees the ministry's Emergency Medical Assistance Team, or EMAT. EMAT is a mobile medical field unit that can be deployed to support a facility, community or region whose health care capacity is severely stressed by an emergency or incident. EMAT is staffed by volunteers from across the province and operated by the Sunnybrook Centre for Prehospital Medicine. Additional information about EMAT can be found on the ministry's website.

Many residents who were evacuated this summer were sent to small communities within the North West LHIN's jurisdiction. As the evacuations increased in number and projected duration, and when the Thunder Bay International Airport was designated as a transport hub, the decision was made to deploy EMAT in support of the North West LHIN.

EMAT was first deployed to the Thunder Bay International Airport to help to provide medical assessments at the airport. When the transport hub closed, EMAT moved into the communities of Geraldton and Longlac where they provided medical and psychosocial assessment and care within the evacuation centres. EMAT also set up a module to provide support to the Geraldton District Hospital as needed – they had approximately 1,000 evacuees in their catchment area, and could easily have become seriously strained.

"Deploying to an evacuation centre was a new role for EMAT," Pat Auger, the Incident Commander of EMAT, told the Planner. "In many ways, providing health care in an evacuation centre is its own discipline of medicine, and it called upon all of the diverse skills of our team members. We learned a lot during this deployment and I am proud of the contributions that EMAT made."

The amount learned through this response was also a common theme during the debrief sessions that the EMB held in August with ministry and health system partners. Great ingenuity was applied to finding local solutions.

The Planner invites readers to share their best practices and lessons learned for inclusion in a special Response to the 2011 Forest Fires supplement to be released this fall. If you are interested in writing up your experience, please contact emergencymanagment.moh@ontario.ca.

More information about the forest fire situation can be accessed through the Ministry of Natural Resources website .

Ontario IMS Steering Committee

The Ontario IMS Steering Committee met in early June and identified a draft version of standardized colours for IMS functions. Some of the main objectives of this initiative are to increase interoperability between response organizations and the cross application of training materials. The draft colours are as follows:

IMS Function	Colour
Command and Command Staff	Green
Operations	Red
Planning	Blue
Logistics	Yellow
Finance and Administration	Grey

The Planner will update readers of any changes to this colour scheme and announce when these IMS colours have been formally adopted by the Steering Committee.

Training and Exercises

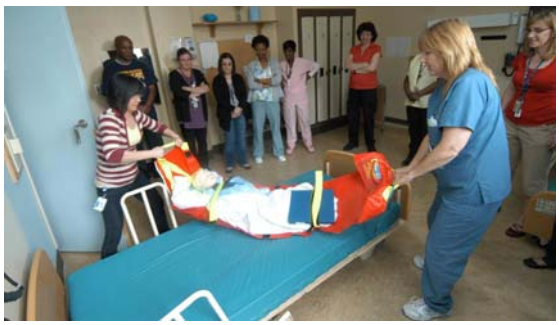
Hands-on practice for Codes Black and Green

~ A guest article from Toronto East General Hospital

Toronto East General Hospital (TEGH) recently carried out some hands-on training sessions focusing on safety issues for staff and patients during Code Black (bomb threat) and Code Green (evacuation) emergencies. Over 500 TEGH staff, physicians and students participated in mock drills led by the Emergency Procedures Committee (EPC) on June 3rd and 10th. The drills were designed to be very low cost, (e.g., using a vacant patient care unit, members of the EPC to conduct the drills and supplies that the hospital had on hand). This allowed TEGH to offer the drills multiple times, providing opportunities for as many staff as possible.

The drills began with a lesson and Q&A session, allowing staff to discuss concerns regarding the possibility of a real-life situation. This was led by EPC chair, Clint Hodges, who kept staff engaged and attentive with his passion.

Following the lesson, staff participated in a search for a 'potential threat' in accordance with the Code Black plan, with a focus on proper procedures for finding and reporting suspicious objects. The importance of marking rooms that had been checked and cleared with emergency evacuation markers was also stressed, in order to ensure the safety of everyone in the hospital during a real Code Black or Green situation. The drills were held every 15 minutes from 8 a.m.- 4 p.m., with minimal disruption to daily routines or schedules.



TEGH employees were also shown the safest ways to evacuate non-ambulatory patients to the closest exit during a Code Green. A life-size doll, weighing approximately 75lbs, was used to demonstrate. Participants were given the opportunity to move the doll from the patient's bed to the hallway and then down the stairs using an evacuation mat. Coaching was provided on how to safely use body mechanics when handling a patient.

Participants found the exercise very useful and informative. They particularly appreciated that it only took 30 minutes and was offered throughout the day to suit their busy schedules.

"I thought it was very effective and really put things in perspective," says Barley Chironda, Organization Safety Specialist. "It really helped ease my anxiety. I've thought before, 'what would I do', but now I know."

The EPC did not have to recreate or stage an area in the hospital. A vacant patient care wing was used with little set-up or take-down. This way, participants were able to act out the situations right in the hospital and understand appropriate evacuation exits.

With this low-cost, minimal-disruption approach, TEGH looks forward to providing more drills in the future. This will also allow staff working evening and night shifts to participate!

*Photo credits: Kevin Holm

Transguard/Trillium Exercise Series

Public Safety Canada (PSC) is coordinating a series of exercises to be held across Canada to enhance transit security, known as the Urban Transit Exercise Program, or Transguard. Transguard I was held in BC prior to the Vancouver Olympics. This year, the Transguard focus is Ontario, with scenarios playing out in both Toronto and Hamilton. Emergency Management Ontario will be co-leading the Ontario program with PSC. A Transguard table-top exercise – under the provincial name "Trillium Navigate" - is taking place in November, and "Trillium Conveyance", a full-scale exercise, is coming up in March. The MOHLTC is working with a number of health stakeholders in Hamilton and Toronto to take advantage of this unique opportunity. Stay tuned for more details in our next issue!

For more information about the exercise contact the Emergency Management Branch.

Upcoming Training:

- **Developing Heat Resilient Individuals and Communities**
  This workshop will be held from 9:00am – 4:30pm on October 12, 2011 at the University of Toronto's Hart House.

Provided by Health Canada, this training will offer public health and emergency management officials, as well as representatives from non-governmental

organizations, with an overview of best practices and guidelines for protecting the health of Canadians from extreme heat.

For more information, please contact Anna Yusa

The 'So What?' Supplement

G20 planning lays the foundation for ALC success – and savings!

One of the priorities for the Toronto Central Local Health Integration Network (TC LHIN) in planning for the G20 Summit was hospital capacity. With routinely high bed occupancy, and up to 20 per cent of acute care beds on any given day occupied by Alternate Level of Care (ALC) patients - i.e. patients occupying a bed in a hospital who do not actually require hospital care and are waiting for a different kind of placement – how could they ensure the Toronto hospitals would be ready if there was a major surge during the summit?

Two major strategies were implemented. The first was a 1-A status declaration, which is an extraordinary measure to prioritize the placement of ALC patients from a specific hospital or group of hospitals – in this case the downtown Toronto hospitals - into available long-term care beds.

The second was a focused collaborative effort to address ALC patients waiting to be transferred from acute to rehabilitation and complex continuing care (CCC) hospitals. This included long-stay ALC patients, defined as those who'd been waiting in hospital for more than 40 days, sometimes up to several years! These patients tend to be complex and high need, facing multiple physical and sometimes mental health issues. Keeping them in acute care beds is costly, a pressure on the system, and a pressure on the patients themselves, but finding appropriate placements is challenging.

In the tight timelines before the summit, a collaborative process was begun to identify and expedite safe and appropriate transfer of these patients. The TC LHIN brought together a working group with representation from the Community Care Access Centre (CCAC), acute care hospitals and the rehab and complex continuing care hospitals. Medical, patient flow, case management and other staff worked together, and specialized sub-groups were formed where needed to address particular groups of patients. This process had unprecedented results – more than 100 ALC patients were moved out of the acute setting in a very short time.

"It really proved the value of a collaborative approach," said Janine Hopkins, Senior Director of Community Engagement and Corporate Affairs at the TC LHIN. "No one hospital can solve these problems alone. What we learned from G20 has been applied to our ongoing ALC reduction efforts with great success – we've reduced the number of ALC patients in our hospitals by 22 per cent in 2010/11."

What is the ALC Reduction Strategy?

As part of Ontario's Wait Times Strategy, the MOHLTC announced $22 million in funding across all 14 LHINs in 2008 to invest in local solutions to address ALC pressures. High numbers of ALC patients increase emergency room wait times by making it difficult to admit patients from the ER to hospital.

As part of their local strategy, the TC LHIN assembled an ALC committee which, similar to the G20 work group, included the CCAC and the full range of hospitals - acute, rehabilitation, mental health and complex continuing care – to take the challenge on as a system.

The CCAC was tasked with identifying and assessing patients, and the CEOs of various hospitals were assigned responsibility for different groups of patients – e.g. West Park looked at long-term ventilated patients, CAMH mental health and addictions, etc. Another group looked at overall discharge planning and how to begin it earlier and more effectively. Patient safety was a priority, with physicians closely involved to ensure placements were truly appropriate.

Beginning in winter 2010, this approach has moved 37 additional patients to a more appropriate level of care, reducing ALC levels by approximately 18,000 hospital bed days – the equivalent of $27M dollars freed up to be redirected to more appropriate services within the hospitals.

"The G20 allowed us to build relationships across the sectors and demonstrate the value of joint problem-solving on a patient-by-patient, population-by-population basis," commented Hopkins. "The G20 planning gave us a ready-made pilot opportunity. We tested innovative ways of working to solve one of our greatest current health system challenges."

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