Bree Collaborative | Health Impacts of Extreme Heat
February 14th, 2024| 3-4:30PM
Hybrid

MEMBERS PRESENT VIRTUALLY

Christopher Chen, HCA
LuAnn Chen, CHPW
Jeff Duchin, PHSKC
Billie Dickinson, WSMA
MaryBeth Bennett, UW Pediatric Residency Program
Jessi Kelley, UW Collab on Extreme Heat Resilience
Brad Kramer, PHSKC
Onora Lien, NWHRN
Kelly Naismith, DOH
Kristina Petsas, UHC
Kumara Raj Sundar, KP
Stefan Wheat, UW CHanGE

MEMBERS PRESENT IN PERSON

June Spector, L&I

STAFF AND MEMBERS OF THE PUBLIC

Beth Bojkov, MPH, RN, Bree Collaborative
Emily Nudelman, DNP, RN, Bree Collaborative
Karie Nicholas, MA, GC, Bree Collaborative

WELCOME

Beth Bojkov, Bree Collaborative, welcomed everyone to the first Bree Health Impacts of Extreme Heat Workgroup. Members who were unable to attend last month introduced themselves to the group.

Motion to approve January meeting minutes: motion approved.

Evaluation Sub-committee
Karie Nicholas, MA, GC reviewed request for 2-5 people to participate in the evaluation sub-committee. The sub-committee we will mee for 45 minutes once a month to help develop the evaluation plan to measure progress for guidelines detailed in this report. A few members of the workgroup volunteered to participate. Names have been provided to Ms. Nicholas who will follow up with volunteers.

PRESENT: NORTHWEST HEALTHCARE RESPONSE NETWORK

By Onora Lien Executive Director, Northwest Healthcare Response Network (NWHRN)

- A non-profit that Leads a coalition of partners across the healthcare system to build a resilient healthcare ecosystem.
- Began in 2005, guided and formed by healthcare in Washington State
- Focus on before, during and after an emergency or event.
    - Before: planning, guidance, tools and resources, training and exercises
    - During: coordinate providers and organizations, data, information, resources, mitigation strategies, operational planning, and policy issues
    - After: advocate for and support healthcare through the recovery process

- Four main areas: Creative innovative solutions, ensure a shared awareness of the state of Washington state healthcare ecosystem, provide real time support to the healthcare system, advance policy and advocacy efforts.
- Example of work: Washington Medical Coordination Center (adult and pediatric)
- Provided response during the 2021 heat dome to Western Washington and Puget Sound area

Questions

- Chris: Has the group worked with payors?
    - Historically the group has not as much and is looking for opportunities to connect more with payors.
- Chris: What would like to engage with payors on the most?
    - Payors funding air filtration or air conditioners to mitigate the expense of the back end and promote equity.
- Chris: How do you define an emergency your organization will respond to?
    - Definition depends on what actions are needed, for instance supply chain impacts. When hospitals need assistance brokering access to or impact to a facility that needs more traditional emergency response coordination.
    - When there is an event that will have impact on other facilities, being more flexible about the event definition is more aligned with what the organization does
    - During an emergency, payors have a role in allocating scarce resources, and defining what an emergency is knowing we have more and more events related to climate change
- Jeff: Are there other things from an emergency response and hospital coordination perspective that this group should consider, or facilitate as we make recommendations?
    - Understanding the preparedness work and seeing that as critical. CMS has emergency preparedness requirements, where we can reinforce that is critical.
    - Still understanding where payors may be most useful, but it is difficult to focus on preparedness when we cant actually move the needle on the things that are barriers to day to day capacity constraints – getting patients out of the hospital.
    - Where this group has an important voice could connect to those constraints and the daily stressors
    - Where we can create flexibilities for long term care organizations to take patients, a lot of the disaster management models rely on discharging patients to have room for new patients
    - It really limits what we can do when we don't have the space for patients in hospitals
    - **Action:** at a minimum, mention the constraint on the hospital system with hospital discharge backups
    - NWHRN tracks weekly the emergency department boarding numbers, WMCC shares that data in their reports as well, from hospital capacity perspective, most hospitals average bed census 20-30% of beds that could be discharged
- Raj Comment: sometimes there's a difficulty for payors to share risk because people switch plans year to year, but since there's such widespread impact with something like climate disasters, there's opportunity to invest in something that is mutually beneficial for all payors, this is a struggle with value based care, what would it take for an organization to invest in something like this? we have to make a case for payors working together
- Kristina: Payors do play a critical role in acute events - UHC during the Maui wildfire reported that payors who all had patients on the island got on a emergency coordination phone call to identify who was on the island and how to best coordinate care for clients.
    - Patients were identified with increased needs

    - Two folds to payor preparation:
        - Are we preparing for the acute event for a catastrophic event?
        - Are we preparing to avoid the rush for care?
    - SDOH are a very important factor for if a client will experience a climate event, and payors are great at having data. We do see members abandoning prescriptions, have their zip codes, have reported social needs
    - Lacking collaboration between clinicians and where to direct them for support and resources. That missed opportunity led to a lot of medicalization of social issues.
- Onora shared idea: can look across the patient population and identify top three diagnosis, what can payors do in advance of an event and start communicating in advance of an event, what can we do to mitigate people ending up in the hospital?

PRESENT& DISCUSS: PRELIMINARY EVIDENCE REVIEW

Ms. Bojkov presented findings from preliminary evidence reviewed for the report. Resources reviewed: UW Climate Impacts Group, CDC, NWHRN, US Climate Resilience Toolkit, HHS, DOH, King County Extreme Heath Response Plan, Americares Climate Resilience Toolkit, Oregon Health Authority, UW Pacific Northwest Agricultural Safety and Health Center Heat Illness Toolkit, L&U Heat Exposure, Preventing Heat-Related Illness among Outdoor Workers — Opportunities for Clinicians and Policymakers Rosemary K. Sokas, M.D., M.O.H., and Emily Senay, M.D., M.P.H., Migrant Clinician Network.

Onora: HHS has lots of resources for tracking temperature and data to indicate when an extreme heat event is happening
Harvard is working on updating the Americares toolkit, updates should be out this spring or summer

Action: review updated toolkit when released

Chris: did not see much on primary care, didn't see much for payors either. For people to leave the hospital safely we have to have a strong primary care system that can support that transition. Also on a population health level, these different sectors have population health strategies for different conditions. I'm not sure if we will take it another level down to operationalize those initiatives, but we could look at common protocols for identifying members that are at most risk, that might be another gap.

Jeff: I was wondering in the context of data needs, are we allowed to delineate what kind of information we want hospital systems to be capturing or contributing to a common data base to understand who is at risk within their organization.
Do we have someone at the Climate Interest Group? Tonya working in occupational/environmental health world, Jessi Kelley works with them.

Action: Can invite Jeremy Hess to speak once focus areas are narrowed down

Stefan: one repository of resources I've found helpful in this space are areas of the country that have been dealing with this a lot longer than us, Pheonix has a robust heat action plan and we can learn a lot from them.

Action: contact David Hondula to invite to speak about Pheonix's heat response plan

DISCUSSION: DRAFT FOCUS AREAS

Ms. Bojkov transitioned the group to discuss focus areas for the report and how to narrow the scope of the report.

What are the biggest problems or gaps in the healthcare system when it comes to extreme heat? Are there any low-hanging fruit that haven't been addressed?

- Role of Payors
- Primary Care (access and availability to support complex needs), role is disaster response and prevention.
- population health strategies—how to operationalize these strategies. How to identify which members are of highest risk.
- Low hanging fruit = Patients on dialysis
- Data needs and capacities: HHS emPOWER Program - About emPOWER Map
- Should someone from https://cig.uw.edu/ be a part of the group. Tonya, Jeremy Hess
- Proactive patient heat education/planning, Especially equipping primary care providers in this regard
- Identifying people who are getting sick from heat at work—industry occupation information
- Dialysis needs, HHS EMPOWER
- Industry occupation information and data
- Proactive patient head education/planning,
- Public cooling centers and access to cool drinking water during events

If you had to narrow down a couple priority actions to make the biggest impact, what would they be? How would you know they were worthwhile? (how would you measure it?)

1. What to before, during and after.
2. Cross cutting themes that need to be addresses at all level
    a. Vulnerable population (like dialysis patients), public engagement & outreach, communication for clinicians and patients, how to support people in their home environment, payor strategies (financial), data needs

- Date comment:
    - Identifying data source that is real-time enough to figure out who is at risk for an extreme heat event, DSHS and HCA utilized an algorithm to identify who is home-bound and at risk for COVID, something like that
    - I would also add capturing recommendations for new data needs. Where the current m easures are missing or imperfect.
        - For home environment: measuring % of people with cooling in home or access t o cooling within 1 mile, etc. Goal to increase.
    - How did we know the response was better for 2022 than 2021? The collaboration was better, organizations leaning in understanding extreme heat's effect on equipment needs, anytime you can get chief executives in hospitals to talk about capacity planning frequently it's an achievement.
        - If we were to develop measures it might be some list of preparedness measures, think it would be hard to capture this across healthcare system.
        - Noting fewer volumes in the emergency department
        - Organizations had taken extra precautions, moreso than the previous year, but hard to measure that. Might be easier to
- Capacity development and education of healthcare workforce should also be a focus area, prehospital providers are an important part of this.
- Stefan: When we look at the evidence, **public access to cooling centers and drinking water seems to be the intervention with the biggest impact** if we are really narrowing down into

targeted actions, don't want to lose that in all the other recommendations and structure we could have.

- Good example. We did add home cooling questions to the statewide BRFSS a year or so ago, which is an example of the type of recommendations and actions that could be taken.

PUBLIC COMMENT AND GOOD OF THE ORDER

Beth invited final comments or public comments, then thanked all for attending. At the next workgroup meeting, the group will continue to review evidence and discuss focus of the report. The workgroup's next meeting will be on Wednesday, March 13th from 3-4:30PM.