Trish Kritek:

Welcome back to Town Hall, UW Medicine Town Hall. This is October, which is unbelievable to me. I'm Trish Kritek, pulmonary critical care doctor at UWMC Montlake and the associate dean for faculty affairs.

Trish Kritek:

Joining me today are John Lynch, our head of infection prevention and head of the medical response for COVID across UW Medicine. Santiago Neme, the medical director at UWMC Northwest, Keri Nasenbeny, associate CNO at UWMC Northwest, Tim Dellit, chief medical officer for UW Medicine, Cindy Sayre, chief nursing officer for UWMC Montlake UWMC and Anne Browning, assistant dean for wellbeing and Jerome Dayao, chief nursing officer at Harborview Medical Center. Tom Stager and Rick Goss have other personal commitments so they're not with us today.

Trish Kritek:

So, thanks everybody for joining us. As I said a second ago, I can't quite believe it's November. It's not November. Oh my God. I can't quite believe it's October and I obviously am disoriented to date. That's because that life seems to just keep getting crazier. Today, as I think probably everybody knows, we learned that the president of the United States is positive for COVID and I think if there could be another thing that's on the table of making it a crazy time, that's another thing.

Trish Kritek:

I'm going to actually start off today talking about this kind of sense about are we seeing more COVID and are we seeing things rising and I think a growing sense of anxiety about that that I'm hearing from people. So, Tim I'm going to start with you and maybe you could reflect on the big picture around cases of COVID. Then I have some follow up questions about stuff that's happening right here locally.

Tim Dellit:

Great. Thanks, Trish and again welcome everyone. First I do want to extend our wishes to the president and first lady and hope that they recover from their current illness just as we wish anyone who has COVID-19 during this challenging time.

Tim Dellit:

I think if you look at the big picture, we crossed over 200,000 deaths in this country. What's I think worrisome to many of us is that early projections say that by January 1, we may be up to 400,000 deaths in this country. Now a lot of that is going to depend on what we do as a society between now and then.

Tim Dellit:

It's also concerning when you look at the news and over half the states are seeing increased number of cases. I think this is a reminder both the president now being infected, the increased number of cases and as we head into fall and we head into traditional respiratory virus season as the weather gets colder, as it gets wetter here in the Northwest and people are inside, we still have to continue those fundamental practices.

Tim Dellit:

The physical distancing, the masking, the hand hygiene. All of those practices that have helped us to see reductions locally over the last few weeks although right now, we're starting to see maybe some gradual increase. But we have to remember those basic elements as we go forward. We also have seen IHME projections that we shared at this week's LDI.

Tim Dellit:

Because things had been coming down here, their projections pushed out that potential next surge. What they're looking at now, and again these change weekly as we get closer to the dates, potentially the second half of November we would start to see some increase here locally in Washington and then continuing through December and what they're estimating their mean estimate across our four campuses right now is right around 130 patients.

Tim Dellit:

Keep in mind, in April we were around 122 at our peak. So, similar to what was projected there, but in my mind, it really depends on what do we do as a community between now and then to try to again, keep flattening that curve and pushing it out and keeping our healthcare systems from getting overwhelmed. But absolutely it is a concerning time.

Tim Dellit:

Some schools are going back in person. UW students returned last week and we talk a little bit about that and certainly when you look around the country, universities, colleges have had challenges in terms of rising cases when students have come back. So, there are a lot of changes right now but again, I would urge all of us to really keep those basic practices in place that honestly have served our region really well when you look compared to many places in the rest of the country.

Trish Kritek:

Yeah I appreciate that a lot. I think that that kind of sense of are we starting to see stuff percolating up is something that I got in the themes of the questions in just talking to people. I think you raised kind of us coming back to school and in the local news, we heard about a second outbreak on Greek Row at UW and I wondered if you could talk a little bit about what the results of the testing so far that's been happening, the husky testing and what kind of numbers we're seeing there.

Tim Dellit:

Yeah. Absolutely. There are two testing programs in support of the students. I want to thank everyone from UW Medicine who really helped to do the testing for those students who were moving back from the September 22nd to 25th on campus. So, in that scenario, UW Medicine provided the testing support. We tested I believe about 1600 individuals and very few were positive.

Tim Dellit:

Around .25%. So, extremely low numbers of positive students and half of those actually were known to be positive from before and they were just persistently positive. So, really only about a half dozen new students that were identified in the move in. We have now as in the news last night, we have seen an increase in students in the Greek housing. We saw this earlier in the summer and then we got it contained.

Tim Dellit:

Right now, they're up to about 117 students across 11 houses. There's been a lot of communication from the university with the leadership within the Greek housing, from public health, from the Department of Health directly to the individuals living there and the real issues is congregate living.

Tim Dellit:

So, whether you're in Greek housing or other congregate living around here, around the campus, I think it is challenging to be able to keep that distance and there are obviously behavioral pieces around potential parties and other things that are happening that we are trying to also discourage. I would keep in mind that the Greek housing is not part of the university so there's limited authority of what the university can do here in that off campus housing situation, but there's a lot of communication.

Tim Dellit:

The other things that they're doing to help support the students is all of us are testing. When we come to work that we don't have symptoms. Same thing with the students. The students are getting texts every day. Do you have any symptoms? Have you been around anyone with symptoms or who has been diagnosed?

Tim Dellit:

They also now are doing testing through a scan which is the Seattle Flu Study. So, it's not directly our teams, but the Seattle Flu Study that's supporting the testing, they're urging everyone within the Greek housing to be tested now because of the rise in cases and they're going to be doing serial testing every three days of everyone within the Greek housing system again in order to identify people, those who are positive, they're quarantining.

Tim Dellit:

Either if they have separate rooms within the houses they can do that or we also have areas within the doors where we're able to quarantine them. So, in the big picture, even though it's 117, if you look at what has happened around other colleges, this is not totally surprising and not unanticipated. The real question is how do we respond to it and keep it from rising?

Trish Kritek:

Yeah it sounds like a coordinated process of testing, of isolation and then retesting and higher numbers than we'd like in Greek row, but a lot of collaboration and really quite low numbers when we just tested the 1600 people coming back to campus.

Trish Kritek:

I want to follow up on one thing about the attestation. Very local now. I think people are seeing more folks in health sciences than they did before and there was a question that came in about are those folks having an attestation like we do when we go into the medical center. Sounds like the answer to that is yes.

Tim Dellit:

Yes. Yeah. Anyone who's coming on campus, including within the health system, now in the clinical environment, you may be signing documents. For instance, when I come into my office, I do it through

workday. So, everyone is required to do that attestation if they're going to be physically our campus for that day.

Trish Kritek:

Okay. I have one more question for you. It's a little bit tangential, but since you talked about people being tested, it is something that came up. There were a couple people who asked about the rapid testing that we're using for football players and the decision making around that.

Tim Dellit:

Well, I'd first say there are a lot of politics around college sports and pressures when some conferences are continuing to play and others are not. There are different views. This rapid antigen test is not that sensitive. Certainly not as sensitive as our PCR. There are some concerns that when you use such a test in people who don't have symptoms, that it is not a very good test in that scenario and even if you get a positive result, it could be a false positive.

Tim Dellit:

So, I think there is some concern from that test. Now, I also saw that they are backing it up with a PCR. I know there's some universities such as Stanford who is retesting their negatives with a PCR test. So, I think we're still learning here.

Trish Kritek:

Okay.

Tim Dellit:

But this is why we haven't been promoting the antigen test for people without symptoms because I'm not sure that it's really the best screening test and John and Santiago can chime in as well. But they're trying to say, "Well, if we do it more frequently," but if the test isn't that good to begin with, there are some concerns there, but we'll have to watch and see how things evolve, but I think there's just a lot of pressure quite frankly on the college level to bring these athletics back.

Trish Kritek:

Yeah. I think there's a lot of mixed emotions because there's great things about college sports and then there's some challenges that we're seeing. So, thank you for reflecting that. John's talked about the antigen testing before and its imperfections and I think you just reiterated that it's an imperfect test. I'm actually going to pivot to John. That was a good intro. Good way for me to swing it over to John.

Trish Kritek:

John, I do have some testing questions, but can we start off with numbers? Because I think people are always curious about numbers.

John Lynch:

Yeah. Absolutely. So, welcome my new video setup here. You can see my beautiful green walls. Yeah so in terms of our COVID numbers at UW Medicine, we are currently actually up a little bit. We have 27 patients in UW Medicine facilities. 17 of those people are in acute care and 8 of those people are in the

ICU, including one person who continues at Montlake on what's called ECMO or ECLS, a bypass machine for severe illness.

John Lynch:

Valley Medical Center actually admitted I think three or four people in the last 24 hours. Up to 10 people. Northwest is at five. Montlake is at five and Harborview is at seven. Those are numbers just from this morning, so they may be off by one or two.

John Lynch:

But we are seeing a couple more cases in our facilities over the last day and after following a period of kind of stability for the past couple of weeks around 20.

Trish Kritek:

Okay. Yeah so I think that fits with that little bit of sense of concern that people are feeling. I have a tangential question. Do you know if we're still updating our numbers on our website on a regular basis? Do you know by any chance?

John Lynch:

I can't confirm that. I'm not really part of that process. There's no reason that we wouldn't be.

Trish Kritek:

Okay.

John Lynch:

So, if it's not being done, I'm sure it's an oversight and I'm happy to take it back to our emergency operations center and then make sure it continues to happen.

Trish Kritek:

That would be great. I totally would appreciate that because that did come through in the questions. How about numbers in the state? How are we doing in the state?

John Lynch:

Yeah so as Tim mentioned, across the US, so before Labor Day, the US was probably around 30,000 cases per day and it sort of after Labor Day climbed up about a week, week and a half later, up to kind of the mid about 50,000. So, this kind of increase in number of cases. In Washington State, we actually saw things kind of kept going down the level. Even through that uptick across the country, but over I say since Tuesday or so, we've actually started to see a slight increase.

John Lynch:

Now, not the same magnitude that we're seeing in the country, but definitely a reversal. So, instead of being flat, it's actually going up a little bit. Fortunately we haven't seen that roll out at the state level in terms of hospitalizations or deaths which is obviously critical, but when I look at our numbers today, it's only one day, it makes me worry because when we start seeing an increase in just overall number of cases which tend to be right now happening to younger people, what we're really worried about, I'm sure what Tim is alluding to is that when you see the younger folks get infected and get tested, what's

concerning is that they then potentially can infect older adults who then end up potentially in the hospital.

Trish Kritek:

Yeah.

John Lynch:

So, that's what we're paying close attention to.

Trish Kritek:

I hear you. So that slow creep up. You kind of answered the next question I was going to ask you. Which is the demographics of who we're seeing as positive and I heard you say younger folks which we've been saying for several weeks now that we're seeing more infections in younger folks. Is that still the case that it's mostly younger people that are testing positive?

John Lynch:

Yeah. So, if you look over the entire epidemic in Washington State, and particularly here in King County where the demographic tracking is really, really good, there's basically two biggest groups of people who have COVID-19 are folks who are 80 years and older and between 20 and 29. With the 80 years and older folks are really the March, April, the spring cases we saw.

John Lynch:

What we're seeing over the summer and now are really the largest proportional number of cases is in younger people. That 20 to 29 year group and it's certainly contributed by things like the Greek outbreak and other things and reopening and activities that younger people engaged in.

John Lynch:

For the other age groups, it's actually pretty similar, the 30 to 39, 40 to 49, 50 to 59, they're all about the same, but where we're really seeing the uptick is in that 20 to 29 year old age group.

Trish Kritek:

So, in March, 80 year olds and older. Now the younger folks and I guess we'll keep following them and we'll report back if that starts to change as we worry about other folks getting infected with more contact.

John Lynch:

Yeah can I just say one quick thing? The COVID message just went out today and I did put a bunch of links in there for a lot of the places that I go everyday to look at that. So, if you're interested in those numbers and really on a weekly basis or less frequently, the links are all in today's message for you to take, to look at if you want to.

Trish Kritek:

I'm going to suggest take that email and stick it in folder so you can go back to it and click on those links so you can keep checking it. Thank you for sharing that. That's great. Because I think there are people,

there's something about a sense of control if you know what the numbers are. I don't know if it's a real sense of control, but that knowledge is helpful. So I think people like to know.

Trish Kritek:

I'm going to shift gears with you John and I think it was last town hall, but I can't remember for sure. We talk about switching to a clearance based on symptoms and there were some follow up questions about that particularly in the folks from the outpatient setting saying, "Do we really feel like it's safe for someone to come to clinic if they're cleared by the symptom clearance of post-positive?"

Trish Kritek:

So, I thought it would be useful if you could walk through that clearance strategy and kind of the evidence or the science behind making that decision.

John Lynch:

Yeah. Absolutely. So, what the transition you're talking about is about instead of requiring people who have COVID-19 to have multiple negative tests. Say they get better and then they require negative tests to come out of precautions. We are no longer requiring those negative tests. That's in large part due to two things.

John Lynch:

One, is something that Tim mentioned. People can have a positive test for a very long time. We're seeing people out even months after their recovery have a positive test. So, that really becomes problematic when you try to get people out of precautions or to be seen in clinic.

John Lynch:

The second thing is that we now have lots and lots of data from all over the world and lots of different circumstances showing that after about day eight, people really can not transmit COVID-19, SARS-CoV-2 the virus that causes that disease to other people.

John Lynch:

So, that's been shown in many trials now, both in the lab and out in the world. Again, some of these studies came out even early in the spring so we've had multiple throughout the epidemic now. So, we have lots of good data and just to your point around the ambulatory healthcare worker, we've actually been doing this in the ambulatory setting now for several months. They were actually the first place that we did this and public health's been doing the same thing in terms of the recommendations.

John Lynch:

What really changed about I guess two weeks ago now is we decided to do the same thing on the inpatient side. So, we developed the policies around this and just briefly what that means is that for patients who are in acute care, a normal hospital floor whose symptoms get better by day 10 and have no fever without any Tylenol or anything like that can be taken out of those transmission based precautions, the special droplet contact.

John Lynch:

For folks who are in the ICU, we go to 20 days. The issue there is we just don't have as much information around some of the really critically ill and immuno suppressed people and AGPs. So when people are intubated in those places. So, 20 days, if they're better, no fever, they can also come out of precautions.

John Lynch:

So, the most important thing here is even with that 20 day rule, in those populations, there's still no data showing that they're infectious after day seven or eight. So, we're just sort of extending it because out of caution. When we do these clearances, the infection control teams are involved, just like we do tuberculosis and we assess them and we're going to lean conservative.

John Lynch:

So, the first person we looked at last week to get off, he was on Tylenol here at Harborview, round the clock, we took it off. He actually developed a fever. He got his Tylenol back and he stayed in precautions and we reassessed after three more days.

Trish Kritek:

Okay. So, that was really helpful. I think I didn't realize we were already doing the outpatient setting, but it sounds like we have a fair amount of data for particularly people who aren't critically ill that after seven days, we think that we're pretty safe and we're going longer, 10 days, 20 days in the critical care setting. AGPs are aerosol generating procedures for those of you who noticed John sneak that acronym in.

John Lynch:

Sorry.

Trish Kritek:

Those are those patients on ventilators and things where we worry about aerosols. So, that's really helpful. I appreciate all of that. The last thing I heard you say, and we're being conservative. I have follow up from an earlier question, but first I want to ask another question about clinic because I think the outpatient folks have a bunch of questions.

Trish Kritek:

The other one that I see now a bunch of times in the Q&A that I wanted to bring up is this concept of people who have tested positive but still come up to their clinic and whether or not, what our decision making is about that. So, evidently there are people who test positive and then come to clinic.

John Lynch:

So, I want to make sure I understand your question. So, I work on this with Jerome at Harborview and see if he can help me here as well. But all patients and visitors are screened when they come into our hospitals. So, for instance, here at Harborview, we have a screening station by the emergency department and another one by Ninth and Jefferson and patients are screened for symptoms and also have you been exposed to COVID-19 in the last 14 days or have you tested positive in the last 14 days?

John Lynch:

We pick those number to be broad, to be conservative. Said it's easy for people to understand two weeks. So, every patient that should be happening to. So, when you say that someone is positive, sometimes that someone who's positive and is out of their precautions, they've tested positive weeks and weeks ago or maybe even months ago and some of those people are someone who are recently positive.

John Lynch:

I think what's most important is do we really want to capture the people who are recently positive and when that happens, we want to communicate with the destination. Again, Jerome has worked on this at Harborview and I'm sure others on this call have done similar actions where there's a phone call to the clinic and there's a plan made for sort of expediting that patient's movement through the facility and into a patient room or exam room.

John Lynch:

To be clear, we don't allow visitors with a positive COVID test or exposure or symptoms. So, this is really about patient care. I say just the underlying philosophy here. I just want to be very, very clear about is that UW Medicine cares for all patients regardless of their COVID-19 status. There are some certain cases where we can put off or reschedule care, but if care can be delivered regardless of their COVID-19 status, we're going to do that and we should continue to stick with that.

Trish Kritek:

So, Jerome I don't know if you wanted to add to that since John referenced you.

Jerome Dayao:

Yeah. That is very true. The screening does happen like that. I think the most important part here, Trish is that we are expected, especially if people are going to be seeing patients through the clinics or anywhere to be wearing the PPEs that are required to be worn as precautions.

Jerome Dayao:

So, I think that's a very important distinction too that has to be made because people will sometimes say that they're symptom free and all of a sudden they come up and they have symptoms and all of that. The best way to protect really is to be cognizant and be compliant with the precautions that we have set forth.

Trish Kritek:

Yeah. I think I'm going to come back to that. First, thank you Jerome. I'm going to come back to the first principal that John said at the end which is we take care of all of our patients and that includes patients who have tested positive for COVID and we're trying to facilitate getting them to the place where they're cared for.

Trish Kritek:

I think that that transit time between coming in the door and having symptoms and/or knowing someone's COVID positive and getting to their appointment and a room where they're isolated is the part that people get nervous about. I think what I heard from Jerome is we're assuring that they're

masked as they go from point A to point B and that we're using PPE all of us are using PPE as well as in those moments of interaction.

Trish Kritek:

Is there anything anyone wants to add to that because I get the sense of discomfort of somebody walking through the hospital with symptoms when we're trying to avoid that.

John Lynch:

Yeah I'd say just couple things. One is the eye protection. We continue to see a lot of health workers struggle around eye protection. I think it's just a muscle memory. We're now pretty used to wearing our masks, but we've got to get that way with our eye protection. Always, wear it more than you think you need to wear it.

John Lynch:

Not only patient interactions, but you can wear that in other interactions throughout the facility. Someone did put in the QA, sometimes patients may not disclose their symptoms at the front door and disclose them later. We can only do our best we possibly can. This goes back to Jerome's point is that we're going to universal source control. We're all wearing eye protection, we're all wearing masks to keep ourselves safe for that very reason.

John Lynch:

The other question that came up was we are working, we would love to personally escort every patient from the front door to their destination. But I think there's a lot of challenges to that. Again Jerome has worked hard on this and many others at the facilities, but I think Jerome, correct me if I'm wrong, it's really relying upon communicating with the patient, communicating with the clinic to make that connection happen.

John Lynch:

So, if a patient's called, hey we got a patient here, and they don't show up for an hour or two, that's a problem. I'm hoping that the clinics are engaging in figuring that out, but again, I'd refer to Jerome.

Trish Kritek:

He seems to be nodding in agreement with you and I see Cindy nodding and I see Keri nodding which means that all of our institutions were trying to have structured processes to make sure that patients get from being screened to where they need to be into a room in an expedited and as safe a process as possible. Is that accurate? They're all nodding, so I'm going to go with yes on that.

Trish Kritek:

Okay. These are some challenges. I think it's just good to talk about the challenges because they make us nervous. So, we want to do the best by our patients and by everybody else in our medical centers. Actually I'm going to pivot because I think from John I'm going to come to you Keri.

Trish Kritek:

Relevant to this, there were still some questions about plexiglass and plexiglass in clinics and I'm curious if you know anything about us getting plexiglass in all our clinics.

Keri Nasenbeny:

Yeah so I had an opportunity to speak with Pam [Rena 00:25:58] about this and we do have guiding principles around the use of plexiglass and essentially those guiding principles are that if the clinic is located where it is the location where a patient would be primarily screened or screened for the first time, we put plexiglass in those locations.

Keri Nasenbeny:

So, I go into the medical office building here at Northwest and I go directly in my clinic, I've not been screening, there'll be plexiglass in that clinic. However, if I'm at Montlake, I go in the front entrance at Montlake or I go in the front entrance at Harborview, I get screened there and then I go to a clinic that's beyond that screening point, there would not be plexiglass there because that person's already been screened.

Keri Nasenbeny:

So, that is the guiding principle. So, the answer is no. We're not doing it at all clinics because the understanding is that those patients would have been screened prior to that entry point for that clinic.

Trish Kritek:

I'll just put this out there. Something for us to think about. The challenge is in the patient who screened positive with symptoms and we still need to get them there, that there's no plexiglass there because that's the question that's being asked by folks. So, I understand the principle which is if you're screened, then we don't have the plexiglass barrier.

Keri Nasenbeny:

Yeah.

Trish Kritek:

If you're not screened, then we do.

Keri Nasenbeny:

But I think that goes back to Jerome's point that we make a plan for getting that patient directly in to an isolation room in that clinic. They don't go to the front desk and we're all wearing PPE, right? So, everybody in the clinic should have a mask, eye protection on, and whatever we need to protect ourselves. So, I think we have a mechanism, I suppose that it's possible that somebody could slip through.

Trish Kritek:

But I think your point is if screened positive again, we're trying to do that communication to get somebody right in to a room in the places where we screen.

Keri Nasenbeny:

Yeah.

Trish Kritek:

Thank you for going over that. I think relevant to that, I'll stick with the Chief Nursing Officers for a little bit. There's still a lot of concern about the visitor masking policy. Cindy Sayre, maybe you want to comment a little bit on-

Cindy Sayre:

Yes.

Trish Kritek:

Visitor masking policy. I have some follow ups, but you can just talk about it in general.

Cindy Sayre:

Sure. I'm happy to. So, we do expect all visitors in the medical centers to wear a mask at all times. This becomes a challenge sometimes with visitors that either can't comply because they have some kind of health issue that makes it difficult for them to use a mask or sometimes we just get flat out pushback.

Cindy Sayre:

I think we are working to finalize a policy right now to be consistent with the ADA law that we have to make some accommodations for patients that have disabilities. So, we're talking about having face shields for example at the screening locations. We don't recommend that in general as a replacement for a mask, but if you have somebody that can't wear the mask, then the face shield is better than nothing.

Cindy Sayre:

So, we're making those kinds of policies for accommodations. In general, we're taking a pretty strict line with visitors in general. They have to have a mask on in the building. There's exceptions like we have somebody that has a developmental delay or a patient that has some other special needs and they have to have that caregiver with them, then we need to work and think creatively about accommodations.

Trish Kritek:

Okay. So, baseline is visitors wear masks, we're working on some accommodations for ADA for folks who can't wear a mask and we're working around taking care of our patients and if there's somebody who needs to be there and we have some challenges, we're kind of trying to work through that on an individual basis.

Trish Kritek:

In general, when someone's in the patients room and in patient setting, are they still supposed to be wearing a mask?

Cindy Sayre:

Yes.

Trish Kritek:

Yeah.

Cindy Sayre:

We're having them wear masks at all times.

Trish Kritek:

Masks at all times. I know that there are some exceptions and I'm hearing people say that there are some exceptions, so I'm going to suggest that those are conversations with the leaders in those areas about those exceptions.

Cindy Sayre:

Right and I think this is similar to the visitation policy where you put the policy down and you can't write in a policy every eventuality, right? So, this is where the unit management and the leaders need to partner with staff and with patients and families to make sure that we get the highest level of protection possible for staff and for patients and visitors.

Trish Kritek:

Yeah. I hear you. I think it's good to just keep talking about this because I think it is a place that causes again some anxiety. I think we'll keep working on a global sense of what our policy is and understand that there are times when we have specific conversation.

Trish Kritek:

Jerome, I'm going to actually ask kind of a little bit different question, but it came up a couple times. People have talked about being in conference rooms and not knowing how those conference rooms are cleaned or what access they have to wipes because they're shared spaces. I wondered if you knew anything about what our process or policy is on that.

Jerome Dayao:

So, I did connect with our EVS colleagues about the cleaning of these conference rooms. I was made aware that this conference rooms are cleaned at least once daily and as needed when people request for them. In terms of cleaning, we follow a strict guideline. This is in all areas of the hospital with regard to how these rooms are cleaned, how our EVS personnel are trained.

Jerome Dayao:

I was also made aware that we have a universal policy of cleaning that is adopted in all of our sites so that we are all standard in how these areas are cleaned. In addition with that, there's a checklist. People are checked off so that we are confident that they are indeed cleaning these rooms up to the standards.

Jerome Dayao:

So, that's the updates that with have from our EVS colleagues with regard to cleaning up rooms.

Trish Kritek:

Thank you for talking to EVS. I think, and I'll ask anybody here, I think people are kind of worried they go in a room and it's a whiteboard and there's markers there and then someone uses them and then they come in and then they use the same markers, do we have wipes or anything like that in any of our conference rooms or is that a process that we're doing anywhere? Keri, you unmuted.

Keri Nasenbeny:

Yeah. I know in the several conference rooms I've been at Northwest, we have wipes. So, I think that if somebody goes in a conference room and they don't have wipes, they should go the nearest unit. We have wipes galore through all the hospitals. Just go to a unit and ask for some wipes. But I know for sure at Northwest, I've seen signs up. They say, "Please clean the conference room after use," and wipes are there.

Trish Kritek:

So, regularly clean in a standard EVS way, but if you want wipes to clean stuff off that you're going to be touching, either they're in the room or go to the nearest unit and get some wipes. We're not in a place where we don't have enough wipes to do that. That accurate?

Tim Dellit:

And wash your hands.

Trish Kritek:

What'd you say?

Jerome Dayao:

For the most part, yeah. Go ahead.

Tim Dellit:

I said wash your hands.

Trish Kritek:

Yeah.

Tim Dellit:

What I mean by that is if you are touching things and you don't know if it's been cleaned or not, the next level of protection is hand hygiene.

Trish Kritek:

Yeah. I agree.

Jerome Dayao:

For the most part, our conference rooms do have hand gels and wash stations.

Trish Kritek:

Great. So, hand gel near a conference room is great because we want to wash hands and wipes if we want to wipe stuff down. Thank you for the answer.

Keri Nasenbeny:

I would encourage people if they're going to eat in conference rooms and I know people are in an effort to spread out, wipe down your space before you eat.

Trish Kritek:

Okay. I think I want people to reach out if they aren't finding access to wipes because I think we want people to have those access to wipes or anything for hand hygiene because we want to make sure people have the opportunity for hand hygiene. There are sinks and soap in lots of places as well which is another alternative.

Trish Kritek:

I'm going to pivot to talking a little bit about finance and workload. Before I do that, John, there was one follow up question that came up that I forgot to ask you real quickly. That was we said that the highest number of people testing positive are folks in that 18 to 20s kind of range. What about hospitalizations? Do we have demographics on who's being hospitalized?

John Lynch:

Well, I mean when we look across hospitalization, really across the summer which is probably a better snapshot than the spring where we saw disproportional impacts in skilled nursing facilities, it really starts, the hospitalization rates go up per decade.

John Lynch:

So, once you sort of hit 30, sorry everyone, 30s is higher than 20s. 20s is not that much. 30s we start seeing patients in our facilities, little more in 40s, 50s and so forth. There appears to be depending on the study, there appears to be a bigger impact around age 70 and definitely around age 80.

John Lynch:

Still a lot of diversity in terms of the data out there around worse outcomes in men versus those who identify as women. So, I would say that it seems to go up as you go older. Just because you're asking that question, I just wanted you to know that you did ask me about numbers. Adam Parcher, administrator extraordinaire did text me and let me know that the October one data, the situation report is posted on the site now and it's being posted twice weekly.

John Lynch:

So, if you don't see the data being updated, it's because it's only twice a week. Not everyday. So it's there now. Thank you.

Trish Kritek:

Thank you Adam Parcher for that amazingly rapid response and for clarifying that that should be there twice a week. We appreciate that.

John Lynch:

He's a behind the scenes superstar.

Trish Kritek:

Yeah I agree. Okay. Tim, I want to follow up with you on how we're doing financially. There were a few folks who reached out and said, "Can you briefly update us on how we're doing financially?"

Tim Dellit:

Yeah. I think when you look at the end of the fiscal year which ended the end of June, so June 30th, for UW Medicine as a whole, we had a deficit of $17 million. Now, that's because we received almost $106 million in stimulus. So, if we hadn't received that stimulus, we would have had a negative amount by about $123 million.

Tim Dellit:

Now with that said, it has been very busy within the hospitals over the summer and continues to be. In fact, the real positive news is when you look at this current fiscal year, July August, the hospitals as a whole were ahead of budget. So, that is huge and really wonderful news. In September at least, I just looked at the UWP numbers and we are 6% over budget for work RBUs and 9% over cash again on the professional billing side.

Tim Dellit:

So, again I think we are really working very hard as everyone knows. The hospitals are very full so thank you everyone, but that is really helping to stabilize going into this fiscal year because we still don't know what may happen here over the next several months, particularly if we do see an increased number of cases. But right now, the hospitals are off to a good start in this current fiscal year.

Trish Kritek:

So, good financial news. Ahead of where we would budget for these last three months or moving towards three months which is great news. You alluded to the thing that I also saw in a serious question which is that we're super busy. Santiago, I realize that you're the medical director at Northwest, but I know you've been collaborating on this.

Trish Kritek:

There were some questions about what are we doing with Harborview being over 100% capacity day in and day out and concerns about that actually.

Santiago Neme:

Yeah. So, what we're all working together trying to make sure that we continue to have adequate access for our patients, but also in a safe manner. As you know, early in the summer Harborview was seeing just extremely high volumes in the era of COVID that poses additional safety concerns.

Santiago Neme:

But as the system, I would say we're making significant improvement. Not only as UWMC with two campuses, but also with Harborview and also trying to incorporate Valley so then we can establish pretty efficient transfers as appropriate. So, I would say that this year alone we've made significant improvement and it's been a result of tremendous partnership with the CNOs and the medical directors, Tim's office, everyone really and the CEOs have been actively involved in this process. So, it's been really encouraging.

Trish Kritek:

Yeah. So a lot of collaboration. I know that for a fact there were patients that went from the Harborview MICU to the UWMC Montlake MICU which is one of the first times that I've seen that in a really long time, so I know that we're kind of thinking outside the box on trying to level load as much as we can.

Trish Kritek:

I think the other place where people are feeling pinched is that the ORs are so busy. I think it reflects what Tim was just saying which is a lot of cases and think the staffing has felt stressed. So, Keri, I'm going to start with you and Cindy or Jerome if you want to add in. The question that we got asked specifically is are we going to get more OR staff because it feels like there's so many surgeries and many late surgeries.

Keri Nasenbeny:

Yeah. I can start with Montlake and I actually had a conversation with Carla today about this too because I know this is an issue at both ORs. We are actively hiring I think and Jerome can speak up for Harborview. We have vacancies I think in both of our ORs.

Keri Nasenbeny:

We're using travelers, recruiting more travelers. Actually saw a traveler profile go by my email today and the recruiter said actually Montlake is going to take this traveler. I was like, "Oh darn." So, I think in some ways we're competing for all the same travelers, we're competing for all the same staff across all three campuses actually. I've seen this happen more than once and actively trying to fill these gaps.

Keri Nasenbeny:

These are highly sought after positions. It's not just the OR nurses. Actually the scrub techs are probably in higher demand and we're seeing places like Swedish offer $10,000 sign on bonuses for those positions. So, we're actively working with UW Medicine recruitment to up our recruitment game to talk about any innovative strategies that we can use to recruit, not just OR staff, I would nurses, CNAs, PCT staff across all of our areas.

Keri Nasenbeny:

So, looking at doing a recruitment fair just for our OR teams though and really thinking about other ways that we can help fill these gaps.

Trish Kritek:

So, creative and aggressive recruitment of OR staff and other nurses in a competitive market it sounds like. So, that need is being felt for sure and I think it's also being heard and we're trying to find folks for those positions. Jerome did you want to add to that?

Jerome Dayao:

Oh yeah. I just wanted to add that it's a great time to be a nurse because the choice really is for you to select where you want to work, what environment you want to work, what kind of pay you want to receive because it's really a nurses market. There's lots of competition, but we are doing as what Keri said, all of these interventions so that we can bring in staff here because our priority is to have the adequate amount of staff as required by our matrices and the volumes that we see.

Trish Kritek:

So, we want nurses and we're being creative in trying to make this the place to be the employer of choice and the place where people want to work. So I think it's heard that we need more people and we're working on it.

Trish Kritek:

Okay, I'm going to go back to COVID and John for a little bit, but before that Santiago, I have to ask you one mask question. Interestingly, I heard from a question was people asking if they had to wear their mask in their office when they were alone because of concerns about ventilation in buildings that aren't the hospitals. Do people need to wear masks when they're in their offices alone?

Santiago Neme:

If they are alone in the office, my answer would be no. I would be fine if your alone. Now, if you have other members, other colleagues in that space, even though you are greater than six feet as Tim clarified last week or last time we met, we should be wearing a mask. So, if you're within that space that's indoor, even greater than six feet from your colleagues, you should wear a mask, but if you're by yourself, I would say no. I welcome others input.

Trish Kritek:

Is anyone else worried about ventilation in buildings like where I am in the VP building that I would be at risk because I'm not wearing a mask? Tim you're in health sciences too.

Tim Dellit:

I'm not worried.

Trish Kritek:

And I'm not wearing a mask.

Santiago Neme:

Me either no. I'm not. John what do you think? I wouldn't be worried about it?

John Lynch:

I'm not worried.

Trish Kritek:

Yeah. All of us are in our offices by ourselves and we're not wearing a mask and I put a mask on when someone comes in, sits at the table in my office and talks with me. So, I appreciate the question. That's why I asked. John, I have a few more questions for you. I forgot though I have to check in with Anne about childcare. So, Anne, do you want to give us ... I know that there was the taskforce went forward, people did just want to know were there any new resources for folks who have school age kids or smaller?

Anne:

Yes. We've had some resources shared out on the parents in ListServ and again, all of that information from the parents in ListServ will also be on the central HR website in case you didn't get this last round. But King County has stepped in with some financial supports to support families with kind of childcare burdens, depending on level of income.

Anne:

So, we've seen some shifts in terms of kind of localized support. We certainly know we have folks outside of King County and I believe that HR website has supports out of Snohomish and other areas that are pretty close by where we might have some folks living. Otherwise, we've got recommendations from the UW Medicine taskforce that are making their way through that executive sponsor group and on to kind of the leadership.

Anne:

A lot of it is trying to make sense of how can we take kind of what is fairly broad UW policy and make it make sense across UW Medicine and within the school of medicine. So, there are some challenges there given kind of how people do their work here. But certainly some really thoughtful considerations about how do we think about maximum flexibility and support people during what is a really tough time.

Trish Kritek:

Is it something that we'll keep hearing more about because I think that there are still lots of questions out there and I think people are hoping to still hear more about potential resources.

Anne:

Yes I think so. We had the president in provost message last week and I think this week, we're still kind of filtering through that some of that means within UW Medicine and I would anticipate, I can kick this to Tim as well, but Tim and Lisa likely sharing messaging around what some of that will look like within UW Medicine probably within the next week or so.

Trish Kritek:

Okay. I think Tim's nodding.

Tim Dellit:

Yeah I would just add I think we're looking forward to seeing well what are those proposals and recommendations that are coming from the group as leadership considers how best do we support all of our employees. So, we have done a lot. We need to do more. We did the emergency fun at a period last spring as well to really help people particularly during the furlough time.

Tim Dellit:

So, I think we're always trying to think collectively how can we best support our employees and recognizing the challenges that everyone is facing. So, it's ongoing dialogue and thought but it's very much foremost on everyone's mind.

Trish Kritek:

Yeah I think the financial part of it is something that I think is definitely weighing on members of our community that we'll keep talking about and thinking about how we might do something creative there.

Trish Kritek:

Okay, John I'm going to come back to you and ask you a little bit about the flu and then relationship to COVID. So, is the nasal flu vaccine equivalent to injected vaccine? The person was actually asking about a kid.

John Lynch:

Yeah. So, the nasal vaccine, the inhaled one has kind of come and gone. At least here in the United States. Even the year that we didn't have it, it's interesting across the board in Canada, they maintained it as a useful tool in pediatrics there. So, it is now back in the formulary from all the recommendations we have, it appears to be as effective in the indicated age groups as the intramuscular vaccine.

Trish Kritek:

Okay. So, nasal for children in the ages that it's indicated for. Good to go with that.

John Lynch:

Yep.

Trish Kritek:

I think I know the answer to this question, but I'm going to ask it. Is the flu vaccine that I would get at UWMC as good as the one or better than the one I would get at my pharmacy? Another way to say that is can I get my flu vaccine at my pharmacy?

John Lynch:

Yes. So, all the vaccines that are available are equally effective and so if you want to get your local pharmacy, that's the easiest place to do it. So you're working from home, that's great. Go for it. You can use your UW Medicine, University of Washington insurance to do that and get it done easy.

John Lynch:

The vaccine that we give in our facilities is the same one you'll be getting out there.

Trish Kritek:

So, it's okay. Get vaccinated and it's available now.

John Lynch:

That's what I always say. People always ask, "When is the best time?" I'm like, "The best time is when you're near a vaccine. Get it whenever it's close."

Trish Kritek:

Noted. Last two questions about the flu. One is actually people have gotten colds. It's not even the flu. They've gotten colds and they've gone and gotten swabbed for COVID and they've been negative and then they say, "Well, what was it that I got because I definitely got something but I've been wearing a mask and I've been doing all the hand hygiene and I've kept six feet away," so are people actually getting colds?

John Lynch:

Yeah. I think so. So, I've heard lots of stories just like the one you're talking about and yes, I think people are getting colds. We know that for a fact that a cold virus called Rhinovirus, rhino like your nose, virus is circulating out there. Not in huge levels, but it is out there.

John Lynch:

When the epidemic first hit, all the viruses kind of went away because we were doing distancing and staying home and wearing masks. That included flu and also Rhinovirus, but over time, most of it has stayed down, but we've seen a little uptick in Rhinovirus. I actually reached out to one of our resident respiratory virus experts, Dr. Helen Chu who's a world expert in this and talked about it.

John Lynch:

She agrees that we are seeing rhino. It might be that this is a heartier virus. Maybe it sticks a little bit more to those surfaces and it might slip in between the things that we've learned are probably safe on the COVID end but maybe less safe for Rhinovirus. It's a virus that just is really good and really hearty and maybe it sticks to things a little bit harder.

John Lynch:

This is why I go back to Tim's point. We've got to think about preventing flu. Masking, distancing are probably the most important things besides staying home when you're sick, but for Rhino and all these other cold stuff, washing your hands is absolutely critical. It really helps a lot for preventing those transmission events.

Trish Kritek:

So, it's possible you could get the cold right now and we're going to wash our hands, wash our hands, wash our hands. Okay. On the far other end of the spectrum, last question for you before I kick it over to Anne. Someone asked, "How does that fatality rate for flu compare to fatality rate for COIVD?"

John Lynch:

Yeah so this is a bit tricky. Remember, we're well under a year since we first learned about SARS-CoV-2, the virus that causes COVID-19. We know there's a lot of variation in flu and how morbid and how mortal it is. How many people it makes sick and how many people it kills. So, what's one thing I always tell people is every flu season is different and unique.

John Lynch:

I can't predict what's going to happen. I can't predict which populations it's necessarily going to hit harder than others, so those of you remember the 2009 outbreak with the new H1N1 and the disproportionate impact on younger people, people who were pregnant, really these awful cases, that hasn't really played out subsequent years.

John Lynch:

So, it depends on the flu strain and then when you think about COVID, if you look at if you're 70s, 80s and you're still nursing facility, people aren't wearing PPE, it's pretty dangerous. If you don't have access to testing it's pretty dangerous. So, I would say that there are definitely scientists probably even on this call who know a lot about the virological aspects of a SARS-CoV-2 virus and how dangerous it is for each person or for a person.

John Lynch:

What I would argue is that that's critical information that scientists are working on, but from a broad strokes, when you look at right now, humans are not immune to COVID-19, to SARS-CoV-2. From most

recent data, 91% of us have never seen it, have no immunity to it which is very different than flu. All of us have probably seen flu if we're all within six months of age. We probably have some level of immunity that deals with new viruses, new flu viruses.

John Lynch:

Last I'd say the numbers sort of speak for themselves. Tim quoted I'll just be very clear is a tragic number. 200,000 plus thousand people in the United States are dead that we know of. You can make arguments about how dangerous it is. You can make arguments about who ends up in the hospital. You can't argue with mortality.

Trish Kritek:

Yeah.

John Lynch:

How many more people died this year because of COVID-19, at a minimum it's 200,000 people and it's likely higher. So, I would say that SARS-CoV-2, COVID-19 is an extremely dangerous disease that is extremely variable in who it infects and who it puts in the hospital and who it kills, but it is a very dangerous infection.

Trish Kritek:

Okay. So, hard question. Lots of nuances. Still very concerned. The majority, the vast majority of us still haven't been exposed and thus have zero immunity or little immunity to it. We welcome folks who are experts on it, sharing their thoughts as well. I know there's many more questions and there were lots of questions to ask a friendly ID doc, so I want to give some time for that and I'm going to hand it over to Anne and I think she's going to talk with Santiago today.

Anne:

Yes. Thank you very much. So, I've got Santiago Neme, thank you so much for being our friendly infectious disease doc for today. It's getting colder and darker, lot of questions about trying to do recreation indoors. Specifically would you feel comfortable swimming laps in an indoor pool?

Santiago Neme:

Yes. I very much like swimming and I've been swimming [crosstalk 00:52:54] gym, yeah.

Anne:

Good. Gyms in general, people are all masked up, how do you feel about folks working out inside gyms these days?

Santiago Neme:

Not for me. I haven't done that. I'm concerned about just the ventilation, the exertion, the deep breathing, the machines, there's just too many opportunities for lapses and having people very close to you. Even with physical distancing. I just wouldn't feel comfortable indoors.

Anne:

Okay. Thank you. Being out and about in the world. We've talked a lot about restaurants, but we had a question come in last time around movie theaters open up, you can be distanced, people can mask. How do you feel about going to the movies?

Santiago Neme:

That's a no for me. It's an optional activity. It's indoors. Some people eat while at the movie theater. I just think it's not worth the risk benefit for me.

Anne:

Lot of questions around travel. One was if you had to fly, would you want to quarantine yourself afterwards?

Santiago Neme:

I haven't flown since COVID, but I would say the answer is probably not. I would not quarantine. I think we listen to Tim's and John's kind of guidelines of recommendations as to what to do and I think we know what we can do to travel safer. So, I'm comfortable with that.

Anne:

If you had a spouse who had to travel for work and return, would you ask that person to possibly be tested once they returned home as an extra safety measure for the family?

Santiago Neme:

I wouldn't. In my situation, my husband is an architect but is pretty savvy about what to do and I think that a lot of our family members have really understood that we have a bundle of preventions and things that we can do and there's no one single strategy that we do. I feel like testing is only one of the pieces that we have, but definitely not the most important.

Santiago Neme:

So, I would say that I would feel that if my family member understands what it takes to do these things more safely, then I would feel comfortable with that. It's really about the knowledge and how they implement the practices that we've been really talking about.

Anne:

This one it's like the million dollar question. When do you think it will be safe for folks to travel again and see family and friends?

Santiago Neme:

I think that's a tough one and it's very hard because a lot of folks are feeling very lonely. For instance, most of my family is in Argentina and even if I wanted to go there, I couldn't go. So I would say I don't know the answer to that. I think that I just don't have a idea as to when that would happen.

Santiago Neme:

I'm hoping that when the vaccine comes and the rates come down and we continue to really drive the message about the bundle of interventions. We just saw that our president got infected. Someone who gets tested multiple times a week and yet gets infected. So, we know that not one thing that I do will

work. It's everything we're doing. So, I don't have the answer, but I hope that it's sooner rather than later because we all need it.

Anne:

Yeah. Yeah. We heard a lot of folks just wanting to be with family and kind of trying to balance that safety with really deeply wanting connection. So, thanks for your thoughts there. Got a couple quick ones. Basic sanitation. Do you wash your clothes after you've been out in public even if they're not necessarily dirty?

Santiago Neme:

I haven't changed the way I do laundry or anything. I haven't really adapt to that. I'd like to wear clean clothes every day and I hope that I aspire to that every day. I can't say that I always achieve it, but I try to.

Anne:

I see John Lynch shaking his head like that's too high a bar for me. If you were having home repairs done, had to go stay in an Airbnb, would you bring your own sheets or are you good to go?

Santiago Neme:

I'm good to go provided that the place is clean and again, I trust the environment. I feel like the evidence around vomit and things has shifted too, so it's started to be less important too so I think that's part of my equation of risk.

Anne:

Yeah. I know a lot of folks wrote in with questions thinking about holiday gatherings, especially with Thanksgiving coming up. We might even wait two weeks and really kind of dig into how we're feeling about family gatherings in that time. I want to give a couple minutes.

Anne:

We had Dr. John Lynch share a couple ideas on and concerns around Halloween last time. I know he's done a little bit more thinking as we've been processing what does trick or treating look like in this world. So, I want to give him a chance to potentially update his response.

John Lynch:

So after last time on this, I got accused of canceling Halloween. So, it was great that people provided some feedback and their perspectives and actually there's been a lot of discussion around this in public health, south King County, by infectious disease colleagues across the country and I've sort of thought about it a bit.

John Lynch:

So, I'll give you my quick perspective. I think we can probably do Halloween. So, just to be clear. I told you I love Halloween. I think we can do a lot of Halloween. I see Keri is cheering and I know Tim agreed with me last time, we'll see what he says this time.

John Lynch:

The issue is that it's an outdoor activity. Outdoor is the safest place for us to be if we can continue to do the things that we know work. Distance, wear masks, wash our hands, outdoors, I think we can do that. You can wear a costume, yourself or your family or your kids can wear a costume with a mask, a real mask on underneath their costume. The plastic mask doesn't count with the little hole in the middle. So, wearing a real mask and maybe integrating into your costume. Keeping the distance out there.

John Lynch:

The big question is what do you do with candy? I think being inventive about it. This came from the public health blog on this. I recommend people go to Public Health Insider and just Google Public Health Insider Halloween and they'll give a really nice set of recommendations. They threw out things like candy tubes. Maybe you shoot a candy down a plastic tube or something similar that it goes out there.

John Lynch:

Putting markers out. There's all kinds of symbols associated with Halloween, skulls and cats and stuff. Maybe putting marks on the ground that are six feet apart so that people are coming to your door while you're wearing a mask, they're wearing a mask and they're spaced out, you can do that. Making hand hygiene super accessible.

John Lynch:

I think Anne actually had this idea or someone else that having a table out and you have one piece of candy here, one piece of candy there, one piece of candy there, but you're not going through a bowl, you're not handing it out, you're not close and the kid can just pick it up and you can say, "Happy Halloween," and then there's maybe a hand hygiene station at the end and they wash their hands.

John Lynch:

So, I think those things are all make it possible to do this in a reasonably safe way. Remember all these things are going to carry some risk. Going for a swim carries some risk, going to an outdoor bar carries some risk, but I think in even those things, this is probably on the less risky side.

John Lynch:

I think we need to recognize that not everything is something to be scared of. So, I'm retracting my previous Halloween cancellation and actually giving a cautious thumbs up if we do it right. For the adults in the audience, my neighborhood, we always finish our day or Halloween at a friend’s house and there's a get together and the kids spread all the candy and the adults partake of beverages. So, I don't think that's in the cards this year.

John Lynch:

So, that's not going to happen. But our kids or the kids inside of us who like to trick or treat, I think that's still in the cards. So, there's my update.

Trish Kritek:

Great. I'm going to jump in here because we wanted to give Dr. Lynch a little extra airwaves time to take back canceling Halloween and with very much appreciate that. I want to thank Anne and Santiago. Santiago, those are always hard and you did a lovely job with them and Anne, you bring great questions to the table.

Trish Kritek:

John, I don't think the Grinch took away Halloween but I'm happy to not have you and this town all feeling like you were the Grinch. We're not going to ask Tim's opinion because we're going to leave on that high note and I'm going to say thank you all very much for all that you do to take care of our patients and their families and as I always say, taking care of each other as well.

Trish Kritek:

We'll see you back in two weeks and we look forward to that conversation then. Bye bye.

Anne:

Bye, all.