Trish:

Welcome back to UW Medicine, Town Hall, I'm Trish Kritek, Associate Dean for Faculty Affairs. And it's my pleasure to bring Town Tall back to you this mid October session. So we have a lot of people here. We have a special guest... two guests today, and I'll just walk through who's here with us. So we have Tim Dellit, our Chief Medical Officer from UW Medicine. Tom Staiger, Medical Director UWMC, Santiago Neme, Medical Director UWMC Northwest. Rick Goss, Medical Director Harborview Medical Center. John Lynch, we're happy to say is either on Orcas Island or on his way to Orcas Island. So Seth Cohen, head of infection prevention for UWMC is here. I'm not going to say playing the role of John Lynch, but doing his thing for us. So thank you.

Trish:

We have Jerome Dayao, Chief Nursing Officer from Harborview, Cindy Sayre, Chief Nursing Officer from Montlake, and Keri Nasenbeny, Associate Chief Nursing Officer from Northwest, Anne Browning, our Assistant Dean for Well-Being, and it's my pleasure to welcome Nicki McGraw, who's our Assistant Vice President for HR for UW Medicine. Who's here to answer some of the HR questions this week. So thank you all for being here. And it has been... It feels like kind of a crazy week. I feel like there is growing anxiety for many reasons. I think there's... the weather's changing. The election is coming. There are reports of more cases. And I think for our community this week we learned about and talked about more, this outbreak of COVID-19 at Harborview. So I'm actually going to start by going to Tim, our Chief Medical Officer to talk a little bit about the outbreak at Harborview. And then there were a bunch of questions about it. So I'll ask some follow-up questions once you tell us kind of where things stand. So Tim, thanks.

Tim:

Great. Thanks Trish. And again, thank you everyone for joining us here this afternoon. This has been a really challenging time for our community, and our thoughts go out to those four patients who acquired COVID-19 within our facilities and their families. And in particular, our hearts go out to the patient who died. As healthcare providers, as members of our healthcare team, when things like this happen, it's really devastating for us. Patients come into our facilities for healing, for care in a safe environment. And so when something like this happens, it really impacts all of us. I also want to acknowledge and wish well and recovery. We have 10 clinicians and staff who are infected as part of this outbreak. And we, again, wish them speedy recovery. They are all doing well recovering at home right now.

Tim:

We also, as part, this outbreak have 30 individuals from that same unit who are out and quarantine for 14 days, because they had unprotected exposure to someone who was subsequently diagnosed with COVID-19. Now over the last eight months, I think we have done a tremendous job within UW Medicine, creating a safe environment within our clinics, within our hospitals, for our patients, for our staff. And we've learned along the way, we've adjusted along the way, and that bundle of practices, the masking, the eye protection, physical distancing, whenever possible, the cleaning of the environment, the ease to testing all of those things have allowed us to create that safe environment. And that's evident by when we did serology testing of our 11,000 employees, 2.1% were positive compared to over 5%. When you look at the patient population as a whole whether our patients are all the tests done within the lab.

Tim:

So I truly believe what we have put together in that bundle of practices really has created a safe environment. However, when we look at this investigation, it's also very clear that we had lapses in our infection control practices that contributed to transmission, to patients and to our staff, our coworkers, our colleagues, we saw inconsistent mass cues, and there are challenges here. So for instance, and we'll talk about this more, but if you're in a break room, right? And you're given report, you have to keep that mascot. If you are eating within six feet of someone, you have to be masked and that's challenging. So you have to space more than six feet, right? So, that's the thing. If you're going to be eating more than six foot distance, you can't be eating side by side. And in an environment where you aren't appropriately masked in that setting, we have inconsistent use of eye protection.

Tim:

And again, those mucous membranes are critical to protect. And we also, as part of this outbreak know that we have seen healthcare workers who came to work and worked while they had symptoms. This is really challenging. And I think we're all feeling the fatigue over the last eight months. And so it's understandable from a human perspective, it's really hard to maintain this sort of diligence on a constant manner. And many of us as healthcare workers are so committed to our jobs that in the past we're used to working when we had a minor cold or symptoms, we can't do that anymore. When we come to work with symptoms, we put our colleagues at risk. We put our patients at risk. We just simply can't do that. And so I am really asking our community to come together, to learn from this outbreak. And again, it's contained to one unit we're continuing to work on that unit, but we collectively, as a community, have to take what we see now and learn from this.

Tim:

And going forward, we have to have a 100% adherence to these practices that have worked up until now. We have to have consistent masks use. We have to use eye protection. We have to physically distance, especially when we don't have our masks on and are eating. We have to stay at home when we have symptoms. We just have to do that to protect our patients, our colleagues, our families, and each other. We just need to do this. And so again, I think this is a devastating time for our community, at the same time I think there's an opportunity to learn and go forward, especially as we anticipate potential surge later here in the fall. This is our opportunity to really reinforce and commit to one another and our practices.

Trish:

So, Tim, thank you for talking through that, because it's obviously a space of a lot of emotion for a lot of people and a lot of worry for a lot of people. There were a bunch of questions that came in about what practices we might do to help prevent this from happening again. And I think you've highlighted kind of our infection prevention bundle. Other questions that people asked about was, are we considering testing routine testing of healthcare workers on a periodic basis for asymptomatic healthcare workers? We've talked about this before, but I think the question is, has this changed our approach on that?

Tim:

Yeah, no, that's a good question. In the setting of an outbreak, like what we had on this unit, we did go through and we tested all the patients, because we wanted to identify even those who may not have symptoms. Similarly, we tested all the staff to identify those individuals who, again, even without symptoms may be infected, but we only do that in the setting of an outbreak. We are not going to routinely do a random testing of healthcare workers. At least that's not our plan right now. This is an

unusual situation where we had a clear outbreak and in that setting, then testing healthcare workers make sense. Similarly, like when we have an outbreak say of MRC on a unit, or influenza, or norovirus, it's in those settings where we expand our testing but not on a routine basis, at least not right now.

Trish:

So not right now, testing related to an outbreak only. And then obviously if symptomatic, we ask everyone to get tested. The second question about continuing safety was a question, multiple questions actually about, if we were wearing N95s, if this would have been different in terms of health care workers being exposed?

Tim:

The use of N95s and this setting would not have prevented this outbreak. I feel very confident about that. This was because we had lapses in those basic processes around mask use, eye protection and coming to work when sick. And then we have to keep in mind when we have seen healthcare workers infected throughout this pandemic. When we really look at those, we're not acquiring it from patients. The vast majority of these cases are scenarios where we either have contact with one another, whether it be at work or outside of work in an unprotected environment, meaning where we're not wearing masks and the PPE. Right? And so using an N95 would not have protected or prevented this outbreak. That's not how that transmission occurred.

Trish:

Okay. I do think there's this question about N95s, and I know that... well, I'll ask you, have we talked about N95s in any greater detail recently?

Tim:

Yeah, I would say, and this has been a source of discussion since this pandemic began, right. Between the use of mask and eye protection, gown and gloves, droplet contact precautions for routine care, certainly using N95s PAPRs for aerosol generating procedures, absolutely. Everyone agrees with that. I think there's much less data supporting the use of N95s for routine use, but it's something that we're continuing to discuss. We're discussing it with our infection prevention colleagues, we're discussing it with other healthcare systems, learning what they're doing, and we're discussing it with the department of health. And so it's a topic that we are continuing to discuss. Right now we haven't made any decisions to change our current practices, which we believe have been working, but it's an ongoing discussion. And just as in the past, we've learned and adjusted and changed when new information comes out or we have growing consensus. So we may change in the future, but it's an ongoing discussion.

Trish:

Yeah. And I appreciate the questions because when we talk about these things, we do sometimes change and it just causes us to look at things again. So sometimes like right now, we feel good about where we are and we'll keep thinking about it and talking about it. And we don't think that N95s would have protected folks in this situation specifically.

Tim:

The other piece with the N95s that we're doing some back work on, is working with our supply chain. Part of this is really looking at our supply and our utilization and anticipating if we see 200 patients later in December or January, we need to make sure that we have the appropriate protection for those higher

risk procedures. And so that factors in as well as we really look at our overall utilization rates and supply and ensuring that we can continue to protect our healthcare workers, because that's, again, that's our number one priority. And ensuring that our health care workers are safe as they're caring for patients with COVID-19. And so that factors in as well.

Trish:

So that balance between supply for the folks when we need them and keeping everybody in all situations as safe as possible. So thank you for going over that again. I have one last question for you, and then I'm going to turn to other folks. I think people ask, do we feel like we need to readjust what do, in terms of self out of station, do we think that's still working if we have people coming to work who are sick?

Tim:

Yeah. That's another area of a lot of discussion. And I worry sometimes that we become complacent and just kind of checking the box. And so we have started the pilot activities, particularly at Harborview in the setting of this outbreak. Do we incorporate that into some of the staff huddles at the beginning of the day? So it's not only a self out of station, but it's literally confirming with each individual who's coming and working on that unit that they truly don't have symptoms. And so again, I think, it's something that there's a certain amount of fatigue eight months into this. And so how do we best support people in terms of helping to identify when maybe they shouldn't be working and they're better off staying at home until they're feeling better?

Trish:

Yeah. Maybe we take advantage of the community part of that and do the talking it through instead of just checking or signing like a lot of us do every day. I think it was a great question as well. Jerome Dayao, Chief Nursing Officer Harborview. Jerome, there a bunch of questions about the impact of the visitor policy. So I was wondering if you could just go over what the visitor policy is now at Harborview after these events.

Jerome:

Thank you, Trish for that question. Yes, indeed. Beginning this Monday, we have changed our visitor window, visiting window, rather from 2:00 PM to 6:00 PM daily. So this applies to everyone that's going to be visiting patients at Harborview. We believe that narrowing the visitation window is going to allow us to decrease community for traffic within Harborview, which is going to be essential in preventing the spread of COVID internally. So the visitation policy itself is not changed, meaning to say that we still make exemptions for end of life, for instance. And other reasonable exemptions to be given to patients and their visitors, but for the majority of everyone visiting Harborview, it's going to be from that timeframe. That is the big change. And we have distributed this memo to all staff.

Trish:

So two to six for Harborview, with the same exceptions around end of life and needs for people to be like a caregiver, or something like that.

Jerome:

That is correct.

Trish:

Okay. Relevant to something that Tim mentioned. I think the other thing Jerome, I'll ask you about, and then I'll ask Rick, as well is, concerns about, people wanting and needing to eat, not being able to go outside and needing to stay that six feet apart. So questions about what we're doing in terms of break rooms, and Rick, I'll ask you next about team rooms or clinical spaces for not eating in clinical spaces, but places near clinical work areas where people can eat and still be six feet apart.

Jerome:

We are actually looking at lots of alternatives on that, including areas that are not currently being utilized as break rooms, such as the conference rooms and opening them for the staff to be able to utilize. We are also assessing the viability of utilizing some of our waiting rooms, and transform them into some of those break rooms. But more discussions are to happen with that because part of the important thing that has to happen there is planning because we also don't want to open all of these places. And then everyone congregates in them and defeats the purpose of social distancing.

Trish:

So some strategy on using spaces that we might repurpose to be break spaces for eating with distance. And Rick Goss, Chief Medical Director at Harborview. How about approaches for team rooms or other spaces where people might be six feet closer on the clinical team?

Rick:

Thank you Trish. And thank you Tim, for a really nice summary, which does convey our sympathies to those that are infected. And also just recognizing the months and months of just a tremendous effort on our infection control teams and incident command and leadership to create such a consistent environment. And I think as you said, we just need to look deeper, learn and continue to expand our preventive strategy. And along those lines, the question I think is very much on the, how to fully utilize our space, our rooms, to create an environment of the greatest degree of distancing that we can employ for people who need a break, who are eating lunch, and then the teams. They are doing their notes and having their patient care conferences, we've already created quite a large number of those types of rooms.

Rick:

But I think with this example, we can do more. I'm on service right now myself on the medicine service. So I'm getting a very much of a firsthand look at sort of the flow of the teams and where congregation happens and how these rooms are used. So I did take the opportunity today to go open the doors of about, I don't know, 10 or 12 rooms that are either for meeting rooms, conference rooms, or break rooms. And working with Jerome, working with Paul Hayes beginning, effectively, Monday, we're going to sit down and really map that out, to try to, again, what are the functions that are going on there? How can we redistribute some of that work? And I think what I'm really looking at, and I've already started doing this today, which is much more around what is the actual workflow of the team. It's not just, there's a room available. It's how does that match the proximity to their work.

Rick:

And does it have the number of workstations needed and how can we really build that into the workflows? So that takes a little bit more of a drill down to really help, whether it's the medicine, the surgical teams, the nursing functions and other teams working. So we're really going to take a really

thorough look there an inventory of the space. So I'm sure we'll have more to report in the very near future.

Trish:

That's great. I will come back to that when we returned next Town Hall, because I think that interdisciplinary flow oriented work oriented approach sounds great. And I think people want to hear about kind of what we found as opportunities to do that. But it sounds like folks who are on it and working on it. I'm going to broaden this next question to all the Chief Nursing Officers. And it may be where I bring in Nicki's voice as well. Folks asked about how do we support, one of the things that Tim said was that somebody came to work sick, and I don't want to get into the specifics of an individual, but I think people are concerned that some people may be out of sick days or have below on sick days. And so... I see Keri and Cindy, both un-muting and nodding at me. So I think the question is how do we support people who have limited numbers of sick days? And we really want people to stay home if they're sick. So Cindy, I'll start with you and then I'll go to Keri.

Cindy:

Yeah. Well, thank you Trish. And thanks to everybody for joining. I think that our HR partners have worked to try to broaden the use of other kinds of benefit time to be used for sick time. So for example, if you have vacation time, holiday time, that's been banked your personal holiday, all of that time can be used for if you are sick and need to stay home. So we're trying to do everything we can to make it financially viable for people to do the right thing.

Trish:

Okay. Keri, did you want to add anything before I asked Nicki about it?

Keri:

I think the only thing that I would add would be that, well first let me just say that my thoughts got to Harborview and everybody affected by that. I think we all feel tremendously just that in our departments so these go out to everybody. Secondly, I think the only other thing I would add would just be to say that if you wake up and you feel kind of crappy stay home, you're totally out of all time, we're short right now. We probably could reschedule you later on in the week. Right. So that's the other option. We are really, I think, across all three entities working tirelessly to fix our staffing shortages, because that's the other thing I worry about is that somebody maybe is coming to work because we are short.

Keri:

So that's, I think a work in progress at all three entities is really to boost our staffing levels given our current census level.

Trish:

Okay. So short on staffing, but really hearing it from everybody. If you don't feel well, you have a question about it, stay home and we'll figure out a solution to the staffing and taking care of you. Nicki McGraw, again, guests today, head of Human Relations, for UW Medicine.

Nicki:

Yeah. Thanks Trish. I wish I could come on and give you a really great HR answer to solve that problem, but the fact is there really isn't one. I would just echo what both Cindy and Keri said, that try to work with your manager. There often are ways that they can work with you to reschedule that time. But I also want to go back to what Tim said, it's all of our responsibility to stay home, to protect our families, our community, and our patients and their families and our coworkers. And so we just have to be responsible about that. And so I realized that sometimes puts people in a hard position, but, we will try our best to work these things out with individuals one-on-one if they don't have sick leave. But, know that you can use other leaves because of COVID. As Cindy said, we've opened up other types of leave.

Nicki:

Also in certain circumstances, that there is shared leave available. So talk to your leave specialist if you're in a situation where you're out of leaving and you're not really sure what's available to you, you can ask those questions of them and we can certainly try to work out whatever we can with you, because we don't want people to be in that situation and what we'll try our best to help however we can with that.

Trish:

Okay. So talk to your lead specialists. There may be some creative ways to support people. You're going to partner to try to-

Nicki:

We certainly want to try to do that. Yes.

Trish:

Okay.

Nicki:

That's probably a good opportunity for me to segue into the FFCRA.

Trish:

Hold on. You have to say what FFCRA-

Nicki:

I was about to. They taught me that in law school, but years ago when I became a lawyer, but now a recovering lawyer. I think that's why they asked me to tell you a little bit about this. So in the spring, Congress passed a law called the FFCRA, the Family's First Coronavirus Relief Act, or Response Act, I think it is. And it provides some basic leave benefits to employees. At the time when it was passed, it exempted all employees who worked for medical centers of any sort. And the reason it did that was because of public policy. And they wanted to ensure that the medical facilities would be fully staffed for patients during the pandemic. So any employee who worked for any type of a medical center was exempted from the leave benefits under that law for that public policy reason.

Nicki:

But the Washington department of labor just recently a few weeks ago changed their rules. And it was based on the state law out of New York. Several other States have also made the change. And they've

now changed their law to say that a medical center can't just exempt everyone. So you have to look at every single position type and you have to put it into one of three buckets. And so the three buckets are you're exempt because you're a healthcare worker and there's a definition for that, or some guidelines around that. You're exempt because you're an emergency responder and there are some guidelines around that. Or you're now eligible for benefits under the FFCRA. So when that rule came out, we did a detailed analysis along with our ADs of every single position that you'd have medicine has. And we did that using the DOL guidance.

Nicki:

And all of you received an email from Lisa Brandenburg yesterday that sent out a spreadsheet, and it identified every single position we had and it was color coded and it put them into one of those three buckets. Notifications were also sent to all employees who are now eligible for leave under the FFCRA. So I want to pause right there, Trish and see if you have any clarifying questions before I say anything else.

Trish:

Nicki, thank you. Because I think it is confusing. It has lots of acronyms and we're an acronym group, but that's a newer set of acronyms for us. I think if I'm understanding you correctly at the beginning, no one in our health center could take advantage of this paid sick and family leave. Now, there are some people who work in the health centers who can correct the very specific roles where that's the case. And in general, they're not the folks who are providing healthcare to patients on a regular basis.

Nicki:

That's pretty generally true. The guidelines that DOL gave weren't really clear. That's why people like me have jobs because it was really, really mushy. And we had to go in and look at everything on a case by case basis. There are some general guidelines and generally speaking, people who do direct patient care are still exempt, generally speaking. I'm saying generally and then people who are emergency responders, I want to give you an example. For example, everyone at air lift is an emergency responder. They're just like ambulance in the air, right? So that's an emergency responder, but some of our other folks are not going to... will now be eligible. And I don't want to product cross-reference and guess positions right now because we have hundreds of physicians, but that list does identify a number of positions that will now be eligible for this leave.

Trish:

Okay. So I think, look at the spreadsheet to look for your specific job in general, if your emergency responder like airlift Northwest, or you're a direct patient care provider for the most part, you're still not going to be eligible for this specific benefit.

Nicki:

Under that same public policy reason. That's always been there again. I'll be the first to admit it's clear as mud. It took us a good couple of weeks to figure it out. The benefit start September 16th, there'll be retroactively effective. They run to the end of this year. When you look at the chart, if you have questions, we have leave specialists who are available for you to contact, and you can ask questions about your specific issues. Also, I want to apologize because I have a 3:30 meeting, so I can't be on the whole Town Hall, but Trish, really knows how to track me down very easily. And so I'm happy to come back at any time if you guys have additional questions about that or Trish can track me down during the

week for additional questions. So I have to sign off, but we're happy to answer more questions about this because we know it's a really confusing topic.

Trish:

Thank you for joining us today. I appreciate your explaining that and run off and do your other meeting. We will follow up and I will track you down.

Nicki:

I have no doubt you will. Thanks everyone.

Trish:

Bye.

Nicki:

Have a good weekend.

Trish:

All right. I'm going to actually come back to where we usually start the day, which is with numbers. And I think we deviated from that because of some things that were, I think really at the forefront of all of our concerns right now. I think at the same time, I did get a bunch of questions about where we stand in terms of numbers here across UW Medicine and in the state and maybe even kind of the country. Because I think that, like I said, at the beginning, people are feeling a little sense of increasing worries. So Seth, it's my pleasure to turn to you in lieu of John Lynch, today to tell us kind of our numbers across the system and beyond.

Seth:

Hi, Trish. Hi, everybody. Thanks so much for having me. So we have a total of 22 patients across the system today. So that includes Harborview, Montlake, Northwest and Valley. This includes nine patients who were in the ICU across the system 13 in acute care. And I can break that down by campus. So Valley has 12 patients, and Northwest has two patients. Montlake has two and Harborview has six. And one of those at Harborview is on ECMO. And I'll just say, for context, the census of about 22 patients has been relatively stable since about the beginning of the month where we've consistently been in the 20s. But it is a little bit higher compared to our low point in mid September where we were more consistently in the teens.

Seth:

I'd be happy to talk a little bit about testing as well. So in the past week, we've sent about 3,800 tests across the system with a positivity rate of about 0.8% which is really great and speaks to all the hard work that our folks and our colleagues in the lab are doing. For employee testing, we've tested a total of about 8,400 employees since this all started with a total positivity rate of about 3.6%. And in general, that means symptomatic employees who are seeking testing. Yesterday for instance, we had no employees test positive, but in the last week we tested about 357 of them. And about 1.4% were positive. So we've had a few little spikes and employee positivity rates. And for antibody testing, as Tim alluded to about 2.1% of all of our UW Medicine employees. So we tested over 11,000 staff and about 2.1% had positive antibodies.

Seth:

And I can just transition to what's happening sort of slightly more regional level. So in Seattle, sorry, go ahead.

Trish:

No, that's great. Go ahead.

Seth:

Okay. So in Seattle King County, as you may know, they have a terrific dashboard where you can explore all sorts of trends at kingcounty.gov. There's actually a really nice article in the Seattle times about a week ago that said that Seattle has one of the lowest rates of COVID in any major city, which was really nice to have a little bit of good news for a change. I would say King County still has one of the highest rates in the state. So our rolling positivity rate is about 2.2% over the last seven days, which is up from where we've been. And our current rate of new cases is 92 per 100,000. And that's higher than we would like to see, the goal for the County is less than 25 per 100,000 we're at 92. And then the other thing that we look at is the effective reproductive number, which helps us estimate whether the outbreak is growing or shrinking. And that number is 1.5. That means the outbreak is growing and that's higher than we would like it to be.

Seth:

I do think we're doing a great job in a County of getting people connected to testing quickly. And in general in Washington state infections are up slightly and our state positivity rate is about 3.4% though. I will say that deaths and hospitalizations due to COVID are down, which is also great to see, just in terms of other numbers, rates of new infections-

Trish:

Right. I'm going to stop you for a second. I like to summarize a little bit as you go because otherwise I can't keep track of everything you're saying. So it sounds like the numbers across UW Medicine are stable. It sounds like the numbers in King County are going up and the numbers in the state are slightly going up in terms of testing. And at the same time, we're not seeing an increase in the rates of hospitalization or deaths. Is that right?

Seth:

That's exactly right. Thanks for summarizing.

Trish:

No, that's okay. Now you can keep going.

Seth:

Okay. And then I was also just going to say, the rates of new infections are also highest for people who identify as black, Hispanic, or native Hawaiian or Pacific Islander. And then we're also seeing spikes and people who are age 20 to 29. So certainly, there are specific demographics and pockets that I think are still at very high risk. And then nationally, we've had about 22, sorry, 220,000 deaths, since this began, I think these official case counts are significant underestimates. The rate of new cases in our country is also increasing. We had 65,000 new cases just yesterday. It's really hard to wrap your brain around that

number. That's just yesterday 65,000 new cases. And that's up about 25% in the last few weeks. And certainly certain hotspots in the country are emerging now, like in the upper Midwest, Wisconsin, but also Utah, Montana, Wyoming and Dakota.

Seth:

So anyway, I wish I had more good news to share, but I'll just say, our local rates are relatively low though. There's room for improvement, but the trend is upward and I still think there are significant disparities.

Trish:

Yeah. So we're still seeing the same vulnerable populations with higher rates in our communities. And we're also still seeing a bunch of young people who are being infected, which we've talked about as themes, both of those themes before. You highlighted the kingcounty.gov as a good site for numbers locally. And one of the questions I had was is there a good site for national numbers? Like the ones you were referring to about kind of hotspots? Do you have a go to site for that?

Seth:

Yeah. There are several sites. The CDC is one, and there's a great site called COVID tracker, which does a great job. And then several publications, including the New York times really have very nice infographics that are updated, essentially daily.

Trish:

Okay. I use the New York times, but I'm going to check out COVID tracker. Thank you for that comprehensive review. I'm going to ask a couple related to testing questions for you before I can move on. One is, you told us our antibody testing rate across UW Medicine. And one of the questions that came in is, are we planning to do antibody testing again for employees? Is that on the docket?

Seth:

Yeah. Well, I think it would be fascinating to look at, I don't know if there are any immediate plans to do that. I think most of our work right now is really focused on kind of tightening up our infection prevention practices and making sure we're all prepared for a possible surge this fall.

Trish:

Okay. So no plans right now for antibody testing, focusing on infection prevention strategies. The second one is when somebody is getting tested and they're staying out of work, like we've been talking about, is it required for them to get their testing at a UW site or can they get it elsewhere? And I'll just ask that to start with.

Seth:

Yeah, that's a good question. So I would say yes, we strongly urge health care workers, particularly those with symptoms to get tested at UW. And that's because one, we can get people in quickly and we have an excellent test, but also it's just really important for us to track rates of staff illness. And we really need to be able to quickly identify clusters within our system. And the other challenge that people may or may not know is that with employee health, we're not allowed to access your personal health records. So if you test elsewhere, we are usually the last people to know about it. And so it really leads

to significant delays with contact tracing and patient notifications and all of that. So, I think, if you need a test for pre-travel yeah, you don't have to go to employee health for that, but for symptomatic tests, or if you're asked to get tested by infection prevention, please get tested through employee health. It's really important.

Trish:

Okay. So test through employee house for anything related to symptoms. I think that's clear. Thank you for that. I'm going to pivot to Santiago Neme, infectious disease doctor and our Medical Director at Northwest. And Santiago, I think you've done a lot of work along the way about pre-procedural testing. So I'm going to actually come to you. One of the things... I think everyone's got a heightened sense of worrying about people coming into the hospital and bringing COVID whether that's visitors or patients. So one of the questions that came up was why is it that we test people three days before our procedure instead of closer to the procedure?

Santiago:

Yeah. So when we discuss pre-procedure testing, we basically discuss the whole time range, right? There are centers who are saying five days for us that felt too long because in five days a lot can change. And then we landed in two days, but then two days was a little bit too close in terms of just getting the patient in, getting the result back. So we want it a little bit of leeway that kind of a longer window that was still safe. So that's why we landed on three days we found longer was just unsafe, and closer is impractical. That being said, many patients get their tests the day before, even the day off. It's not ideal because the day off you're using one of the rapid kind of fast turn around tests for emergency. But for instance, for a hospital like Harborview, that does a lot of trauma cases that comes in pretty handy.

Trish:

So generally we're still preferring the PCR if at all possible, because we think that's the best test and the turnaround time, even though good is a little longer. So logistically that's why we're going with three days.

Santiago:

Yeah. And I did want to say that unlike other systems for pre-procedure testing, we're beginning the test collection time with the highest sensitivity, which is the nasal for angel test. We're not doing intra-nasal testing for these procedures. We're doing the highest sensitivity sampling type, which is the nasal for angel, the deep swab.

Trish:

Okay. So the type of test and the logistics are what's driving three days and longer, we didn't think it was safe, but shorter was hard to make that happen in an effective way. I'm going to ask you about two other procedure-ish things. One is there was a question about whether or not there's risk in terms of aerosol generation for laparoscopic surgery. How did you look into that? Or do you know anything about that?

Santiago:

Technically, whenever you insufflate, you insert air and accommodate, you are concerned about aerosolizing and although SARS COVID two is a respiratory infection. We know that there could be some communication with the airway and there's some reports about GI procedures. That's why we kind of

switched to basically any EGD for us is actually an AGP and aerosol generating procedure. That's how we categorized it. Although, the data is somewhat conflicting. Some folks said yes, some folks don't think so. But we decided to take the safer approach and say, all EGD will be that. And then in laparoscopic procedures we're concerned about the insufflation of air, but also these are done under general anesthesia. So, and again, in intuition, as you know, Trisha, is an AGB. So I think it's... yeah.

Trish:

They're going to be treated as an aerosol generating procedure because they're in the OR getting intubated anyway, but we do worry about it. And we extrapolated that. We worry about stuff other than respiratory secretions, so we do EGD is as aerosol generating procedures. I think I'm going to leave it there. I may come back to you with a... Actually, I'm going to ask the group about masks for a second. So we have a bunch of things about masks and one of them I'm going to start with, and I'm looking for people to unmute and volunteer on this one. There's two things that I think people are struggling with. The first one is how do we compel visitors to wear their masks, including when they're in rooms. And so I'm going to look to Jerome, Cindy, I hope Cindy's un-muted, Cindy, can you talk chief nursing.

Cindy:

Thank you. So this is a really important issue for all of our staff and leadership. We have our support from the highest levels of our executive leadership to mandate masks for visitors in the medical center. We are still working on the final touches for an ADA policy that is going to allow for a small percentage of visitors to be exempted or have a different alternative. But for everybody else they have to have a mask on. In support of this we'd had signs developed now that are going to go into every patient room in clinic and she carries holding one up right now. These are laminated signs. It'll be everywhere that basically send a message. If you're not masked, you're going to be asked to lead for visitors. And the ask is that they have them on at all times. I think the story from Harborview also highlights that even when staff are not in the room, we need visitors to be wearing their masks 100% of the time to protect the patients.

Cindy:

So we are taking this very seriously. These signs are going up on now as we speak, and that's the answer.

Trish:

Okay. So new signage, new policy, really pushing to reinforce it. I think it's the whole team's effort to help contribute to that messaging. The other thing-

Keri:

About that, that I think is important is that in talking to patients and families. And I ask myself as a family member recently, I think when you are with a family member that you live with, you think, why do I need a mask on? Right? And so I don't think people are, most people aren't ill intended. And so I think that's some of the work we need to do is to really make sure our families understand the why of this. Because, I think they are taking off their masks cause they're elderly mom can't hear them, or because they live with them and they think, why do I need a mask? And so I think that has to be part of that equation of helping our families understand the importance of masking.

Trish:

Some education for the importance of masking, because at home we don't wear a mask next to each other and they can't hear me. I think that's great. Thank you. The other challenge that I heard, and I think Tim alluded to it, maybe others have alluded to it and that is, I know my colleagues are doing things that I would put in the category of risky behaviors. How do I speak up to say something to them? Or what should I do about the fact that I know this? Some people asked the question, is there a way to report? Some people asked, how do I have this conversation? So I'm going to look at the whole group again and ask for some thoughts on that, which I think could be a difficult conversation. Tim, what do you think?

Tim:

Well, I think, within the work environment, it's a little bit easier, right? Because, we all have to feel it's just like hand hygiene. We have to be able to remind each other to do these practices. The more difficult conversation I think that you're really alluding to is what people do outside of work. Right? We know unfortunately, or fortunately, but people are feeling that challenge of physical distancing. And there is a desire to get together with small groups from work outside of the social context. Unfortunately, that is sometimes where we're seeing transmission occur, that then comes back into the work environment. And so those are tougher conversations. I think we have to try to keep reminding one another, because when I think of the numbers that Seth described and you look at what's happening around the country, the only way we are going to maintain our ability to preserve all of our care for our community and not get overwhelmed, is to continue to do everything together as a community to decrease that risk.

Tim:

So the more we as a community do the lower those projections will become in the future. And so that to me is we have to keep thinking about that we all have a role, not just at work, but within the community to ensure that we can decrease the number of infections so that our hospital doesn't get overwhelmed. And so trying to put it in some context and what our overall community needs to do. But those are tough conversations and it's hard, do we have any authority to sell people no, you can't have a party with X number of individuals, no. But I think how do we do it in a supportive manner, understanding the need to socialize, but how can you do that in a safe manner that doesn't put either you or your colleagues at risk subsequently?

Trish:

Yeah. I think that sense of community and about caring for each other and looking out for each other as part of this, and maybe what you're arguing is the entry to that conversation. I appreciate you talking about it. Because, I think it's a hard thing. And I think we all kind of hear stuff and we want to say something and I guess I'm going to encourage people to speak up to their friends and colleagues and express their concern. I have two quick follow ups and then I have two random topics I need to touch on before we go to ask an ID doc. So Keri, people couldn't see your sign. So I'm going to ask you to send me a PDF of it and we'll send it out with the Town Hall recording.

Trish:

And then secondly, I think people are asking, okay, if I educate the visitor or the visitor, that's still doesn't want to wear a mask. And I feel like I've done my best to whom can I turn if I feel that we're not getting there?

Cindy:

I can take a stab at that. Yeah, well I think if we're not getting anywhere with the visitor with the masking policy, we need to escalate it through our chain of command. So maybe that's the charge nurse and depending on how much resistance you're getting. I mean, if there's a lot of resistance, if I need to escalate to a manager very quickly and then plus, or minus, we might need our pit public safety colleagues to come and help us reinforce the policy. Just depending on the situation. I really do want to reemphasize Keri's point that a lot of this is educational, so we would start there of course. But we need to protect everybody. So we should escalate this pretty quickly, through our chain of command.

Trish:

Okay. So use chain of command, start with listening and understanding and education and if necessary charge nurse, nurse manager of the chain of command. Great. Thank you. Jerome. Do you want to add to that?

Jerome:

Oh, you're up to informing security because we are very serious about the safety of everyone that's inside our hospitals, and that if those would be necessary, that is done as well.

Trish:

Yeah. So public safety or security, depending on the institution is another part of that process. Thank you for clarifying that. I forgot to add it. Okay. I'm going to pivot because there was a couple other things that people asked about that I want to try to fit in relatively quickly. Santiago, first one for you quickly, if I'm doing telemedicine in my office in an exam room and I'm in there alone and nobody else is there, do I still need to wear my mask?

Santiago:

No.

Trish:

No, you do not. Okay. That's a good one. That's an easy one. Thank you for the quick answer, Tom Staiger, our Medical Director UWMC very different question. We have talked about limited lab hours at Roosevelt and other sites and people, there were several questions asking, do we have any follow up on that, and issues related to it?

Tom:

Yeah, so Cindy Hecker, our Executive Director of UWMC, asked Thomas Hay, our Associate Medical Director for ambulatory care and myself to look into the impacts at the Roosevelt lab for reduction in hours and to develop a plan for mitigation. So we've had two meetings with the clinic medical directors and clinic managers. We had a town hall that included Cindy Sayre, Santiago, a wide group of us and now have a better understanding of the impacts and some of the impacts that are difficult to mitigate despite best efforts. There's a meeting on Monday morning, Thomas and I with lab leadership to review a proposed plan. And I hope to bring a plan to Cindy later on next week for mitigation. So more to follow up, hopefully in the near future.

Trish:

Okay. So people can be looking out for some information in the near future and we can come back to it at next Town Hall, which isn't a couple of weeks. Thank you, Tom, for the work on that. It's an area that people are still concerned about. So I appreciate that. Okay. And I'm going to ask you two questions before I hand it to you to ask Tim questions. So there a couple of questions about wondering if there was any updates on support for folks who have an IEP in terms of childcare.

Speaker 11:

Sure. Actually we've got a really good week of work in on the IEP front. That's an individual education plan for kids who have some special needs around learning differences. We're partnering with occupational and speech therapy and they have a lend program which is leadership education and neurological development. And they've been sharing a ton of resources with us. We're posting all of those resources to our wellbeing support COVID-19 page, that's on our faculty site and that's linked from the huddle easily as well. We'll probably have some more information out on our next wellbeing message that we'll share next week as well, but actually some really good progress there in trying to put together some resources for folks.

Trish:

That's great. Thank you for all your work in that. So check out the huddle link to the faculty websites, faculty website, but it's for everybody, the resources are for everybody. The other, one's not really childcare it's a little different, it was someone saying I'm actually new to Seattle because I came here for a new job. I don't know if this person's a trainee, but I thought in my head they were trainee and I'm single. And it's hard to get to know people during this time. Do we have any resources for that or suggestions?

Speaker 11:

I've been thinking about this one since I saw the question come through and it's tough. Most of what I can think of is stuff that we work in a pre COVID. So actually like went to Google. There are some recommendations in terms of kind of how to have social connection and meet folks in new areas. When we're stuck in COVID times even recommendations around best practices for dating apps. So in case that's your situation I would check it out, use the Google.

Trish:

If, you wish a link to that. Some of that in our website, just to acknowledge that challenge.

Speaker 11:

I think so. And overall, as I was thinking about it, I think it's a tricky time where so many of us are staying connected virtually. I think this might be a time where we're really leaning on our connections and relationships that we've developed previously and elsewhere. Since so many of us, I've got tons of friends who are in Seattle and I still haven't seen them face to face in a really long time. So acknowledging that, that's a challenge, but that social connection is so important, even if we're not physically near each other.

Trish:

Right. We say physical distance, but socially connect. And so maybe using your broader network of friends, not physically in Seattle, but can still stay connected socially. All right. I am going to hand it to you to talk to Tim. Who's on the hot seat today for a series of friendly ID doc questions.

Speaker 11:

Excellent. Thank you. So here we go, Tim. Halloween is a couple of weeks away. We've heard John share some ideas around no common candy bowl. Don't have folks come all the way up to your door, trying to keep kiddos physically distanced. I was wondering if, especially as we've seen some numbers take up, do you have any other recommendations or concerns that are emerging now that neighborhoods and communities should be thinking about?

Tim:

And one thing I would recommend is if they go to the CDC website, they actually have a list of low risk, moderate risk and high risk activities around Halloween around Thanksgiving. That's actually a good reference, not only to see what may be more risky or not, but also good ideas. I mean their ideas on there, for instance, do a virtual Halloween costume contest, right? Do an outdoor scavenger hut. If you are putting together a single packs of candy, how to do that. So I think there's a lot of good tips there. So it's not that we can't have Halloween, but Halloween is going to be different. And so it's how do we incorporate these other safety features while still enjoying the holiday?

Speaker 11:

Good. And one thing I know my street is thinking about is trying to get everybody on the same page in advance, because I think it'll be tough if there isn't a conversation and then you've got kiddos everywhere. Lot of questions around Thanksgiving and travel and I wanted to hold some of these for you. First we'll start with some basic travel ones. Folks are thinking about flying potentially around the holidays, potentially sooner. They want to know what would you do? Would you wear a blue three layer mask or would you try and scrounge up a N95?

Tim:

I would not personally wear an N95. I would wear a cloth mask. And then I would also try to get eye protection, like some of the disposable eye protection, or goggles just to watch that as well. N95, quite frankly, I think it would be really hard to wear for a long flight. They're tough to break through and I don't think it's necessary. And I'd also carry a little hand gel with me as well to constantly clean your hands.

Anne:

You mentioned, last time we talked, maybe the time before that you've got some college age kids. Are you going to be able to have your kids come home for Thanksgiving? Have you been thinking about it?

Tim:

Yeah. I have two in New York. They're actually not coming back, but more so because if they come here and then go back to school, one of them dances in New York that then they would not be able to go or participate in their in-person dance for 14 days after getting back to New York. So it's more that they don't want to have that then subsequent isolation and inability to participate in certain activities once they get back. So they're not flying back during Thanksgiving.

Anne:

Generally for folks who might have kids coming back, would you recommend that they have their kids tested when they arrive or tested before they travel home?

Tim:

Yeah. I'm not a big proponent of asymptomatic testing, so if they were able to come back, I would have them here. I may talk to them a little bit about maybe kind of self isolating within our house for the period of time and watch for symptoms, but I wouldn't go and have them tested unless they had symptoms or a known contact.

Anne:

I'll ask you one more kind of Thanksgiving question. Folks are usually gathering around a meal. People are asking, is there any way that they can safely gather indoors with others right now?

Tim:

I think that's really tough. I mean, for me, it's probably going to be more limited to immediate family, children. I would be hesitant to have grandparents over mixed with younger children. And so I think those large multi-generation gatherings are going to be challenging. And I think it's really going back to who's in your bubble and keeping within that bubble which is challenging, but then virtually connect with the grandparents. If they've been part of your bubble, they live in your house, that's a different story, but I think we still have to be careful. And even nationally, if you see Dr. Fauci, has made some comments around these large family gatherings with all good intent, can be at risk as well.

Anne:

Good. Thank you. We'll do a couple of rapid fire – skiing: good idea, or bad idea this winter?

Tim:

I think that's fine. It's outdoors, you can be careful.

Anne:

Would you use an Uber?

Tim:

I actually have a once because I didn't have access to a car in that situation. I washed my hands. I had my mask on I felt pretty safe. I had the window down in the back and it was a short distance more than I wanted to walk, but not that far of a drive. So I felt safe doing that.

Anne:

If you had a kind of physician recommended massage therapy in the past, would you resume that yet?

Tim:

I think those activities, as long as both are masks, they're using hand hygiene, to me it's similar to coming into care, right. So I do think we have to be able to do some of those things that have medical value.

Anne:

Alright. Rapid fire on kids. Sports are starting up, would you let your kid play soccer or basketball on masks?

Tim:

No.

Anne:

Would you let your kiddo hang out with a boyfriend girlfriend, significant other, not physically distanced?

Tim:

Because of COVID or other reasons?

Anne:

They're rhetoric.

Trish:

We're getting way too personal. Last question.

Anne:

Last question. A kid needs to take driver's ed, would you let them do driver's ed with other folks in a car?

Tim:

Yeah. I'd want to know the scenario, and whether they can limit how many kids do all the kids have to be in the car at the same time, or can they do things where they're just one kid and the instructor. But I also feel like we can't... we have to allow people to progress in their development as well. And so if it were my child, I probably would figure out a way to allow them to be able to do that as opposed to saying no, you're just not going to drive for another year. But those are individual decisions.

Anne:

Good. Thank you so much. It's four. So I have to hand it back to Trish. Thanks Tim.

Trish:

Thank you both. I appreciate it. I know everyone really appreciates hearing the insights into these things that we're all dealing with. And as this goes on longer and longer, these challenges become harder. And that's where we started today by saying it's easy to get fatigued right now because it is a lot and there's other stressors in our lives. And I think maybe if I heard one message, it's like, let's keep coming back together as a community because it's by taking care of each other, that we're going to get through this. And that's how we've gotten this far. So it's been, some challenges this week for sure, for a lot of people and for some families, some really difficult times. And I have faith in our community that we will get through this new set of challenges like we have other sets of challenges over the last many months.

Trish:

So time is short. I want to thank Seth, for joining us today. I want to thank Nicki, she's gone already, but I thank her for joining us as well. And thank all of the panelists as always for coming together. I want to thank everybody who's out there who’s watching as always, I'll say taking care of our patients, their

families, and really, like I said, a moment ago, each other. Thanks for coming together at Town Hall, and we'll see you in two weeks. Bye everybody.