Trish Kritek:

Welcome back to UW Medicine Town Hall, I'm Trish Kritek, Associate Dean for Faculty Affairs in the School of Medicine, and it's my pleasure to have many of the same town hall crew with us today, including Santiago Neme, our Medical Director at UWMC Northwest, Tom Staiger, Medical Director UWMC Montlake, Tim Dellit, CMO for UW Medicine, Cindy Sayre, Chief Nursing Officer for UWMC, Jerome Dayao, Chief Nursing Officer at Harborview Medical Center, Keri Nasenbeny, Associate Nurse, Chief Nursing Officer, for UWMC at Northwest, John Lynch Head of Infection Prevention, and Employee Health at Harborview, and Anne Browning, our Assistant Dean for Well-Being. Whew. I don't know, it's been a long week, so I apologize for my inability to say the titles that I know so well, and yet still seem to struggle with each time we come together.

Trish Kritek:

I'm going to actually begin by saying welcome back. It is almost the end of October, which is a little bit remarkable to me, and it is a time of starting to get darker during the day and feeling like we're moving into Fall, and I think it's been a particularly challenging time for lots of us, and I'm going to start of, as we have many times before, going to Anne Browning for a well-being message. Anne?

Anne Browning:

Sure, hello everyone. We have a really challenging week ahead with the upcoming election, and I know we've all been getting inundated with media, so as a well-being piece, I want to start by just thinking about how do we be a little bit more mindful about our media consumption. So two quick recommendations, one, as we move through this coming week, consider turning off the notifications on your phone so that you're not getting buzzes and beeps every time there's another news article that wants to grab your attention, so that you can kind of choose when you want to actually look at the media, and then as you're actually viewing the media itself, before you click and read or watch, I had a colleague reference it as doom scrolling as you're going through and looking at everything that's kind of washing over you, give yourself a moment to pause and think about will reading this or watching this help my well-being? Will I feel better, or am I likely to feel worse if I watch this?

Anne Browning:

Give yourself permission to step back and take a break from media when you can. One thing we do anticipate in this coming week is that we're likely to see continued uncertainty and with it quite a bit of stress and anxiety in folks. So a couple things that we are going to put in place for next week across our community is we're going to hold a couple of virtual spaces for folks to come together no matter what happens next Wednesday, Thursday, and Friday to really kind of think about coping with some uncertainty in our lives right now, and for folks who just need a break, we're also going to do a couple of mindful walks, where we give folks a chance to gather, physically distanced, but get outside in the middle of the day, and still be a community, but to actually take a break from everything around us.

Anne Browning:

We're in for a bumpy road ahead, I anticipate, but I'm really glad that we can do some work to come together in this time. Trish.

Trish Kritek:

Thanks so much Anne, and I would just add that I think the Office of Healthcare Equity, and Paula Houston's team is also planning to have race-based caucuses on Wednesday, so another opportunity for

folks to come together if that feels like the right space to do so, and I want to thank you, Anne, for the work on that, because this has been a tough few weeks, and I think next week is going to be challenging as well.

Trish Kritek:

Speaking of, where we are right now, I'm going to mix it up a little bit today and I'm going to actually start with Tim telling us some numbers. So Tim, can you start off by just telling us where we stand across UW Medicine in terms of patients with COVID?

Tim Dellit:

Thank you, and again, welcome everyone. I also want to just thank Anne and Trish, Paula Houston, our whole community, and especially during this time, lean on one another. It has been amazing how much support you can get from your colleagues. We need to continue to do that. These next two months are going to be tough, I think, from the pandemic.

Tim Dellit:

I want to back out a little bit. We are seeing records set every day. Yesterday 89,000 new cases of COVID-19 across The United States. We're almost at nine million cases since then began, with over 228,000 deaths. In Washington state we are over 100,000 cases, around 105, 8,400 deaths, and we're seeing 600 cases a day. Now, in perspective, we were at 400 cases a day back in April, so we have seen that increase. We're not seeing the impact on our healthcare systems yet like we did in April, but we are seeing that gradual increase in numbers.

Tim Dellit:

King County 27,000 cases, 800 deaths, about 175 new cases a day compared to the 200 that we were at in April. Fortunately, the overall percent of beds by COVID patients in King County is only at 2%. We were at 10% in April. So again, the concern though is that as we see those increasing cases, if they get into vulnerable populations, and we are seeing that growth now in all age groups, not just the 20 to 40 year olds anymore, it's all age groups that we're starting to see that increase within our state.

Tim Dellit:

The last thing I want to say from a national standpoint is if you look at The United States, and the CDC has a great interactive map, the Northwest and the New England Northeast are doing relatively well. The rest of the country is really, and you see this in the news, really significant increases and their healthcare systems are at capacity and overflowing. So again, I really ask all of us, as we go through these next two months, go through the holidays, we have to be diligent as a community to maintain where we are at now. We're going to see an increase, but we need to keep that at a point where our healthcare systems don't get overwhelmed, so I really appreciate everyone, everything we've done as a state to date.

Tim Dellit:

Now within UW Medicine, we have 28 cases right now. So we are still hovering in that 20 to 30 range. The most number are at Valley, they have 15. Overall 19 in acute care, nine in the ICUs. Northwest campus has two in acute care. Montlake has four in the ICU. Harborview has four in acute care, three in the ICU. So it's South King County where we've seen that little bit of an uptick, but we're holding right at that upper 20 range, which is a manageable level right now.

Trish Kritek:

Yeah, we've kind of held there for a while now. I feel like we've had a couple of town halls where we've been in that range. I heard one thing that sounded a little different is we're seeing rises in all age groups, and earlier we were really seeing a lot of rise in the younger age groups, so that's one difference I heard, and then I clearly heard the distinction of the coasts versus the middle of the country right now, which is really feeling the most strain, and I think we all see that in the little bits or large bits of news that we follow.

Trish Kritek:

Tim, I'll come back to you, I have some other types of questions. I'm going to ask, I'm going to pivot to John and ask him one followup question to what we just talked about. John Lynch, Medical Director of the COVID Response. One question we had John, and I know you've looked into this, and that's why I'm coming to you, is there was some press about healthcare workers being a big portion of the folks who are testing positive for COVID. I actually heard the piece on NPR, I'm sure it was in some writing as well, and there were some questions about that. I was wondering if you could, do you have any more detail on the percentage of folks who are healthcare workers, particularly nurses, and I think it was MAs, or nurse's aides, and other folks.

John Lynch:

Yeah, thanks for asking that question, Trish. Just quickly before I answer that, and hopefully, I think we'll circle around back to this is that I understand people's stress, and I really thank you for everything that you're doing, it's just amazing what you're capable of, and again, hopefully we have a convo about it a little bit later, but I'm appreciative.

John Lynch:

In terms of this work, we don't have great national tracking. We, just to be clear, in UW Medicine, we've been reporting all positive and negative healthcare workers since March. We've actually been doing really, really well with that. We're one of the first, and for a while we were the only ones submitting every single healthcare worker positive test regardless of where that infection came from, from early on, and we are talking to Public Health and Safety County about thinking about dashboards for health workers.

John Lynch:

What we don't have right now is great insight into how many health workers in Washington State are positive. We know that there's definitely been a fair number. We've experienced this within UW Medicine. We've really been challenged because one of the important things that I continue to message is that health workers are part of the communities that are having transmissions.

John Lynch:

Just the other day I went and plotted the healthcare worker PCR positivity rate for UW Medicine versus King County, where many of us work, live, but not all of us, and early on we were much lower in UW Medicine compared to the community in terms of those cases, the big peak that Tim mentioned, but really since the spring sort of dropped, if you actually plot out UW Medicine PCR positivity rate for all employees, we've been, it basically just overlaps with the King County rate, and with that, the take home message there is that we are part of our community, and we have the same risk as members of our community, and what I'd really shout out right now and really call to action is that we need to be

role models in the community as healthcare workers no matter what we do in order to help break those chains of transmission.

John Lynch:

You may have seen, just recently there's a CDC, what's called an MMWR article that came out yesterday, that I think the NPR, I didn't listen to the NPR thing, but may have been referencing. This was a study that came from the Minnesota Department of Public Health, which has an amazing public health group. I'll just take some quick take aways.

John Lynch:

It's not really super well written, but one really important thing is this was all healthcare workers. Healthcare workers in clinics, urgent cares, acute care, ICUs, hospitals, but really importantly, long-term care, long-term acute care, and other residential facilities, and in fact, most of the people who fit into the exposure category, and the infection category were folks working in long-term care and residential communities. When we look at the ones who turned positive after an exposure, the vast majority were folks living in those long-term care facilities. We know that they're struggling with staffing, they're struggling with testing, and they're struggling with access to PPE.

John Lynch:

The last thing I'll say, Trish, is when we look at, again coming back to being parts of our community, when you look at the risk for becoming SARS-CoV-2 positive, or having COVID-19, in this high risk group it was 6.9% from a high risk exposure at work, and it was 13% in that same group due to exposure to household or social contact. So twice as high. So we've got to continue to pay attention to what we're doing in the community, because that's honestly, in this study, was twice as high risk than working with patients.

Trish Kritek:

All right, so paying attention to what we're doing both at work, but really importantly outside of work, and it sounds like those data, which are pretty impressive, reflect a lot that there were folks working in long-term care facilities or residential settings who potentially were incurring some risk at work, just to say that out loud. I also hope that nobody in Minnesota is watching our program since you were somewhat critical of their writing.

Trish Kritek:

I'm going to ask you John, you were not here last week and we talked the Harborview outbreak, which I know you have been deeply involved with, and there were some followup questions about it that I wanted to ask you about. The first one was why perhaps we didn't hear about the outbreak sooner than we did, and I think there was email, and then we obviously talked about it at town hall two weeks ago, but that there was evidence of infection before that, so maybe you could talk to that a little bit.

John Lynch:

Yeah, so, I'll admit we can always do better with communication. Our goal is rapid communication and transparency. I will say that I, and we could do better with this one, but I would say we actually acted really, really fast with this and we did share it with the key people very, very quickly. So just in terms of the timeline, really briefly here, we had a patient who was positive on the 29th of September, and then

a healthcare worker who was positive on the October first, so two days later. That right away triggered activity.

John Lynch:

So between that 48 hour period, that's when to test all patients on the unit the next day, and that night we found the next positive patient on that surveillance, and that Sunday night, so this is over the weekend, that Sunday night, I'm not saying I'm better than anyone else, but I was on the unit that night meeting with 70 staff at a time that covered their evening, I think their day, evening, and night, or their evening and night shift, to explain what was going on, in person, what was going on.

John Lynch:

So we closed the entire unit, didn't do admissions, and we were sharing through Jerome's safety huddle at 10:00 AM the next morning. So we were distributing that, we were working with the staff, doing the investigation, doing the testing for all the patients including any on the unit that Monday night, and start testing employees, and communicating through our realtime communications. And again, maybe we could do better, not maybe, we can do better with the larger communications that we use, email and other things, but in terms of the realtime where we're talking about it, conversing with people and communicating with the folks affected right there, that was happening, I would argue, in very much realtime, and very, very quickly.

Trish Kritek:

Okay.

Tim Dellit:

Trish, I was just going to add, a couple other things is that we were immediately in contact with public health once we started to recognize what was going on, and so even though there may not have been a public announcement in terms of in the press until a little bit later, there was behind the scenes work with public health, and part of this is really understanding exactly what we have so we can provide enough information and address the questions. So it's a combination of immediately notifying and working with those directly involved, and then as we have additional information, letting the rest of the individuals both within our community, and then one of the things that makes me very proud about UW Medicine is when we have issues like this, we go public. We do so in partnership with public health, but we want to maintain that transparency that's critically important to maintain trust within the community.

Trish Kritek:

Yeah so-

John Lynch:

I did let public health know that Sunday night when I met with the staff, and we met with them as a group on Monday morning.

Trish Kritek:

So it sounds like a lot of communication was fast. Communication with the Department of Public Health, and some within the institution starting to talk more as we worked through it. I will say as everybody on

this call knows, as soon as some people in our community are hearing about stuff, then the message starts percolating out, so perhaps there's an opportunity to, as soon as we can then, to get it out more broadly because otherwise people get part of the story with understanding of Tim saying we like to know enough to share the story. I hear all of that.

Trish Kritek:

It's relevant that, that discussion is very helpful and relevant to a couple of other questions that came in John, which is people wondering about the contact tracing and exactly who gets contacted because there were people who were saying, "I was in this space," or, "I was a resident who was affiliated, who's supposed to reach out to me," and how do we make sure we're not missing people that we need to reach out to?

John Lynch:

Yeah. It's another really important question that I welcome feedback on, and it is an evolution. So, the way it basically works, really quickly, and Santiago can pipe in here as well, is when we hear about an exposure, an unexpected COVID case, not someone who comes to the ED with symptoms, and signs, someone on the unit like this patient, we go to the chart first and find everyone who documented and that's our first. We obviously talk to the staff lead, the charge nurse or something, if it's on a unit or in a clinic, and then we contact those people, and our team, which is working seven days a week at our sites now, will then hear about additional people. "Oh, someone so and so helped feed that patient, so and so helped me turn that patient, here's how this..." And then we collect more people.

John Lynch:

I think in this process, the group that sort of was delayed, and this is on me, was our provider team, so getting the residents involved. Like, who was in the room, who was documenting, doesn't really capture all of that. Another group that I think, I didn't even know existed, and it wasn't in the information streams as we sent out to infolines and similar, was the research teams. So the academic SOM, there's research nurses going to the floors who don't fall into the same listservs, and I didn't even know they existed in that capacity.

John Lynch:

So there's a lot as we go through this, it's really iterative. We try to move through those iterations as fast as possible, but it's always iterative because there's no way to know who was exposed without talking to people. And I will say that these conversations often take a lot of time, and health workers don't remember every single person who they interacted with. We try to err on the side of being conservative. Like HAs, at Harborview there's two HAs, one person's doing half the floor, the other person's doing the other half of the floor. They see everyone. So we don't sit there and say, "Were you in that room for this?" We just assume that you were there. So we do try to make those definitions work.

John Lynch:

I think this particular outbreak did teach us a lot about some of those groups that were harder to get ahold of, and even with another exposure, I think we were able to move much more quickly through the residents, for instance, the attendings, in terms of involving them with communication and testing, and I think it worked, actually, extremely well with healthcare worker exposure about a week later. So we definitely learned. We can always learn more and do better.

Trish Kritek:

Okay. So what I heard was documentation is where we start. Then a lot of conversations that cascade us out. We found some space where we probably have some opportunities to identify people a little bit better and we've already implemented some things around providers, faculty, and particularly trainees, as well as research, clinical research staff. So it sounds like, as with many things, we're learning as we go and it sounds like we've learned some things from that one. Thank you for walking through that. I think that was really very helpful.

Trish Kritek:

I have two more questions for you about this before I pivot to some other topics. One is something that you talked about before and people asked about again, which should we change our daily attestation because we're concerned it about not really working?

John Lynch:

Yup. So, two parts to this. One is that we were already talking about this in the clinical administrator group, and the UW Medicine EOC. We recognize that, this goes back to the comments made earlier, people are tired, it's hard to do this every day. We've seen drift, I've drifted, me personally have drifted from my attestations at times, I need to be better. So we had actually already started to talk about how can change it up, how can we reinvigorate this, how can we use new technology to do this better?

John Lynch:

When this came along, we recognized that we still are struggling with health workers coming to work with symptoms. Some of them are testing, some of them aren't testing, and that is telling me that our attestation process isn't working in the way that we need it to work.

John Lynch:

We also have some visitors with Department of Health here at Harborview this week just doing a site survey, and they also recognized in their questioning that health workers, some health workers, weren't doing their attestation. So we are actively engaged in looking at other tools. Is it a Kronos tool, is it an expanded Workday tool? Valley Medical Center has a really slick way that every day you log into the computer it pops up and asks you for an attestation. Can we use something like that? What do we do for folks who don't log into computers every day? So we need to have tools for that, but I agree entirely, we are dependent upon those attestations as a moment to reflect, check in on ourselves, make sure we feel good, and then we communicate that through signing that paper, or clicking that, "Yes, I have no symptoms," button, or something similar. So we are definitely working on that right now. Hoping to see something newer soon.

Trish Kritek:

Okay. So stay tuned for something new in attestation, and I look forward to talking about that when we come back to town hall next time because I will say I have a little bit of a rote behavior with it because I do it every day and I have tried to reinvigorate my thinking about it, but I do think we need a change because we've been doing the same thing for a really long time.

Trish Kritek:

The last one that I'm going to ask, last two that I'm going to ask about this is this brought up this question about screening of healthcare workers again as well, and not temperature screening, but actually swab screening. And I know I've asked this question many times, but I'm going to ask it again. Is there any plan to include screening of asymptomatic healthcare workers as part of our plan?

John Lynch:

So we have no plan to do screening at this point.

Trish Kritek:

Okay. And the last question I have is, without going into all the details of what exactly we thought happened, were we concerned that a visitor was a contributor to infection? And the reason I ask is because multiple people asked if we didn't think it was a visitor, why did we change our visitor policy.

John Lynch:

Yes. I would say that first, we are part of a community, we are human beings, we are all exhausted, and we're looking for connection in contact with our friends, our family, our communities, and lots of things. I get it, but I would say the two things that probably, we can never determine this absolutely 100% sure, but the things that contributed to this outbreak were, one, probably a visitor. It took us a long time to learn that this first, the patient, had a family member who had COVID, and was in the hospital visiting her without a mask during her infection period. And despite multiple conversations, including by Dr. Goss, with the family, they didn't disclose that until we were very concrete about asking the question, so it took us a while to figure it out. That's why these disclosures sometimes take a long time.

John Lynch:

On the other side, on the health worker side, when we don't have an identified COVID-19 patient involved, we ask lots of other questions, and healthcare workers are engaging with other people. I hate to use the term risky behaviors, but it's hard to recognize that in current days if you aren't wearing a mask, that means, that other person's not wearing a mask, that means you potentially are exposed, and we've got to move to this really uncomfortable situation where we have to assume everyone has COVID-19, and that is super hard. So I want to be clear I am not blaming anyone, but we do think that visitors and health workers are bringing COVID into the facility. And that's true in that Minnesota Department of Public Health report for health workers and probably links to some of these skilled nursing facility outbreaks as well.

Trish Kritek:

Great. That's helpful because I think people were curious why our visitor policy changed, because we didn't necessarily hear about the visitor part of it right away and it sounds like it took sometime to determine that aspect of it, and I appreciate that clarification. It helps me pivot to, there were still questions, or again questions, about our visitor policy, so I'm going to look to our three Chief Nursing Officers. I'll start with you, Jerome, if that's okay.

Trish Kritek:

One of the things that folks asked was can you clarify if it's one visitor at a time visiting a patient, or is it one visitor per day.

Jerome Dayao:

One visitor per day.

Trish Kritek:

Okay. And how do we keep track of that?

Jerome Dayao:

Well, the nursing units do keep track of that information, so the security, or the screeners up in front, would call when there's visitors that show up through our doors here at HMC from 2:00 PM to 6:00 PM, they check in with the unit and that's how we know if the patient already have had a visitor.

Trish Kritek:

Okay, so you're checking, kind of keep track of it at the unit level.

Jerome Dayao:

Correct.

Trish Kritek:

Keri, I saw you shaking your head, it suggests to me that maybe it's done differently at Northwest.

Keri Nasenbeny:

Well no, I think what we would say is it's the same, it's one visitor per day. We have our admitting reg folks, by and large, doing our screening, and because they have multiple duties they are not able, in general, to call up to the unit to check and see if that patient has had a visitor or not, and so it's not perfect. There are occasions where people might have one visitor in the morning, and somebody else in the afternoon, but we really, I think, try to do two things. One is at the time of admission and also in the surgery clinics, actually are emphasizing that it should be one designated visitor to the degree that's possible. Sometimes that's not possible, but really trying to reinforce one designated visitor to minimize exposure, and then really trying to adhere to that one visitor per day.

Trish Kritek:

So I would say, "Keri Nasenbeny is my designated visitor."

Keri Nasenbeny:

Yup.

Trish Kritek:

And I kind of name that person so that there's clarity for everybody.

Keri Nasenbeny:

Yeah, yeah.

Trish Kritek:

And you could be my designated visitor, I would be happy with that.

Keri Nasenbeny:

Why wouldn't you want a nurse, right? Taking care of you.

Trish Kritek:

Exactly, much better than a doctor.

Keri Nasenbeny:

That's right!

Trish Kritek:

I know. Relevant to visitors, Cindy, this is unique to Montlake, so I'm going to ask you about it, people were asking if we allow visitors at things like the third floor coffee shop. So are there boundaries on where visitors are supposed to be going? There's some understanding that they're supposed to come in and go directly to their room and stay in their room, so could you answer that for me?

Cindy Sayre:

Yeah, things are changing a little bit. For the extended visitors, and those are the visitors where the patient meets and exclusion, we would allow them to grab a cup of coffee. This is changing though because we're making different decisions about visitors eating or drinking in the patient room. So I would say maybe up to this point we have allowed them to grab a cup of coffee and go up and be six feet away from the patient. The rules are evolving even as we speak, and I've seen many drafts of the visitor policy that's going to pivot more toward not having visitors eat or drink in the patient rooms, or in the waiting areas.

Cindy Sayre:

So we're still grappling with, well, but if you have somebody who needs an exclusion, like a patient that has a developmental delay, how do their friends and family, or whoever's that designated visitor, how do they get food and water? Where do they consume? So I guess the best answer and the shortest one would've been to say it's evolving.

Trish Kritek:

Yeah, and I think, thank you. It sounds like the answer's right now it is okay, we're evolving to maybe put some more boundaries on it, but we also have to understand how we take care of the folks who need to be there long-term with somebody who needs their support, and it's really hard to know who those people are when they're in the hospital. There's not an easy way to identify that person as we look, so that's a challenging one.

Trish Kritek:

One last question for the three of you before I, I may come back, but for right now, the other that I'm going to pivot to is questions about masks. So, there's still some questions about who's helping enforce that folks wear masks? And we've asked this before, but the specific question was are, "Are manager, nurse managers helping with enforcing of mask wearing?"

Cindy Sayre:

I would say it's a shared accountability for all of us. I think our entire team, and I have really even stepped up my own game walking through the lobbies, and asking people to cover their nose. I still see people with an uncovered nose. So my answer would be yes, the managers, but we all, every single UW Medicine team member, we all need to be doing this together, yeah.

Trish Kritek:

Yes, I agree with you.

Jerome Dayao:

I concur with what Cindy said. This is the same thing here at Harborview, including John Lynch. John, do you want to share your experience with that?

John Lynch:

The vendor?

Jerome Dayao:

Yeah.

John Lynch:

Yeah, just briefly, I just, I think it's a really great message here is that the managers, and supervisors, and, the directors have our back when we call people out on needing to wear a mask. I ran into a vendor who was drinking a soda in the hallway going over to the OR, and I said, "You need to put your mask on." He just said, "I have this," and kind of went away, and I asked him, I said, "That's not sufficient," and I got from where he was from, and I let Ketra Hayes, who runs the OR, know that he needs to leave until he's retrained because he wasn't listening.

John Lynch:

Ketra communicated it with him, he took care of it, he needs to be retrained before he comes back. But it was easy. It's not, I don't want to do this, but it's straight forward, and the managers, and the supervisors, we all need, just as Cindy said, it's a shared responsibility, but if we're uncomfortable, I think going to our local leaders is very reasonable.

Trish Kritek:

I think going to your local leaders, asking for support, and then I think if there are places where we think we're having particular troubles, I think people would like to hear about that as well, but the shared responsibility is important, and I will take that as a personal charge as well.

Trish Kritek:

All right, and I'm going to ask folks to transition to the Q&A so that we can save the questions so that we can keep a record of them because that allows us to be able to have a durable record.

Trish Kritek:

All right, speaking of masks, Santiago Neme, ID doctor, and Medical Director, I'd like to ask a couple questions about masking. One of the questions people asked was when we were early in this pandemic,

we didn't have enough masks, and now we have many more masks. Does it really make sense to wear the same mask for 12 hours?

Santiago Neme:

Yeah, so Trish, great question, and I think it comes up a lot. Our current process is that whenever you are in a droplet precaution type of room, those masks are single use. So you're wearing a procedure mask, you go in, you finish, you discard the mask. Outside of those situations, then you're supposed to keep your mask unless you are concerned about the integrity of the mask, and we would always encourage the staff, "If you're concerned about the masking, wet, dirty, or falling apart, whatever the concern is, exchange it, no problem."

Santiago Neme:

Currently we have, and John will have this data better, but we have like, 60 days on hand based on the process that we currently have. So if we were to really say, "You have an unlimited number of mask exchanges throughout the day," then that number would be reduced. So it's not like we have an immense number of masks, but it's not like we have too few, so currently it feels like it's a safe balance.

Trish Kritek:

So, two things that I heard were, if something gets on your mask, change your mask, or if it's wet, change your mask. And the second thing is we have enough, but that's with the way that we're using them right now and if we change that way, we would not be in that situation anymore.

Santiago Neme:

Right. Technically we're in contingency status, and 60 days is good, but we're going into, as Tim was saying, the numbers are rising, so we want to be able to do this safely, and we never want to run out of masks, and I think we never will, but that's...

Trish Kritek:

Okay, I appreciate that. I have two questions about things that might generate aerosols because you have been a leader in the aerosol generating procedures categories. So the first one is NG tubes, are they considered an aerosol generation procedure?

Santiago Neme:

No. NG tubes are not considered an AGP. I would like to say, and I think we've said this before, every professional society feels like their procedure is an AGP. They all come from a very conservative approach of, "What I do is an AGP." And we have really, a small working group that's a UW Medicine OR and procedural group that meets twice a month and we actually look at the evidence and look at the data, and we have an agreed upon understanding of what constitutes an AGP, and what doesn't, and if you go on the website, you'll see that one of the, I think it's document number five, has the list of AGPs that have been approved, and it has a disclaimer, there's some, treat like AGP, because there's some areas of controversy and we decided to be conservative and include them, but for NG we're pretty clear, no.

Trish Kritek:

Okay. So there's a group that approves them, there's a process using whatever evidence we have, it's on the web, document five, evidently. The other one is not really a procedure, but people were concerned about toilets, and toilet flushing, is that aerosol generating.

Santiago Neme:

So, there is a study, and I believe it's from Shanghai, that found some viral RNA in the setting of toileting. The issue around picking up viral particles is it doesn't necessarily equate to infectiousness, and to our knowledge, at least to my knowledge, and John probably knows more about this, I'm not aware of any outbreak associated with this type of process or situation.

Trish Kritek:

Okay, so-

Santiago Neme:

Yeah, so you would find viral particles, but the question is does that cross the threshold for infection or transmission?

Trish Kritek:

And it sounds like we have found viral particles, but we don't have any evidence that it transmits infection, right?

Santiago Neme:

Right.

Trish Kritek:

Okay.

Santiago Neme:

Exactly.

Trish Kritek:

Thank you. I'm going to come back to you with some questions in a little bit, I'm going to bounce around a little bit to get through a bunch of disparate things.

Trish Kritek:

Rick Goss, I didn't introduce you before, but Medical Director of Harborview Medical Center. Rick, some folks were asking about what we may be trying to do to decompress the ED at Harborview, which has been quite full again. I wonder if you could comment on that.

Rick Goss:

Sure, well, good afternoon everyone. I think people understand that the emergency department at Harborview is such an important part of the program. 75% of the patients that are coming in as admissions come through the emergency department, and the ED team just does such a phenomenal job with, year in and year out, managing all the different types of cases. No greater challenge than we've

seen this last year, and as we've seen the peaks and valleys of COVID, it puts a particular on stress on the emergency department because people are entering the facility where you don't know what their COVID status is and it's being sorted out right there in that space, and it does add to the uncertainty and the anxiety that we're all experiencing.

Rick Goss:

Some number of, several weeks ago, it was in the surge that we were going through in the summer, that we as a hospital really said, "Rather than using some of our historic thresholds for what we call an emergency high census meeting opportunity," we've really lowered that now to a goal that says, "When Harborview's running with more than single digits boarding, we know we're pushing our environment to its maximum ability to process, to rule in, to rule out patients."

Rick Goss:

So for example, today we had 15 boarders, so that's higher than our goal. So what we do in that setting is all the traditional things of trying to discharge our patients to appropriate places early in the day, to major programs around that, but the biggest change that has allowed us to stay as low as possible, and we're frequently in single digits, much of the time just above, is we are working collectively with all of our partners. With Tom Staiger, and Santiago, and our nursing partners at all of our sites. Working with Valley.

Rick Goss:

When we get to those higher numbers, we are on speed dial with each other. We were communicating this morning because Valley Medical Center is having some high census issues, so we want to try to equilibrate around that, and that is truly how we keep Harborview doing what it does for its mission, keeping our environment as safe as possible, and truly relying on this team and these hospitals to work together to keep everybody as safe as possible.

Rick Goss:

I want to thank everybody on this call, and who are participating in that.

Trish Kritek:

Thank you Rick. So it sounds like lowering our threshold for all of those things that we do when we are seeing high census, so calling something lower a high census, and then a lot of collaboration about moving folks to other sites, and supporting each other. We've talked about that before, but I appreciate you walking through that. I think it's understandable, it causes people to stress because the concerns about risk of infection, and I understand that.

Trish Kritek:

Tom Staiger, I had a question about the ED at UWMC, it was not about crowding, it was about how many HVAC cycles there are for the ED waiting room, and I gave you a preview of that question, because I wasn't sure that would be off the top of your head something you could answer.

Tom Staiger:

Thank you Trish, that was not information I knew at the start of today. However, I reached out to our ops and maintenance team, who have detail on all different parts of the building as to what the air

exchanges are, and just before town hall got back to me saying that the ER waiting room is 15 air exchanges per hour, that it needs to be more than 12, and that in fact it is, there's three fans and it is a negative pressurized area, so that is being outside from that area, so it meets our standards and is a safely ventilated area.

Trish Kritek:

Thank you for learning that, and thank you for teaching all of us that because I'm pretty sure we didn't know that. Tim's unmuted, maybe he did know that.

Tim Dellit:

I just wanted to add one other context piece. So that 12 air exchanges, that's the same standard for our negative pressure rooms for tuberculosis patients, as an example, so it's analogous, so that's actually quite good.

Trish Kritek:

Okay, that's great to hear. I'm actually going to stick with you Tim, and ask you a couple questions. Thanks for showing us how good that air exchange is.

Trish Kritek:

This is two totally different topics, actually, pretty quickly. The first is, there was an email that went out from Jacque Cabe today, and I think we got a bunch of a questions later today saying, "Are we really having a profit? And what does that mean in the setting of having had furloughs for people," and a little bit of distress in reading that, and I thought maybe I'd ask you to reflect on that tension that people were feeling when they read that message.

Tim Dellit:

Yeah, no, absolutely, and I want to comment on, first how we finished fiscal year 20, so at the end of June, and as was in that email, it mentioned that if we hadn't had the stimulus of 126 million, we would've had a $67 million loss. We ended up with a $59 million positive. 36 million of that though was due to the way we keep track of retirement benefits. The other important piece is that's a 1% margin, which means, normal you try to, most healthcare systems try to target a 4% to be able to reinvest in their people, reinvest in their equipment. The other component here is part of why we were able to come out to that degree is because of the expense reduction efforts that we did, unfortunately.

Tim Dellit:

It's the impact of those furloughs that contributed to being able to help stabilize the system. Similarly, when you look at the first quarter of fiscal year 21, so July, August, September, UW Medicine as a whole is ahead of budget by 53 million. Now, 20 million of that is in the School of Medicine, and some of that is just a timing of when they received money, but that is great news. It reflects the clinical recovery. People are working really hard, but it also really is an impact of expense reduction that we had done. If we didn't do all of that expense reduction, we wouldn't have that same positive margin.

Tim Dellit:

I would also say we don't know what's going to happen over the next quarter as we go through and potentially see an increase in the second surge here in Washington State, so I think this is good news. I

also want to emphasize all of these are interrelated, meaning that the only reason it is this good is because, unfortunately, of the expense reductions that we had to do. So I don't want people to have a misimpression that, "Gosh, we didn't need to do all that."

Tim Dellit:

We had to do everything we did to help stabilize the system and prevent permanent layoffs so the furloughs, again, temporary, totally appreciate that was very difficult for a lot of our staff, really challenging. At the same time, it avoided the permanent layoffs and has allowed us to be in a better financial situation as we face the next phase of the pandemic.

Trish Kritek:

So I hear you saying it's a sign of our recovery, I hear you saying it's because of some money that came in and the cost cutting that we did. To be frank, someone said, "Does that mean people are going to get bonuses now because we're in the black?" And I'll just directly ask you that question.

Tim Dellit:

No, no. There are no bonuses. And again, keep in mind, we need to be able to have some margin to be able to just replace equipment that gets broken down, to reinvest, to cover the, if we had merit increases next year, which we didn't this year, so all of those sorts of things, we have to have that positive margin, and if you look at compared to other academic health systems, our margin is much lower than most, and we need to continue to do that so that we can reinvest in our facilities and people.

Trish Kritek:

So margin is to invest in the future in terms of people, programs, structures, and not to give people extra bonus money.

Tim Dellit:

No. And if anything, we want to be able to preserve our workforce as we go through, right? We've seen a lot of healthcare workers who have lost their positions around the country, right? And we don't want to do that. We need to be able to maintain our workforce to be able to care for our patients now, and then particularly if we see an additional surge of COVID-19 patients.

Trish Kritek:

Okay, thank you for talking about it.

Cindy Sayre:

Can I make a comment too?

Trish Kritek:

Sure.

Cindy Sayre:

I think one of the overlays of this is that we are facing some short staffing at the medical centers that is not intentional, and I think people feel it because we are working short. I think this is true at all of our campuses, but this is not a budgetary, this piece is not a budgetary tactic, it has to do with just delays in

being able to onboard people because it's complicated and a long on ramp. So I just wanted to add that. I think people might get confused because we are working short, but that's not intentional.

Trish Kritek:

Thank you Cindy, because there were questions about staffing, and the answer to that one is, we're not intentionally low on staffing, we're trying to hire, we're actively hiring, and it's slower perhaps than usual to onboard because of logistical challenges, is that correct? Yeah, I think it is... It's part of this stress, right? It's the stress of we're busy, we don't have as many people as we want, and then you hear a message like, "Did we really have to do all this?" And I think it's hard to feel like, "Yeah, it was okay," even though I heard you walking through that Tim, which I really appreciate you doing because I think it was, I could see how it would be a hard message to interpret.

Trish Kritek:

Speaking of things that are challenging, I only got a couple questions, but I did get a couple questions about D1, and I think we may, in the next town hall, invite someone from D1 to come join us to be able to answer some questions, but the one I'm going to ask you specifically, Tim, about, is people were concerned about the infection side of having to training about D1 in a room with other people when they're really trying to avoid not being around people, which we've been talking about over and over again. I wonder if you could comment on that part of it.

Tim Dellit:

The training... So first of all, I want to acknowledge, it has been really difficult to do the registration, and I think everyone on the Destination One team recognizes this has not gone as well as anyone would have liked. So I really appreciate everyone's patience, working with their managers, working with their departments, and getting everyone registered for the training.

Tim Dellit:

As we look at this training, we're doing this in a pandemic, and so the training is very different that it perhaps otherwise would be. If you think of how this is being laid out, we have the preflight, which is now optional because we recognize that many people know how to use Zoom, and are very familiar with those tools. We're allowing people to test out of some of the early series of training if they've had any Epic experience.

Tim Dellit:

The next level of training, at least for the practitioners, what we refer to as the 200 series, is all by Zoom, so it's remote. It's still on scheduled times, but it's remote, and not in-person. The piece that is in-person is the personalization tools for those who are on the in-patient side. The thought was, even there, there are people who are already in the hospital, or already on campus, and to be able to personalize, which is a huge benefit going forward for ease of use of the electronic health record, that we really felt needed to be in-person, but we're continuing to evaluate that.

Tim Dellit:

In the ambulatory side, because it's been on Epic, that's virtual. So we tried to move everything away from in-person as much as possible, but we still feel there's benefit, and we have to do that carefully, obviously. We have to be masked, we have to watch the distance, we have to wipe down the environment, and again, as we go forward, if we see changes in what's happening, we'll readjust.

Tim Dellit:

So that's another piece here, and we've had these conversations with the Destination One team. We are very sensitive to what's happening with the pandemic, and watching how that impacts how we proceed with training and the overall program, so we're really paying close attention to that and trying to minimize that exposure risk as much as possible. And again, we feel it's safe. If we had to do it in person with the appropriate distancing, and PPE, but we've really moved to a virtual training for the vast majority of it.

Trish Kritek:

Okay. So the majority of it's remote. The personalization for in-patient is the one that's in-person right now, and I think, I'm going to amplify the last thing that I heard you say, which is, and we're watching how things are evolving, and being flexible in terms of how we might approach as things might change. Is that fair?

Tim Dellit:

That is fair. The other in-person, there's some areas that have new hardware. So if you have new hardware, in anesthesia, as an example, or some of the OB, some of that does need to be training where there's actually new hardware, and you just need to know how to use the system, and it can't be done virtual, but again, even there we're trying to explore how we can do it.

Trish Kritek:

Okay, I appreciate that, and I appreciate the D1 team being open to feedback and hearing from people, and modifying the approach based on hearing what folks are concerned about.

Trish Kritek:

One last question for you, Tim, before I hand it over to Anne, and that is that King County has extended the mandatory work from home order until July, and folks are curious, have we changed our approach to work from home?

Tim Dellit:

Keep in mind UW Medicine is part of The University of Washington, so we have to follow how The University of Washington is moving this, and they are tied to the phases from the governor. So we're in phase two now, we're not going to be increasing. I would be shocked if we increase. Whether we stay at phase two or go back, we'll see what happens in the future, but I just want to emphasize that because we as UW Medicine can't make that decision on our own, it has to follow what the overall university does from a work from home, but I'm not personally anticipating any significant change at least through next spring. I know the County extended out through July, it's something we're watching, but we're trying to stay in alignment with the overall University approach.

Trish Kritek:

Okay. So we're aligning with UW as a whole, which is basing it on the phase system, and we're at phase two. It seems unlikely to change before springtime, and maybe beyond.

Tim Dellit:

Right.

Trish Kritek:

Thank you, and we may come back to this. People will keep asking, and I think we're hearing across the board more concerns that people are having about getting infected, and I think that that's a theme across a lot of the different questions, and to be frank, we had many more questions for this town hall than we have in the last couple, and I think it's because of that sense of anxiety.

Trish Kritek:

And I'm going to hand it over now to Anne to ask a friendly ID doc, because I know that there were a bunch of questions about similar kinds of things in terms of concerns about infection, so Anne, the floor is yours, and I think you're talking to John today.

Anne Browning:

Yup. So thank you John for joining me as our friendly infectious disease doc. We had a ton of really specific questions around the upcoming holidays and questions around travel and gathering. I'm going to try and break those out into some more generalized themes for folks, but first, John, with some increases in cases, do you have any real takeaways around Halloween since that's happening tomorrow?

John Lynch:

I think I'm going to stick with my prior remarks. I think that there's outdoor activities, limited, I'm not worried about candy. Washing hands, and wearing masks. Distancing, masks, and hand hygiene. No parties indoors.

Anne Browning:

Great. So we're going to jump right into Thanksgiving. Can Grandma come to dinner?

John Lynch:

Does Grandma live in Seattle?

Anne Browning:

Yes.

John Lynch:

I am very hesitant about having any in-person gatherings this year. I'm really worried about where we're headed, in terms of the numbers in King County. We're right at 100 new infections per 100,000 over the last 14 days, which is... Back in April, spring, we were at 114 or so, and I'm really worried about where we're headed.

John Lynch:

So my plans right now are to hunker down, and I would love to see something change, and things go in the right direction here in our area, but I wouldn't plan on it.

Anne Browning:

I feel like most of the questions that are coming in now are hyper-specific of, "Can we quarantine for two weeks? What if we all get tested in advance? Is there a way to game the system?"

John Lynch:

I think those are great questions, and one of the Q&As touched on this, so if you're able to lock down in your life for two weeks. Let's say you're in your home, and you lock down, and Grandma locks down, for two weeks, 14 days, then yeah. I think that's a not irrational thing. Testing, I'm not going to advocate it. Testing could have a role in it, people are doing it, successfully, the NBA did it in their bubble, right? So that's what you're making is a bubble of your little family, and that works. The challenge is when people kind of cut it short, or they're like, "I just do this and that, but it still counts." And testing can have false positive, can have false negative, it's only good for about a day from the time you swab, not from the time you get the result.

John Lynch:

So depending upon where you get your test, if it takes 24 hours, it's already not really going to help you anymore. So that's sort of the thing I have with that. Yeah, those tools can work, but they're super hard to really engage in.

Anne Browning:

Some folks are thinking about outdoor gathering, physically distanced, but wanting to kind of go with bringing some food. Would you eat food that another family cooked?

John Lynch:

If they're in my bubble, that's about it. I don't think food's a way to get COVID, this is something you breathe, but I don't want to encourage people to be bringing food over to my house unless they're in my one or two family group.

Anne Browning:

Here's a tricky one. So what if you're a family who has childcare support from another person, that person wants to travel for the holidays and return, do you have them stay masked when they're watching your kids? Do you have them isolate for two weeks? What would you do?

John Lynch:

Yeah, I think asking people to isolate for two weeks if they're engaged in taking care of your kids in addition to being away, is really helpful. So I think that's going to pretty difficult to ask people to do, particularly childcare folks who are generally getting paid by the hour or by the day. Yeah, so that'd be the optimal situation.

John Lynch:

I think it is reasonable to ask them to wear a mask when they're in your household if they're there to take care of your kids. Wash your hands, awesome. Pay attention to those symptoms, and wearing masks. And honestly, having a big, open, transparent conversation about expectations, I think is healthy for them and healthy for you.

Anne Browning:

Good. A lot of folks are thinking travel for Thanksgiving, are even already thinking towards winter holidays, and how do folks come back into our community, whether they're students returning, or colleagues returning to work post-holidays if they've been flying.

John Lynch:

So, I don't think being in a plane is really the issue. The air exchanges, the filtration, most of the plane companies, but not all, are requiring masking throughout except when people are nibbling or drinking coffee, so the planes, I think, themselves, the challenge is the airports, which I'll just let you know that SeaTac has called me and they're very invested in the air exchanges, and filtration, and cleaning, but the Uber, and everything else around it, and also what they're doing at either end.

John Lynch:

I'm not worried about people being on a plane or traveling, I'm worried about where they're going. And someone mentioned what we're seeing in the Upper Midwest versus Texas, California, and Missouri, it's really hard, and even your question about Grandma, all of these things link to the background infection rate. If the rate's low, yeah, doing testing and quarantine is easy, it's going to be fine. When the rates get high, it make it extremely hard to mitigate, and that's the real challenge.

Anne Browning:

I'm going to squeeze in one more question before I hand it to Trish. Restaurants, I see a lot of folks putting up tents outside, with the side panels, not totally sure that life under a tent is really well ventilated. What do you think about winter patio dining?

John Lynch:

Yeah, so I'm increasingly concerned about that. So I'll tell you, really my mantra is, distance, masks, and time. People keep talking about different types of transmission. We just know the longer you're around other people, the greater the risk. That makes sense, right? And those tents are getting more and more and more covered. They started being outdoors, picnic tables, then a cover, and now they're wrapped around, and those open entrances get smaller and smaller because it gets colder, and they're starting to look like being indoors.

John Lynch:

So, I'm not comfortable with that. I've let other folks in this call know that I haven't been to one of those outdoor ones, and I haven't been to an indoor one, but those outdoor ones look like indoors, so easy answer.

Anne Browning:

Well John, thank you so much for being our friendly infectious disease doc. With that I'll hand it back to Trish.

Trish Kritek:

If I had to summarize an answer, it was no, tents outside are not okay. That was the take home on that one. All right, Anne and John, thank you as always to all of the panelists. A huge thank you to everybody who sent in questions. I know I didn't get to all your questions this time. I know there were so many, and I apologize that we just had a lot more, and we'll keep working through them. It may be that we increase our frequency of town halls over time, and if we're feeling like things are heating up, we'll start coming back every week, so just to say that out loud. And I thank you all for coming and joining us for town hall. As always, I'll say thank you to all the folks who contributed, and all of the folks across UW Medicine, for taking care of our patients, their families, and each other. It's going to be really important as we move

forward through next week that we come together and take care of each other. We'll see you back in two weeks, bye.