Trish Kritek:

Welcome back to UW Medicine, Town Hall. I'm Trish Kritek and I'm the associate dean for faculty affairs, and it's my pleasure to welcome you back. I will quickly introduce our panel and then we'll jump into a lot of questions that were sent in, in the last week.

Trish Kritek:

Joining us today are, going around my screen, Anne Browning, our assistant dean for Well-Being, Santiago Neme, medical director at Northwest Hospital, John Lynch, head of infection prevention and the medical technical response for COVID, at Harborview and across UW Medicine. Tim Dellit, our chief medical officer for UW Medicine, Keri Nasenbeny, our chief nursing officer at Northwest. Cindy Sayre, our chief nursing officer at UWMC, across Montlake and Northwest. Tom Staiger, our medical director at UWMC, Rick Goss, our medical director at Harborview.

Trish Kritek:

And with that, I'll say welcome, I will give one caveat to everybody. I had periodontal surgery yesterday, so I have a plate in my mouth and I don't sound like myself. Feel no need to comment on my sounding weird in the Q&A and have sympathy for me, because I really appreciate my periodontist but it's not really my favorite activity. All right, with that, it has been a super busy week, it has been a week of a lot of news about COVID and a lot of information about rising numbers. We're going to jump into that pretty quickly but I'm going to begin the week's Town Hall with a message from Anne, focused on Well-Being. Anne, to you.

Anne Browning:

Sure. Thanks, Trish. We're nine months into this and for many folks, this is nine months into working from home and feeling pretty isolated, from friends and from colleagues. And for some folks who are living alone and unable to connect in with family and friends right now, this is an incredibly challenging time. Some things we've heard this week are folks mentioning that they haven't even had a chance to hug anyone since March. We just want to acknowledge that, that can be such a hard spot to be in. And some of us, we've lost family members since the beginning of this pandemic and moving into this holiday week coming up, it adds a layer of not being able to gather with folks to grieve and to remember, as well.

Anne Browning:

I've been trying to think, "What are some ways in which we can try and connect with folks in a meaningful way, especially in this coming week?" And a little while back, one of my good friends who actually lives on the other side of the planet, she sent me a message and she asked me if I could text her on occasion and just say, "Hey, what are you doing to take care of yourself today?" And even through thinking through that prompt and some of the dialogue that's come from it, I think it's helped me focus on how I'm trying to care of myself and it's been a good way to connect.

Anne Browning:

I wanted to maybe recommend, if you can, think about how, especially if you have folks in your life who you think might be feeling isolated right now, and maybe start that conversation, "What are you doing to take care of yourself today?" And try and actually have those conversations in this coming week. And honestly, if anybody needs a pal to be your text buddy, I'm going to put my email address in the chat and if you want to email me, I will start a string of texting and hopefully get some folks able to connect

in with each other. Take good care, I think this is going to be a tough week ahead but I hope it's actually a week where we can connect with each other, even if it's not in-person, thanks.

Trish Kritek:

Anne, thank you, that was kind and caring and a really wonderful offer to our community, thank you for that, I personally really appreciate it. Okay, John, I'm going to turn to you to start us off. I think there are many questions about, what's the current status? And I'm going to have you start off by just telling us where we stand across UW Medicine and I'll have a bunch of follow-up questions.

John Lynch:

Sure thing, Trish. We have seen a big increase in the number of inpatients, people at Valley, Northwest, Montlake and Harborview. We are currently at 77 patients in our hospital, that was as of this morning, 61 of them are in acute care and 16 of them are in the ICU. The vast majority of the increase, just to be clear, has been at Valley Medical Center, although all of our sites have seen more patients. And I think that the increase in Valley is reflective of the much larger number of new cases, in south King County.

Trish Kritek:

One of the questions that I think folks have is, how do we compare to the rest of the state and what's going on around the states? Maybe you could give that context, and then-

John Lynch:

Yeah. What we're seeing is increased numbers across the state and it's not just positive tests, but it's also hospitalizations. Some of this information is a bit delayed, the most recent update from Washington state shows that the number of new cases has increased dramatically. We're up around 1,700 new cases per day, if you go back about a week and a half, two weeks ago, we were around 1,000 cases per day. We're getting close to doubling, overall, and as I just want to emphasize, that's from November 12th.

John Lynch:

We're about a week out from the most recent update and, at that same time, the hospitalizations had also increased to about 60 patients per day, across the state, and again, we know the number has grown since then. I will also point out that the numbers in King County are actually growing at a much faster rate, so our slope of new cases is essentially approaching vertical. And I've used this term, exponential, before and we're in this exponential growth phase.

John Lynch:

Someone just asked, "How many deaths?" Those data are even more delayed. I want to point out that, when we look at not only cases but hospitalizations, hospitalizations generally take about a week or so or two weeks after the cases start to increase, so we see a delay. And deaths take somewhere around four weeks, actually, Trevor Bedford, a scientists from Fred Hutch, just calculated, it's taken about 22 days, in terms of the lag. And we know this in our own experience, because of how long critical care patients are often in the hospital, it takes a while and we won't really know that for a bit longer.

Trish Kritek:

I think, relevant to that, one of the follow-up questions I had, and I'm just going to ask a couple now and then come back to you, but someone wrote in, "How does the percentage of folks in acute care versus in critical care compare now, to how it was earlier in the pandemic?"

John Lynch:

I think this is a really important point as well. If you think about, we've had three peaks, right? We're in a third. The first peak was in the spring and most of the people in that peak were much older, right? Folks who came to acute care, very, very ill and a large number of those folks end up in the ICU and we had a very high death rate, and that was associated with comorbidities and the age.

John Lynch:

We also recognize that our testing capability wasn't great at that point, it was probably many people were infected who we didn't know were positive, particularly out in the community. In the summer surge that we all experienced, both in Eastern Washington and Western Washington, it was a lot of much younger people, people 20s to 30s, 30s to 40s, I remember talking about this on Town Hall. It was all age groups but it was really concentrated in that group, people who generally didn't get as sick, once they did get COVID-19.

John Lynch:

Although we definitely saw people end up in acute care, in the ICU, and die from all those age groups. What we're looking at now is, really widespread transmission of COVID-19 in multiple age groups, really across the ages. We're seeing in rural areas, we're seeing in urban areas, we're seeing in 20-year-olds, we're seeing in 60-year-olds. And unfortunately, as hard as the long-term care facilities have tried to keep this out of their facilities, we are starting to see some signals in some of those facilities, despite all the incredible work that the folks have done on the ground, to keep them safe. And so it's something that is really throughout the community, and is occurring in all age groups. In many ways, this surge we're in right now is different than the summer and is definitely different than we saw in the spring.

Trish Kritek:

Across all age groups, in the summer was younger people, more distributed than the first surge when it was a lot older, sicker folks. And I think you said this but I just want to pull it out, and there's fewer percentage of patients in ICUs right now than acute care, as compared to before, is that right?

John Lynch:

That's right. Definitely fewer.

Trish Kritek:

And I lived that, the acute care service was much busier than the ICU, when I was recently on service. But-

John Lynch:

I just want to back that up with just one thing, I know you want to move on but one of the really important things I want to acknowledge, that as we think about even a smaller number of people, proportionally, the absolute number is still very, very meaningful and likely to increase. And when we think about our capacity within healthcare settings, all healthcare settings, all hospitals, critical care

units are going to be tested because of staffing and just beds, right? The ability to take care of critical care patients is enormously resource-intensive, most importantly, the people on this call, the nurses, the therapists, and all the people who take care of folks in the ICU.

Trish Kritek:

Yup. I think that we're all feeling that in the ICU. The last question I'm going to ask you now, John, and it's really maybe a request that I got and that is, are we going to start posting updates more often, sending more messages, getting a way so that everybody can see what our numbers are on a regular basis, like we had back in April?

John Lynch:

Yeah. I am 100% on board with sharing as much information as we possibly can.

Trish Kritek:

Maybe we will get to talk with our IT folks about that, because I think people are wanting to see messages from you more often. And I think some more clear transparency about our numbers, day-to-day. Tim?

Tim Dellit:

Trish, just to comment that our situation reports, which come out daily, they are posted on The Huddle. If people go to The Huddle and in particular, it's the password-protected site where you go to look at all the policies and procedures, and then on the right-hand side are the most recent situation updates and so any of our employees are able to access that information. We can think about how we can make that even more readily available, but it is there for people to find as well.

Trish Kritek:

There's a situation report daily now, at least every weekday, for people to go and access. It is on the right-hand column, it's not entirely intuitive but it's definitely there. Okay, thank you. Tim, since you spoke up, I'm actually going to turn to you and say, with the numbers that John's talking about, our command center has been ramping up. We got an email about changes in surgery so I just want you to comment for a little bit, about what are we doing right now to prepare for these or respond to these larger numbers of patients?

Tim Dellit:

Yeah, thank you very much. And as John mentioned, we definitely are in that next phase of this pandemic and, importantly, as John mentioned, we are seeing increases across the state. And what that has led to is, over 600 individuals with COVID-19 hospitalized in our state, including over 80 on ventilators. There is a shortage of beds across the state, especially ICU beds, there are essentially no ICU beds in Eastern Washington right now, very few in Western Washington. And so this is very different than what we experienced previously, and with that in mind, that is our EOC has ramped up, we're meeting in the morning and in the evening, and really focused on, what do we need to do from a bed capacity standpoint, from a personnel standpoint? We feel pretty good about our PPE supply right now, but it's really the space and the people that we're really focused on.

Tim Dellit:

And because of that, we also have been coordinating with the other healthcare systems through the Washington State Hospital Association, to have agreement that, given the lack of bed capacity right now within our region, we all need to decrease some of those non-urgent surgeries. And again, this is different than April, in April, this was an on or off switch, we had the Governor's proclamation and we decreased our OR volumes by about 65%.

Tim Dellit:

Right now, we're trying to do this more as a dial, there's an opportunity for the hospitals to demonstrate that, together we can increase the capacity and meet that surge in bed needs. And the way we're doing that is essentially, and again, this is rapidly evolving, where we're at right now is trying to identify all of those non-urgent surgeries, that would require hospitalization, and postpone them if it will not lead to medical harm for the patient.

Tim Dellit:

We're still looking at each case, looking at the individual from an urgency standpoint, does it need to be done now? And if possible, we're trying to postpone it until after February 1st. And we picked a date that's further out because, originally, we were looking at January 1st and we anticipate things will likely be worse at that time, and certainly not better in terms of resuming those non-urgent surgeries. And so a lot of conversations with the surgical chairs, with our OR teams and there's been some iteration here and I appreciate everyone's flexibility and patience, because things are rapidly evolving, almost on a daily basis. But that's really why we're starting to pull back, as are other hospitals, those surgeries, to build bed capacity and free up potential individuals to help respond to the increased COVID-19 surge.

Trish Kritek:

Okay. Putting off until February 1st, non-emergent, urgent surgeries on an individual assessment basis. I think one of the questions that came in as well, how does that compare, percentage wise, to the amount we cut back before? Because you're saying it's a dial, was is it half as much back? Is it three-quarters as back?

Tim Dellit:

Our goal is to try to... And what we've done, working with our surgical colleagues, is modified the American College of Surgeons acuity triage score for elective surgeries, and looking at both the urgency and the utilization. And to scale this back so that we're trying to achieve what we've referred to as a tier two, but essentially those non-urgent surgeries that would require hospitalization, and try to get 75% reduction in those.

Tim Dellit:

It's not going to be as much as what we saw in the spring, right now, but that's the caveat that we're going to start here. And if we still don't have adequate capacity, then we may need to pull back others. For instance, let me give you an example, for surgeries that are outpatient procedures that don't require hospitalization, canceling those right now doesn't give us anything, from a bed capacity standpoint. Those, we're not pulling back as this first tier, then we'll see how we're doing and if we need to make adjustments, we will. But that's part of the strategy, is really looking at and some modeling to see, "If we canceled these procedures, what does that do to our bed availability and what does that free up in terms of personnel?"

Trish Kritek:

Okay. Making strategic decisions based on beds and staffing, ICU beds, probably part of that as well. And it will still be a continuously evolving situation, so we're going to stay tuned to hear how we continue to dial, potentially back even further. The most common question that we received is a variation around travel and quarantine, based on the messaging about needing to self-quarantine for 14 days, if you leave the state. And I know this is a challenging space but, where do we stand on this recommendation across UW Medicine?

Tim Dellit:

People saw that the Governor put out a travel advisory, basically also urging people not to travel but if they do, that they should then self-quarantine for 14 days after returning to the state. UW Medicine, earlier this week, we just went back to where we were, really, last March and April. And so we issued a travel restriction that is a little bit more strict than the overall university, in-part and largely because we need to preserve our workforce. Because of the staffing challenges that we just touched on, we need to preserve our workforce and so we have restricted work-related travel, and we are strongly discouraging personal travel.

Tim Dellit:

If people still choose to travel, personally, then we are strongly recommending that they follow the Governor's advisory, and then do self-quarantine for 14 days upon their return. It's also important to note, the CDC also came out today in very similar thought of, for Thanksgiving, unfortunately, and I totally appreciate this is hard, but we've got to do this, given what's happening to our healthcare systems. CDC is saying, "Limit to your household and don't travel," and so we are right in alignment with those national recommendations, the state recommendations. And again, we have additional work-related travel restrictions, simply because we need to maintain the personnel and staff to respond.

Trish Kritek:

We have a work-related travel restriction, we have a strong recommendation to follow the state guideline on this. And it sounds like we are strongly recommending people, self-quarantine if they do travel, but that we can't mandate that that's the case.

Tim Dellit:

That's correct.

Trish Kritek:

Is that right?

Tim Dellit:

That's correct.

Trish Kritek:

Okay.

John Lynch:

And I was responding to the Q&A, did you mention the testing burden?

Tim Dellit:

Oh, that's a great-

Trish Kritek:

I have a... Okay.

Tim Dellit:

Let me-

John Lynch:

Related to this.

Tim Dellit:

Yeah.

Trish Kritek:

I know but let it flow, but go ahead, feel free.

Tim Dellit:

John's just an eager beaver.

Trish Kritek:

I know.

John Lynch:

I'm multi tasking.

Tim Dellit:

One of the things that we've really noticed, and the Governor, when he first came out, I think with good intent, also mentioned, "Could you self-isolate for seven days before Thanksgiving, get tested within 48 hours and then gather?" Or testing to allow you to travel. We are really strongly discouraging testing for both of those, because what we are seeing is that we are seeing our testing sites, whether it be within UW Medicine, the city, other healthcare systems are completely overwhelmed right now, with people getting tested to travel. And it is prohibiting our ability to test those patients who actually have symptoms and need to get tested.

Tim Dellit:

And so we've got to reduce that and the message is really, just don't travel, don't get tested to travel, just don't travel. I know that's difficult but that test is a single point in time, it doesn't mean anything about what happened subsequently in terms of your exposures, and it's really causing strains on our ability to appropriately care for those patients who would need to be tested, due to symptoms.

Trish Kritek:

I think just as follow-up to that, Tim, I think the message is pretty clear, that we're strongly recommending people don't travel and that we don't do testing, and get a false sense of security from that testing, and it's putting a burden on our testing sites. There were questions about, are we going to open additional testing sites? And I think it's driven partly by that but also partly because, there are more people who are asymptomatic in our neighborhoods and communities right now.

Tim Dellit:

Well, the city has opened more testing sites, for instance, in south King County. And in fact, our lab medicine is looking at opening a site, potentially, on the university in one of the parking areas near the stadium. Again, I don't think that'll be up and running, probably for another month, because of some of the logistics. But they are trying to increase testing capacity, recognizing that need. And other healthcare systems and the city are doing the same so, yes, we recognize we need to expand that but we also remember we had reagent shortages before as well. And so we've got to be cognizant of that too, when we do a lot of additional testing, then that decreases our supply of reagents as well.

Trish Kritek:

Yeah. Okay. Supplies are an issue there as well, and we're responding and trying to get more testing sites up and running. Last question for you, Tim, before I pivot back to John. And that is, there were a lot of questions about free parking and I think people are worried about taking buses and public transportation more now, in the setting of increasing community spread. I'm wondering if there have been conversations about increasing access to parking for folks.

Tim Dellit:

We very much hear those concerns, we've started to have conversations through our clinical leadership group. We also need to have conversations with upper campus because, for instance, on the Montlake campus, parking is managed by the university. We're having those conversations and hopefully we'll have more updates here in the near future, but we absolutely appreciate the concerns and have heard those concerns.

Trish Kritek:

Thank you. And I look forward to hearing more about it because I think it causes people a lot of distress. John, there were a series of questions about, well, how do we think people are getting... How do we think patients... Sorry, how do we think providers got infected at Harborview, if they got infected at Harborview? And how does that happen when people are wearing masks? And I think it's actually a bigger question, there were a lot of questions about what's happening at Mayo and with 900 plus healthcare providers getting infected. And I think this fear that, we're wearing masks when we're at work and eye protection and yet people are getting infected. I wonder if you could reflect on that a little bit.

John Lynch:

Sure. It's complex, as you implied, it's a complex answer. I don't know much about the Mayo set up or what the response, aside from the media part. And the part that's said in the media is that, they have 900 people who are infected and I think they said 98% of them are associated with healthcare work and community exposures. And remember, Mayo is a huge organization similar to ours, 30,000 people, and so more details, hopefully, will come.

John Lynch:

I will say that, that number is reflective of what we're seeing as well. We are doing a lot of exposure investigations following the diagnosis of patients with COVID-19, as well as healthcare workers with COVID-19. And when I looked at your questions today, I tried to do a quick data collection this afternoon on how many healthcare workers can I say, "That person got COVID-19 from a patient, while masked?"

John Lynch:

And we were only able to identify about five, maybe six, in the whole system so far. I haven't gotten the complete report from Valley yet, and I'm happy to bring this back at our next Town Hall, as I collect data. But it is a extremely small number and, for instance, just to give an example, one of the healthcare workers here at Harborview was wearing a mask but wasn't wearing eye protection, while feeding a patient who was then found, subsequently, to have COVID-19, right? And that goes to our eye protection policy.

John Lynch:

And I just want to be very, very, very clear that I am not talking about blaming anyone, about where they got COVID, right? I never would ever accuse anyone or hold someone responsible for contracting the infectious disease. It's just relaying the epidemiology of what we're seeing, the greatest risk to people is coming from healthcare workers, their colleagues and what's happening in the community. Many of those things are totally out of our control, and it's just a fact of the matter.

Trish Kritek:

It sounds like, I think I heard you say five people that we think contracted it.

John Lynch:

Five or six, yeah.

Trish Kritek:

Five to six people who contracted it, despite wearing masks, in the hospital setting.

John Lynch:

And I've heard about one of our... A UW Medicine person who was at another facility, many of our folks go to different facilities, who got infected, right soon, very, very soon after being around a patient who was then positive, the next day. And where that mask came... The patient's mask came off just a few times, over the course of a head and neck procedure. And gain, but that was one of those and when we look at all of those types of procedures, thousands upon thousands of them, right? We do get these reports but when you look at the greater scheme of things, they appear to, so far, be extremely rare.

Trish Kritek:

Relevant to that, there were a bunch of questions about whether or not we should be asking patients to wear masks.

John Lynch:

Yes. The quick answer is, yes. Remember, in outpatient settings, we expect patients to be wearing masks all the time. Obviously, as clinical people, sometimes those masks come off as we're doing something in

their mouth or in their nose, or we have to look in there or something similar. But yes, on the inpatient setting, in the outpatient setting, we want to empower you to ask patients to put masks on, if they don't put them on themselves, and that includes the inpatient setting.

John Lynch:

We have updated our policies in this but we need to do better around communication, and I just want to give a shout out to some Harborview nurses who thought about this back in the spring. But as our supply chains have increased, as our recognition of the potential of masks has improved and the evidence behind it, I think we've really gotten behind this as a tool to help keep healthcare workers safe. Now, recognize it can be challenging, some patients can't wear masks, there might be medical reasons, there might be a behavioral health reasons. And it's hard for places where there are shared spaces, for a patient to wear a mask 24 hours a day, for the entire course of their stay. There are challenges but, yes, as a health care worker, you are very much supported to ask a patient to put a mask on, when you're working with them.

Trish Kritek:

Okay. I think there's an opportunity for, as you said, more messaging on that, because there were lots of questions about teams coming into inpatient rooms, and whether or not patients could be asked to wear a mask, I think that's an opportunity for us to message that more. I'm going to ask you two quick ambulatory questions, because we focus a lot on the inpatient setting and not as much in the ambulatory setting, and you just brought it up. One is a question about, if a patient has tested positive for COVID and now they want to come back into the ambulatory setting, do we have guidelines on when they can come back and be seen? Knowing that people can be seen, even if they're sick, because we want them to be seen if they're sick.

John Lynch:

Right.

Trish Kritek:

When's it safe to come back?

John Lynch:

We definitely do. We've actually had ambulatory guidelines around discontinuation of isolation for many months now, they've been working really, really well. And this is the time and symptom-based discontinuation of precautions or isolation, when people are in the outpatient setting, that's the 10-day rule. If you're a better, your symptoms have improved by day 10 and you have no fever and not taking Tylenol or something like that, then you can come back to clinic and be seen in a normal way, for any care.

John Lynch:

And as you mentioned, if you need to be seen for any medical reason, we have the capacity to do that in our clinics. And it may not be in this specific clinic, it may be at Harborview, in the restaurant plus clinic, right? Where a specialist can see you in that setting. We do have systems and policies in place to do that work.

Trish Kritek:

10 days of no symptoms and no fever.

John Lynch:

10 days and your symptoms have improved.

Trish Kritek:

Have Improved.

John Lynch:

Right. Not completely gone, just have improved and no fever.

Trish Kritek:

Moving in the right direction and no fever.

John Lynch:

Right.

Trish Kritek:

Okay. Thank you for clarifying that. I know you won't have this answer, but I'm going to put it out there. There are lots of questions about air exchanges and people wanting to know what the air exchanges are. And do you know of any way that people can know what the air exchanges are, in ambulatory, in our wide variety of ambulatory settings?

John Lynch:

Yeah. I want to be careful here because I don't want our outstanding facilities and engineering folks, to get a bajillion calls on Monday morning. And so I would recommend touching base with your manager or supervisor or your medical director, and asking them first so we can pace this out. But not all spaces but many spaces, and particularly our clinical space, is going to be assessed for air exchanges by our facilities teams. It does take work, time, resources, so it's not something you can just look up on a computer, for the most part.

John Lynch:

Clinical spaces where patients are, are monitored regularly. Operating rooms and similar are monitored regularly and the reports are generated, and infection control gets those reports in our hospitals. But for many other settings, those things aren't monitored on a regular basis but they can be assessed. Again, check with your supervisors, check with your managers, maybe it's already been done, and if it hasn't and it's an important tool for your work and your safety, then it's possible. Just, we want to make sure that it's done in a reasonable way, in case.

Trish Kritek:

Okay. Check with your local leaders first and then we can bump it up to the ops people.

Tim Dellit:

But I would also just say that, just as part of being certified to be able to deliver clinical care, the space has to meet certain requirements. And so it's an important question, but I also want to avoid a lot of requests to go out and measure air exchanges, in all of our clinics and everywhere. I don't think that that's necessary, because they are really built to a certain degree of standard. And honestly, the ventilation, as John said, that's measured constantly within the inpatient arenas, the ORs, certainly our pressure rooms. But it's build to a certain code within the healthcare system and, again, I would say that within our hospitals and our clinics, the ventilation is a lot better than what is raised in the media. Is much more in these restaurant environments, much more closed environments, that's not the healthcare situation.

Trish Kritek:

I appreciate that. In general, we should feel relatively reassured that, normally, this is where we have good air exchanges. I think it's just knowledge, people want knowledge because it's an anxiety-provoking time. I don't want to inundate anybody but if we could share it publicly in some way, that might make people feel better, we can think about that. I'm going to actually pivot to this question, to either John or Tim, really quickly. There've been a couple of questions in the Q&A that have come in that are asking, "What are the modes of transmission in the community?" And I just heard Tim saying restaurants and indoor settings, and I didn't know if one of you wanted to comment on where we think the majority of community spread is occurring.

John Lynch:

It's actually really hard to know, there have been some theories. We do think restaurants and bars are major drivers of transmission, if you look at the data from other cities, that's definitely been published. These are places where people are close together and, by definition, many of them are unmasked, particularly bars where people are really close together and people are less than inhibited around being close and following precautions.

John Lynch:

We also think, theoretically, that people are gathering as temperatures have dropped. Some of those, I've learned this term, Netflix and chill or a Seahawks game, you have a person or two or three or five over. And I remember hearing this early on, we sit on opposite ends of the couch but you're sitting together for two hours, right? Watching Netflix, that's not what we mean. And so I think it's a lot, a lot, a lot of small gatherings and restaurants, and bars and the occasional unmasked yoga or spin class.

Trish Kritek:

Okay. Thank you. And I know that we're hypothesizing and I don't know what Netflix and chill is, but I'm going to leave it at that for now.

John Lynch:

I learned it this week.

Trish Kritek:

Okay. Thank you for teaching me. Santiago, I'm going to start engaging some more voices so I'm going to have you wear your ID doc hat. There was evidently a rumor or a concern that we are having... We are reprocessing N95s and people are using N95s that somebody else used before, is this the case?

Santiago Neme:

No, it's not. We're not reusing N95s. Initially, we were investigating different methods and companies to do that, but we're not doing that anywhere in the system.

Trish Kritek:

We are not reusing N95s and certainly we're not reusing someone else's N95.

Santiago Neme:

Oh, for sure. We're not.

Trish Kritek:

There were a bunch of questions about, if someone in my household is being tested for COVID and I am a clinical worker, do I need to be tested for COVID at the same time, before coming back to work?

Santiago Neme:

We don't recommend, we haven't been recommending that. What we do recommend is that, when that employee... When that family member is positive, we know the person is positive, then that's a signal that we need to get tested. But in the absence of a positive test, we're not testing the employee.

Trish Kritek:

Okay. So-

Santiago Neme:

At least for now, whether that changes as the transmission rates go up, then that's something to be evaluated. But our policy, our protocol doesn't recommend that.

Trish Kritek:

Does not say, "You need to be tested if someone in your household is being tested."

Santiago Neme:

Unless you know it's positive.

Trish Kritek:

Yeah. Okay, if that's positive then do you need to be tested?

Santiago Neme:

Yes. For sure.

Trish Kritek:

Okay. Just to close the loop on that one. As we've changed our visitor policy, and I'm going to turn to our chief nursing officers in a minute, to talk about visitors. There was some questions about whether or not we should test the limited visitors we're allowing into the hospital, now. Support people for patients during labor or folks who need a caregiver, has that been something we've discussed? Santiago, I'm asking you.

Santiago Neme:

Oh, sorry, I thought you were asking one of the CNOs.

Trish Kritek:

Oh, I said before I go to them.

Santiago Neme:

Oh, sorry.

Trish Kritek:

I was giving them a heads up, I was coming to them next.

Santiago Neme:

Okay. The question is whether we test the visitor, correct?

Trish Kritek:

Specifically the visitors who are come... The limited visitors that we have now for labor and things like that.

Santiago Neme:

We're not testing them. We're not testing regular visitors.

Trish Kritek:

Okay. Is it something that we've discussed? I guess, is the question.

Santiago Neme:

We have disgusted it in the past, it just becomes very cumbersome and complicated.

Trish Kritek:

Okay. For right now, no testing of the extra visitors and then I have one more question for you, before I go elsewhere. And that is this concern about team rooms and space for teams in team rooms, strategies on how to keep people six feet apart when they're trying to do work in a room.

Santiago Neme:

This is a very challenging question, we continue to work with facilities around limiting some of the capacity. What I would say for folks to feel a little bit better about this, when we run into problems around tight spaces is when folks are not wearing their mask. To be honest, we've seen a lot of tight spaces and the mini-clusters that we've identified, were not really related to the space, they were actually related to the fact that folks remove their masks as they were typing, it's a long day, it's a long call day.

Santiago Neme:

And that's the factor that we're identifying, it's not ideal to be in a small space and we certainly work with facilities around that. But when we look at the folks who acquire COVID, have been around those

settings, in the setting of having lunch, in the setting of eating something or talking without their mask, that's the area where I would focus. I don't know if John or Tim or anybody have any other questions, but space is a struggle and finding a space to eat has been a problem.

Trish Kritek:

Yeah. I think maybe not eating in the team rooms is part of that, but.

Santiago Neme:

Exactly. Right now, a lot of the team rooms would have a sign that says, "Beverage alone," so small sips are okay but no eating. But it's the talking, it's the chatting, we've seen a lot of those.

Trish Kritek:

Okay. Last, John, even the whole time you were there, it's challenged to... It's a challenge to stay apart and I think we're working on spaces. Okay, I am going to transition to the chief nursing officers but I can not do that without acknowledging the multiple people, who have corrected us and raised our alert to the fact that the phrase, Netflix and chill, has a meaning that perhaps was not at all what John intended.

John Lynch:

I apologize. I was not told that was the case, I thought that was just people come over and watch Netflix together.

Trish Kritek:

And evidently, if you Google it, that's not the case and so, with that, I'm pretty sure everyone who doesn't know what it is, is Googling it right now.

Tim Dellit:

It's a learning environment, it's always good to learn.

Trish Kritek:

It is. We are learning, I just learned and I want to thank the people who clarified it in the chat and acknowledge that, I think it was said with very good intentions and not knowing that, I certainly didn't know that.

John Lynch:

I just meant watching Netflix together, that's all.

Anne Browning:

Do not Netflix and chill, it's not good for stopping community spread so to anyone, let's just avoid it, avoid that.

Trish Kritek:

Okay. And with that, this will be known as the Netflix and chill Town Hall, and I'm going to pivot to our chief nursing officers and try to refocus. Cindy, Jerome and Keri, there are a bunch of questions about screening hours and whether or not we're going to increase the hours that we have someone at the

front desk, screening. And with the caveat that we also are changing our visiting, I'm not sure if those questions have faded. Cindy, are there any plans to change our screening hours of folks, bringing screeners at the front entrance?

Cindy Sayre:

I can say, for the Montlake campus, that we're reevaluating our staffing model for the screeners. We've been using float personnel from ambulatory care, we're going to switch over to maybe more dedicated screening roles. And I think that might be the time when we reevaluate the hours.

Trish Kritek:

Okay. Jerome, anything different at Harborview?

Jerome Dayao:

Nothing different from Harborview, the only difference here is we do have dedicated individuals, doing screening for us. But there's no discussions yet, about changing the hours but we are continuing to look at it, as the visitation changed.

Trish Kritek:

Okay. Maybe changing the folks at Montlake. Keri, how about you? Any difference in screening?

Keri Nasenbeny:

Nope. No changes at Northwest, Mm-mm (negative).

Trish Kritek:

Okay. Maybe dedicated folks and no changes in hours now, but as with everything right now, things are changing rapidly and I think we'll keep re-assessing them. There were a bunch of questions about, are we going to start redeploying staff? And I'll just tell you, in partnership with those questions, were concerns about furloughs, particularly as we start talking about not doing all the surgeries that we might be doing right now. Keri, I'll look to you because you're un-muted, are there plans in place for redeploying staff?

Keri Nasenbeny:

Yeah. I think that's a really... It's a great question and an important question. Right now, we're in a space where the OR schedule is rapidly changing. And that's obviously, I think, the place where we will have some staff available, we just don't know to what degree because we're going to keep doing those day surgeries. And for Northwest, that's actually a significant portion of our surgical population and we've been short-staffed, I would say, in our OR.

Keri Nasenbeny:

For sure there will be some staff that will likely be redeployed, but it won't be to the same degree that it was last time. Because that day surgery population, that urgent, emergent population will still continue. Over the last week, we've been doing a lot of work around planning for that, thinking about what are the rules that we need and how do we solicit volunteers? Et cetera. And how do we do that differently and better, this go around, given we know what we know, we know what we need and the learning that we had from the last experience?

Trish Kritek:

Okay. Some redeploying coming up, perhaps, looking for volunteers, not the same scope as before because we're going to keep trying to do some dialing up and down, as we talked about. Cindy, there are questions about furloughs so I'm going to look to you and ask you, are there planned furloughs?

Cindy Sayre:

And the answer is very similar to what Keri just said. I mean, we're living in such a space of short staffing right now and it's just going to start next week, that we dial down on the surgery. We have to live in that reality for a little while and assess what the staffing needs are going to be. I will say, we're not making furlough plan, I have not been doing that this week. We are working to make sure we have enough staff, still, this week. Now, next week, we're going to be in a different reality.

Trish Kritek:

And would I be correct in saying, there's no plans for furloughs right now? We're going to assess it week to week. And right now, we're still short of staff, is that correct?

Cindy Sayre:

That's correct.

Trish Kritek:

Jerome, do you want to add to that at all?

Jerome Dayao:

Yeah, we are faced with the same situation. We need lots of staff, including trained up servers within our hospital. And we are committed to making sure that we have these individuals so if there would be excesses of staff, which we're not anticipating that there's going to be a lot, that they will be utilized in their full capacity, however we can use them safely, utilizing their competencies.

Trish Kritek:

Okay. I'm going to say it again, right now, no plans for furloughs. This is obviously a dynamic situation so we will revisit this question because it's, I think, going to percolate up again. My last question for the three of you is, again, about a focus on ambulatory a little bit. We've restricted visitors in the inpatient setting, has there been discussion of restricting visitors in the outpatient setting? Go ahead, Keri.

Keri Nasenbeny:

Yes, we are restricting visitors. And so the policy was updated to say that, "No visitors are allowed in the ambulatory setting," unless somebody needs a caregiver to accompany them to their appointment. And I think that's true across all of our settings, I'm looking at Jerome and Cindy. I can't remember the exact language but it was around needing a caregiver to accompany them.

Trish Kritek:

Okay. And I see Santiago nodding too so we have restricted visitors in the outpatient setting, unless you need a caregiver to get to the appointment or be with you during that appointment, is that right?

Keri Nasenbeny:

Mm-hmm (affirmative).

Trish Kritek:

Okay. Thank you very much. Relevant to this, shifting gears, Tom and Rick, I'm going to look to the two of you. There were questions about how we're putting patients with COVID on different services and whether or not we're ramping up new services, as we see these rising numbers. I'll start with you Tom, to talk about what's happening at Montlake.

Tom Staiger:

Yeah. At Montlake, we admit patients with COVID as a primary diagnosis to our medicine services, both our teaching and hospital services, or to the MICU service. If they have some other primary diagnosis and COVID is a less serious problem, they might be admitted to an oncology service or a surgery service. At Northwest, we admit patients to our hospitalists there and we are actively engaging in planning, including with many of the folks who are part of this Town Hall, in identifying what our medical staff surge staffing plan will be as the number of patients increases, which we certainly expect to occur over the coming weeks. And so we were looking at redeploying some people who are under utilized, moonlighting options and other ways of meeting our staffing needs as best as possible.

Trish Kritek:

Okay. And Rick, do you want to reflect, what's happening on Harborview in terms of that?

Rick Goss:

They're pretty similar to what Tom outlined, as we anticipate the surge and model at different thresholds, we've anticipated how we would expand the team structures, both in the ICU and in the acute care, there's really not new services, there's just additional services. Similarly, if there's a primary diagnosis that's other than COVID, but the person happens to be positive, to the extent possible, that primary team would manage with, of course, the support of the COVID consultation. And then supporting, perhaps, ED expansion with tents, things like that, where we would be looking to bring medical staff and others there. Pretty similar to what Tom outlined.

Trish Kritek:

Okay. Potentially increasing ED capacity with tents, going to primary services if positive for COVID but not sick with COVID, per se. And that our medicine, various different medicine and medical ICU services for folks who are sick with COVID. And it sounds like we're starting to talk about redeploying people and bringing folks, extra hands on board, more to come on that. Rick, I'm going to follow-up with you quickly on one of the thing, which is our response for folks who are marginally housed and homeless.

Rick Goss:

Sure.

Trish Kritek:

Have we ramped up support for that, over the last week or two?

Rick Goss:

Well, here's what I can tell you that I know. And folks like Dr. Sugg and Tricia Madden and others have a lot more of the detail. But fundamentally, our primary program's working with Pioneer Square, the ED respite at Harborview hall. All of that, we've continually been very focused on vulnerable, homeless, working with the vans, the testing. What I know is that, the primary way to scale that work is really working with the King County Department of Public Health.

Rick Goss:

And so there's a lot of interface there, understanding the pressures right now, that are expanding to better facilitate what's called isolation and quarantine facilities, that allow people who are either symptomatic or waiting a test to have a safe place to be, that also requires enhanced transportation to safely have people move into those spaces. And of course, the turnaround time on the testing is really important because you want to be able to quickly identify, whether somebody can be in a homeless environment or needs a private hotel space. I think the major challenges continue to be transportation and safe facilities, that I know our teams are working very closely. I think that's Harborview and King County's overall.

Trish Kritek:

Ongoing partnership with King County, the resources were talking about in terms of Pioneer Square Clinic and our vans, and really focusing on places for them, for patients to stay if they're positive, where they can be quarantined and get testing turnaround as well as the transportation.

Rick Goss:

Yeah.

Trish Kritek:

Thank you. I'm going to try to fit in, there's so many questions and I'm so sorry for the fact I'm never going to get through all of them. I'm going to pop around really quickly, on a bunch of disparate questions. Anne, I'm going to start with you because I asked you to look into this. There were a lot of people who were frustrated with the fact that we're still playing football, this weekend, and I know that you reached out to the athletic department to touch base, so I'm going to just ask you what you heard.

Anne Browning:

Sure. They sent me quite a few... Quite a bit of information back, they are doing daily testing with all of their student athletes. And so far, across the pack 12, they haven't seen any spread within the athletic setting, positive cases have come from roommates or social gatherings. And overall, they're actually seeing the rates for athletes whose teams are in season, their COVID rates are actually much lower than the general student population or athletes who are out of season. They're realizing that the opportunity to practice and play is actually, so far, keeping folks really adhering to public health guidelines. As of now, they are not planning to shift gears but I trust that they're paying pretty close attention, and tend to focus on student athlete well-being.

Trish Kritek:

It's a hard space and I can understand people's frustration, and particularly as we limit what we're doing, it can feel dissonant, so I appreciate you reaching out and trying to understand the perspective. Tim, I'm going to ask you a quick question about, are we going to restrict nonclinical visitors like vendors or research auditors, or other folks who are coming into our institution? Do you know anything about that?

Tim Dellit:

I think the research auditors are trying to do virtually, whenever possible. I think the vendors, we have to really start to look at too, especially if they're coming from out-of-state, they would fall into the Governor's travel advisory. And so each of those, we have to look at, what is the clinical need? There may be some that we absolutely need, but I think we have to look at those on an individual basis and limit those that are absolutely not essential.

Trish Kritek:

Okay. We're examining that a little bit more. Anne, there were some questions... There was a lot of frustration, actually, about wanting more backup care, and I'm handing you a question that I actually know the answer to. Do you want to update us on backup care, for childcare?

Anne Browning:

Sure. We actually had a big win in the last 24 hours, we had heard from some physicians that, the big news is actually expanded emergency care. And so right now you get up to five days with Bright Horizons emergency backup care. We were able to lift that so now folks who are in clinical service can have unlimited backup care, for the rest of the year until, basically, our resources are exhausted, folks are green-lighting that. I'll mention, the way to do that is by emailing childcare@uw.edu and I'll put in the chat, what you have to include in that email but, as of now, unlimited emergency backup care.

Trish Kritek:

It's a big deal for a lot of people who are feeling stressed, about needing backup care at short notice, with more people testing positive. Thank you for your work on that. John, do you have any updates on COVID vaccination plans?

John Lynch:

I don't have much on the plan, aside from saying that, UW Medicine is very much to engage in this. Our operations team is working very hard in the emergency operation center, we have folks working with the Department of Health, we have a large system intact for getting prepared for this. UW Medicine has also completed a recent, very complex survey that needed to be submitted, to allow access to vaccine when it comes out. I'll just stop there, we're doing all the work, I have to say I'm very excited about this potential, the news releases look extremely promising. We're going to get ready to make this happen, should it become available to us.

Trish Kritek:

Getting ready so we're ready when it comes, and it sounds like we'll keep updating people on it as we learn more, yes?

John Lynch:

I promise.

Trish Kritek:

I know you will.

John Lynch:

I'm thrilled to do so.

Trish Kritek:

Okay. As am I. And I will say, I'm curious to ask a bunch of questions about remdesivir, this app to contact trace, whether or not we've had people test positive again for COVID. I know there's a bunch more questions, I however, also want to hand over to Anne to do a brief, ask the ID doc, because we had a bunch of questions that she was going to ask to John. I'm going to hand it to Anne, to ask those questions and, in advance, apologize for lots of really good questions this week.

Anne Browning:

Good. Thank you. We're putting Dr. John Lynch on the hot seat for, ask a friendly infectious disease doc questions. Folks are concerned about transmission within their household even, and so they were wondering, do you use an air purifier in your house?

John Lynch:

I do not use an air purifier in my house. I love cold, fresh air, so we tend to keep a window cracked open, much to the chagrin of my family.

Anne Browning:

I've a couple of folks ask questions around, with the rising number of cases, how are we feeling about having kids in daycare, childcare? Would you still send a kiddo, five years or younger, into daycare right now?

John Lynch:

Yeah. I think I want to be honest about this and it goes back to that thing, Santiago's comments. We have tools that we know work and if those tools are being used, that everyone is being completely transparent, all the parents, all the families, all the teachers, about this, the steps that they are taking, I believe that can happen safely.

Anne Browning:

Cool. Thank you. Folks are also wondering, more school-age children knowing some private schools are open, there's some pressure to open some public schools, would you let your kid attend, if there were school-aged kiddos?

John Lynch:

I have two middle school kids and I don't think they should be in school right now.

Anne Browning:

Okay, good. Next one's pandemic survival, would you have a house cleaner to support your own sanity, right now?

John Lynch:

Yup. I think we covered this before and I haven't changed my opinions on that. If I wear a mask, if I'm around that person, if they're wearing a mask when they're in my household, if I space out my

household, they move from one room to another and we flip it, I think that, that can be done reasonably. Again, with the windows open, if at all possible.

Anne Browning:

Cool. I'll have this as my last one. Say somebody is in a holiday cookie exchange, this is not in break rooms within hospital spaces, this is within their community. Would you take those cookies and set them away for a while or would you dig right in, to cookies baked in someone else's house?

John Lynch:

I love cookies and it would be impossible for me to resist eating them immediately. The evidence just continues to accrue that, we're not getting COVID from surfaces and definitely not from food. The issue, just to be clear, in healthcare environments is, we don't want people unmasking together and eating, in the same thing. That's the issue, It's not that the food is giving you COVID, it's the activities around the food and this slippery slope that we'll all jump onto when we start engaging in those group activities. But as far as someone dropped off cookies at my front door, you're welcome to, I will eat them all immediately.

Anne Browning:

And we'll put John's address in the chat as well. And congrats to the person who asked the cookie question, dig right in. With that, Trish, I'll pass it back to you.

Trish Kritek:

Thanks so much, Anne, and thanks, John, again, for being on the spot. I'm going to close today by acknowledging that this is our last Town Hall before Thanksgiving. We've talked a lot about Thanksgiving and we've talked about how this is going to be a different Thanksgiving. And for me, it's a special holiday, I love to cook, I love to share my food, it's hard not to think about sharing my food but I'm still going to cook. And I love it because it's about being grateful, and Anne talked about this being a different Thanksgiving and I'm going to make my Thanksgiving slightly different, by taking this moment to be grateful for a lot of things, in a public way, that I don't normally do, I usually do it around the Thanksgiving table.

Trish Kritek:

I want to say thanks to all of my family and friends, who have supported me in small and big ways this last year, it's been so important to me, a special thanks to Andy who tolerates me day in and day out. I want to thank the amazing ICU team at UWMC Montlake, who have been outstanding to work with in the last couple of weeks, but all year. Nurses, doctors, therapists, [arches 00:57:23], pharmacists, social workers, everybody, it's a privilege to work with you.

Trish Kritek:

I want to thank all the people on this call who've become my Friday afternoon family. For putting up with the questions I ask of them, smiling, laughing, and answering honestly, I really appreciate it. And then I want to thank the whole UW Medicine community, because I have been inspired by the way you've come together to take care of each other, the last several months. The questions you ask, the thoughtful ways you take in the knowledge we have, and then challenge us to evolve. I really appreciate all of you and I feel honored to be part of this community.

Trish Kritek:

And with that, I'm going to say thank you, again, like I always do. Thank you for taking care of your teams, whether they be clinical teams, research teams, community teams, learner teams. All the care that you provide to your teams, to our patients and their families, and most of all, for taking care of each other. I wish you all a different but really wonderful Thanksgiving, and we'll see you back in December. We'll be back week to week, for the month. Take care. Bye-bye.

John Lynch:

Thank you, everyone.

Anne Browning:

Take care, y’all.