

Trish Kritek:

All right. Welcome back to UW Medicine Town Hall. I'm Trish Kritek, the associate dean for faculty affairs and it's my pleasure to have you back for UW Medicine Town Hall. I think we have a whole complete cohort of folks today. I have Tim Dellit, the chief medical officer for UW Medicine, Santiago Neme, medical director at the UWMC-Northwest campus, John Lynch, medical director of infection prevention and head of the medical response for COVID for UW Medicine, Jerome Dayao, who is the chief nursing officer at Harborview Medical Center, Anne Browning, assistant dean for well-being, Keri Nasenbeny, the chief nursing officer, UWMC-Northwest, Tom Staiger, medical director, UWMC, Cindy Sayre, chief nursing officer, UWMC, and Rick Goss, medical director, Harborview Medical Center. And, for those of you playing at home, I've never gotten through that completely with getting everyone's name and title correct, and I will continue to work on it.

Trish Kritek:

I hope everyone had a holiday that brought some joy, even though it was different than their usual holiday or happy to be back with you. I'm going to begin by saying the number of questions that we got about vaccines was higher than any other category by a lot and it's completely understandable why there would be so many questions about vaccines.

Trish Kritek:

Tim and I will have made the decision that next week's town hall will be predominantly focused on all the questions around vaccines. So, that will be our focus for next week. We'll answer some of them today, but know that we're going to dedicate next week's town hall to talking about vaccines and that you can send in more questions about them. I'm collecting them from this week and I'll add to it from next week for next week's town hall. So, I want to say that up front so that you know to plan for that.

Trish Kritek:

With no further ado, I'm going to hand it over to Anne for a well-being message.

Anne Browning:

Sure. Thanks, Trish. In talking with several colleagues yesterday, one of them remarked that it's starting to feel a lot like March, meaning that we're scrambling throughout to increased COVID cases without a clear sense of how bad it's going to get, but a whole lot of concern about what is being predicted. If we think back to how we experienced March and there's so much stress and anxiety, our fuses got shorter and shorter and shorter and the gap between stimulus and response, in which we try to choose how we respond kept on getting smaller and smaller.

Anne Browning:

We're feeling that now as kind of tensions are rising. I want to think about how we talk to each other and how do we communicate. We're feeling brittle and exhausted from the last nine months and needing to find the energy to really go again.

Anne Browning:

So, I'll mention a couple ideas. The first, our brains have mirror neurons whose sole purpose is to understand the emotional state of the folks with whom we're interacting and unconsciously, we start to

mirror back those emotions. Our patients, our colleagues, our families are experiencing stress and anxiety and fear and our default is to mirror with those emotional states.

Anne Browning:

The big thing I would want to mention today is that calm is just as contagious as fear. When we can show up intentionally with calm and compassion, we can actually shift the emotional states of the folks around us, and that's a challenge when we're under stress and anxiety, too, but being intentional about sticking with calm and compassion can help us hold that space between stimulus and response so that we can react as our best selves even when we're in really challenging moments. So, hang in there, you all. Thanks, Trish.

Trish Kritek:

Thank you and I definitely think that we're all feeling it a lot more recently, both when I was in the hospital, when I was on service and now back out in the administrative world. So, thank you for that piece of advice.

Trish Kritek:

Tim, speaking of kind of people feeling it, I'm going to turn to you first and ask you to reflect on our current numbers and kind of how we're preparing for what we're already feeling and that is the second surge.

Tim Dellit:

Yeah, no. Thanks, Trish, and thank you everyone for joining us again and for all the work you're doing, both caring for our patients, but really taking care of one another. I thought Anne's message was spot on. We definitely are feeling that increase in intensity. Part of that is a reflection that we've crossed over the hundred patients within our four campuses now this week, for the first time since last April, so we are feeling that increase.

Tim Dellit:

That's indicative of what we're seeing across the state where this time, compared to the spring or summer, the entire state is feeling that increase in number of patients and you may have seen that on the front page of The Seattle Times here today as well, where we're seeing roughly a thousand patients across the state, 20% within the ICUs in our hospitals.

Tim Dellit:

Within UW Medicine, again, we continue to meet twice a day through our EOC and a lot of other work going on and because of that, I really think even though we're feeling that increased intensity, I do always try to step back and reflect, we are in a much better shape and position right now than we were last March. We have that infrastructure and structure and we'd learned a lot about the virus, the response, and how to support one another over the past 10 months. And so, I do think we are in a much better position now as we continue to go into this surge.

Tim Dellit:

I just want to highlight a couple of things. Many of the hospitals around Washington State including us have now started to decrease non-urgent surgeries and procedures that require hospitalization as long

as it doesn't cause medical harm to the patients, and by doing so, we have been able to build some capacity from a bed standpoint within our systems.

Tim Dellit:

Again, our EOC is really focusing on do we have enough beds, do we have enough people, and do we have enough supplies to safely care for these patients? And we'll hear more about the supply component with the N95s from John later.

Tim Dellit:

There's also been a lot of coordination with the Washington State Hospital Association Department of Health in the governor's office, again, looking at what are the hospitals doing to maintain that capacity and we're really working together on that, but also then trying to reflect what can we do to decrease this community transmission that we're seeing that is causing the number of patients in our hospitals essentially to double every three weeks right now and that is not a trajectory that we want to continue.

Tim Dellit:

There's also encouraging news, as you mentioned. A lot of positive news around the vaccine, and so I'm starting to think about this and others are looking at this, that there is a light at the end of the tunnel when we start to think about this vaccine. It's not the sole answer. We still have to do all the other things such as masking, the physical distancing, those aspects as well, but there is light at the end of the tunnel. And so how do we now develop that roadmap to get to the other side of this pandemic?

Tim Dellit:

And while this is incredibly difficult, especially now during the holiday season, but all of us, as a community, not just within UW Medicine, but our larger community, really have to take this opportunity to hunker down and really look at how do we get to that other side, especially now that the vaccine is likely to be here, available for health care workers by the end of this month.

Trish Kritek:

So, that's the third time today that I've heard light at the end of the tunnel, so I think we're all kind of thinking, "Think I'm going to take that optimistic review about the vaccine and how that's going to change the landscape and really intensify our efforts," as we do see increasing numbers across the state as well as within our system. And I'm going to ask John to delineate those more in a minute.

Trish Kritek:

I think, Tim, I want to ask you a couple more questions that came up a fair amount of time in the submissions and those have to do kind of hearkening back to March as well. The first one is that there is a rising series of questions about concerns about furloughs. So, I was wondering if you can speak to the concerns about a second round of furloughs.

Tim Dellit:

Mm-hmm (affirmative). Yeah. So, I just want to be clear. There are absolutely no plans right now to issue furloughs. What is happening and quite frankly, the best way that we can avoid furloughs when we see shifts in volumes, so we may see shifts where maybe some areas are less active, such as if we do decrease our non-urgent procedures and surgeries and some areas are going to be more active. Having

the ability to redeploy and shift people from an area where it's less active to an area that's more active is a great way to avoid furloughs. And, in order to do that, we are actively negotiating with the unions around how do we do that? How do we do that in terms of redeployment if we need to do that? And as part of that conversation, we're trying to essentially come to agreement of if we reach a situation where we were to have to consider furloughs, how do we do that and we'd rather have that planning and agreement in terms of how we do that in advance as opposed to trying to do that when we're in crisis.

Tim Dellit:

And so, that is the distinction that I want to emphasize. Yes, there is planning in terms of with the units up, if we had to do that, how we would do that but there are absolutely no plans to do that and all of us absolutely want to do everything possible to avoid using furloughs. We don't want to do that and, in fact, again, I think it's going to be quite busy, but we also have to think about worst case scenario and if we do need to do that, we need to have a plan in place.

Trish Kritek:

Okay. So, no furloughs right now but there are conversations ongoing, so we're prepared if we need to and an emphasis on redeploying to meet the needs that are evolving over time. The corollary to that question is many months ago, we said, "Faculty can't be furloughed." That was the situation and people wanted to ask, "Is that still the case?" There were going to be discussions about whether or not there were changes and what the impact could be on faculty?

Tim Dellit:

Yeah. Faculty are not able to be furloughed right now. This really goes back to the faculty code and the impact for faculty across the entire university and so that is not an option. And again, I just really want to emphasize, we are doing everything possible to avoid any sort of furloughs but, again, I think it's important to do planning.

Tim Dellit:

The other piece I just want to highlight is last April, we got caught where we have this shift in activity, but we weren't able to match when we had these low volumes. And so that's where really impacted and felt like the timing was just not there. Again, we're really trying to avoid that and learn from what experienced earlier. And again, if there is a change, we will absolutely let people know, but we are not contemplating that at all right now.

Trish Kritek:

Okay. One last question, which was the second most common question after vaccines, which is, "Where do we stand with conversations about transitioning back to free parking?" People have expressed concerns that buses don't feel safe because people don't routinely wear their masks and the financial constraints of paying for parking.

Tim Dellit:

Yeah, no. I understand those concerns. We are trying to do things to help from a financial standpoint. There still are the emergency funds that are available that people can apply for. With the parking itself, one of the differences right now compared to where we were in the spring. In the spring, when we shut everything down and we didn't have patients coming in, we actually had the parking was available. Right now, there is no availability in the parking because we're still providing that care and patients are using

that parking as our staff. And so it's a little bit of a different situation. We definitely have heard these concerns. As I mentioned last time, too, it has to be a conversation with the university who actually manages the parking for UW Medical Center. Harborview is a little bit different but UW Medical Center, the parking is managed by the university.

Tim Dellit:

And so, there have been discussions. I think it's something that we can keep front of mind as we're going forward but right now, there's just not available parking in the lots to begin with, but it is something that we are continuing to monitor.

Trish Kritek:

Okay. So, no change in parking status yet and it's being heard and there are ongoing discussions. So, I know folks feel passionately about this. I want them to know that you're hearing them, as well, about it.

Trish Kritek:

Okay. I'm going to pivot to John. John, do you want to just tell us where we stand with each institution real quickly on patients with COVID?

John Lynch:

Yeah. Absolutely, Trish. So, as of this morning, as Tim mentioned we're at 103 patients. Just to give a sense. We started off the week around 96, jumped on 104, 109 yesterday and that 103 today. Valley has 37 patients with COVID-19, 28 in the acute care unit, nine in the ICU, a couple in their birth center, which is always important to remember how this is impacting all populations and that's the first time actually this week they've been below sort of 50-ish, so that's good news.

John Lynch:

Northwest is up at 29, 26 people in acute care, and three in the ICU, and I think Santiago's going to talk a bit more about their numbers here shortly. Montlake's at 14, nine in acute care, five in the ICU, and Harborview's at 23 with 11 in acute care and 12 in the ICU, including three people on ECMO, the heart lung bypass or ECLS. So, 103 total, as Tim mentioned, the highest numbers we've seen since the spring.

John Lynch:

One thing I just want to call out is the incredible work, especially throughout the hospitals in COVID care but the acute care teams, the nurses, the docs, the therapists, the social workers, the case managers who are effectively discharging people with COVID, so they're getting people well enough to go home, is making a huge difference. And that's really the result of everything we've learned over this last year to how to take care of people and it's leading to, again, that ability to safely discharge people home, because if it wasn't for that, we would actually be well up, like probably closer to the 140s or 150s in terms of patients.

John Lynch:

And the other part is the isolation precautions that we put into place, that discontinuation at day 10, at day 20 have also really, really served us well, as well as while keeping everyone safe. So, those things have really been a game changer.

Trish Kritek:

So, the rate of rise seems a little bit less and it sounds like the rate of rise might be a little bit less mostly because we're discharging patients in a more expedited way and clearing people from needing precautions to allow us to keep taking care of folks.

John Lynch:

Correct.

Trish Kritek:

Okay. I'm going to ask, I'm going to drill down on some stuff that came up in the questions that are kind of tangents on that.

Trish Kritek:

So, one of the questions that has come up before is, "How often do we have people test positive when they're getting a kind of screening test, whether that's because they're getting admitted to the hospital for another reason or because they're going to have a procedure or surgery?"

John Lynch:

Yeah. So, I try to dig into that a little bit. So, when we look at the pre-procedure positivity rate, so people who don't have symptoms who get tested, it's been pretty stable between two and 3% for quite a while. It's really hard to pick trends because it's actually got a lot of noise. It depends on how many people are getting testing and the day they get tested and so forth. So, that's been pretty stable. And that allows us to effectively have those folks either reschedule their procedure or proceed with their procedure under airborne precautions, so it improves the safety all around.

John Lynch:

For the medical admissions, I actually talked to the hospitals team here at Harborview about this yesterday. And so the question is, of the people who are getting tested who we don't think have COVID-19, who aren't suspect or thought to possibly have COVID or we know have COVID from history, of those folks who just get tested, the rate is actually very low and the way we look at that isn't that we're tracking for that reason specifically, but we're looking at those patients as potential exposures, so that's someone who is positive unexpectedly, who is off in one of the floors where we're not expecting this to happen.

John Lynch:

And that actually happens pretty rarely. We do see it. Everyone is very meaningful when it happens, especially if you're one of the health workers who's part of that exposure. It's a big deal and that's appropriate, but it doesn't happen very often.

John Lynch:

And so what I really think about that, I think that the emergency medicine teams, the clinic teams, the acute care teams, the ICU teams are doing a really good job of really delving into asking people about those subtle signs and symptoms of COVID-19 and making sure that their suspicions or concerns are dialed the right level. We're not missing people at a high rate.

Trish Kritek:

Okay. So, it sounds like two to 3% of people before procedures, that hasn't changed with a higher rate of community spread that you can tell for sure.

John Lynch:

Right.

Trish Kritek:

And then the second one is people who come in and then subsequently test positive when we didn't think that they had COVID is a small number. Are we still testing everybody as they get admitted to the hospital or not?

John Lynch:

We're testing everybody who comes into the hospital and we are retesting people regularly in certain scenarios. So, for instance, ICUs, if you're negative, you get retested. If you're getting an aerosol-generating procedure on the acute care floor, you're getting retested. We are retesting the people currently living in respite at Harborview. Some of the psychiatric floors are retesting as well because they're congregate areas, and it depends upon which unit, but we are doing regular retesting in a number of scenarios and always reassessing where we can expand that and improve that retesting.

Trish Kritek:

Well, that's relevant to my last question on this topic and I have two more after that for you. But some people ask, "Well, why don't we just retest everybody a couple days after they come in," in case they could have slipped through those cracks you were just describing?

John Lynch:

Yeah. It's not an unreasonable question. I think the real challenge comes into some extent's a little bit logistics and a little bit of supply chain. And why I say that is that we have four hospitals, each with hundreds of patients in them and operationalizing, retesting on an every other day basis or every third day basis is doing a lot of testing and, in terms of the ... I mean, our lab is doing amazing work. Tens of thousands of tests, over a million tests so far, but I would say that, between the symptomatic folks who need testing at UW Medicine, the employees who need testing, the pre-procedure testing, they're kind of bumping up against the ceiling there, and so adding more to that cart,-

Trish Kritek:

Carton of tests, yup.

John Lynch:

... number of tests, it would be a big challenge for us and run up against reagents and so forth. So, we're always balancing those things. And when I look at the few number of folks receiving this thing, it's not perfect and balancing, again, is really exceeding our thresholds, capacity. That's what's something we're dealing with every day.

Trish Kritek:

Okay. So, something that we've talked about and consider not doing because of the logistics and the supplies really and the time that it would take to turn around those tests. Okay. Thank you.

Trish Kritek:

I've two other topics to touch on before I do follow up with Santiago and Keri about the numbers. There are people who are worried about numbers of staff who are testing positive and curious about us sharing. I think you've said many time that we don't share individuals who are testing positive to maintain their privacy but numbers of staff who are testing positive. Where do we stand on sharing those numbers?

John Lynch:

So, Tim had mentioned this at our last town hall. It's actually my fault. I didn't go back and confirm but we share, I report out the employee testing numbers and the day of the week and overall every emergency operation center meeting Monday through Friday. We only have them on weekends. And I believe those numbers make it into the report that's published on The Huddle. I'm looking at Tim a little bit, out in the corner pocket there, but we report those out to a very large EOC group every single day and those are included in that report as far as I know. So, yeah. I'd say it's-

Trish Kritek:

And even if they're not included, you would be okay with them being included?

John Lynch:

I have no problem with them being included. This doesn't violate any HIPAA or any concerns on our part and I think transparency is important. That's why I report them out abundantly. And, in fact, I've even changed the sort of PowerPoint so that everyone can see them. They're not just hearing them. They can see them every morning.

Trish Kritek:

Okay. I see Tim unmuting.

Tim Dellit:

The only thing I was going to add is I absolutely agree, we should share that information. The caveat is we don't separate that out by where they may have been exposed or been infected, so it's just any of our employees who get tested, here's how many, but I just want to make sure people don't misunderstand that that is a reflection of people who are getting infected at work. It's really not. It's just of people who are employees, how many people have tested positive regardless of where they may have been exposed.

Trish Kritek:

Right. It's positivity, full stop, not work exposure caused positive necessarily because we aren't discriminating between that and what we report.

John Lynch:

Right, and I did, just before this meeting, just touched base with the Harborview exposure team to ask them are they seeing more people who are positive health care workers? They go back and look at all of

them in the hospital or in the community. And the response back is it's really seeing a very large number of, the new increase is really in the community.

John Lynch:

I also want to just mention, I'm going back to the transparency, Adam Parcher, who's one of our amazing member of our team, did say they're posted in the sitstat report, so the situation status report bottom right of the COVID piece. Thank you, Adam.

Trish Kritek:

Adam always chimes in when we have any questions about what's on that page. Thanks, Adam, from me as well.

Trish Kritek:

Okay, John, I have one more question and it was question number three in popularity, and that is there is a new policy around N95s, and there were a lot of questions about N95s. So, I'm going to actually ask you simply to walk through what the new policy is and I may have a couple follow-up questions based on the questions that came in.

John Lynch:

Yeah, absolutely. So, on the last town hall, which was before Thanksgiving, someone asked me about this and I said, "We are looking at it as an infection prevention team." Are there opportunities to use what supply we have in a different way?

John Lynch:

Last week, working with the supply chain team, Erik Walerius and all that group of folks, his team was able to actually find a new supply of N95s. And so, he pursued those, as I mentioned in my message yesterday at a very high cost, but it was an investment that UW Medicine leadership thought was absolutely appropriate and timely.

John Lynch:

So, that investment was made and they literally arrived on the dock Wednesday night and yesterday. When those things arrive, so we don't believe this until it happens. We want to see it actually arrive in the dock before we make changes, but we had enough confidence in that that we decided to start accelerating the plans that I started talking about a couple weeks ago around expanding the use of respirators.

John Lynch:

So, when we think about respirators, remember, there's two pieces. It's not just having the respirator. You also have to make sure the respirator fits the person. That's called fit testing. And that's done in different ways but we've done it at all of our facilities for a long time, but it does take effort and not everyone is fit tested.

John Lynch:

So, when we think about using respirators, expanding use of respirators, we also have to make sure that we can fit test all the people who are appropriate, as well as having the models. So, one of the great

benefits of this supply chain work is that the models we're able to purchase are the models that we historically also use in our facilities. These are the 3M 1860 regulars, 1860 smalls, which doesn't cover everything, but is a huge benefit and allows us to kind of put those into supply.

John Lynch:

And for people who are fit tested, who are right now in the first phase, working with people with COVID, we've going to test our first phase, partly because the limitations is making sure everyone's fit tested and stocking, that we can go ahead and make that happen today. And I know this has happened at Montlake and in Northwest as well.

John Lynch:

And then, as we are able to expand fit testing, we're going to expand access to the respirators. We really want to make sure that we're using the respirators safely and appropriately. We want to make sure that the benefit of respirators isn't really the material, it's the fit and we also want to, behind all this, as I mentioned, is that our current process is safe. The surgical mask, the eye protection that we're using are safe. That has been demonstrated time and time again, in our testing, in our monitoring, our exposure team workups and evaluations.

John Lynch:

So, it is not something that we see as signal of concern. What we see is a supply chain solution to something that we committed to back in the spring as an infection control team. I don't remember when we started town halls, but we did make a commitment early on that when we have enough supply to align with CDC regs, we would shift to that. And as of literally Wednesday night, 48 hours ago, we have enough supply to make that commitment because one of the key measures here is, as we make that commitment, we're making a commitment that is lasting for months.

John Lynch:

And I'm not sure who's going to talk about this but when we think about the surge right now, we're thinking about December, January, February, March, not just the next two weeks. And so we really want to be able to make that commitment so we can sustain whatever practice we put into place throughout that entire arc, because I really don't want to put people in that emotional space where they are using a higher level of PPE and then we are taking it away from them, for lack of a better term. That's not a good position and I don't ever, ever, ever want to do that. So, there's a quick explanation.

Trish Kritek:

Thank you for going into it and I think this is okay. I mean, I want to ask a few follow-up questions because I think it's important. So, we got a lot more of them, so much so that we feel like for the longer, not long, forever, but longer term, we can provide N95s.

Trish Kritek:

So, a couple discreet questions. Is it mandatory if you're taking care of patients with COVID to wear an N95 or not?

John Lynch:

It is not mandatory at this time. It is optional and, again, focused on the areas where we know there are COVID patients, you know this person has COVID. And we can get into the subtleties of that definition, but for the sake of time, we're going to focus on optional use, fit-tested folks in the care of COVID patients.

Trish Kritek:

So, I am going to ask two follow-up questions to that. One is does that include outpatient settings if there are patients with COVID?

John Lynch:

So, right now, if someone you know has COVID. So, for instance, there are certain areas in our system where that's where we're setting patients with now patient, we know they have COVID or they're recovering and they're not still out of isolation. Those situations, yes. For routine ambulatory right now, no, but our goal is to get to all of that. And again, part of that is that fit testing, not just throwing these respirators out there doesn't actually maximize the potential for safety.

Trish Kritek:

Okay. I think you actually answered the last question, which is are we going to expand to other spaces, and I think the answer to that is yes, as we do more fit testing so that we make sure people are fit tested for the masks that we have. Is that correct?

John Lynch:

That's correct and not only did UW Medicine leadership commit to this purchase, but also committed to adding resources for ... Excuse me. I'm going to have a tough time with word finding this week. I apologize.

Trish Kritek:

You're doing great.

John Lynch:

Testing. Fit-tested, so added resources for fit testing in the coming weeks, so you're going to be seeing a lot more of that in a lot of places and I know this is already happening. Harborview has started Thursday night, right overnight, so we're rolling it out as fast as we can.

Trish Kritek:

I see Santiago nodding, too, so I think across our campuses, people are going to be fit tested for the N95s and we're going to start with the folks who are taking care of patients with COVID in all spaces and then expand beyond there.

Trish Kritek:

Thank you. I'm sure there'll be follow-up questions. I may come back to it later, but I'm going to pivot now to the fact that we heard that there were more patients at Northwest who were positive for COVID. And Santiago, I think we've had in some spaces a conversation about this already. There has been an outbreak at Northwest. So, I'm going to ask you and Kari to comment on that. I guess I'll start with you, Santiago and, then I'll pivot to you, Kari.

Santiago Neme:

Thank you, Trish. So, yeah. Thank you for asking. On December 1st or three days ago, we identified a patient in the geropsych unit of Northwest who had developed diarrhea. The patient was properly tested for COVID. The test was positive. Immediately after that, we closed the unit because, again, it wasn't really clear how this patient got COVID and we were concerned about a larger, a potential outbreak.

Santiago Neme:

This led to testing of all patients in the unit. To give you perspective, there's 26 patients. And the next day we had the information that, out of the 26 patients, there were an additional 11 patients who were positive. These patients were doing well. Immediately after identifying this, we obviously instructed, we get some more deep cleaning and made sure that the unit was adequately put in isolation, et cetera.

Santiago Neme:

But, then, we started expanding this testing to really staff members because, again, if you're caring for patients, there is a potential transmission to staff. And, again, it's hard to determine the direction of these outbreaks. Is it from staff? Is it from patients? It really didn't matter. It was just a question of making sure that everybody was safe.

Santiago Neme:

So, we went ahead and tested almost 40 staff members at this point. And so far we have four staff members whose test results have been positive.

Santiago Neme:

So, again, this was first identified on one patient three days ago. The next day, the whole unit was tested. More than 40 staff members have been tested. We already have four who have been positive. Both the patients and the staff members are doing well and so I feel like we have a pretty good handle.

Santiago Neme:

In terms of the source of the outbreak, we're still undergoing investigation and that typically takes longer. What I can say is that we have set forth a pretty robust mechanisms for surveillance as John was saying. In geropsych units, we do weekly testing. We're making sure that that continues to occur, obviously and we're making sure that everybody is really safe, the patients have been notified. And, again, fortunately, the patients are doing well and the staff is doing well.

Santiago Neme:

I would like to say and this is something that John and Tim have said many times. Infection control in the setting of congregate settings is extremely challenging and just the care model of a unit in psych, it's all around socialization and it's about sharing and it's about contact with people.

Santiago Neme:

So, that has been, this is not the first outbreak, as you may recall in geropsych at Northwest. This is the second, but we have learned a lot and I feel like, within three days, we've gotten really good control of this situation. I would like to pass it on to Keri for additional questions, unless, Trish, you have a question for me.

Trish Kritek:

Keri can speak first and then I will follow up.

Keri Nasenbeny:

Yeah. Thanks, Santiago, for that background. I think the only thing I would add is just really my, well, two things. My thoughts and heart goes out to the staff who tested positive and to the families, obviously, of these patients. Obviously, that's not what we'd ever wish for somebody and we're here to take care of them and so want to say that to start.

Keri Nasenbeny:

And then, also, too, just how amazingly well this unit has responded to this. They have done this before. They really learn from it the first go around. Already, they've had multiple staff meetings. They've really organized around this. We moved one patient off the unit for a variety of reasons actually not related to COVID that were prior to COVID and we've cohorted those 11 patients together and created a hot zone and they are doing the best they can to provide amazing psychiatric care and medical care to some very, very vulnerable patients.

Keri Nasenbeny:

So, it's really a credit to them. They've really risen above this, both the providers and nurses and TNAs who work on that unit, so just really want to give a tremendous amount of credit to them for really leaning into this instead of with fear and anxiety.

Keri Nasenbeny:

So, I don't have anything else to offer. I think we just don't know and, as Santiago alluded to, a congregant living facility is challenging and then you layer on a geriatric population with psychiatric illness. Many of those, too, have cognitive issues, other chronic disabilities. And so it just really proves challenging. Many of them refuse to wear masks. Many of them actually are very hard to swab because they get very agitated. And, in fact, keeping them in the rooms is actually really challenging and so the hot zone has been helpful for that.

Keri Nasenbeny:

We'll continue to test the remaining patients who were negative. We've tested them again today and then we'll test again in another three days. And I think it's entirely possible we'll see more patients convert and we'll then move them into the hot zone and then, for those patients who didn't, we will cohort them.

Keri Nasenbeny:

That unit, we're lucky to have two separate sort of units or pods on that unit and so able to cohort patients separately. So, really appreciative to our EVS staff for all their cleaning and just the way our teams have responded.

Trish Kritek:

Thank you both for walking us through that. I think it's important for people to understand what's going on. It sounds like a particularly challenging situation and a robust response. I agree with you that our

hearts go out to all the folks who have been affected and has been the case with other outbreaks across our system.

Trish Kritek:

You answered one of my questions, which is how are you taking care of folks, so it sounds like you're cohorting people. Sounds like 12 patients total and four staff right now. And we will continue to follow up in this and I'll probably ask you about it again at another town hall as you learn more, as you alluded to.

Trish Kritek:

Santiago, I'm going to ask you one follow-up question that's more broad and Keri alluded to the fact that some of these patients, it's hard to keep a mask on. Last, and I don't want to talk about those patients. I actually want to talk about a broader question. Last time, we talked about a patient masking policy and there are a bunch of questions from folks that said, "I haven't seen that come out in my institution. I haven't heard more about that." So, is this something that we have distributed across our institutions?

Santiago Neme:

Yeah. Our policy has been revised and John has included the topic in a couple of his messages to the system where we really encourage every patient to be masked. And initially the effort was mainly in the outpatient clinics and then the hospital was kind of looser and I think because of just, when your hospitalized, things are more complicated and you're ill and staff now have been really trying to really push this, but it is really a revision of the policy and it's also, there's been a lot of messaging and also the medical directors and CNOs have been trying to push this same information and I apologize if it hasn't reached everybody, but it is in the policy.

Trish Kritek:

It seems like we have an opportunity for more outreach and I'm going to look at Keri and Cindy to see if there's been any efforts around signage or more messaging so that we're getting it out in the hospitals. So, I think the message is there in ambulatory settings.

Keri Nasenbeny:

We've been huddling at Northwest. We've a pretty good huddle structure. I think, though, this is messaging we need to get out even ... And we've been every day in their DSP. There is signage up in every patient room, but I think it's more about the nursing staff enforcing this and actually starting in the EV and our OR areas and then transitioning through, as patients get admitted. Agree that this-

Trish Kritek:

More messaging at the bedside and in the OR and those spaces? Cindy, did you want to add anything to that?

Cindy Sayre:

No. I agree.

Trish Kritek:

Okay. So, I think, just to be clear, that is our policy. We're working on the messaging. If you need help in messaging, bump it up so people can help support you on how to message that, because we want people to feel as if they're safe.

Trish Kritek:

Cindy, I'm going to stick with you, shifting gears a little bit and before I do that, I think you, Santiago and Keri, it's obviously a challenging topic to talk about and I appreciate both of you doing so.

Trish Kritek:

Cindy, I had a question about are we bringing volunteers back at any point and time to help with stuff that's going on in the hospital as things get busy? And so, I'll ask you that question.

Cindy Sayre:

No. A lot in the near future. I think we really, as we've seen with the restrictive visitor policy, our strategy is to try to limit the numbers of people in the medical center as a way to try to limit exposure for our staff. There's no doubt that it adds some extra burden because many of the tasks that they were performing have to be done by other people but, at this point, we're feeling like the risk outweighs the benefit. If that change, if we get into a really big surge, maybe so. I think the other piece is what is the liability also of bringing volunteers in during a pandemic, especially when there's a high rate of positivity in the community.

Trish Kritek:

So, no plans for visitors right now for a variety of reasons-

Cindy Sayre:

For volunteers.

Trish Kritek:

Yeah. What?

Cindy Sayre:

You said, "Visitors." For volunteers, yeah.

Trish Kritek:

Thank you for clarifying. Maybe the other two.

Cindy Sayre:

We make plans with visitors as well, though.

Trish Kritek:

The volunteers. Thank you for correcting me. I appreciate that. Again, Keri and Cindy, Jerome had to go to an emergency and he let me know and I want him to do that. There are questions about are we going to go back to having tents for the ED or for other aspects of our care and I'll ask both of you. I realize Jerome's not here to answer it but Keri, I'll start with you.

Keri Nasenbeny:

Yeah. I think the answer is maybe. Right now, in the ED, we're doing an assessment of needs. The tents, they're good in some ways and not so good in other ways. I will just say that. And so I think we're looking at all the spaces around our ED at Northwest and thinking through how we could provide care and extend the care in our ED into some of those other spaces.

Keri Nasenbeny:

Tents is part of that consideration. No definitive answer yet, but I think a lot of work and process to plan for that EV surgeon should we need more space. Right now, we're doing okay with the space we have and I think it's entirely possible that we'll need additional space. So, yeah.

Trish Kritek:

So, maybe on Northwest. How about at Montlakes, then?

Cindy Sayre:

It's really the same and we're doing a little bit of concurrent planning. I think you just alluded to this, Kari, but we're looking for all other alternative spaces because the tents, especially in the winter, have had challenges and we've identified a vendor for tents in case we need one. And so we're doing all of it at concurrent planning, but hoping not to need them.

Trish Kritek:

Okay. For logistical, coldness reasons and others, hoping not to but making the plan in case we need to. Rick, I'm going to turn to you and just hear if maybe you know as well about Harborview plans for ED.

Rick Goss:

I think, similar. It is being planned for. I think if trends continue, we will probably go in that direction and utilize it in the way that serves best. For example, it may be a waiting area. It could also be a triage and an initial treatment area, still determining.

Trish Kritek:

So, more to come on tents for the ED, and Rick, I'll stay with you and Tom here. One question that folks ask is, "Are we accepting transfers from other states, specifically across WWAMI at this point in time?" Rick, do you want to answer that?

Rick Goss:

Sure. We've heard that question as well. And here to just frame this for people, when we think about the WMCC setup that we have, the Washington Medical Coordinating Center, that group is really looking over the entire state in the context of the region and to the extent that a state or a facility in another state is making a request, our WMCC is going to do everything possible to ensure that that state can manage and only then if Washington State is available to assist another state, then the WMCC would work that into the rotation. So, it wouldn't be a direct call to one of our sites from Alaska or Montana.

Trish Kritek:

Okay. So, using the WMCC prioritizing our state first, which is one of the weird things about all of this is how it's state by state but that is where we're starting and then going from that.

Rick Goss:

Absolutely.

Trish Kritek:

Okay. Thank you. Tom, I'll ask a totally different question for you. The other thing that came up pretty frequently was, "Are we doing physician staffing differently for this surge than we did before and what are our plans right now for physician staffing as we hear about increasing numbers?"

Tom Staiger:

Sure. There's been lots of conversations about how to staff from the physician standpoint as this surge progresses. I would say, largely, we'll be using the same approach but it will be informed by what we learn from the springtime. So, I think we'll be able to be more efficient in our approach. We've already ironed out some of these protocols and practices and we'll be using a combination of moonlighters, individuals, residents, fellows, faculty, working up and above their usual clinical commitment, especially to cover nighttime coverage and we will also be redeploying residents, fellows, faculty who are underutilized because we've got decreased activity going on in surgery or in other areas and redeploying them to fill out teams and to build new teams as we see new needs.

Tom Staiger:

And so, we've already worked with GME to build out a process for a moonlighting pool and have groups that have already expressed willingness to moonlight as needed. So, similar approaches but I think we'll be more streamlined and efficient this go-around.

Trish Kritek:

Great. So, big things I heard were moonlighting for folks who are working above and beyond their committed clinical time and then redeployment of folks across the spectrum for filling in spaces when they're not able to do their regular job because of changes in what we're doing in our hospitals, like that.

Tom Staiger:

Yeah.

Trish Kritek:

Is that right? Okay. Thank you for clarifying. And I guess I should also highlight you said, "And learning from what we did before," which I think is a theme for today, is that we're hearing that we're trying to have learned and we are learning from March, April, and trying to evolve in what we do.

Trish Kritek:

Okay. Tim, I'm going to come back to you. I'm going to ask you a handful of vaccine questions. It doesn't even come close to the series of questions that we've received, which is why we're going to spend next time. But the first, I'm going to ask you some ones that were the most common. So, do you know when we're going to have the vaccine?

Tim Dellit:

Yeah. So, let me just outline a couple of things. So, that ACIP made recommendations to the CDC earlier this week in terms of recommendations around prioritization.

Trish Kritek:

You have to say what ACIP is.

Tim Dellit:

It's the ... Gosh, I can't even-

Trish Kritek:

Just say it in common language, like-

John Lynch:

Advisory Council on Immunization Practices.

Tim Dellit:

Advisory Council on Immunizations, yeah.

Trish Kritek:

Thank you.

Tim Dellit:

So, there's that work going on. At the same time, in parallel, the companies, Pfizer, submitted their emergency use authorization for approval by the FDA. That'll be reviewed on the 10th.

Trish Kritek:

Okay.

Tim Dellit:

Moderna also submitted their EUA. That will be evaluated by the FDA a week later on the 17th. We anticipate right now, that around December 15th, we will likely receive vaccine within our state. Right now, the estimates are, by the end of December, Washington State would receive roughly 400,000 doses of vaccine. We still don't know the exact number that we will get within UW Medicine, but that is in general of what the state is anticipating and they are really then going to push to try to get as many health care workers vaccinated within those initial two to three weeks, at least for that initial dose. Keep in mind, both of these vaccines are two dose vaccines. The Pfizer vaccine is a second dose 21 days later. The Moderna is 28 days later.

Trish Kritek:

Okay. That's really helpful, both of those FDA assessment dates, the 10th and the 17th, and presumably, by the end of December, we will see vaccine here. Number's not yet known.

Trish Kritek:

So, the second question and this is one that we'll go into in a lot more nuance next week is who's going to get it? And you said, "Health care workers," and I'm wondering if you can be a little bit more specific about who's in that first tier.

Tim Dellit:

Yeah. So, the overall recommendations from the CDC are health care personnel and residents in long-term care facilities. Within that health care personnel are UW Medicine, P&T ID subcommittee, chaired by Shireesha Dhanireddy, met yesterday to develop here's our tiering of those health care workers. And so there will be more communication around the details of that next week but in general terms, the first group would be those individuals who are most likely to encounter patients with COVID-19 or infectious materials.

Tim Dellit:

So, think of it as the people and, again, I'm not distinguishing who. It's all members of the team, whether you're a physician, environmental services, nursing, respiratory therapy on a COVID unit. Those would be within that first group, emergency department, testing sites. So, just think of those areas where you have direct contact with patients with COVID-19. Then, the second group after that would be the rest of the clinical groups and then, down the road, more of the administrative staff.

Tim Dellit:

But I think I want to emphasize, it'll be available for all of our health care members of our team and ultimately, we want to be able to offer this even for our non-clinical members of UW Medicine, but that will just be subsequently down the road and so, ultimately everyone will be offered the opportunity to be vaccinated and we strongly encourage people to be vaccinated. This, again, is the way we get to the other side of the pandemic.

Trish Kritek:

So, just to highlight that. More to come. We're actually going to invite Dr. Dhanireddy to join us next week for sure and she said, "Yes," already. So, she'll be part of that conversation but people who are around the care of patients with known COVID and that's all members of the health care team, because a bunch of people asked, "Does that include EVS and nutrition and things like that?" So, just to say very clearly, yes it does, as well as nurses, doctors, RTs, et cetera. And so, we will delineate that in more detail next time.

Trish Kritek:

I think you answered the second question I was going to ask you, which is will it be required and I think the answer to that is no, it's not.

Tim Dellit:

It will not be mandatory. It will not be mandatory. Again, it's a relatively new vaccine. We still don't have long-term follow-up. We believe it's safe. It's gone through the normal FDA process, but it's being approved under an emergency use authorization. So, we strongly will be encouraging people to get vaccinated but it won't be mandatory.

Tim Dellit:

The other piece, and we'll get into this more next week is that it will have more information next week from the FDA in terms of the adverse events, so the side effects, right?

Trish Kritek:

Yeah. That's a big question.

Tim Dellit:

That's going to be the tricky piece and so already recommendations are likely having to stagger vaccinations. So, it's going to be the different than the influence of vaccine because a certain proportion of individuals will develop fevers or muscle aches or headaches and they may need to be off work. Again, we're still working through the details and waiting for the CDC recommendations to see how we manage those individuals, but we're going to have to stagger things so that we maintain our workforce while we vaccinate.

Trish Kritek:

Okay. I'm going to try to fit in three more questions and give Anne a time to talk to Santiago. It's going to be tight. Thank you. I know there's a ton of questions. People do want to know about side effects and risks and things like that, so we will talk about that more.

Trish Kritek:

I'm going to ask you and then John two questions about quarantine. Tim, I want you to just reiterate what are approaches to quarantine for folks who travel outside of the state.

Tim Dellit:

So, first, our travel restriction is no work-related travel. We strongly discourage personal travel. If you travel personally, we strongly recommend that you quarantine for 14 days. That's the time right now after return and this is consistent with the governor's advisory. We can't require it, but we strongly recommend following the governor's advisory on travel.

Trish Kritek:

Okay. So, no work-related travel. Stay home for 14 days if you do travel, but that's a recommendation. It's not a mandatory thing. And that's for doctors, nurses, residents, everybody. Is that true?

Tim Dellit:

It's everyone, yeah. And, again, we really want to discourage travel. Again, I know this is a challenging time of the year, but this is our opportunity collectively to try to gain control and prevent hospitals from being overwhelmed down the road. We've got to stick together and really change our behavior during the season, so that we can get to the other side and then people can travel more freely.

Trish Kritek:

I hear you. It's that light at the end of the tunnel thing that we're going to keep emphasizing and the positive of the vaccine being so close. John, there were several questions about, "Are we going to change our quarantine to seven days like the CDC has come out with?"

John Lynch:

So, we reviewed this yesterday. This just came out Wednesday. We're working with upper campus and local public health officials on this. At the moment, we are not going to change it. The idea here is to try to decrease the burden on folks in the community and large-scale contact tracing.

John Lynch:

In health care facilities, that added risk is something that needs to be thought of carefully. And I just want to be clear, shifting to 10 days, four to seven days plus a test adds additional risk. It's small but it is measurable. That is in the CDC document.

John Lynch:

So, we have to figure out whether that risk is worth it, and, at the moment, we weren't ready to make that transition. And so we're holding tight where we are and we'll be discussing again on Monday.

Trish Kritek:

So, more discussion, but right now, no changes in the duration of the quarantine process. Two other quick ones for you. One's maybe quick and the other one's not quick. I'll do the unquick one. People want to know about why we decided not to do the antibody treatments?

John Lynch:

Yes. So, this'll be good. We should be talk about the beginning of next week, but the basis return here was this was another drug, kind of like remdesivir that was moved very quickly and had what's called emergency use authorization, UA. This one actually got an FDA approval just recently, but the benefit to patients is very low. It's not mortality. It's really about prevention of admissions to the hospital.

John Lynch:

So, if you get outpatients with COVID who don't need oxygen but are at risks and you infuse X number of people, you'll prevent one admission to the hospital. So, when you think about bringing people with infections into health care facilities, infusing them for an hour, monitor them for another hour and a half and think about all the resources needed to do that.

John Lynch:

For pretty minimal benefit for the patients and for the system, we really though, "Well, think about all those resources and this huge amount of really important work we do for vaccination for health care workers." We decided we're going to go for the vaccine work in terms of allocation of resources and hold on the monoclonals and maybe there'll be better data that are emerging, but at the moment, we just don't see, as Dr. Dhanireddy likes to say, "The juice is worth the squeeze."

John Lynch:

And we're not alone in this. Swedish has done and made the same decision. We're going to hold given just the minimal benefits. And this has been the story this year. Hydroxychloroquine, azithromycin, even remdesivir isn't quite what everyone promises to be early on and this may be the exact same thing. So, we're always ready to change and adopt, but right now, we're going to really focus on what we know works, which is the vaccine.

Trish Kritek:

Circumspect on the data, risks benefits, and resources. Thank you.

Trish Kritek:

Last quick question for you. "Should people use the WA app to be contact traced?"

John Lynch:

Yeah. Go for it. Go for it and do it. It's a little tricky in health care because of the way it works. You could be next to someone who has COVID because you're taking care of someone with COVID. It doesn't tell you if you got a notification that you triggered, but go for it. I think, I turn mine on.

Trish Kritek:

I turn mine on, and I've been near lots of people with COVID, so I'm waiting for it to go off, but anyway. Okay. I'm going to give Anne three minutes to talk to Santiago and ask him a few questions. Anne, it's all you.

Anne Browning:

Sure. Thank you. So, Santiago, first theme came up around medicine and medical operations. John already covered the person who's asking about screening for colonoscopies and John gave him a thumbs up in the Q&A.

Anne Browning:

But we had a question come in around if you needed braces, would you get braces knowing that you'd have to go in for orthodonture? Thumbs up.

Santiago Neme:

Yeah. Yeah.

Anne Browning:

You have to say, "Yes," so you trigger your audio. Perfect.

Anne Browning:

The other big thing then was around being outside and ways in which we could do that and people were asking, "With increased community transmission, would you take a walk outside with somebody not in your household if you both wore masks." Is that low risk? Would you do that?

Santiago Neme:

If we're both masked, then we're outside walking at a distance, absolutely.

Anne Browning:

Now, this is another interesting one. Person was saying that they were walking solo outside without a mask and kind of got heckled by another person on the street. Would you take a walk outside unmasked if you were not going to be around anyone?

Santiago Neme:

Medically speaking, there's no need to really wear a mask, but I think we're all trying as a community to do the right thing, and I think some people get that confused. But, medically speaking, there's no need.

Anne Browning:

I talked a little bit at the beginning about that anxiety ratcheting up and I think that's when we get people kind of calling each other out for behaviors. What do you do to try and stay away from shifting to judgment, if you see people doing activities or behaviors that you yourself wouldn't do?

Santiago Neme:

I personally struggle with these situations because we are actually very frustrated about some things that folks do, but at the same time, if you think about it, judging really doesn't modify behavior and I think that the only way to change the social norms is to really work together.

Santiago Neme:

So, I try to find that moment where I can just share some of what I know and try to get people to do the right thing, like getting a vaccine or putting on a mask. So, then we, together, can battle this. I think it's the only way out.

Anne Browning:

Cool. Thank you, Santiago. Trish, I'll hand it back to you with one minute to spare.

Trish Kritek:

That was impressive and that was a wonderful thing to end with, Santiago. I think that sentiment is exactly what we need right now and it's hard to have it, so I appreciate your reinforcing it.

Trish Kritek:

I will say, "Thanks" to all our panelists, as always. I will remind everybody that next week, we'll be really dedicated to discussions about vaccine. So, if you have questions, if you put them in the Q&A today, we'll save them or you can put them into the portal starting now even, if you have questions about vaccine. There's also an email that John's email had an email address that you can send questions to. All of those places are places you can send questions. We'll bring them all together and have an enriched panel for next week to talk about vaccines.

Trish Kritek:

With that, I'm going to say, "Thank you," for coming together again for another town hall. Thank you to, again, all the folks who attended, who are listening later. I am so appreciative of all of you. Thank you for the outstanding care you take of our patients and their families and most of all, like Santiago was just saying, thank you for taking care of each other. We'll see you back next week and talk a lot about vaccines. Bye-bye.