

Trish Kritek:

Welcome back to town hall. It's 2021, remarkable. We haven't had town hall in a few weeks over the holidays, and we're glad to be back with all of you. I'm Trish Kritek, the associate dean for faculty affairs. And with me today, Tim Dellit, our chief medical officer, Anne Browning, assistant dean for wellbeing, Santiago Neme, medical director UWMC Northwest, Keri Nasenbeny, CNO UWMC Northwest, John Lynch, head of infection prevention and the medical response for COVID for UW Medicine, Tom Staiger, medical director UWMC, Rick Goss, medical director Harborview, Cindy Sayre, CNO UWMC and with his mask on Jerome Dayao CNO at Harborview Medical Center. So good to see all of you back and thank you for joining us and thanks to all of you for coming to town hall. We have a bunch of questions because we haven't been here for quite a while and I'm going to kick it off right away to Anne for her wellbeing message.

Anne Browning:

Sure. So happy new year. I would say life didn't change as much as I would have liked it to at the stroke of midnight. It's been crazy first week, but I'm hopeful on many fronts that we're actually moving in a positive direction. Januaries tend to feel like a time of resetting and of making changes to our behaviors and trying to start off this next year better than we left the last. We often think about setting resolutions, but I want to talk a little bit about the difference between resolutions and intentions. Resolutions tend to be kind of clearly defined, they're measurable, and they often come with some judgements about our behaviors as either being good or bad. And we often stick with our resolutions until we don't and then we fall hard off the bandwagon, whether we've resolved to working out or eating healthy or consuming less.

Anne Browning:

But intentions are a little bit different. They tend to be a bit more aspirational. And intention can be a guiding principle that you can follow for a week, a month, a year, your life and you can kind of gently pull your awareness back to it when you need to. And a real core difference between resolutions and intentions and why so many of our resolutions feel as though they're kind of destined to fail is that resolutions are often driven by a sense of guilt rather than a commitment to our own wellbeing. So as you start this year, rather than thinking about all the things you want to stop doing or start doing, take some time to set some intentions about how you want to live and how you want to support your wellbeing as we move through 2021. Thanks y'all.

Trish Kritek:

Thank you. And it begs the question I'll be asking you later, which is what's your intention? What are your intentions for 2021? But I'll let you mull that one over. Obviously there's been a lot in the news about surging COVID across the country, as well as I think even more discussion about vaccines. So Tim, I'm going to start off with you because by far the most questions we had were about vaccines and we'll ask a bunch of questions about them. And I think that maybe I'm going to ask you to start off with a big picture, kind of where do we stand at UW Medicine in terms of our vaccination process right now.

Tim Dellit:

Great, thanks Trish. And again, thank you everyone for joining us. Happy new year. I also want to just acknowledge the horrific events that we all witnessed on Wednesday that I think were incredibly disturbing to many, if not all of us. And it's just another level of anxiety and stress to an already challenging time. And it was really unbelievable and sad to see that. I just want to acknowledge that

because I think it has really impacted many of us this week in terms of how we're thinking about things. Now shifting to hope in terms of the vaccine, again we started our campaign really on the 17th of December and I have to give our vaccine team an amazing amount of credit because by December 30th, we had been able to invite all individuals working within our healthcare setting, everyone who works within our hospitals, within our clinics, had the opportunity to get signed up and be vaccinated.

Tim Dellit:

And in fact I believe right now we're over 16,000 individuals vaccinated, including 3000 individuals from the community. So these are healthcare personnel in our community who did not otherwise have access. So again, we've really tried to dedicate 20% of our doses to helping our community. And what's amazing too, is that number, 16,000, that's 25% of all individuals vaccinated in our state.

Trish Kritek:

That's amazing.

Tim Dellit:

So I think we have done a phenomenal job. And this week actually people are getting their second dose already. Those who got the Pfizer and then would be getting their second dose three weeks later. So I think a lot of positive movement. Now, when you step back, I think there are challenges with the vaccine program as a whole. The distribution is not where we want it. We still are limited by supply. We don't find out until a couple of days in advance, what we're going to get the next week, which does make it challenging to plan. If we had the adequate supply, we actually could vaccinate about 2000 individuals across our system every day, but the supply has been limited. We all are hoping that that will continue to increase, but it's really that distribution when you look across the country we're not where we want it to be. The productivity I think is there. It's a distribution problem in getting it in those sites where we can actually deliver it and get it into the arms of those who need it.

Trish Kritek:

Okay. So 16,000 ish vaccines that we've done already, which is really remarkable. And I want to follow up on one of the things you... a bunch of things you said. So one of them that came up in a bunch of questions is what about folks in the community who are like dentists or physical therapists or private practice physician? Are we engaging with those groups to help with vaccination?

Tim Dellit:

Yes, we are. We actually have a dedicated email UW vaccine liaison that whether you're in a private practice by yourself, whether you're in a small group setting but we've been sharing that with anyone who is inquiring. And so that list is reviewed every day by our vaccine team to try to help prioritize and get them into the queue as well. So we're trying to outreach and help as many healthcare providers in our community receive vaccination.

Trish Kritek:

Okay. Maybe someone can put that email address into the chat so that if people want to share that with others they can. Thank you. So we are collaborating with the community and I'm going to ask a second follow-up to something you said, which is, it sounds like one of the limiting factors is distributing the vaccine, but we hear that the country is shipping out vaccine. Do we know how much vaccine we have right now? Do you know how much vaccine we have right now?

Tim Dellit:

Yeah. We get updates from pharmacy on what we anticipate next week. Right. And right now, for instance, with the Pfizer dose, we're getting additional doses next week to be able to deliver the second dose for those who have already received it. But a lot of the Pfizer vaccine is going over the next couple of weeks to the long-term care facilities, which is absolutely correct. We're getting more Moderna vaccine now across our campuses. And so every day that team is shuffling around looking at the schedule and moving the vaccine to ensure that we have enough at the right location across our four campuses.

Trish Kritek:

Okay. So I think lots of coordination trying to figure out prioritizing long-term care. There are obviously folks, you said, we have now offered it to all the folks who work in our clinical sites, the nonclinical members of UW medicine who aren't in our health centers. Do we know when they will have access to the vaccine?

Tim Dellit:

Yeah. So that's a great question. We had been waiting for the Department of Health to put out their guidance for that next phase. That just came out on Wednesday and they have broken out what we refer to as 1B into four groups. It's a little different than what the CDC had done. That next group, which they're labeling as B1 will include individuals who are 70 years of age and older, or if you are 50 years of age and older and live in a multi-generational household. Now, I'll just be honest that's a little bit challenging to define and so we're right now working with our planning and operations teams to really think about how do we implement these new guidelines. They haven't gone live yet. We're waiting for the Department of Health to let us know when to transition to that next phase.

Tim Dellit:

And this is an important piece that we are really required to follow DOH guidance here in terms of their criteria for who we can vaccinate when. And so, again, as we get that information, we're sharing it there's going to be more detailed information in John Lynch's message that will come out I believe later today. We also send a message to all of our patients letting them know just where we're at in the stage, and that we'll reach out again when it's appropriate time for them to get vaccinated. So again, it's going to be a little bit bumpy here these next couple of weeks as we implement these new guidance from the Department of Health.

Tim Dellit:

I want to say one other really good news I just saw and John sent this to me earlier. Dow Constantine the county executive announced that they are going to be setting up mass vaccine clinics around February 1st. So that's terrific. Because that's one been one of the questions that to date we've really been relying on the health care systems to do all the vaccination and we're going to need as we move into these next phases to really have much greater presence in the community. And so it's terrific to see the county putting that forward. I know the city is also exploring different options. So I'm hoping that here over the next few weeks, there'll be a lot more availability out there in the community beyond just within the hospitals.

Trish Kritek:

Okay. So the next group is B1, 70 years or older or 50 plus in a multi-generational household. And I think you just acknowledged the answer to one of the questions, which is, that's a hard thing to define, and it sounds like we're still working on the details of figuring out how we're going to say, you live in a multi-generational household.

Tim Dellit:

Well, again, we're not going to be, and we can't expect our vaccine clinics to do any of that verification, right? And this is what was in the media around the honor system. We can certainly reach out to patients based on age, but some of these others we have to say, here are the criteria. There's also a phase finder tool that the state is putting out there and people can look to see what phase they would be in. But then we have to rely on people to be honest about their qualifications as they come in, because we can't be in a position and our staff can't be in a position of trying to verify and police that. That just won't work.

Trish Kritek:

Okay. So honor system, this is going to be the next group for our patients, as well as for the-

Tim Dellit:

Employees.

Trish Kritek:

... workforce and within UW Medicine is 70 plus and 50 and older in a multi-generational household.

Tim Dellit:

Correct.

Trish Kritek:

It sounds like we're collaborating and there's going to be county vaccine sites, because that was another question that people asked about. And then, I guess I'm going to come back to vaccines later, but one more question I had, which I thought was wonderful was, do we need more volunteers for our clinics to do this? And I'm looking at you, Tim, but I'm seeing Cindy nod. So Cindy, you can answer that question.

Cindy Sayre:

Yes. Yes, we need more volunteers. And specifically, I know from what like we're looking for either per diem nurses or part-time nurses that can dedicate... Sorry, I leave my... That can dedicate a block of time to doing this. So they're working an eight hour shifts so there's not as many handoffs. That's what we're looking for. I think that's Northwest as well.

Trish Kritek:

Per diem nurses who can give us eight hour shifts.

Cindy Sayre:

Correct.

Trish Kritek:

Keri or Jerome, did you want to add to that?

Keri Nasenbeny:

I should say Northwest we really need people Tuesday, Wednesday, Thursday, and like Cindy says, for an eight or 12 hour shift. MAs as well. Doesn't have to be a nurse.

Trish Kritek:

MAs or nurses. Okay.

Keri Nasenbeny:

Yeah.

Jerome Dayao:

Same is true with Harborview. We need a few more volunteers, but looking at the schedule of the clinics, it looks pretty good for staff.

Trish Kritek:

Do you need nonclinical volunteers?

Jerome Dayao:

Yes, we do. There's lots of duties that people can contribute to get faster.

Trish Kritek:

And maybe through the chat, we can remind people of how they can volunteer if they don't recall. So I'm thrilled that people are asking to volunteer. It's been awesome when I've been in the vaccine clinic, all the people who are there volunteering. So thank you so much. Like I said, I'm going to come back to vaccines, Tim. Thanks for all that context because I think there continue to be lots of questions about when next and I should acknowledge, there were a bunch of questions about spouses and family members and I'm going to extrapolate from what you said and say, that's going to follow those same DOH guidelines and if they're in B1, they'll be up next. Is that right?

Tim Dellit:

That's correct. They follow the same DOH criteria.

Trish Kritek:

Okay. John, I'm going to shift gears and I think while it has been shadowed by recent events in Washington, there are still lots and lots of cases of COVID in this country. I think we might've hit a new milestone in terms of deaths in the last couple of days. So people are curious about our numbers across UW Medicine and in the state. So could you update us on that?

John Lynch:

Yeah, sure. And so you're absolutely right. I think we had the largest number of people who died from COVID in the United States ever yesterday, which is really, really sad and unfortunate. Here in Washington state, things are a lot better, I would say compared to those hotspots that we're hearing

about like Arizona and Southern California and so forth, but we are still seeing a lot of cases. I want to be very clear though, we have a little bit of lack of clarity because a lot of the testing that we were doing sort of falls off, this happens with holidays, quite commonly and it happened with the winter holidays, through Hanukkah, Kwanzaa, Christmas, and the New Year's. People really didn't get tested. And King County went from about 10,000 tests per day to about 2000 tests per day.

John Lynch:

So when I think about all this, it's really with that issue that we're just not seeing as many people getting tested, but what we have information on is who's ended up in the hospital and that's looking pretty stable unfortunately. Within UW Medicine, we currently have 90 people in our four hospitals. 60 of those people are in acute care, 30 of them are in the ICU and four of them are requiring that heart lung bypass we've talked about so many times, the ECLS or ECMO, and those are pretty much the sickest people you can possibly imagine what this infection. And our numbers have kind of hovered stock right in those nineties now for several weeks. And as I think about people, there were gatherings, we know nationally a lot of travel. It is very reasonable in common sense to expect the numbers of tests to go up and unfortunately the number of positive tests to go up in the coming weeks and we might be seeing just a little bit about that across the state now.

Trish Kritek:

Okay. So pretty much stable here and test lagging because we think people weren't getting tested because of the holidays. I will say I'm on service right now, as you can tell probably because I'm in scrubs in the Montlake MICU. And while it was kind of going up when I started at the beginning of the year, we've had fewer admissions in the last few days for what it's worth. The other thing that people asked a bunch about, because again, it's been in the news a lot is about this new strain of the coronavirus. And a couple of questions. One is, have we seen it in Washington or that you know of? And then two, what do they mean by it's 70% more transmissible? What does that mean?

John Lynch:

Yeah. So this is a really important question and I think it's going to be a pretty important topic as we move forward. So what we're talking about are different strains of coronavirus, SARS-CoV-2, the virus that causes COVID-19. One of them was described in the UK. Another one was described in South Africa and there's, I think a third out there as well. And you may have heard like the UK strain, we really want to refer to them as these, more technical terms, the B117 strain. I mean, you'll see these in the news. And what it really means is that these are kind of strains. They're sort of a flavor of SARS-CoV-2 that has accumulated a bunch of different mutations that have given it some different biological properties. And that's what really defines a strain. So it's not just like a mutation. It is not even a mutant. This is what viruses do, they make mistakes and they end up being a little bit different.

John Lynch:

What's really important about these strains is that when scientists have looked at them in populations like in the United Kingdom, is that they go from being rare, to being extremely common. And that makes epidemiologists and virologists very concerned about their ability to sort of push all the other strains aside and become the predominant one out there. So I just started to look and we're still getting lots of data on these is what it looks like is that the reason they sort of displaced all the other ones out there is that they go from one person to another more easily. They seem like that group of mutations that accumulated in each of the different strains makes them... it's just easier for them to get from one

person to another, whether that means that it's because a person has more virus in their body or other things that allow it to attach to receptors. It's probably a combination of several different biological properties.

John Lynch:

And we have wonderful virologists in the University of Washington. They're probably working this now and can answer these questions way better than I can. But the take home here is that these are strains that appear to get from between one person to another person more easily. The upside, the good news right now is that all the data so far does not indicate that these are more dangerous in and of themselves. They don't make people sicker. They're not some sort of super variant that leads to worst disease. The big concern is when you deal with populations, the more people who get infected, because the strains more easily to transmit, obviously the more people who are going to get sick and the more people are going to end up in hospitals.

Trish Kritek:

So natural evolution of viruses, one that we're seeing that seems to get more people infected. We don't know exactly that's because you have more virus or if it does something slightly different biologically, but doesn't seem to make people sicker.

John Lynch:

Right.

Trish Kritek:

The last question that I think came up a bunch of times was, do we think the vaccines are going to work against this new strain?

John Lynch:

So far, it appears like that's the case, that the vaccines will continue to work against the strains that we're seeing. We know about a couple, it is very likely there are other strains out there, which we're going to spend the rest... all of this year learning about and doing this work. You did ask this question about whether we're seeing them here and so far we are not. And so that's really great news, but I think all things being quite... I wouldn't be surprised at all and actually I'm pretty sure we will eventually see them. They will come through our areas, but the really important things right now, the vaccine appears to work for them one and two, all the things that we do right now, masking, distancing, staying home when we're getting sick, the testing when we have symptoms, all work as well for these variants, as it does for sort of the original strains that we've been used to doing.

John Lynch:

So everyone should stick with what's working, be confident in the vaccine and I do really strongly believe we will be able to handle this.

Trish Kritek:

Okay. So what we know so far vaccine works against this and we're feeling good about that and other therapeutics. Excellent. I'm going to go back to infections because there were some more questions

about that. One was, we had talked before about more surveillance for inpatients, and there were questions about have we gone live with that? And if not, when are we going live with that?

John Lynch:

Yep. So we haven't gone live. We're hoping to roll this out in the next week or two. There's a bit of a couple of pieces, just last little pieces with these sort of big operational things. We want to make sure that it rolls out as flawlessly as possible and make it work. For those you haven't heard, the basic idea is I think, we've been testing people on admission who are coming to our hospitals for any reason. We test everyone who comes in, whether they have symptoms or not. We obviously test people before they get procedures and things like that as well. And that's been really great. But as the numbers really started to bump up what we started seeing were people who were admitted for a different reason, a heart attack or a broken leg or something similar, who then later developed signs and symptoms of COVID-19, maybe mild signs and symptoms who then became positive.

John Lynch:

And in that obviously there was the potential for exposure to healthcare workers and other patients who may have been sharing a room or similar. And so what we've decided as a group to do, and as a system is to move towards more frequent surveillance, basically regular testing of people on day zero, three and seven and then every week after that. And again, we've been doing this for some patients who are getting frequent procedures that put them at higher risk and we're going to figure out to see whether this actually increases risk. Excuse me, increases safety-

Trish Kritek:

Decreases.

John Lynch:

Decreases risk for our healthcare workers and fellow patients. I can see Tim laughing, but you know what I mean. This is to make it better. And we'll look at all that data. Maybe this will show us that we don't need to do this, but we don't know until we look. And so we're going to go... We're really invested in this. It will be part of the admission order sets. We're going to get training and if it queues our nursing team, our frontline folks so that we can make this work as easily as possible.

John Lynch:

And just one last thing I know I'm talking too long is we're not going to be doing nasal pharyngeal swabs in all these people like every week, we're going to do the anterior nasal, the front of the nose ones, which are much more tolerable. So for everyone who's cringing and thinking, we're going to do this to everyone many times a week, we're not.

Trish Kritek:

And luckily everyone's learned those hand gestures from you already. So it sounds like we're going to go emission, three, seven. First one, the deep one, after that just the straight up nasal one and then... I'm sorry I missed it, John, the go live date for this?

John Lynch:

We're pretty close, probably about a week to week and a half. Valley's already working on this as a pilot, Northwest is going to be next. They're on a different electronic health record and so we're going to launch it with their system first. I can see Santiago and Keri on here and they can speak to that. And then we're going to follow with Montlake, so we're thinking about a week to week and a half from today.

Trish Kritek:

Okay. Over the next week and a half or so, we're going to see evolution of this across our sites, early Northwest and Valley, and then moving towards Montlake and Harborview. I asked because that question has come up a bunch because there were questions about a couple of different outbreaks that I'm to ask about now. And I'm going to start with John, if you could talk about an outbreak at the Harborview, ED.

John Lynch:

Yeah, sure. We've had over the course of the year a few outbreaks in our facilities and the most recent one for us at Harborview was in our emergency department. And it's a little complex. We don't have all the answers, but the one I think I can tell you is that there are eight employees involved. No patients involved, no known patient to healthcare worker transmissions. We have a handful of folks who we... I mean, to be clear what we're classifying most of them is indeterminant and a small number of them as linked to a community exposure. And so when I say community exposure, that could be... It's a huge variety of possibilities, but being out in the world, like all of us are, being around someone maybe we didn't know have COVID and get exposed and infected. So small number, we're pretty sure connected to specific gatherings, a few others we say classify as indeterminate because we can't connect them to specific events. But really, I mean, obviously I don't want anyone to get infected, especially health workers, but no patients were involved in either direction that we know of.

Trish Kritek:

So eight employees, no patients in the Harborview ED and is everybody doing okay?

John Lynch:

Yeah, everyone's doing okay right now. And no additional infections that we know about, we obviously did huge amounts of testing there. We caught some of those people on that surveillance test and we go out and repeatedly test folks in that environment.

Trish Kritek:

Okay. Thank you. I think these are the moments that make everyone nervous and Santiago, I'm going to look to you next, because I think many folks in our community were aware of there was an outbreak at UWMC Montlake on 4-Northeast and I wondered if you could talk a little bit about that outbreak and who was involved and then I have a couple of follow-up questions about one.

Santiago Neme:

Yeah, sure. Absolutely. Thank you, Trish. So around December 23rd or so we became aware that a patient who had been hospitalized at 4-Northeast developed symptoms associated with COVID after being discharged. The patient was tested, tested positive. That was kind of the initial, that gave us some, the question, could this be isolated? Is this one case, is it a cluster of cases? A couple of days later we identified an employee who tested positive also from the unit. And then we had a second patient who unfortunately had a lot of respiratory issues so was getting a lot of what we call AGPs, so Aerosol

Generating Procedures. A lot of it had to do with BiPAP and CPAP and unfortunately this patient was then found to have COVID and this led to a significant exposure to staff who were caring for this patient.

Santiago Neme:

There was also a code gray because this patient was behaviorally challenging. There was a lot of confusion around this patient so therefore there was a lot of staff members who actually assisted this patient in the setting of an AGP. So therefore we had some exposures. So in total there were two patients. Again, the initial patient who was identified after discharge and then there was a second patient who was identified during the hospitalization. And then we have had a total of eight staff members who acquired COVID. The investigation is ongoing, but what I can say is that out of the eight staff members, six were associated with either patient one or patient two. And clearly patient two, the one getting the AGPs there was a significant... there were several staff members that were associated with caring with this patient.

Santiago Neme:

So I think it's important to know this because the key question that has come up is, does this mean that my BP is not good enough? Is there an issue with my BP? And again, we need to remind ourselves that our policy for AGPs is that if your patient has COVID and is undergoing an AGP, you use a respirator that is a PAPR or an N95. In this case, we didn't know this patient had COVID. And again, this is one of the reasons for this expanded surveillance that John was just alluding to that we're launching next week in Northwest and Valley has already launched. The idea here is to really try to detect as early as possible, any potential case of hospital acquired infections.

Santiago Neme:

All of the staff members, eight of them are doing well. The unit was temporarily closed for six days to make sure that we have a good handle on what's going on. Both patients have done well as well. And the unit was reopened yesterday. Again, 4-Northeast has been amazing. Nancy, the manager has done an incredible job. Our initial concern was that maybe this exposure was associated with socializing in the break room and other things because we had seen that in the past, but in tracking this we have identified that patient getting the AGP has being the source of a lot of the exposures. And lastly, I wanted to say that folks are doing well and that we continue to monitor things and we've done many rounds of testing for both the patients and the staff. And we also have contacted every patient who was discharged from the hospital and has had contact with any of the staff members who subsequently were found to be infected.

Trish Kritek:

Okay. So a lot of contact tracing. Two patients, eight employees. Everyone's okay. I do think that people were worried because people are wearing their masks and their goggles, and there was concern that that's not adequate, but it sounds like the big thing here is that there were Aerosol Generating Procedures. The patient had a special type of respiratory support and mask that caused aerosolizing a virus and we think that that's the way that people became infected.

Santiago Neme:

Absolutely. And I do want to add that it was... I had the pleasure of calling about 10 patients who were discharged and all of the patients were expressing amazing gratitude towards the UWMC staff, the doctors, the nurses, and the units, even though we were calling them with an exposure, a potential

exposure that we're all very grateful to the hospital for their amazing care. So I just wanted to highlight that.

Trish Kritek:

Thank you. And I'm glad to hear that. And I'm glad that we've kind of chased all of that down. The last thing I'm going to ask you to briefly, Santiago, is one of the things that came up with respect to that is, are we moving forward with asking patients to wear masks and would that have helped in this situation?

Santiago Neme:

Absolutely. That's an area where we've identified to be a persistent challenge, because again, when you think of, 4-Northeast or some of our Harborview units, where you have patients with facial trauma or patients who had auto procedures, et cetera, you struggle with a lot of secretions, sometimes you can really fit a mask, but for the vast majority of patients, we really are driving the message that we want every patient to be masked unless it's not possible, unless the patient cannot tolerate it. And that's a lesson that we had, not only from this outbreak, but from other outbreaks and that continues to be a challenge. And I believe there will be messaging and signage specifically geared towards this to drive this practice and the medical directors and the CNOs are also sending additional messaging.

Trish Kritek:

Okay. So we're still working on the messaging, but the place we're trying to get to as patients mask when other folks are in the room. Okay.

Santiago Neme:

Absolutely. Everyone masked.

Trish Kritek:

Okay. I'm just going to say, it's definitely not happening out everywhere that we go, because I think that was the minority of patients that I saw this past week.

Santiago Neme:

And we are aware-

Trish Kritek:

And I forgot that that was the policy so I agree with you that signage would be good. Okay. I'm going to shift gears, talking about exposure. People are still freaked out about too many people on elevators. So not that I think you're experts on elevators, Keri, Cindy, and Jerome, but I'm wondering in our clinical sites have we established a number of people who are supposed to be in elevators and have we done that for all of our elevators? So Jerome you're nodding. So I'll ask you first.

Jerome Dayao:

Yeah. For Harborview is three people in our elevators and we do have signs in our elevators and I've taken the elevator, right and I've seen people very cautious about looking at, is it three? And not stepping in. So I have not been in a situation where it's more than that, but I don't know everything.

Trish Kritek:

That's true. I know you're not spending all day in the elevator. So three at Harborview. Keri, at Northwest?

Keri Nasenbeny:

I'm just kicking myself because I was out today rounding and I meant to look at our elevators and I didn't. So I will go back and do that and if they're not posted, I will do that. I will say that when I do ride the elevators, people are very conscious about this and... Are conscientious rather about this and to Jerome's point, I don't ever see more than two or three people in the elevator and people wait-

Trish Kritek:

Three at Northwest too? Three?

Keri Nasenbeny:

Yeah.

Trish Kritek:

Cindy, three?

Cindy Sayre:

I don't know that we have signs up either, Trish. And we talked about... I mean, anybody that knows some about elevators, they take so long to come as it is. And we think about the unexpected consequence of having people queuing and waiting as well. So at this campus, I think we've decided that the short elevator ride with everybody masked and wearing their mask is a low risk activity. And I do agree with Keri that when I've been on the elevators people are trying to stay away from each other.

Trish Kritek:

It sounds like that that's probably not always the case based on people responding in the chat, but I think we're trying to... It is a short exposure, but we're trying to keep it down to twos and threes. I'll just say I empower people to not get on or ask other people to not get on, if that doesn't feel comfortable. And Tim, that's the same kind of guidance we have across health sciences. Isn't it? In terms of elevators?

Tim Dellit:

Yes, I believe so.

Trish Kritek:

Okay. Jerome, CNOs, while I'm talking to you, I have a couple other questions. There were a bunch of questions about feeling stretched in the OR in terms of staffing. We've talked about this before and curious where we are with enhancing staffing for the OR, other strategies for a group that sounds particularly stretched. Cindy, do you want to comment on what's happening at Montlake?

Cindy Sayre:

So I have a chance to talk to Carla Brannen our assistant administrator for the OR. And she's acknowledging that we are having staffing challenges in the OR. A couple of factors. One is I think many people know it's a very competitive environment for our nurses in our area and there are many opportunities for our nurses right now. So she's looking at things like increasing the pipeline, going to

schools, trying to increase the number of new nurses that she's training to work in the OR and working hard to also find experienced nurses. We are also actively in this area hiring traveler nurses, just to help us get through but it's acknowledged. This is a tough area right now to staff.

Trish Kritek:

So new nurses, outreach to new nurses and recruiting as best we can as well as travelers. Keri you're unmuted, did you want to add to that?

Keri Nasenbeny:

Yeah. I don't think this is unique to nursing. So I think as everybody appreciates the OR is a very multi-specialty area and so this impacts also our scrub techs and it involves our central processing still processing, our instrument techs, our OR systems. This is a problem that I think we're seeing across all of our staff. I think we're all bringing in temporary staff and doing whatever we can to recruit staff. So we're meeting regularly with our recruitment colleagues in HR. And do target a recruitment for these areas of staff. So I think we all acknowledge this is a huge problem and also able to offer that I think it extends into our PACU.

Keri Nasenbeny:

So I think we're all very aware of this, all very concerned. It's been mitigated a little bit at Northwest because we've closed four of our ORs. We've limited to AORs because of COVID and the need to redeploy some staff from the OR. So that's helped a tiny bit, although as we've redeployed staff, then that entails other issues. So I think it's... temporary staff are a bandaid, they're not a permanent solution. So I think we have to... I think we're really looking at upping our recruitment game. The other piece of this is just that the length of time it takes to orient somebody to the OR. So for an example, a nurse, it's the longest orientation that we have across any of our specialty areas, OB's close, but it's like six to seven months. So that's the other piece of this.

Trish Kritek:

Okay. So it takes a long time to train someone or more people once they're here trying to really push the recruiting. Jerome, did you want to add to that?

Jerome Dayao:

No, it's the same at Harborview. I mean more so actually in other areas than the operating room and we have implemented the same strategies and we are getting some of these staff from outside agencies are the ones that we're bringing in here as permanent staff.

Trish Kritek:

Okay. So I think that's... Obviously on all of your minds, it's felt by people and we're doing a variety of different strategies to work on it. I want to come back to the chief nursing officer in a second, but before I leave ORs, Tom and Rick, I think, relevant to what we just heard about staffing, people are saying like, how are we doing this turning up and turning down the dial? Have we changed the dial in terms of what types of surgeries we're doing yet? Or are we still in the same kind of frame of what types of surgeries are happening? Tom you're unmuted, I'll ask you first.

Tom Staiger:

Okay. So as I think most of you know in late November we stopped doing non-urgent surgeries and procedures which freed up some... that required in hospital stays. So that freed up some hospital beds, freed up some staffing. We have not as yet dialed down further, although that's on the radar screen of things that we might have to do if we get substantial increases in the number of patients with COVID to create beds and staff. At the same time, we have been doing a lot of work to identify staffing and here I'm going to speak to the medical staff side with moonlighters and redeployment. So we have had approximately 80 residents who have volunteered to moonlight for around 300 and... 390, I think moonlighting shifts.

Tom Staiger:

We have had multiple physicians particularly in pulmonary critical care, hospitalists, anesthesia who have been moonlighting to take on additional shifts. We have residents who have been redeployed off of electives to help staff. We've had APPs who are moonlighting. So we are currently maximizing to the degree feasible our resources to meet growing needs and recognize at some point it may be come to us to stop doing other certain activities including some of our OR cases to create additional capacity.

Trish Kritek:

Okay. I want to come back to-

Tim Dellit:

I just wanted to clarify... I just want to clarify one thing Tom said for the residents, and they've done a phenomenal job with the moonlighting and it's voluntary redeployment. So we haven't done any involuntary redeployment. These are individuals who maybe they've been on elective and have chosen to help out and work on the COVID-19 teams or where they are needed. So it's only voluntary redeployment at this stage.

Trish Kritek:

Okay. So there are two things that I think we're kind of answered that I was maybe asking both. One is we haven't really changed the category of surgeries we're doing, which is we are still at the point where if you're... if it's an elective surgery, you need to stay in the hospital afterwards we're not doing those right now, is that correct?

Tom Staiger:

Yes.

Trish Kritek:

Okay. But we could dial it... We could be more restrictive. We haven't done that. We haven't also gone back to normal yet. We're kind of in that middle.

Tom Staiger:

It's elective if you need to stay overnight, if it's elective day surgery those are-

Trish Kritek:

You can have it.

Tom Staiger:

Yes.

Trish Kritek:

Yeah. We're not doing the elective surgeries where you'd have to stay in the hospital overnight. That's probably like a double negative. So I just want to finish that thought. Anything to add about those surgeries you're doing at Harborview, Rick?

Rick Goss:

Oh, sure. I think Tom, some that are very well for really our entire system and in Tim's comments as well and just reflecting on Harborview, I think the good news out there, of course, we're all pleased with the vaccine and the hope there. And we're also pleased that the numbers that have been predicted now for weeks and weeks, aren't at those really high levels, though what is clear is that even if we're at 90 at the system level and we have 20 or so here at Harborview, the extra person power that it takes to take care of those individuals in the ICU, in the acute care is it's almost like a doubling of the workforce when you're working in the COVID unit. And we have a fairly narrow group of people in this whole system that can be those frontline.

Rick Goss:

So it's becoming very clear that they are getting extremely stressed in terms of their commitment and willingness to do those extra shifts most of which are through their voluntary basis with of course, some compensation, but the GME workforce, the faculty that are working there, the APPs, the nursing coverage, the folks working with ECMO, RT, all of those teams, the facilities groups, you can just go through and realize how much focus. So I'm aware that even if these trends stay about where they are, I think we really have to be looking out for that extra, that workforce, not to mention if those numbers start to climb as we still per diem. So I couldn't say enough about the appreciation for those workforces.

Trish Kritek:

So I just want to acknowledge that. I asked the question about going to the ER, and all three of you answered a totally different question. And I think it's because you want to call out all the people who are really stepping up and helping out. And I want to amplify that. So it sounds like we have had a bunch of people volunteer to be redeployed, to help take care of patients with COVID in our acute care and our ICU settings. I know that's true because some of them worked with me over the last several days, which is really heartwarming. And then the second part of it is there's been some people who are doing some moonlighting, again, getting some extra compensation, but again, stepping up to say, I'd like to be part of taking care of this patient population, which does take extra time and does take extra workforce. Does that capture what you were saying before, Tim?

Tim Dellit:

Yes.

Trish Kritek:

Okay. Kudos to all those people. I personally got to work with a bunch of them, advanced practice nurses who are doing extra work, residents and fellows who are doing extra work. And they're choosing and volunteering to do that. So thank you very much for that work. And I think as Rick pointed out, we have

lots of nurses and MAs and other folks across, I don't know this for a fact, but I would say respiratory therapists and other people who are stepping up to help, and it's hugely appreciated. For those of you who aren't working in those spaces, it does take a lot longer, the donning and doffing and things like that take more time. So it does take more hands and more bodies. So thanks to all of those people, really huge thanks.

Trish Kritek:

Okay. One last thing for the chief nursing officers before we go back to some more questions on the vaccine. There were a couple of people who asked is our visitation policy going to change with vaccination? And I'll look at you Cindy and ask, are we changing our visitation policy yet because of vaccination?

Cindy Sayre:

Well, we've talked about this in our team and at this point, the answer is no, for several reasons. One is, it would be almost impossible to operationalize who has had the vaccine, who hasn't. And as our infection prevention colleagues have said many times, we still don't really know about the ability to transmit the disease, even once you're vaccinated. So we are not changing our policy and it's really based on community transmission rates.

Trish Kritek:

Okay. So while we're getting vaccinated, the rates in the community are still high, we're not changing our visitor policy at this time. And I see Jerome nodding. So I'm going to say that's true at Harborview as well. And I see Keri nodding so I'm going to say it's true at Northwest as well. I think it's a good question to keep asking, because honestly it's one of the hardest parts of care right now is not having our families present. It's really hard.

Trish Kritek:

I want to go back to talking about the vaccine and I'm going to ping Tim, Santiago and John on these, and I'm going to try to go through them quickly and tense. One question that I got a bunch of times is how are we making sure that people who don't speak English as their first language, who are part of our workforce are learning about the vaccine and getting access to the vaccine? Santiago I'm going to look to you because I know you've been doing some work on this.

Santiago Neme:

Yeah, thank you Trish. So the office of healthcare equity at UW Madison has set up several vaccine safety discussion sessions. Some of them are in English, some of them in Spanish. We're actually working on one in Mandarin and other languages. The main idea is to really provide information so then everyone can make an informed decision about the vaccine. There's concerns sometimes that are cultural. Sometimes it's just a matter of just not understanding the information. We've had already several sessions mainly the English ones have been led by Dr.[Dennerady 00:47:07], again a vaccine expert. I've conducted the ones in Spanish along with Leo Morales. The English sessions have had many participants like over 300 each session. The Spanish ones have had fewer participants, but we've also had participants from the community.

Santiago Neme:

And again, when we have that in Washington state, 30% of health care workers are considering declining vaccination. We really need to focus on providing as much information as possible so then we can get everyone vaccinated, which is the only way we're going to battle this. Thank you.

Trish Kritek:

Huge thanks to the office of healthcare equity and your partnership Santiago on that. I will tell you personally, I'll just give a message. I've been talking to everyone on the ICU. So I talked to all our EVS workers this week when I was on the service and we talked about getting vaccinated and someone asked this question, I got a second vaccine, my arm hurt less, I felt crappier. I got a headache and I got achy and it went away after I took some NSAIDs. Someone told me I shouldn't have taken them, but I took them. And then I felt fine and I'm telling people that, and I'm going to keep sharing that. I checked with Tim to see if I can take NSAIDs. John, can I take NSAIDs after I get the vaccine?

John Lynch:

Tim said, so sure.

Trish Kritek:

That was actually a question. People are worried they're going to blunt their response to the vaccine if they take NSAIDs. What do you think?

Tim Dellit:

No. I think the issue was taking in NSAIDs if you actually have COVID-19, we've seen some complications there. So you want to avoid them there. After the vaccine I'm not aware of a specific recommendations.

John Lynch:

There's no data on that question to be honest. But lots of people do premedicate before taking... A lot of parents do that with their kids. Right? It's pretty common.

Santiago Neme:

I think a key message really is to know that these vaccines are reactogenic, that we expect people to interact with a vaccine and have a reaction. It's not, for the most part, is very mild and these are not things that are going to stop anyone from... Shouldn't stop anyone from getting the vaccine, but being transparent as you just did Trish, I think it's the key to let people know what's happening and still encourage folks to get one of these amazing vaccines because they are incredible.

Trish Kritek:

Yeah. And just so everyone understands that was like Advil. I took some Advil. I took one dose and I felt much better and my symptoms lasted for about four or five hours, but I felt kind of crappy for those four or five hours. I'm not going to say I didn't. And then I went on my way. So anyway, I think talk to people around you that you work with about this, speaking of which I, now that people are getting vaccinated and I'm enthused by the number of people who told me they were vaccinated. John, people are asking, do we still have to wear goggles if we've been vaccinated? Because the concern is that I'm going to infect people, but not realize it, but I should be safer. So do I need to wear goggles?

John Lynch:

Yeah. So I mean, to some extent I really do believe that we're going to see data that indicates these vaccines interrupt transmission. I do believe that it makes sense how many of the other vaccines work, but until we get that data, we're just going to stick with what we know absolutely keeps healthcare workers safe and keeps patients safe. So we're going to stick with, just as we talked about, the exposure policies, the quarantine and eye protection. And when we start seeing some information, we can start engaging with the healthcare worker community and start talking about what are the right things that should evolve. Be it visitors, maybe it's a quarantine policy. But for now the PPE, we're going to keep in place, both eye protection and masking.

Trish Kritek:

Okay. So PPE stays the same, may evolve as we get more data. It probably will evolve as we get more data. And I think the other question I'm going to ask about now that I'm vaccinated people want to know if they can hang out with other vaccinated folk. What do you think, John?

John Lynch:

So again, biologically I'm hoping for very good data. I want to acknowledge the biological plausibility. Do I think that this is a possibility in the future? Yes, I do think this is going to be a possibility, but we do not have the information to make that clear, to know that's not true. And even if a group of people are vaccinated and we learned that you can get infected and transmit without symptoms, you're actually then can maybe infect someone who doesn't have the vaccine, right? Who hasn't been vaccinated. That opportunity to continue the chain of transmission still exists. So again, I think that's going to be the case, but we don't know and until we know let's stick with what we know, especially when we're in the midst of these still very high numbers and thinking about wanting to get our phases going forward and so forth and counties, it's going to take every one of these actions to count.

Trish Kritek:

Okay. Thank you. So for now, we're saying, no, you shouldn't do that. We're going to stick with the rules and there's biologic plausibility, more to come on that. I have a couple more quick ones I'm going to try to get in. Tim, there's been some talk about having the dose of the Moderna or just getting one dose. And I wondered if you could comment on that, particularly in light of what you were saying before about, are we going to have enough vaccine?

Tim Dellit:

Yeah. I think those are really great questions with the idea, can we get more people vaccinated quickly? The issue is that it's not really a productivity issue right now as much as the distribution and the FDA actually just reinforced this on January 4th, because when you look at those studies, the studies were done with two doses. Now, after that first dose of Pfizer, there was 50% protection during that period of time up to about 12 days after the first dose, but because 98% of individuals got the second dose, we really don't know how long lasting even that 50% protection would be. Whereas if you get two doses, it was 95% effective. So right now we need to follow the CDC, the FDA and their recommendations are to follow the evidence, meaning how these vaccines were studied. And based on that, we're still doing the two doses. Totally understand the questions. It's a good thought, but right now, honestly, if we had the distribution, it's not our challenge of putting it into people's arms once we have it, we just need the distribution pipeline to flow better.

Trish Kritek:

So distribution pipeline is the issue, and yes, we're sticking with two doses-

Tim Dellit:

Correct.

Trish Kritek:

... same strategy as was done in the studies. Okay. I want to give Anne some time at the end. Tim I would be remiss if I didn't ask this because there were a bunch of questions about it in town hall questions. Is there any discussion about going back to free parking because people are still scared about being on public transportation with higher community transmission?

Tim Dellit:

Yeah, no, I appreciate that concerns and as we've talked about before, right now, there is not a plan to move back to free or unmonitored parking largely because we're still very busy within the centers and we need that space for patients parking. It's something that continues to be evaluated, but right now there's no change.

Trish Kritek:

Okay. So no change, will be continued to be evaluated. You can keep asking the question, because I know there are people who do keep asking. I'm going to end with, Anne's going to do some asking of questions, but she's going to switch it up a little bit today. So Anne, your new question answerer.

Anne Browning:

Yeah, we're going to do a little ask a friendly CNO today and so Keri Nasenbeny is going to be on the hot seat. Several questions have rolled in, really many questions of the last several weeks. So this'll be a montage of things folks have asked. First is actually some of this post vaccination themes, like how will life be different? How might things change? So Keri, would you eat on the patio of a restaurant or indoors if there was indoor dining after being fully vaccinated?

Keri Nasenbeny:

Well, no I think mainly just because I'm really conservative in my approach, but I, first of all, just feel like while I had my first dose and will have my second dose soon, nobody else around me has and so it just doesn't feel like that we as a community... that anything in the community has changed. And so my behaviors aren't going to change until we see those rates fall, our vaccination numbers come up and you really have a better understanding of the vaccines. So, don't know-

Anne Browning:

So even once you've had a second dose you won't hang out with other people who have also had a second dose and have dinner even in your homes?

Keri Nasenbeny:

I don't think so. Yeah, it's funny. I've had that conversation with my parents who are just about to be vaccinated too, because they're over 75. And how we both just talk about how I don't think anything's going to change for either of us until we see those numbers really come down in our community. The guidance from our governor, liberate and really feeling like we're in a better space. I'm just not... I have

entire faith in the vaccine. Don't get me wrong, but the rest of my family, my husband's not vaccinated, my kids aren't, my parents still aren't. And those are the people in my household right now. So until that happens, I'm not sure how much it's going to change for me.

Anne Browning:

This next question came in and certainly rang true for me. And it's a question around, as you mentioned, for our parents who might be 75, 70 plus, and about to get vaccinated, would it be okay if they came to visit us if we're unvaccinated? I mean, like my wife and I will be in the tier that gets vaccinated sometime between May and that nebulous blob of next December. So what do you think about vaccinated folks coming over, like older adults coming over?

Keri Nasenbeny:

To see unvaccinated people? It makes me uncomfortable. I mean, ultimately it's probably their decision, right? But I guess I would defer to our ID docs on that one. I know I'm speaking of my own parents. It's not going to change any of their behaviors. I think that people are going to have to make good informed decisions because it's 95% effective, but I think there's still a lot we don't know and I think... I'm fairly risk adverse, but I think others may have a different opinion about that.

Anne Browning:

Couple of questions on staying active. Would you swim in a pool if it was limited to one person per lap lane at this point?

Keri Nasenbeny:

If it was outside.

Anne Browning:

Okay. But nothing indoors. Would you give your parents a thumbs up to attend senior shallow water aerobics classes at this point?

Keri Nasenbeny:

No, I don't think so, but...

Anne Browning:

Okay. Next couple questions return to in-person schooling. I know a number of school districts are trying to start up this January, some even February. Would you have your kindergarteners through second grader attend in-person school if it aligned with CDC recommendations?

Keri Nasenbeny:

Yeah. I mean, I think if we can get a... That's a good question. I think, are teachers vaccinated? I mean, the biggest concern I have around Seattle schools are, are they able to provide the social distancing and all of the safety measures that are required. I'm not entirely confident they are yet, but I think if they could get there... I do think there is that risk benefit ratio with kids and getting them back into school. My own kids are not doing well with homeschool. I'll just say that. And I am a terrible teacher. I have the most profound respect now for teachers I always have, but even more so, so that's a hard one. I think

we need to start making some inroads there. I do think we need to really put some effort there and make sure we're resourcing that appropriately as well. That's the key piece of that one.

Anne Browning:

I think what you raised as the hardship of being a teacher at this time and respect for our teachers broadly. Know that huge respect for every parent out there, who's trying their best to hang in there and take care of their own kids and navigate this incredible work and this incredible moment. So Keri I'm sure you're doing a fantastic job.

Keri Nasenbeny:

Oh no.

Keri Nasenbeny:

No, I'm not. Go ask my kids, they would tell you something different. It's all right. We'll get through it.

Anne Browning:

And it is four o'clock so I have to hand it back to Trish, but thank you very much for being on the hot seat with us.

Trish Kritek:

So that was an empathy building experience for Keri too, for John and Santiago and Tim for being on the hot seats so thank you for being a new candidate. They're both smiling. They're all smiling thinking of how happy they are that it was your turn.

Trish Kritek:

That was a lot of stuff. It's been three weeks. I will just say it's super exciting that it's a new year and it was a really hard first week of the year. The events of this week were sobering in a way that I think is unbelievable to many of us and the visions that we saw on television seemed surreal. And I still remain hopeful that the rest of this year is going to get better and we have a vaccine and we have each other and we will get through even this insane, crazy week together.

Trish Kritek:

So we ran a little long. I'm going to release you all back to all the other things you do in your lives and worlds and say, thank you so much for coming together. I want to thank all the panelists. As always, I thank Keri for being on the hot seat today. Thank the vaccine teams because they're really doing an outstanding job. And thank all of you for taking care of our patients, their families, and most importantly, taking care of each other. We'll see you back in a week. Take care. Bye-bye.

Anne Browning:

Thanks y'all. Take care.