

Trish Kritek:

Welcome back to UW Medicine Town Hall. I'm Trish Kritek, Associate Dean for Faculty Affairs and we have almost our whole panel here today. I'll introduce everyone Santiago Neme, Medical Director at UWMC Northwest; John Lynch, our medical lead for the COVID response and head of infection prevention and employee health at Harborview Medical Center; Anne Browning, Assistant Dean for Wellbeing; Tim Dellit, Chief Medical Officer and president of UWP; Cindy Sayre, Chief Nursing Officer for UWMC; Tom Staiger, medical director of UWMC; Rick Goss, medical director at Harborview; Jerome Dale, chief nursing officer Harborview.

Trish Kritek:

And you'll note that Keri Nasenbeny is not here today. That's because she's immersed in vaccination at UWMC, Northwest Campus. We're appreciative of her doing that. I'm going to kick it off with Anne and a well-being message. And then I have a couple of things to say before we get started after that. So Anne, the floor is yours.

Anne Browning:

Sure. Thank you, Trish. So I sent out a message on Wednesday, that was a bit of a reflection on the year that's just happened. It was a bit of an acknowledgment about how this remains an incredibly challenging time for so many of us and it was also a chance to express my own gratitude for what I've seen across UW Medicine. And I wanted to start by saying thank you to everyone who is continuing to show up and take care of each other and our community as we really start and launch this gratitude campaign over the next couple of months. So thank you for everyone for what you're doing.

Anne Browning:

And then today, I wanted to reflect a little bit, what I see is kind of a persistent challenge that we can work nearly in an infinite number of hours and do our best to balance caregiving, teaching our kiddos, managing labs, writing grants, caring for patients and staring into Zoom and it still it often feels like it's just never enough. That is hard to sit with.

Anne Browning:

And last week, I talked a little bit about the difference between setting an intention and making resolutions. The idea that intentions are things we can... And ways in which we can kind of bring our focus back where we want it. Trish asked me actually one of my intentions are. I thought I'd share one with you all.

Anne Browning:

And as much as our lives have been disrupted over the last year, the constraints in our movements have actually meant that we've often gotten stuck more of this default mode of kind of how we operate day to day without a whole lot of novelty in our day to day life. And that combined with a lot of work demands and potential caregiving demands, can feel like a lot just to get through the day.

Anne Browning:

So one of my intentions for the year is to really try and to figure out how to break out of that default mode and build a little bit more intentionality into how I spend my time. One thing that we're trying is that my wife and I have started dating again. Just to clarify, we're dating each other. We're kind of

adding that layer of intentionality and asking each other like, "Hey, are you free later? Can I make you dinner? Can I make you dinner? Fancy walk this evening? Want to sit on the porch and have a cup of coffee?" In a way rather than just kind of grinding through our days, it's a subtle shift but it's helping us make a bit more time for each other and being really intentional about the time we get to spend together rather than kind of just get through.

Anne Browning:

I hope that you all can think about what would be meaningful intentions for you, whether it's about your own kind of work-life integration, your own kind of health and well-being and I really wish you luck as you're reflecting on what you need for this coming year. Trish.

Trish Kritek:

Anne, that was lovely. And I really appreciate it. I appreciate your clarification about dating each other, so nobody had to worry. But I want to actually not talk about my intentions, but maybe that's something I should do some time too, but follow your lead with gratitude. So I want to thank you for really a truly lovely message this week. I heard from so many people about it and I really want to thank you.

Trish Kritek:

I also want to thank the people who sent in the questions. We had an enormous number of questions. And one thing I want to tell now is lots of people said, "I still can't get the situation reports." So this morning, I spent a fair amount of time and they should all be live now. Please check me. You can do it during town hall, but they should all be live now and we will make sure that they're available to you.

Trish Kritek:

The second thing is we've had an extraordinary number of questions that are coming in through the chat and folks are trying to answer them as we go. They will answer some. We won't possibly answer all of the questions. So please know that we're not ignoring you, it's that there's so many and I'm pinging around to different panelists and I need them to be paying attention so that I can ask them questions. So know that we will archive all of them and do our best to answer them.

Trish Kritek:

Keep sending them in, but just know that if we don't get to your question, it's not that we're trying to not answer, it's that we have an extraordinary number of questions, which is great. That's the whole point of town hall. Now, I'm going to start pummeling people with questions. So Tim, I'm going to start with you. I'd say by far again, the most questions we had were about vaccines and a lot of them were about where we stand in terms of how many vaccines we've given out and then next steps with vaccine. So maybe you could just give us an update to start with.

Tim Dellit:

Terrific. And again, thank you everyone for joining us here this afternoon and everything you continue to do for our patients and for all of your colleagues. Where we are at, we have now given over 16,000 first doses to employees and another 7,000 to community partners. So other healthcare workers in the community who otherwise would not have had access.

Tim Dellit:

So in aggregate, we've given 23,000 individuals their first dose and now we're on to the second dose for many people and we've given over 4,000 second dose so truly a phenomenal effort by the entire vaccination team. This is incredibly complicated and again, we still don't know until a couple of days before the next week how many doses of vaccine and which type, Pfizer and Moderna we'll get for each of the campuses. So a lot of effort to keep this coordinated and I'm really proud of the effort that we've done.

Tim Dellit:

Where we are now is that we've largely gotten through one eighth. There are definitely some healthcare workers out there that we still need to get in the community. But we anticipate here at any moment, literally the next few days, we anticipate DOH, again, whose guidance we have to follow, they will transition into that B1 phase.

Tim Dellit:

That next phase is when we pivot from healthcare workers and residents of long-term care facilities, really to now shifting towards the community. So individuals who are 70 years of age and older as well as individuals who are 50 years of age and older in a multi-generational house. And because that definition is a little complicated, I've asked Anne to post that so people can actually see and read that.

Tim Dellit:

And again, as we begin to message broader to our patients, as well as our employees in non-clinical areas, we will include those definitions. And so just to reiterate, for our patients, for our employees and non-clinical areas, they will be eligible for vaccination based on the DOH criteria as we move through these phases and more information will be released here, I think any day to give instructions once you are eligible, how to then be able to register and get scheduled.

Trish Kritek:

Okay. So 27,000-ish vaccines given, moving in very soon to B1 or 1B, I can't remember which way it's supposed to go. And we will be messaging about that. I'm going to ask some follow up questions. There are multiple who people asked about the multi-generational thing. So it's in the chat, because a lot of people don't watch live, they watch recorded, it's people who are 70 years or older and people who are 50 years or older in a multi-generational house, which sounds like if I'm reading this correctly, and someone here can correct me, is if they're living 50 years older and living with somebody who helps provide care to them or if they're 50 years or older and have grandchildren for whom they're caring for not kids, just kids. Is that right?

Tim Dellit:

Yeah. And again, really look at those details. Now, the other thing is that if you use that Phase Finder Tool from DOH, that logic is being built in there. So that will walk you through all of those decision tree standpoints. And so if you describe your situation in there, it'll then identify whether you're eligible at this point or when you would be eligible.

Tim Dellit:

So use the Phase Finder Tool as well.

Trish Kritek:

So Phase Finder to help answer your specific question. And we will also be messaging out as soon as we get the news from DOH, and I think what I heard you say is we're going to follow what the Washington Department of Health says on the next phases.

Tim Dellit:

Yeah, so just let me reiterate because this is important because... And this is also why it's confusing. You may have recommendations from the CDC, but then every single states, the Department of Health, modifies those and implements them, ultimately, all with a goal of how do we in a limited supply situation, how do we prioritize those who are at greatest risk for severe disease and greatest risk for acquisition?

Tim Dellit:

But because each state is doing it slightly different and different than what you may see on the CDC website, it gets very confusing. But ultimately, we are required to follow Washington State Department of Health guidance on this.

Trish Kritek:

I think that answers one of the questions that came up a lot, which was the 65 versus 70 because the CDC had said 65 and our state has chosen 70.

Tim Dellit:

Well, HHS said 65. I'm waiting to see if the CDC modifies to do that. They likely will, but even with that, then our Department of Health is considering whether they make that change. But as of now, they've said no. They're holding up to 70.

Trish Kritek:

Okay.

Tim Dellit:

And some of this is supply limitation. If we get much more supply, which there's been a lot discussion around that, if there's increased supply, then there's a greater likelihood of being able to expand more quickly as well.

Trish Kritek:

Okay, thank you for clarifying and correcting what I said. So let me follow up on two things there. The first one, I think is relatively easy. There were still questions about access for community, clinicians, dentist, physicians, other folks and I believe that you said there was an email that people could use to ask about that.

Tim Dellit:

Yes, we can put that in the chat as well. It's UW Medicine Liaison or UW Vaccine liaison email. Again, anyone out there can use that email contact about it. List is reviewed every day and we're trying to get those people scheduled because again, we want to help as many people in our community that are healthcare workers and otherwise don't have access as possible in order to allow us to move to that next phase.

Trish Kritek:

Okay. And where do we find the Phase Finder? How would people find the Phase Finder, Tim?

Tim Dellit:

There's also if you go to the Washington State Department of Health COVID-19 Vaccine, there's a whole page where you can see here are all the phases listed. I think the tool is on there, more detailed description around the phases is on there. They're also good links to other resources as well, as well as their own FAQ around the vaccine.

Trish Kritek:

Okay, thanks. The second thing that I want to follow up with before we kind of move on and we'll come back to more vaccine questions is something you alluded to, which is numbers of vaccines. So there were lots of questions that people were worried that they got the first vaccine but because of limited supplies, they're not going to be able to get the second vaccine. How are we making sure that we're going to have a second vaccine for people?

Tim Dellit:

Yeah, I really have a lot of confidence on our team. It's complicated, but they are keeping track how many are scheduled this week for first dose, how many are scheduled for a second dose, they're making sure as we go through that they have adequate supply to cover both of those. So don't worry about that. Our team has this under control. They're monitoring this extremely closely, but we understand that question, just by what people are hearing in the media.

Trish Kritek:

So we're keeping track of it? And I'm going to come back to some more questions about second dose because there were a bunch of them. I'll return to that. I lied, I do want to ask one other follow up. There are many questions about people who are parts of the UW Medicine community who are not patient-facing or in a clinical setting and when they will be incorporated into this process. And the corollary to that is, do they need to go to their primary care doctor or will they be able to get it through UW Medicine.

Tim Dellit:

They would be able to get it through UW Medicine, they will be eligible though, based on those same criteria. So as we switch into that 1B phase, it's our patients and all of our employees in that non-clinical arena that would then be eligible when they meet those criteria.

Tim Dellit:

Now, if they receive their care in another health system and they can get access there, absolutely, you can go and do that as well. But our intent is to be able to offer that to all of our employees including those in the nonclinical areas, it's just a matter of when they meet the DOH eligibility criteria.

Trish Kritek:

Okay, so we will offer the vaccination to everyone who's an employee in our system and we will continue to follow the DOH stepwise process.

Tim Dellit:

Correct.

Trish Kritek:

That's really helpful. This is the thing that lots of people are anxious about is like, when will I be up for the next, next step?

Tim Dellit:

Let me just say one more thing, because this sometimes comes up. Our goal is to get everyone vaccinated and we also acknowledge whether you're in the clinical environment or in a non-clinical or in a research environment, every member of our UW Medicine team is absolutely essential and critical to the success of our organization and the response to the pandemic.

Tim Dellit:

I just really want to emphasize this. This is not about who's more important or not. Everyone is absolutely important and plays a role. It's a matter of how do we prioritize based on the greatest risk of exposure and severe disease. And again, we're obligated to follow the DOH criteria. So I just really want to emphasize that because I totally understand that frustration that people are having and we're really trying to support everyone as we go through this for entire community.

Trish Kritek:

Thank you for walking through that because I get it. I actually completely understand why it's a distressing situation. I keep lying. One last one. Don't mute yourself. I think you said this, but I want to reinforce it.

Trish Kritek:

A lot of our healthcare providers are wondering when the messaging will go to our patient. And I'm assuming that messaging is going to go when we get the next phase from DOH, is that correct?

Tim Dellit:

That's correct. I anticipate literally any day now. The message has been drafted, it's ready to go, we're just waiting for the signal from Department of Health so that we can move to that next phase. I really think it's going to be just a matter of days.

Trish Kritek:

Okay, more to come on vaccines. I'm going to pivot though to John and ask him to give us what he usually does, which are the current numbers across the UW Medicine and I think also what's going on in the state in the county because I think people are feeling like those numbers feel discordant and maybe you could talk a little bit about that.

John Lynch:

Yeah. Thanks Trish. You're right. I think anybody who feels like it's a little bit discordant, that's probably appropriate. So within UW Medicine, just to focus on our hospitals right now, we're actually down quite a bit from last time I talked to you. We're at 65 people in our hospitals right now who are actively in COVID precautions.

John Lynch:

We certainly have more people who have moved out of precautions who still require inpatient care, but the folks who are in that COVID level of precautions is 65, 18 of them are in ICUs. Two of those people are in that ECLs that ECMO, the bypass I talk about. That seems to be a pretty consistent number. And that number, it is newer patients, that's what continues to happen. 47 are in acute care units.

John Lynch:

The county numbers and the state numbers are a little bit hard to figure out. I think the county numbers and I've talked about this before, basically after December 24, we were doing around 11,000-10,000 tests per day in Kane County and it dropped dramatically down to 3000-4000, even down at 2000-something and that hasn't recovered.

John Lynch:

We are seeing that number of positive cases go up. But I think it's really hard to figure out in the context of so much fewer, many fewer, tests being done overall. That's the county stuff. So I think what we keep coming back to is how many patients do we have in the hospital, how many patients are being admitted at other hospitals in Kane County. And that's pretty stable, about 25-26 people being admitted per day.

John Lynch:

I think a little bit more clear is the information at the state level. When we look at the number of new diagnoses per day in Washington State, it's actually pretty clearly coming back up. It's coming up to a level not quite there, but it looks like it'll soon be at the same level as it was before the holidays hit.

John Lynch:

So that's 2,600 or so new cases per day. And the hospitalizations are following the same trajectory. So we kind of came down, right around 100 and now it's gone up 100-teens per day. And so when I look at that state data, which we've got a great system in the state for level loading, moving patients around the state for the best possible care and then make sure no site gets overwhelmed. What's happening in eastern Washington or North Washington or South East is going to eventually impact us as the type of care we deliver in UW Medicine. I anticipate we're gonna probably see some stabilization of numbers, and maybe even going back up again. But as we've all learned, we just take it week by week.

Trish Kritek:

Okay, I appreciate you walking through that. So our numbers are down quite a bit. County numbers are harder to interpret because there's fewer tests being done and that state numbers are relatively clearly up somewhat, not skyrocketing, but up from where they were. We'll keep following them. And hopefully, everyone will have access to the situation report so they can follow as well. Thank you.

Trish Kritek:

Is there some reason why we had a significant decline in the number that we have in-house? Or is it that we just discharged a lot of people?

John Lynch:

Well, there's a lot of reasons why we count the number of people who are in the hospital COVID-19. There's sort of knowledge as a frontline clinical person, as someone involved in medicine, someone who's talking to their friends and family about what's going on. These numbers are really important.

John Lynch:

But sometimes we have to figure out how to report them. Is it someone who gets admitted and it is now sick with COVID-19, they have symptoms of COVID-19 but they leave the hospital. Is it someone who comes into the hospital and like I mentioned people who are in precautions, but then sort of move out of precautions and become going to what's called standard precautions. They don't require that same level of PPE and so forth or something else.

John Lynch:

What's really important when we think about the COVID impact on hospitalizations, there's really two big buckets. There's people who are on our hospitals for COVID for any reason at all. And that's a really important number. And that's actually a number that we report to federal authorities. That's a regular thing we've been doing quite regularly in terms of reporting out to HHS and other stakeholders. So they understand sort of how COVID is impacting our systems.

John Lynch:

But internally, one of the things that we've really tried to align around and more recently is how many people are in that precaution phase, sort of where we need special spaces, special PPE, special procedures, more intense resources, allocation. And basically, we've just... I think some of that numbers is we've all finally kind of aligned on that as the number we want to look at internally. So the number I report out every morning in our emergency operations center, the number I'm reporting today.

John Lynch:

Are the patients who are admitted with COVID-19 who are in precautions right now? But some of those... We have more people who have had COVID, who are still in the hospital. And that's still a good sized number of folks, probably about maybe, depending on the date, 30 to 40% more on top of them, who have had COVID and are in that sort of recovery phase.

Trish Kritek:

So I think that that's an important thing for people who are watching the numbers. It sounds like we refined our clarity on the fact that we're only reporting out the people who are in precautions for COVID. And so that's the number they're going to be seeing on our internal reporting.

Trish Kritek:

We report everybody who tests positive for COVID to the national numbers. Thank you for that clarity. I have a couple more testing questions before I move on. You had mentioned quantitative PCR, I think we talked about it very briefly. People just wondered, are we doing quantitative PCR in our lab right now?

John Lynch:

Yeah. Our clinical virology lab is doing a huge number of tests per day. I think yesterday reported out with Santiago, like 14,000 PCRs yesterday for COVID-19. Huge numbers every single day. And to make



that work, they're actually using a variety of what are called platforms. Basically, different machines using essentially the same very, very similar technology.

John Lynch:

Some of those machines report out more details than others. And one of the details, it's most machines report this thing called cycle time. It's basically how many cycles of the molecular amplification it takes to say yes or no. Historically, in laboratory reporting, all we get is that yes or no and that cycle time, the number of times it takes to get it to detect yes or no is something in the background they use for quality control and other tools.

John Lynch:

And basically, what we're learning and we're still in the learning phase of this is that there appears to be some relationship between that number of cycles, cycle time, CT, and is this an old infection, is this a new infection? There's even some data coming out now associating that number with how severe the person's illnesses and we're still learning a lot about that. But the most important thing to take away is that yes, we're getting those numbers from many of the machines, but not all and we're still learning about how to use that number in a reliable way.

John Lynch:

So definitely, we're working on it. We're learning about it every day. Our infection prevention teams, our physicians are looking at it. But it's still in that not sure phase in terms of how useful it is for any of those questions.

Trish Kritek:

Okay, so we measure it on some but not all machines, still trying to understand how to use that in a clinical sense and understand the meaning of it. More to come. Thank you. One last testing question. We talked about this ages ago, but I think just for clarity, there was a question about what tests do we send on patients who are intubated who have a breathing tube in and are in the ICU? Do we send the nasal pharyngeal? Do we send an endotracheal aspirate? Do we send both? And maybe you can just briefly tell us what our standard is on that?

John Lynch:

Yeah. So our standard across the board are basically nasal pharyngeal or anterior larynx testing. We really want that someone come to the hospital, you want at least that first nasal pharyngeal test when it goes to the back for all patients.

John Lynch:

Because we've in the past, we have had challenges with some testing for influenza testing in intubated patients. Basically, we're looking at differences between what happens up in the upper respiratory tract and the lower respiratory tract. We've historically gotten samples from both because sometimes we see differences. Because of that, in some occasions, like at Harborview and some other ICUs. We're testing both for people who have a web of symptoms and are intubated.

John Lynch:

Just to get a sense is that what we're seeing and we're not seeing that same issue like we did with flu. And so really, our reliance, our workhorse here is the nasal pharyngeal swab of people coming into the hospital without symptoms or with symptoms, whether intubated or not intubated. But for some of those intubated people with symptoms, we're just learning basically. We're doing this upper airway and lower airway testing, to see whether there's that same problem. And again, we haven't seen that issue.

Trish Kritek:

Okay, so we haven't seen differences between nasal pharyngeal and endotracheal-

John Lynch:

We've seen a couple. We've seen a couple. But we don't whether that means something.

Trish Kritek:

Okay. Do we do it for all patients who are symptomatic with COVID who are intubated? Is that part of what we're saying we should be doing? That's what this question is.

John Lynch:

That's our policy right now. Yes.

Trish Kritek:

Okay. So the answer is, yes.

John Lynch:

Symptomatic people who are intubated.

Trish Kritek:

Symptomatic people who are intubated, nasal pharyngeal and endotracheal aspirate, thank you. Perfect. Okay, I'm going to pivot to masks and I'm going to bounce around and I might be out of sequence of what I usually was going to do. So John, one more for you before I pivot to somebody else. Can you explain what we're supposed to be doing about when we're supposed to change our mask? And I actually personally asked this question because I have generally worn my mask up to my office, taking it off and then put it back on but maybe I'm breaking the rules now. So maybe you could explain that.

John Lynch:

Sure. I think your confusion, you're not alone and I'll take responsibility for that. We need to do better around communication and we're going to keep doing that. It's evolving like most of the things I'm saying. Really what we want people to do around surgical masks, the ones we wear on our units, in our offices, is that once that comes off, we want you to put a new one on. That's the thing. You can keep it on for long periods of time, if you're working in a shared office setting, you can leave it on, but when you go out to have a cup of coffee, have lunch or whatever, when that mask is off, I would like you to put a fresh one. We have sufficient supply to get a brand new surgical mask for you to put a new one on.

John Lynch:

And the same thing occurs if you are in a clinical setting and you go into, for instance, a room with droplet contact precautions, where we have a surgical mask, that thing's not covered with a face shield,

take it off when you leave the room and get a fresh one and put on. So basically, anytime that there's a potential change in the mask or contamination, take it off, put a new one on. Before coffee, after coffee, before lunch and after lunch whenever it's soiled or dirty or worn.

Trish Kritek:

Thank you, I think that's really helpful. Anytime you take it off, you're supposed to put a new one on. That seems like the rule, which means that when I go up to my office, I should bring a second mask with me. So I have a mask to put on and then go back downstairs. Is that right?

John Lynch:

That would be optimal. Yes.

Trish Kritek:

Okay, I need to change my behavior. Thank you for teaching me that. That's definitely different than what I've been doing and luckily, you can't see the mask that's sitting over there that I took off, but I will change my behavior.

John Lynch:

Thank you Trish.

Trish Kritek:

No problem. Thank you for teaching me relevant to that. I'm going to pivot to Cindy and Jerome because there are a bunch of questions about now we've put up signs that say patients should wear masks. And yet patients aren't always wearing masks. And folks wanted to know what can they do about this? So I'll start with you, Jerome. Do you have guidance for what to do in that situation?

Jerome Dale:

Well, the conversation first needs to happen with the patient because what we've realized was that certain patients feel that they could just remove that. So that crucial conversation really as to why they have to be wearing a mask to protect themselves and to protect the other healthcare workers.

Jerome Dale:

But I would just like to add Trish, we would have individuals that would just be removing them or individuals that might be clinically not be able to be wearing the mask at all times, talking about patients. That's why it's even more so important for our caregivers within all of our hospitals to always be cognizant about wearing their mask properly and doing the hand hygiene.

Trish Kritek:

Thank you. And I think the highlight there might be clinical reasons. Start with a conversation. Cindy, do you want to add to that?

Cindy Sayre:

Oh, nothing to add. I think that's exactly right.

Trish Kritek:

Okay. I'm going to come back to the two of you with some other questions about vaccines. But I just wanted to follow through my train of thought on masks, and I'm going to come up to you Santiago and ask about... We talked last time about the for Northeast outbreak and the fact that that patient had aerosol generating procedures or had been on non-invasive. I think and I guess the question that was asked is, are we changing our behavior when people have aerosol generating procedures, regardless if they're COVID, positive or not because of this risk? I.e., should we be wearing an N95 in all of those situations?

Santiago Neme:

Yeah, so thank you Trish. That's a great question. We have thought about this outbreak, very carefully and we found that it wasn't really that we had a PPE issue and PPE... That the PPE was ineffective. We found that we just didn't know the patient was actually positive and was getting an AGP. So at this point, we're not going to modify our PPE for AGPs, but it is an ongoing discussion within the teams whether all AGPs regardless of your test results should be done with a respirator.

Santiago Neme:

It's an ongoing discussion but our approach has been really relying on our excellent testing. Now, we're actually going to be doing even more testing serially for patients. So we were pretty confident in our approach and also our safety data supports that. We're very excited about a process that we just launched at Northwest and it's coming to Montlake and Harborview next week, where we're going to be testing patients on day 0, 3, 7, 14, 21, 28 etc, regardless of symptoms. So we're going to have a lot of tests on our patients and we're going to be able to protect some of our PPE supply and continue to rely on our practices.

Trish Kritek:

The take home there is we're not changing our policy around what to wear for AGPs in all patients and we are changing our policy and our testing 0, 3, 7, 14, which is what we talked about last week.

Santiago Neme:

Exactly.

Trish Kritek:

I will come back to N95 if we have some time because there were more questions about that. Someone has reminded me in the Q&A that they've asked us three times. So I'm going to ask you because I have neglected to ask their question. And that is, when you decide about what is an AGP and specifically people were curious about... This person was curious about laryngoscopy and why it is or is not, in this case an AGP.

Santiago Neme:

Right. So thank you Trish. That's a really frequent question and it's complex because there's different definitions. So what we've done is we've gathered a team of experts, multidisciplinary team that gathered and thought about what CDC classifies as an AGP and what we think we should treat it like an AGP. Basically that's all captured in document 1E, E as in echo and on the website and you can find. So anything that's ENT, and the larynx being part of the upper airway, any airway manipulation, we treat like an AGP even though CDC or other organizations might not consider that to be an HEP, we do.

Trish Kritek:

We do?

Santiago Neme:

We do. We do. Any EMT procedure, any airway manipulation, we consider and treat like an AGP.

Trish Kritek:

Okay. That's really helpful.

Santiago Neme:

Endoscopy, CDC might say that it's not an AGP. But professional societies say that they are an AGP. We treat it like an AGP, any endoscopy.

Trish Kritek:

So anything with the airway, any endoscopy, regardless of what the CDC says, we've lumped them into saying, "Yes, AGP." Thank you for clarifying that.

Santiago Neme:

Yeah. And then I invite folks to review the document. It's one page and it's very clear, we think. 1E as in echo.

Trish Kritek:

I love that. It's very clear, we think, but if it's not clear, we want to hear your questions about it. So thank you. I'm going to pivot to some questions about vaccines. I'm actually going to start with you, Tim, again. It's come up in the Q&A and chat and came up beforehand too.

Trish Kritek:

We take care of a lot of patients who are homeless or marginally housed. And there are questions about are we going to do mobile vaccine vans or are we going to do some type of outreach to get vaccines to folks who aren't probably able to be reached in our normal strategies?

Tim Dellit:

I think that's a really good question. And where we are, is that to-date we've been hospital based in our vaccine approach. I think the good news is that both Kane County and the City of Seattle have announced plans for mass vaccination sites.

Tim Dellit:

Now, we're still waiting for the details around that. So I think part of this is that the plan is still evolving because we can't do it alone. But we need to see what the city and county are going to do and how we best partner with them to ensure vaccination for those vulnerable populations. I think there'll be more information to come. But part of this is really looking at how well we go from the hospital base to the community based with the county and city sites.

Trish Kritek:

Okay, so we're going to partner with the city and county. There are plans for mass vaccination sites, because that was another question. We just don't know the details of those and we'll keep working with them to figure out what's needed to reach those individual populations. Thank you. John, I'm going to ask you about this. There were a bunch of questions...

Trish Kritek:

We talked about it last week, but I'm going to talk about it again. Folks are wondering about like are there any data now that say that I could be a carrier after I'm vaccinated or can I feel... Is there anything that reassures me that I'm not a carrier after I'm vaccinated?

John Lynch:

Yeah. This is an ongoing conversation. I would say that there aren't any new data since last Friday, I think when we last touched base on this. I'm not sure if I said this last week, but I think there's biological plausibility the vaccine is going to interrupt acquisition and transmission. It makes sense, just given how impactful this pandemic has been, and how morbid this disease can be.

John Lynch:

We really do want to... Like we've done throughout this whole time and you've all heard me talk about rely on evidence. We've been really great about going back to evidence every time with making big decisions and we just want to stick with that. The other really important part of this is that we really don't want to make big shifts when most people, remember it's still 90+ percent of 95, 98, 99% of people are still not vaccinated. And we want to keep everyone safe. All the actions we're taking are about protecting ourselves, our families and our communities and our patients. That's... We just want to hold the course when we have a lot of people who got both vaccines and we got weeks under our belts in that situation, we're going to be learning a lot about the situation and soon as we get data and experience, we're going to definitely translate that.

John Lynch:

The thing behind this Trish, I know I'll be really quick is that I understand people's desire here is to get out of this. They want some normalization, they want the vaccine to mean something around masking and so forth. And I do too. We're going to get there, we just need a little bit more time to get the evidence and the data to back that up.

Trish Kritek:

So we're still waiting on data. And for now, we're continuing our masking processes as we do. Are we testing people to see if they have an immune response? Are we checking antibodies?

John Lynch:

We aren't. There's no data to support that mechanism. We know from other vaccine situations with other infectious diseases that testing doesn't really necessarily tell you whether the person's immune or going to resist the infection. And so there's no recommendations to test, we are not testing, there may be research scenarios where that's happening, maybe research projects within UW Medicine where that's happening. But as you know on the clinical side, we are not testing employees, I don't recommend that they get tested routinely before or after they get vaccinated for antibodies.

Trish Kritek:

Okay, thank you. I think people are just understandably want things to be different and want to know that they're protected. And it's... I get it too. I'm going to ask Cindy and Jerome this, but you might have to pass. I'm not sure. There are a lot of questions about what we're doing with the doses at the end of a vaccine clinic that are "left over" so that we're not wasting any. So Cindy, do you know what our strategy is and those-

Cindy Sayre:

I think this is kind of under transition right now. We are looking at strategies to try to give some of that extra dose to patients. And I think they've already reached out in Northwest Campus, I think gave a dose to somebody in their psychiatric unit. Is that right, Santiago? I think that happened.

Santiago Neme:

I don't know that that's happened, but that's an act of discussion because we initially wanted to vaccinate folks who hadn't been vaccinated in terms of the staff, but then fortunately, all the staff has received their dose and they're waiting for a second dose. So then I believe the vaccination group and Dr. Dan Reddy and Jenny are really strategizing. Because we're thinking about some populations like the psych patients, home-based patients, patients who are going to a congregate setting would be top candidates, but we want to make sure that we do it within the regulations that are in place.

Cindy Sayre:

That's right. Yeah. So we would be following the DLH guidelines for the same populations, but potentially people that are in patient.

Trish Kritek:

Okay. So we're starting to use... First off, we started off trying to get employees vaccinated if they needed to be vaccinated. Now we're thinking about patients. Excellent. And more to come on that I think people are just want to make sure we're using it and want to understand how we're using it.

Tim Dellit:

Definitely-

Santiago Neme:

Just rest assured that we're not wasting, we're not throwing away it. We know if we have extra, and we're going to utilize it.

Tim Dellit:

And we're tracking it. So we're looking at metrics on a daily basis because we don't want doses to go to waste. That's a very key metric that we're following.

Trish Kritek:

So we're keeping track of it and we're doing our best to make sure we don't waste doses. So thank you. And people, that was why they asked. A couple more of vaccine questions. Santiago, people wanted to know if they can take Tylenol or ibuprofen after the vaccine.

Santiago Neme:

I'm going to tell you my personal story. I don't know, maybe Tim or John, but what happened to me is that I was pretty tired for the subsequent 48 hours and I was tempted to take some ibuprofen or Tylenol, but I wanted to see what happened. Mentally, I didn't want to impact my immune response or my inflammation. So I didn't take anything. Day three, I was totally fine.

Santiago Neme:

Now, that being said and then I had discussions with Steve Burgum and other people and the truth is that there's a lot of theoretical concerns around kind of affecting or disrupting your inflammation and therefore your immune response. It doesn't seem to be solidified by evidence or science. So what I'm going to tell you is that for my next dose, I'm going to have some ibuprofen ready if I'm suffering because I already know what happened. So I invite Tim and John and other folks to tell us what they think. But I'm not aware of anything scientific that tells us that ibuprofen is bad after the vaccine.

Trish Kritek:

Tim or John, do you want to chime in? I already told everyone that I took some ibuprofen after my second one.

John Lynch:

My arm was sore, so I went and done one. I'm not doing... I'm not taking anything.

Tim Dellit:

But I think the big difference is there's been some recommendations if you actually have COVID-19 to avoid NSAIDs. This is different if you are vaccinated versus if you actually have the infection with SARS-COV-2. And so I think that's the important point here. And that's where the question I think has arisen.

Tim Dellit:

I'm not aware of any evidence around the vaccine and the use of those medications as compared to if you actually have the infection. So we don't have any evidence that says you shouldn't take them.

Trish Kritek:

If people take them, that's understandable. I think lots of us clinicians and scientists wonder about disrupting an inflammatory response and we don't have any evidence that says that that's the case. Okay. Tim, back to you. Since you were on.

Trish Kritek:

People, were asking two things about symptoms, since we're talking about symptoms. One is I had really bad symptoms the first time, should I still get the second dose? Not allergic reactions, I felt fatigued, crappy, fever, should I still get the second dose?

Tim Dellit:

We would encourage you to still get the second. The studies and we've seen anecdotally this bear out that people have tended to have more symptoms with the second dose. But I think we've also heard of people quite frankly who have pre medicated with Tylenol or ibuprofen before that second dose as well.

Tim Dellit:



But I really would encourage you to get the second dose, you want to be protected against COVID-19. It may be uncomfortable for a day or two but it's going to be worth it in the long run.

Trish Kritek:

Okay. And then the converse, people are asked, "I didn't feel crappy. Does that mean I'm not protected by the vaccine?"

Tim Dellit:

No.

Trish Kritek:

So you don't have to have a reaction. It's just what some people have. Is that right?

Tim Dellit:

I think that's right. Everyone responds a little differently.

Santiago Neme:

And honestly, most people don't feel anything. They just feel the local pain at the side. But there's been some reactions that people have some skin reactions at day seven sometimes. So I think it's good to make people aware that if they have that, it's not like it's never been reported. These things are being reported. But the question is, is it severe enough for you to stop? And we're always happy to do a consult with Dr. Dan Reddy, our allergist or any other experts that we have.

John Lynch:

And this is just a good plug for the V-safe app that... So the QRs code for everyone getting their vaccine, the way we can answer these questions is that people use that QRS, do their daily attestation or symptom tracking on the V-safe app. I've been doing it every day, it's been going really easy. Please do it. Tell everyone to do it, because then we'll actually know what's going on.

Trish Kritek:

Help gather data, so we understand this better by using this app that you can scan when you get your vaccine, they give you a piece of paper to scan that. John, maybe you know this, people have asked, "Do we know how many severe adverse reactions have happened within our community?"

John Lynch:

I don't off the top my head. We actually... Given the number of vaccines we've given, we've seen very few severe reactions. Definitely people like things Santiago mentioned, people get lymph adenopathy, that means their lymph nodes swell, sort of like when you get a cold or ear infection, but they resolve skin reaction. Some of these reports that have come out where days later, they get a patch of redness. I've heard a few of these myself.

John Lynch:

But they all resolve. They all do well. We've not heard of... As far as I know, Santiago, Tim, anyone on this call, have heard large scale or even numerous severe reactions. They've been pretty small. And I

would say way better than we were anticipating. When we look at all the research data, we are anticipating much, much, much greater reactions, it has been going really well.

Trish Kritek:

Great. Very few severe adverse reactions. We don't know a number per se, we can follow up on that for people and in general, there are things like this delayed arm swelling, people asked about that and pain in their arm six, seven days out. We know that that's happening, as well as rashes and swollen lymph nodes and those all seem to get better is everything that we've heard. So thank you for answering all those. There's one more thing on vaccines before I pivot to some other types of questions. That's actually I'm looking back at Jerome and Cindy.

Trish Kritek:

Last time, we talked about volunteers for vaccination clinic. And the question this time actually was, "Are we thinking about hiring people to do our vaccine clinics?" Because it seems like this is going to be an ongoing need. So Jerome, I'll start with you.

Jerome Dale:

At this moment in time, Trish, we are doing volunteers for this vaccine clinics though we are starting to explore how can we further support this because we are having volunteers coming from the inpatient and now we also have inpatient needs and so we're carefully weighing our options and this one and carefully projecting how much more workforce we will need.

Trish Kritek:

Okay. And Cindy, it sounds like maybe it might be evolving differently at UW Montlake.

Cindy Sayre:

Montlake is hiring for positions in our vaccine clinic to support the effort. And we are also received a lot of emails today strengthening our volunteer program around the vaccination clinics. For example, I think a few weeks ago, I said, we're not thinking about retired RNs. Well, now we are and there's been some state guidance on how we might be able to use those people because we really have an imperative to ramp up the number of vaccines that we're delivering, so we're going to need multi-modal response.

Trish Kritek:

Retired nurses are in the mix, hiring at UWMC Montlake. Are we hiring at Northwest?

Cindy Sayre:

I can't confirm that. I don't know for sure. Not hiring right now at Harborview but kind of evolving picture and look, keep coming back to this because I think people...

Trish Kritek:

Either people want to understand how to help. And they also understand kind of what our plans are. So thank you both for answering that.

Jerome Dale:

Absolutely.

Trish Kritek:

Tom and Rick, it's been a long time since I talked to both of you. John led off earlier about less numbers around COVID in our institutions and folks asked the question of, "Are we winding down our COVID services in acute care and ICU?" So, Tom, maybe you can tell us what's happening at Montlake. And then I'll ask Rick.

Tom Staiger:

We are pleased that our numbers have dropped over the last week. That said, we want to be fully prepared for what may be coming and given the recent holidays, some expectations that the numbers could rise again over the next few weeks.

Tom Staiger:

We are maintaining being fully prepared. We don't want to be over prepared but we want adequate staffing for increases that could ensue over the next coming weeks to months.

Trish Kritek:

Okay. Rick, at Harborview.

Rick Goss:

The same principle. Since the beginning, we have expanded and contracted teams, not necessarily on a day in and day out basis because that's very disruptive. Here, we've been anticipating a pretty significant surge. We've had some pretty high numbers. So we have some extra teams that have been deployed and people from GMA and faculty and APPs and nursing are all contributing, much appreciated.

Rick Goss:

So if the trend continues, we would obviously slowly back that back down, all the while still planning for the worst case scenario as we are seeing in other parts of the country.

Trish Kritek:

Okay. So it's not that we're kind of holding steady, but appreciative of the lower numbers, may start to pare things back and be ready to bump back up as needed if there are more cases. And again, I think a thanks to the people who have been a part of the response I heard from both of you. I'll ask the two of you a question. I could ask anyone here, but I'll ask the two of you.

Trish Kritek:

There are people who asked if we're changing our approach to in-person meeting. So have you gone to back to in-person meetings in places in the medical staff or across the hospitals? And I'll start with you, Rick. Has that changed at Harborview?

Rick Goss:

Not yet. There's still where people do gather in the same room, the principles of masking and working six feet apart. But no sort of meetings have changed from our new normal, which is sort of a Zoom format to that in-person. As of yet, we hope to get there.

Trish Kritek:

Okay. And Tom is at the same at Montlake?

Tom Staiger:

Yes, it's the same and my leg and we look forward to the day when we will be able to gather for in-person meetings, but we await guidance from our public health and infectious disease colleagues as to when it might be safe to do that.

Trish Kritek:

Okay, so right now we're still sticking with Zoom and sometimes in-person, but in the same protected ways that we've been doing it but no increase in that. Thank you both. John, I have a potpourri of somewhat random questions that I want to ask you. Quickly.

John Lynch:

Bring it on.

Trish Kritek:

What's the prevalence of flu this year?

John Lynch:

Almost zero. So we've been working through surveillance with a lot of different folks, Seattle Children's Hospital, SCCA and our own clinical virology lab is doing pooled samples, especially from the city sites. It's just sampling large numbers all at once. Is there any flu in any of this? And last time I heard I haven't been updated this week, I think out of like 27,000, almost 30,000 samples, I think there were four cases.

John Lynch:

So we have not seen this in our ICUs. We've not seen this in acute care units. We're not seeing ambulatory. And it's really, really wild. It's not just flu. It's also things like respiratory syncytial virus, which is very dangerous for little kids. It's major cause of disease in babies in pediatrics, I've not seeing any of it. The one thing I want to just point out here is that we know now how to interrupt disease and death from flu in RSV. And so don't put those masks away forever.

Trish Kritek:

Yeah. I think the take home is masks work and hopefully hand washing also helps. Really zero, almost zero.

John Lynch:

Yeah. It's not just us, it's the planet.

Trish Kritek:

Yeah, they're really interesting. Okay, I told you these are random and not connected. Do you know that the radius for under... When you have that app, that senses about people who have COVID near you. Do you know how close that person has to have been to you?

John Lynch:

Yeah, I phoned a friend, Dr. Janet Baseman, a professor in the School of Public Health who's been really instrumental in this rollout in Washington State. I checked with her. And she says it's a little hard to tell you because it depends upon the Bluetooth strength. So basically, it's Bluetooth, the Bluetooth interaction of phones and it collects these random information going back and forth.

John Lynch:

And so depends on is it in your pocket, is it like denim? Is it not? Is it all these things. But in general, roughly, it's about six feet. So six feet radius. Six feet in all direction around you is the guiding sort of thought on that.

Trish Kritek:

Okay, so six feet, depending on your Bluetooth. Thank you.

John Lynch:

And your blue jeans.

Trish Kritek:

That was a hard one. And your jeans. This is relevant to something I asked you before. Do I still have to quarantine before coming back to work if I go out of state, if I've been vaccinated?

John Lynch:

We have not incorporated vaccination to any of our quarantine or exposure definitions at this time.

Trish Kritek:

Okay, so the answer is yes. You still need to quarantine. If you go out of state, even if you have been vaccinated. Yeah?

John Lynch:

If you can do it, that would be the best thing to do.

Trish Kritek:

Okay. I had told Santiago, I was going to ask him this but I'm going to ask you since you're on the hot seat right now. Do we need to wash our clothes in warm water? If we want to kill the virus or can I wash in cold water? And Santiago is really excited right now that I chose you for this question.

John Lynch:

Well, remember, my understanding, I'll make assumptions here. When people wash clothes, there's two things. There's water and then there's detergent. The temperature is not actually that important. It's probably the detergent more than anything. Detergents are incredibly powerful of ripping pretty much every thing that that has a fatty liquid envelope. And so the detergent is price efficient. I wouldn't change your water temperature for your cleaning for this reason.

Trish Kritek:

Okay. So detergent and water, wash with the water temperature you have, use detergent.

John Lynch:

Yep.

Trish Kritek:

Not at any particular detergent, because you're not making an advertisement with detergent.

John Lynch:

It's soap.

Trish Kritek:

Thank you. One more and then I have the last two questions. When people say this vaccine, Moderna and Pfizer are 95% effective, what does 95% effective mean? What are they saying by that?

John Lynch:

Okay, so I will give you my best way to sort of... The way I think about it simply is that if we gave 100 people the vaccine and you took... Let me think about this right. Compared to a group of people who have the vaccine and the people who don't have the vaccine, if we look at the number of people don't get the vaccine, we look the number you will get infected, say there's like 100 people in that group who get infected, whatever number it is, 100 people, if you take the vaccinated group, compared to that 95% fewer people will get infected or get severe disease, in the case, what we know now as severe disease or die. So that means that if we compare like 100 people, 5% in the vaccinated group will have that negative outcome.

Trish Kritek:

So it means that a group of people, 95% of them will be protected. Is that what you're saying?

John Lynch:

That's what I'm trying to say. Yes.

Trish Kritek:

Okay. Awesome. Thank you.

John Lynch:

They should have you the question Trish.

Trish Kritek:

No, there's no asking me questions. That's the beauty of this job.

John Lynch:

I think that's what next week's theme should be. Put Patricia on the hot seat. What would Trish do? You hear that Anne?

Trish Kritek:

Yeah, well, I have to break everyone's heart today and say that we're going to not do how to ask a friendly ID doctor a CNO, but I'm going to ask you two quick ones, because there weren't as many this week. Please feel free to share some more.

Trish Kritek:

But there were two that I think are kind of the same thing. And that is people are asking if they can go visit their parents now that they're vaccinated. That was an extremely common question. I wanted to ask you that.

John Lynch:

That's for me, right?

Trish Kritek:

Yeah.

John Lynch:

Okay. Yeah. So and this goes back to my earlier comment, I totally get it. We really, really, really want to get back to some sort of normalcy and part of that normalcy is our interactions with our loved ones. I understand. The thing is, is that again, going back to some of the answers I gave before, until we have good evidence that this vaccine interrupts transmission and it probably will, but until we know it, I don't want to be the person as an expert, as someone that people listen to, I'm not ready to tell you that.

John Lynch:

So when I get that evidence, trust me, I'll be shouting from the rooftops, I will let everyone's call know as soon as I do. I am hopeful that that's what we do. But until we hear that, I'm not ready to say, "Go for it and hang out." Because you got to also remember, they're not vaccinated. And if they get infected, their chance of becoming very sick is much, much greater. I know... I want to be very thoughtful here. But just... I know, I will say this the right way. Is it just how you feel what would happen if that happened? That if you were that person who brought that into that home?

John Lynch:

And I don't want to put anyone ever in that situation, until I know, for sure what that's going to do.

Trish Kritek:

I think what I'm hearing is we're erring on the side of being cautious, because we just don't know. And we're hopeful that we're going to get to that point where we do know, and we can say, "Go." We just aren't there yet, which is hard. I'm dying to see my parents too, to be honest. They're reassured hearing that on this recording.

Trish Kritek:

The other question, the last question for today is, what if they get vaccinated? Will you feel differently?

John Lynch:

If everyone is vaccinated, the purpose of the vaccine is to prevent serious infection, serious disease and death. I think you could make a fairly good argument in that situation, that the risk has changed. The

purpose of the vaccine is to prevent serious disease. And that's what the whole concern is. So if you're reducing that by 95%, now, going back to your prior comments, but I always like to remind people 95% is not 100%.

John Lynch:

And with big numbers, out of 1000 people who get infected, even with a vaccine, 50 of them will get seriously ill, and then that serious look of some of them will die. So it's still not perfect. But you can make a pretty good argument and this goes back to meetings and loved ones. Is that if everyone's vaccinated and I mean, everyone, lots of people who are interacting with, that's a possibility.

John Lynch:

I think that being together, now all of a sudden becomes a lot less risky, because you're not going to get sick and die. But again, that's when you know everyone's vaccinated. And going back to work situations where we actually don't know that's true. There's going to be lots of situations, we're not going to be checking everyone, we're not going to have bracelets saying, "I got vaccinated." And so that's a different scenario versus the one you just described.

Trish Kritek:

Right. And I think you've highlighted, we don't know the data yet, there are some people even when they're vaccinated, who won't be protected. So we're going to be a little bit cautious, it will evolve as more and more people, including your parents get vaccinated and will start to feel slightly different as we get more and more and more of the population vaccinated will definitely feel different. Yes?

John Lynch:

Yeah. And I'd say just say that's just, we find that the vaccine doesn't interrupt transmission, say that's the worst possible outcome, I think there's still that possibility of everyone in your family's vaccinated getting together becomes a very reasonable thing, because the chance of bad outcomes is dropped so much.

John Lynch:

That's not the worst possible news. Not the news, we think we want but it's not the worst news either.

Trish Kritek:

So we're getting there. I'm going to go with we're getting there. And I'm going to end with that. It is going to be harder and harder to be patient now, because we can see that light. And so I encourage us all to hang in there and support each other and I'll end by thanking all the panelists for being willing to answer the questions that they did as always and all the folks out there who are viewing and sending in their questions and we know there's a lot of them, we'll keep looking at them. We really appreciate it.

Trish Kritek:

Thank each and every one of you for taking care of our patients, their families and as always, most importantly, continuing to take care of each other. We'll see you back next week and I hope you have a wonderful three-day holiday. Bye.