

Trish Kritek:

Thank you, Jason. And we're on. Hello everyone, we'll give it a minute while folks get online. Good afternoon, happy January 22nd. Big week, this week. Welcome, just going to give it another 30 seconds or so, and then we'll get going. All right. Welcome back ... Well, welcome back to UW Medicine Town Hall. My lighting is kind of crazy today. I'm Trish Kritek, and I'm happy to see you again this week. With us this week, we have one guest, a re-current guest, Dr. Shireesha Dhanireddy, who we're happy to have back to help answer some questions about vaccine and vaccine rollout. In addition, we have Tim Dellit, our Chief Medical Officer, John Lynch, the Head of Infection Prevention & Employee Health at Harborview, and the head of our medical response to the COVID pandemic, Keri Nasenbeny, Chief Nursing Officer at UWMC Northwest, Anne Browning, our Assistant Dean for Well-Being. Tom Staiger, our Medical Director at UWMC, and Cindy Sayre, Chief Nursing Officer at UWMC. And you'll notice a few folks not here. That's cause they're off dealing with stuff like Keri was dealing with vaccines last week. So thanks for everyone being back. It has been a big week. There's a lot of stuff going on, included Martin Luther King Day, a year of this pandemic in the United States and then inauguration. And I'm going to hand it off to Anne to reflect a little bit on that.

Anne:

Sure. Thanks, Trish. So, on January 21st, 2020 we had our first case of COVID-19 detected in North America and it was only miles away from where I'm sitting right now. And then on January 21st, 2021 my mom was able to get vaccinated in Tacoma. And then my dad followed suit and got vaccinated earlier today. And that path from that first identification through to vaccinations has been staggeringly fast. And yet it feels far from fast enough for the over 400,000 deaths we've seen within our own country and over 2 million globally. And that certainly has weighed on me. And I think on all of us this week as we reflect. But this week has brought some new hope as well. For me, my parents getting vaccinated starts a new clock suddenly with some certainty, in five weeks or so, they might be able to gain a little bit of mobility back. And hopefully we're not talking about grandparents gone wild or anything, but maybe hugs, maybe getting to share a meal with them. So, stay tuned on that front.

Anne:

I'm going to ask Tim as our friendly infectious disease doc at the end of the hour for some of his thoughts on how we might build engage with folks once they're getting vaccinated and once we're vaccinated ourselves. But for now, I hope that you're all finding some moments of hope this week, as well as having a chance to reflect on what it means to be in this world of COVID-19 and then our region for a year now. And by saying thank you to all of you who have had a hand in supporting our COVID-19 response, to keeping our community healthy and to developing and distributing the vaccines that give us a bit of hope for the future as well. So thank you. Trish.

Trish Kritek:

Thank you. And I'll just start now and an echo that, thanks for the unbelievable efforts to get the vaccine to so many people in such a short period of time, which makes me turn to Tim, because Shireesha here too, but we're going to start off talking about vaccines with you. And I wondered if you could talk ... start off with some numbers. Can you talk with me about how many vaccines we have administered both kind of to folks within UW Medicine and now folks in the community so far?

Tim Dellit:

Yeah, absolutely. So, we have administered now over 40,000 doses, that breaks down to over 32,000 individuals who have received their first dose including 15,000 individuals from the community. So, really impressive. And I just can't say enough about the entire, very large team that has been not only involved with the planning, but the implementation and operations. This has not been easy. We also recognize it's a little bumpy here as we have transitioned this week into the first tier of phase 1B, meaning pivoting from healthcare workers for us to individual 65 years of age and older or 50 years of age and older and multi-generational homes. And that changes the workflow within the vaccination clinics as well.

Tim Dellit:

The last thing I just want to say, and again, really appreciate everyone's patience as is very clearly documented in the media, we continue to have a very unpredictable supply of vaccine within the state, both from the state knowing what they're going to get from the federal level and then the state allocation process. And we are still in that period of time where we really don't know until a day or two ahead, what we're going to get for the next week. So, the team is really trying to balance that and make sure that we're scheduling to match potential availability, but it's challenging and obviously a huge demand, which is great to see. But I also appreciate it's frustrating for some, until we get increased supply overall in our community.

Trish Kritek:

Yeah. I think people are anxious and that uncertainty that we hear in the greater community plays into that. I have a bunch of follow-up questions. The first one is people are worried based on what you just said, that there's going to be enough vaccine for their second dose. So, can you talk to kind of our supplies of vaccine right now and being prepared for that?

Tim Dellit:

Again, we are week by week meaning that we are trying to ensure that we have enough vaccine to cover those appointed for the next week. I have absolute confidence that everyone who has received their first dose will get their second dose. So I just want to dispel concerns there. Could there be a potential at some point in the future where we may have to delay a little bit for that second dose? And in fact, the CDC to say, "Today's said that you can delay that second dose up to six weeks." We have no plans to do so right now, but we recognize it depends on the supply. So everyone will get that second dose. Potentially, there could be a delay if the vaccine supply doesn't allow that, but we're not there right now.

Trish Kritek:

So right now, we're in a good place for everyone to get their second dose in the timeframe that we expect. And I'm going to come back to that question later. And we have heard from the CDC that it could be stretched out longer and be okay to do that. And like I said, well, I'm going to clarify that a little bit more in a minute. We know that we have clinics within our institutions right now. And there were a bunch of questions about, are we working with the state on a mass vaccination site? Are we going to use Husky Stadium? Are we going to do stuff in the South Sound? Can you talk to me about what we're thinking about as other sites for vaccination, how we're collaborating with the state?

Tim Dellit:

Yeah. So we're having daily conversations with everyone from the governor staff to Department of Health, Washington State Hospital Association. The governor announced plans for mass vaccination sites, particularly in locations of Eastern Washington, it's not completely clear when they will be up and running and ready to begin. We also have had conversations with the county and the city, both of whom plan to have vaccination sites. Again, the details we're still waiting for that clarity that we and other healthcare systems are absolutely working with them. They're in a little bit of the same challenge where they just don't know what the supply is going to be yet. But we're absolutely trying to coordinate. And within our own vaccination sites, we are looking at where if we are going to expand, if the supply is there, what other location do we need to be and that may be more accessible, particularly for our patients. So a lot of moving parts right now, but absolutely trying to stay in coordination. And everyone is really working well within the community together.

Trish Kritek:

So working with the community, other institutions and the state, no site determined right now for mass vaccination. How about our clinics? Are we thinking of vaccinating people in our clinics?

Tim Dellit:

Not in, say, our primary care clinics as an example. Right now, because the supply is so limited, we're keeping it more centralized with the vaccine clinics at each of our campuses, but we don't have enough supply yet to be able to decentralize. Now, that could come down the road probably not for a few months. So, we have to wait and see, but right now we, the supply is just too limited to be able to have that type of approach. We really have to track and maintain them and implement this in a very controlled fashion right now.

Trish Kritek:

Okay. So, not a distributed model while the supply is so variable and unclear to week to week.

Tim Dellit:

Correct.

Trish Kritek:

Maybe in the future. Last two questions for you is about people who can get vaccinated. You said we are in the first tier of 1B. So, folks who are not currently UW Medicine patients, but fit into that category, can they get vaccinated at UW right now?

Tim Dellit:

They can, it's easiest, there are different ways. And again, the teams are recognizing and trying to make this as easy as possible. For our patients, the easiest way is through e-care. And that seems to be working really well. For people who are not our patients, there is a phone number. We recognize that there can be some delay in that call back, but there's a process there or register through e-care. I also want to apologize for our nonclinical employees, particularly in the school of medicine, because we recognize that the absence of an AMC log-in is creating challenges for the use of that electronic survey.

Tim Dellit:

So the team is really working to come up with a solution around that while utilizing these other tools in the meantime. So again, I apologize, because again, that's an example of where it hasn't been as smooth as what we would like. We're very much aware of that and we're trying to make that improvement. It was in no way intentional or trying to make it more difficult for those very important members of our community. But it is something that we're trying to address. And again, I apologize for that difficulty right now.

Trish Kritek:

Okay. So right now the best way to do it is e-care? The glitch that's affecting some of our members of our community is that you need an AMC log on and we're working on that. And then there's a phone number to call, and I'm going to come back to this question again later. And Shireesha, I'm going to Telegraph, I might ask you about this. People are worried about people who are not technologically savvy in their ability to schedule appointments. So I'm going to talk a little bit more about that. Just want to follow up on that last thing you were talking about, Tim, and I appreciate the apology about the AMC log on. So, what you're saying is our research faculty and staff are eligible, but just to clarify, you're saying that that is if they fit into that first tier of 1B. Is that correct?

Tim Dellit:

Yes, they are eligible if they meet those DOH requirements based on the age as we went over earlier. And again, we're still offering vaccine to those who are 1A, if we have people in our hospitals and clinics that may be delayed and are now interested, they are also welcome to register. But yeah, I just want to clarify, because I think there is some confusion through different messaging earlier today, but for those individuals in nonclinical areas, outside of our hospitals and clinics, if you meet those DOH criteria, 65 years of age and older or 50 years of age and older and a multi-generational home, then you would be eligible. But you have to meet those DOH criteria.

Trish Kritek:

Okay. That's very helpful. I'm going to ask a question that I pretty much think I know the answer to, because I think you've said it, but we got so many questions about this. People spouses, people are worried about their significant others with whom they live. Are they eligible for getting vaccinated in any way outside of the usual tiers of vaccination that are set out by the state?

Tim Dellit:

No, they have to meet those criteria. And again, we have actually have a work group co-chaired by Paula Houston and Santiago Neme focused on equity. It is really important that we approach this vaccination process through an equity lens. So there's not preferential treatment for family members. There's not preferential treatment for those individuals in our nonclinical space compared to our patients. If they meet those same DOH criteria then we absolutely want to get everyone vaccinated, but we really are trying to do this in a non preferential manner. And as you alluded to it and we can talk about that more, we have to be cognizant of those vulnerable populations and ensuring we get vaccine to those groups as well.

Trish Kritek:

Yeah. Thank you. So, I think emphasis on equity, wanting to be clear about that. If you fit into the categories, you can get vaccinated, but we're going to follow the tiers from the Department of Health.

Tim Dellit:

Yeah.

Trish Kritek:

Shireesha-

Tim Dellit:

Patients, it's going to take, people, we're already scheduling out through mid-March. So it may not be next week. But you have to be patient here. Wait, it's a very large number of individuals with a limited supply until that increases.

Trish Kritek:

Yeah. And so patients, because we're waiting on supply. Shireesha, I'm going to look to you to clarify something that I asked him to clarify last time and I think he was trying to tell me what you told him. So, your understanding of the over 50 and multi-generational household, could you walk through what that means?

Dr. Shireesha Dhanireddy:

Yeah, it's a little bit different than the US Census Bureau definition of multi-generational, which is three or more generations in a household. It's two or more, but with some caveats. So 65 and older is a given in the first tier of 1B, but then 50 and older, if you are unable to live independently and require a caregiver for someone who is in the home. And if that person is working outside the home as well, those are reasons for that 50 plus person to get vaccinated. In addition to that, even if you able to live independently as a 50 year old, and you're caring for someone who is not your own child, so a grandchild, a niece or nephew, then you would also be eligible really getting at multi-generational that way.

Trish Kritek:

Okay. So, I'm going to restate that. So the 65, we'll take aside. The 50 is if you need someone to help care for you in your home, you're on the list. And if you are taking care of someone other than just your children, meaning your grandchildren, and you said nieces and nephews too, which wouldn't be like three generations, is that-

Dr. Shireesha Dhanireddy:

That's correct. That's why it says two or more because of that caveat. It's basically other family members that are not your own children.

Trish Kritek:

Okay. Thank you for clarifying that. I really appreciate it. Because I think it is a really confusing thing for people to understand. I'm going to go to John in a minute, but before I do that, the other big question that people asked about, and we might talk about this more as we go, but do you know two more pieces of data about the vaccine? The first is, and I'm asking you Shireesha, how often people are in our workforce are declining the vaccine?

Dr. Shireesha Dhanireddy:

Yeah. So, our overall declination rates, if we look at active declination is around 8 to 9%. That's overall pretty low, but we're missing a lot of passive declination. So people who don't actually click on the link once they're invited to schedule we are trying to get more information about that. And we look at certain groups in terms of active declination, there are definitely certain job groups that have a much higher active declination upwards of 25 to 40% for certain job classifications. So as Tim mentioned, there is a work chaired by Paula Houston and Santiago Neme to really address this and encourage those people in those groups to get vaccinated by looking at peers in those groups who have gotten vaccinated and can talk to them about their experience, as well as more concerted efforts working with those managers and other people in that those departments.

Trish Kritek:

So targeted outreach and education, our official declination rate is 8 to 9%, but we're worried that we're having some not ability to gain everybody that we want to, to get the opportunity to get back vaccinated. So thank you. The second question, Shireesha, before I pivot is the other thing that a lot of people ask about is waste of vaccine. Based on what Tim was just saying, a lot of other people are really wanting to get vaccinated. Do you know how we're doing in terms of waste of vaccine?

Dr. Shireesha Dhanireddy:

Yeah, there's actually a daily report to look at waste minimization and there's a plan that Cynthia Dold and Jenny Brackett came up with and we have our waste minimization or waste rate is less than 1%. Yesterday, I believe it was 0.15%. So we are extremely low on wasting doses. We are very aware that there's such a demand. And if we have a process for making sure that there's not unnecessarily vials opened up at the end of the day and that the minimum number of vials are opened up at the end of the day for the anticipated number of patients coming in to get vaccinated.

Trish Kritek:

So a lot of process around not wasting them, yesterday was 0.15. We think it's less than a 1% overall. Great, thank you. More to come on vaccines. I'm going to go to John Lynch and ask a few questions about kind of where we stand in terms of numbers of patients with COVID in our hospitals. So, maybe you can start with just where we stand across UW Medicine, John.

John Lynch:

Sure. Thanks, Trish. Hi everyone, happy Friday. Yeah, we're down a little bit. we've been studying for the past few days, our total number in the hospital right now is 62 people with COVID-19, with Valley still at the lead of that with 34 folks, and Montlake at the lower end with six people.

Trish Kritek:

Okay. That's great. That's really exciting. I think that's good news. I think what's now causing anxiety because it feels like there's always something new is worrying about these novels, these new strains that we talked about a little bit last week, the one that we hear about in the UK and the one in South Africa. So, I was wondering if you could talk a little bit about what we're hearing in the news. And I think the two questions that people are most concerned about is do we need to do things different because they're more infectious or transmissible? And then the second one, I think maybe even a bigger worry, is the vaccine going to work for these two?

John Lynch:

Yeah. So currently, if you look at the CDC website, you look at the different medias reports out there, there are three variants that people are worried about. Two of them are ones you just mentioned, one was described in the United Kingdom. That's the B117. You'll hear that in the media as well. And one was described in South Africa and that's the B1351. And there's lots of other names for these as well, but those are the big names. And the first thing, I'm going to answer your question backwards is that all the things that we've been doing, masking, distancing, stay home when you're sick, wash your hands, were just as well for these. So, really they are first step in this is for is all of us to make sure we're doing them all, the best we possibly can, because those work the absolute best.

John Lynch:

So reducing transmissions and infections is the way to slow down new variants from causing any mischief. But going back to your other point is what is it going to look like when around vaccinations? Well, there's definitely good data for both of those strains that I mentioned, the one from South African, the one from UK, that they are more transmissible, maybe on the order of 50% more infections occurring as a result for each person. That's definitely a concern, so wider, faster transmission. For either of them, no evidence that either that they're more dangerous once you're infected, but we have to remember the more people who are infected, that's just more people who could get very sick and more people who die as a result. That's their danger.

John Lynch:

And so in terms of the vaccine data, there's still a lot to be learned, but what it looks like right now from various studies is that the UK variant is for folks who've been infected before, seemed to be similarly resistant to the UK variant. And the vaccine match seems to be really good as well. That's good news. The variant from South Africa, we have some data from laboratories that people who've been infected before when you take their antibodies that that variant does appear to maybe get by those antibodies. What we don't have is good data on whether the vaccine or the complete immune response that a person has, right?

John Lynch:

It's not just antibodies. It's lots of things, is not sufficient to fight back that virus. So, still a bit to learn, actually, a lot to learn, maybe some signals of concern, but ultimately what we have to continue going back to is that the best way to battle these things is to stick with what works, the masking, the hand hygiene, and then ultimately getting the vaccine rolled out as quickly as possible, because the more we can reduce infections, the greater the barrier is to new variants emerging. And someone texted Larry Corey from Fred Hudson UW, did a great grand rounds yesterday on this topic. So you can find that on the internet.

Trish Kritek:

Great. Thank you for that tip from whoever sent that in. That's wonderful. And I thank you for kind of giving a brief synopsis of concerns about transmissibility, some gray space around the South African variant strain and the vaccine. More to come on that and stick with what the things that we know, which raises the next question, set of questions that I'm going to ask you, which have to do with masks because of you just said, "Keep masking." So, people have heard that Joe Biden wears two masks, he's a double masker, and there has been some discussion of people in the UK now wearing N95s all the time. So, a lot of people are asking, do we need to do something different with our masks based on what we know about these other strains?

John Lynch:

Well, you know what? We've got a great data from the last year, now it's really a year of testing employees and healthcare workers working on COVID some emergency departments and other. And what I would say is that that is really demonstrating that our approach is working extremely well. In fact, along as the healthcare worker rate never got up as high as that big winter spike, and more recently, we actually had a couple of days this week where we had zero health co-worker infections, which is way lower than even what we're seeing in the counties, Pierce, Snohomish, King, where most of our employees work. So in terms of the concrete answers to your questions around double masking, I haven't seen data on that. The more layers of course, the better. There's no argument about that, that makes good physical and biological sense, but there's also breathability and accessibility and how often do you change those things.

John Lynch:

And currently, our N95 project, that's ongoing discussion every single week. Our med tech team meets to discuss this, working with supply chain. There's still not great visibility on most of our respirator parts. And so we haven't expanded that at this time, but again, I just found off a national conversation as well, and talked to many hospitals across the country, similar academic centers, and to be honest, most many of them are using the exact same approach and actually using masks in more scenarios than we are right now. And so we are definitely not alone in our approach.

Trish Kritek:

Okay. I apologize that I got distracted transiently there. Did you comment on the use of N95s in more spaces than we're currently using them?

John Lynch:

I don't know if I did.

Trish Kritek:

Okay.

John Lynch:

But I don't think-

Trish Kritek:

I don't think that neither of us know what you said just now.

John Lynch:

Right now, we are not. We don't have a plan right now to expand the use of respirators of any type N95s or others in additional space.

Trish Kritek:

Okay. Because that is a question that keeps coming up as well as like now that we fit tested people, are we going to expand? And the answer is, not right now. We're not saying wearing an N95 in places that aren't places where we're currently wearing N95.

John Lynch:

Right now, we're not having any plan for that.

Trish Kritek:

Okay. Can I ask one more question about N95s to you?

John Lynch:

No, absolutely not.

Trish Kritek:

Thank you. Do we reprocess our N95s, because we've had different answers about that and people are asking again.

John Lynch:

I think I've contributed some of this confusion. And I apologize. So, we do reprocess N95s fives, but those reprocessed N95s go into storage. So, we don't reuse the reprocessed N95s. And so I know it's a lot of res in there, but that's basically our disaster supply. We take all those N95s, they go off to the Battelle, I think it's in Illinois or something, they get shipped there and they get processed and then they're brought back and stored. But all of the respirators we're using, we're using them for single use. So, once it comes off, the next one that goes on is a brand new one.

Trish Kritek:

Okay. That's incredibly helpful. So we are reprocessing them to save them. So we have a backup if you will, but the ones that anyone's putting on their face are new ones.

John Lynch:

That's right. And that's our approach is that in the way we're using respirators, we think that's the safest way to use them. And that's because we've stewarded our supply. Because of the way we're using, anyone who needs to use them can use them in the safest possible way. And our concern is if we were to expand and supply chain goes down, help workers would then be using N95s in potentially a less safe way. And so that's the balance in why we're doing it the way we are.

Trish Kritek:

Thank you. I think that's helpful because there has been confusion about that. All right. While I'm talking about masks, I'm going to look at Carrie and Cindy. There are still concerns from folks about patients who don't want to wear mask and say that they aren't going to wear a mask. And maybe that's because of medical reasons or not. And people are asking if they're caring for those patients, can they have full PPE to care for them since the patient won't mask or can they stay 6' away? Or what else can they do because the patient doesn't want or can't wear a mask. Carrie, you're unmuted. So, I'll start with you.

Carrie:

Yeah. So, I did some rounding on this with staff today in our inpatient units, just to ask what was happening and to really understand what that practice was. And I was delighted to hear actually that from all of our staff that I spoke to in Grant, this is a small sample size. It was only on a couple of units that by and large patients are agreeing to wear masks. Now, there are obviously patients who can't

tolerate masks and really what I heard from them most frequently the problem was that the patients forget, right. Or we forget to remind them, as the case may be, I think. And so when I did talk to staff, I said, "If you encounter this, here's what I would suggest.

Carrie:

I think, one is I think we need to explain and make sure patients understand the why of the mask." And then two, I don't want us nurses to engage in conflict, right? And so what I said is, "Reach out to your manager, reach out to the attending, and it's going to be different at other places," the hospital here at Northwest, and those folks need you to get involved and we need to figure out a path forward. I think we truly have some patients that actually can't tolerate a mask for short of breath, the oxygen therapy on. But many and most can. And really what I heard from our staff is that the patients are very open and want to do this as well. But I think here at Northwest, my advice has been engage others in that conversation and let's help support that nurse in that conversation and not leave them out there to figure this out on their own.

Trish Kritek:

Okay. So, talk about it with the patient, educate, understand, and then use your allies, both your nurse manager, as well as the attending for the team.

Carrie:

Yeah.

Trish Kritek:

Cindy, did you want to add anything to that?

Cindy:

Yeah, I agree with everything you said, Carrie.

Trish Kritek:

Okay. Well, since you're unmuted, you were unmuted, I'm going to pivot back to vaccines. And I have another question on masks but later. There were a lot of questions about the Montlake Vaccine Clinic feeling really overwhelmed earlier this week with long lines and a lot of people around. And I wondered if you could comment on what we're doing to try to mitigate that at the Montlake Vaccine Clinic.

Cindy:

Yes. Thanks for that question. We were asked to scale that clinic up in terms of capacity very quickly. We had to move from ... It was set up for 450 vaccines a day, and we were asked to go to 850 all within a matter of days to meet community demand. And so we have worked to, we can figure at the clinic to increase the capacity, and I am totally aware of this line that kind of snakes around. We do have markings on the floor for people the stay physically distanced. And in the short term, I think we're going to need to just have a lot of grace and mercy for hitting as many people through this.

Cindy:

A couple of things that will help, one is unlike other appointments, it's not helpful if people up early because we are really positioned to get a certain amount every 15 minutes, basically. So, it's helpful if

you'd come at the designated time. And I think you can expect that you might have to, just depends on time of day, you might have to wait. So, asking for grace and mercy, that seems staff is working just as fast as they possibly can.

Cindy:

And then longer term, we talked about this earlier in this meeting, we are working to relocate that vaccine clinic to somewhere outside of the medical center. And that is still being worked out exactly where that will be, but we know that that space is going to be sustainable for the long-term if we're going to get up to 1,000 vaccinations, et cetera. So, appreciate everyone's patience. And we're doing the very best that we can.

Trish Kritek:

Okay. So big ramp up, aware of the lines, working on it, reconfigured, come when your appointment time is, don't come early. I'm an early person, so that's a good thing to know, and going to move eventually, and that's part of the stuff that Tim was talking about.

Cindy:

Right. And then just one other, since we're talking about this, we are not allowing children under the age of 16 into the building per our visitation policy. So, people need to know not to bring their young children with them because we're not going to be able to let them into the building.

Trish Kritek:

Okay. So don't bring your children with you. All right. I'm going to talk to maybe all of you two and Tom about this, how do people want to volunteer? And it sounds like we need volunteers. So Cindy or Carrie, you are unmuted. How can people volunteer to help?

Carrie:

Well, currently at Northwest, they can email me, they can email Jenny Brackett or they could email Mary Jo Kelly. We are working on a system actually across the system for volunteers that hasn't rolled out yet. But my understanding is that roll roll out very quickly. So if you've seen the Swedish website that manages their volunteers, my understanding is that we are moving towards a webpage and a format like that that will help us with not only the anting of volunteers, the screening of volunteers, but also the scheduling of volunteers. We're just not quite there yet. So I think at the moment, and Cindy can speak to how this works. This is working a little bit differently at each entity right now, but the goal is to move to a system structure and process for volunteer for recruiting volunteers and bringing them into our system at all of our clinics.

Trish Kritek:

So right now at Northwest is still direct email to you.

Carrie:

Yeah.

Trish Kritek:

Okay. That's fine.

Carrie:

Yeah.

Cindy:

Yeah, I put in the chat, the spreadsheet link for the Montlake Campus. And as Carrie says, we're working on a more robust solution, but there is a link in the chat for people that want to volunteer here. And so many kudos to all of the volunteers and sometimes on very short notice that are helping.

Carrie:

I think that's true at all sites, that just people are stepping in. So appreciate all the help.

Trish Kritek:

Lots of volunteers, couple of different ways. I'm sorry that Jerome's not here right now to say how to volunteer at Harborview. I don't know if John or Shireesha knows how to volunteer at Harborview.

John Lynch:

I'm sorry, I don't.

Trish Kritek:

That's okay. We'll get it out to people. Tom, people ask, "I'm a doctor, can I help in the vaccine clinic?"

Tom Staiger:

Yes.

Trish Kritek:

How do you sign up? Same way?

Tom Staiger:

No. It differs a little bit from site to site right now. So at Montlake in part, because we were gearing up this week I was asked to send something out to all of our medical staff that includes a link where people can sign up to administer vaccines and there was a pretty robust response. I believe Rick either has or plans to send out something in Harborview shortly. At Northwest, we still don't have a scheduling link set up, but the plan is to get something by early February. We also have individuals who are not UW Medicine physicians who have felt one way or the other asking if they can volunteer. And just this week we made a decision to start using our disaster privileging process. So, we've had a handful of individuals who have been in communication, who are in the process of applying for disaster privileging so they could administer vaccines. And then we're working out the scheduling of those individuals and our various clinics.

Trish Kritek:

Okay. So we're actually doing some disaster privileging. So the folks who are not part of our employees right now can be part of the help. That's great.

Tom Staiger:

That's great.

Trish Kritek:

Thanks. And how about folks who aren't doctors or nurses, do we have need for folks, I think I saw some dieticians and therapists and other folks who are wanting to volunteer.

Carrie:

Yes. Well, at Northwest, we had to reroute our whole clinic flow just because of the increasing numbers. And so we have a screener now at the front entrance. And so we can definitely use volunteers there. There was a need for some data entry with all that epic backlog we have, I think we're doing better there, but we have a need for a screener seven days a week, 12 hours, 10, 12 hours a day. So, for sure.

Trish Kritek:

Volunteers, yes. Cindy, you're putting it in the chat just to the panelists instead of to the whole group.

Cindy:

I just now figured that out. Sorry, I'll do it again. Thank you.

Trish Kritek:

All right. It's coming to you. All right. I'm going back to ... Where am I going? John. John, last time at the very end, I asked you, what does 95% effective mean? And I did not give you enough time. And I want to thank all of the credibly, thoughtful members of our community who said, "There's a better way to explain 95% effective." I learned a lot from those emails. I know you did too, because many went to both of us. So, I'm going to ask you, what does 95% effective mean when they say that about these vaccines?

John Lynch:

Yeah. So, thanks. I was trying to make it simple without overdoing it and I don't think I succeeded. And thanks to Dr. Joe and Dr. Bishop who gave me some good feedback in conversations they're having with patients. So, let me just put it up this way. So, as a human being, if you get vaccinated, your risk of getting severe disease or dying from COVID-19 with either Moderna or the Pfizer product, goes down about 95%. The other way to think about that is, and I just ran the numbers really quickly, in this two studies from Moderna and Pfizer, the vaccinated group, 32,398 people got vaccinated in the study, 19 got infected, and actually almost none of them had severe disease. So, they just got infected. In the placebo group, people that didn't get vaccinated, same number of people at 32,398 people were in the placebo group, 347 of them got infected.

John Lynch:

And the last way to think about it, in these studies about 1% of people got infected, in overall. But if you got vaccinated that rate went down to 0.05, so 95% reduction per person. So, if you're thinking about this for yourself or you're talking to your patients, it is perfectly adequate and appropriate to think about talking to those folks on a per person level, in terms of the effective efficacy of the vaccine. So, a reduction in severe disease and death, and again, actually no deaths and almost no serious disease in the vaccinated people. Is that a little bit better?

Trish Kritek:

That was awesome. I'm going to give it a check and I'm going to not even summarize it. I'm just going to go with what you said. That was very nice. Thank you for doing that again. And I'm sorry, I didn't give you enough time last time.

John Lynch:

No, no, no, it's totally cool.

Trish Kritek:

Shireesha, can I ask you a couple more questions about the vaccine? People have had to get Hep-B vaccines repeatedly because they were a non-responder. Do we know if there are people who are non-responders to the COVID vaccine?

Dr. Shireesha Dhanireddy:

That's a really good question. There are populations that we have not really looked at robustly with the COVID vaccine trials to date, specifically immunocompromised persons. So, there are probably people that don't respond as well to vaccine as the general population. There isn't a tighter that is recommended right now to look at vaccine response. And that's actually the case for most of our vaccines that we give, the flu vaccine, we don't look for an immunologic response to that. And as with many of other vaccines, Hep-B is a little bit unusual because we have a clear correlative immunity in terms of what level of antibody is associated with degree of protection. So the answer is yes, there are probably people that are not going to respond as well. We don't know exactly who those people are yet, and there's not a test that's being recommended at this point.

Trish Kritek:

Okay. So no way to assess it, but yeah, probably like other vaccines. And I think I know the answer to this, but do we know how long the immunity lasts for folks once they get vaccinated and the average person getting vaccinated?

Dr. Shireesha Dhanireddy:

Yeah. We don't know that data right now because we don't have long-term studies yet to know the durability of vaccine response. The current recommendations from the CDC are that people don't get booster vaccines and don't get repeated vaccines. We're hoping that we can end this pandemic to obviate the need for further vaccine. So, there aren't any other recommendations at this time.

Trish Kritek:

Okay. So we think it's durable. There's no need for another shot necessarily, unlike our flu vaccine, which we get every year, and we'll learn more over time. I said, I would come back to this. Can you talk briefly about the ideal timing of the second dose? And what's the wiggle room on that for the second dose for the Pfizer and Moderna?

Dr. Shireesha Dhanireddy:

Yeah. And I know that there's a lot of anxiety about this. So, for the Pfizer vaccine, it's 21 days with a grace period of four days, minus four days. So as soon as 17 days after the first dose you get the second dose. Similarly, with Moderna, it's 28 days with a grace period of four days. So, 25 days to get that or 24 days, sorry, to get that second dose. Because our sites are switching back from Moderna and Pfizer, as

Tim mentioned, this is really all dependent on our supply. For scheduling purposes and to avoid error, we've switched to 24 as being the minimum for either vaccine. So, some people may notice that their second dose scheduling is if they are getting Pfizer is pushed back a little bit. The CDC guidance that came out yesterday really it's totally fine to delay it. And even delay up to 42 days for that second dose for either vaccine. Beyond that, if somebody gets a dose beyond that, that second dose, there's still no recommendation to repeat any dosing. It's just, we don't have data.

Trish Kritek:

Okay. So, we're targeting 24 days because we're not sure which one you're going to get. And that's within the timeframe for either one of them, 21 or 28. And CDC is saying even longer 42. So, I think there is some wiggle room there and we're learning more as we go. Thank you for explaining that. I really appreciate it. Tim, I'm going to look to you. One of the questions I got was, or we got, is are department's supposed to be tracking if folks are getting vaccinated in their departments, are we keeping track of this like we do with the flu vaccine? Is anyone responsible for knowing that?

Tim Dellit:

Yeah, so within the clinical arena, so the hospitals and clinics, just like the flu vaccine, we expect everyone to participate. So, we're just now starting to go back, and now that we've gone through that first dose for most people, looking at where we are in terms of both staff and faculty and making sure that everyone has responded to that survey. So, we're just in the process of gathering that information, but it will be very similar to what we do with the flu vaccine. Again, only those within the clinical arenas that typically use our hospital employee health programs.

Trish Kritek:

Okay. So parallel for the clinical folks to the flu, we're just starting to roll it out like that. Shireesha, I lied, I'm coming back to you. I said I was going to ask this and then I forgot to follow up on it and now I forgot the question. Good Lord. My brain is not working today.

John Lynch:

It's been a crazy week, Trish. Totally fine.

Trish Kritek:

It has been a crazy week. Thank you for your grace for that. I know, I got it. Thank you for the grace time to think of it. A bunch of people wrote in, we're targeting elderly folks and my elderly family member doesn't text, which is not the trick case in my family. Just to say it out loud, my parents are excellent texters, but they don't text. They aren't on e-care. They have a hard time with kind of the scheduling. What are we doing to try to do outreach or trauma day people to get signed up who are older?

Dr. Shireesha Dhanireddy:

Yeah, so the operations team including Jenny Brackett actually met with all the ambulatory clinic leaders to look at how to coordinate messaging to patients who are not just on e-care. So, pushing out that e-care message that went out to all patients, but then also working directly with the clinics to identify patients who meet that criteria and actively reach out to those patients. And so different clinics are doing it differently. Like here at Harborview, at this clinic, at Two West clinic, where actually it pulled a list of everyone 65 and over, and are just reaching out to everyone. People are really excited to hear that we're ready to offer them vaccine and then actually just schedule through the clinic directly.

Dr. Shireesha Dhanireddy:

So patients don't actually have to go through e-care, particularly ones who are not proficient in English or technologically proficient. We can just call even with an interpreter, get them scheduled. And actually we're even using interpreters, just keeping them on the line and calling multiple patients if need be so all over our Mharic speaking patients or Spanish speaking patients, we can get them scheduled. And then in our specific clinic, we're also working with our social workers to identify patients who may fit into that multi-generational home, that definition. And so I think the easiest is to look at 65 and over, and try to recruit from that list and get those patients scheduled. So, I know each clinic is doing it a little bit differently. Some providers are directly calling their patients on their panel to get them scheduled. And there's actually an easy workflow for you to be able to do that for your patients.

Trish Kritek:

Great. So some very specific targeted outreach from the clinics, which is great. And I think you hit on a second thing, which is, and using interpreters, so we can make sure that people understand what we're calling about, and we can engage them to get them in to get vaccinated. So, I think that was one of the vulnerable populations that people are too long older, and non-English speaking that people were concerned about and how we're doing it. Thank you for going over that. John, I have a couple of policy questions for you, before I hand over to Anne. Have we changed anything in terms of quarantine for out-of-state travel? People are still curious about that.

John Lynch:

No, we have not changed any of our quarantine or isolation recommendations. We are talking through how potentially vaccination of healthcare workers impacts quarantine. We still have a little ways to go before we have a really robustly vaccinated healthcare workforce. So, we have a little bit of time, but that's the most active thing we're talking about. So, as far as travel and all those sorts of things, everything is staying the course. And what I always liked around, people's remember, we don't know who else in our workforce or our team is vaccinated, and that's going to be true going forward. And so until we have more complete vaccination information, we're going to hold the course.

Trish Kritek:

So thinking about it, but not changing now, as we get more vaccinated, we'll reassess. There's a bunch of questions about timing of things, and it's not quite a policy, but I'm going to get to a policy part of it. People are asking when they talk to patients or over themselves, what timing around vaccination should they have a procedure like a surgery or some other procedure? Is there a timeframe?

John Lynch:

Yeah. I think we just updated this, I'm looking at Dr. Dhanireddy, I believe we've asked people, we're putting language together and it might be all done now. And this will be obviously for procedural teams as well to share. We would like people to try to not vaccinated closer than seven days a week before the procedure. Shireesha, thumbs up, right? One week. Okay. This is Dr. Dhanireddy, the lead on this.

Trish Kritek:

Sorry.

John Lynch:

No, no, no. I'm just channeling her as her factotum here. So, the seven days. So the idea is that it's not that the vaccine interferes with surgery, it's just that we don't want people who have an immune response and have symptoms that then requires testing or recreates other complications. Being vaccinated, getting surgery is not a problem by itself. It's just that we don't want to have to deal with the symptoms or testing or similar. And of course we want that vaccine close to where someone's having surgery either. So those are the main things that are come on this.

Trish Kritek:

So, a week from vaccination to surgery, just so you don't get confused about symptoms. And how about with the various other vaccines, like for shingles vaccine, is there a timeframe we're saying you should wait between them?

John Lynch:

No, we have historically not required any type of scheduling arrangement between other vaccines and this one. I would say, and again, this is a hot topic right now is that the range of immune responses we're seeing with the COVID-19 vaccines, we actually anticipated to be much more, but they're still, and they're not. It's much less than we anticipated, but they are still happening and they're quite robust and they are very variable. One of our panel members might talk about their response next week on this. It's like I think some people are sailing through it without anything and others are maybe not feeling awesome. And so that's the issue, whereas for a lot of these other vaccines, it's pretty much a sore arm at most.

Trish Kritek:

Okay. So no rules on that one, you could do them, but know that there are people that are having a response. Like I talked about mine and I think you foreshadowed more stories. Okay, last question ... Oh, last two questions for you quickly. One is somebody was in our system and was going to have a procedure and they check the box that said, "I've been around someone with COVID," because they're working with patients with COVID, and then they were told they couldn't have their procedure. Do we have something that we could, UW Medicine system make it clear that that's not a reason not to have your procedure?

John Lynch:

Yes. And so that's why we try to include definitions at the top of our policies. And so when we say exposed, we mean an unprotected exposure that would lead to something like quarantine and, or testing and not being around someone. So, as a nurse at the bedside of a COVID, we don't consider those folks having a high risk exposure, which is what this one is. So, we can certainly take that back to the policy.

Trish Kritek:

That would be great, because we want to make sure that people get the procedures they need.

John Lynch:

Absolutely.

Trish Kritek:

And I think the questions can be confusing.

John Lynch:

If it ever happens to you, just call me and I'll help clarify that.

Trish Kritek:

You heard it here, call John Lynch.

John Lynch:

I mean, I'm hoping it's rare enough, but I don't get bored with it. But we don't want any health worker to ever get there procedurally for that reason. It's not the goal.

Trish Kritek:

And then my last question for you, we talked about it last time, the mask and getting rid of your masks. I just want to clarify that again, because there were a lot of follow-up questions about it. So, if I go, not out of the building, but just go to the break room, take my mask off to eat, am I supposed to put a new mask on after I eat?

John Lynch:

The goal is that once that mask comes off, just like the respirator we talked about, you get a fresh one. So bring a fresh one with you, that's the optimal goal. If you forget to bring one with you, please exchange it when you get back to your unit or your workplace. The goal is that once that mask comes off your face, that it goes into the garbage.

Trish Kritek:

Okay. Thank you. I think we have some messaging work on that one because lots of people said that's not what I'm understanding on the units that I'm on. So, I think we can-

John Lynch:

We keep on going on with it.

Trish Kritek:

... get that word out. I'm going to hand it over to Anne to talk to Tim. And Tim, before I do that, because lots of people said it, I'm going to ask you one last time maybe, I'm not sure. Is there any change in parking availability for people across UW Medicine?

Tim Dellit:

There's no change at this time.

Trish Kritek:

Okay. I'm going to leave it at that because in reality, our numbers are better and things are moving in the right direction. So, I don't suspect that's going to change in the near future, but I want to honor the fact that people have asked that question. And with that, I'm going to hand it over to Anne to ask Tim some other types of questions.

Anne:

Thank you. I assume you still have 86 questions and comments in the Q&A, I think we're missing Santiago's very fast fingers today. And so apologies that we're not able to get through all of them, but we're trying our best to navigate and pull up the theme. So thanks for your patience on that. All right. Let's ask our friendly infectious disease doc, and I've got some questions for Tim. There've been a lot of questions coming in around post vaccination, how behaviors might change. Tim, would you feel comfortable traveling or flying once you've been fully vaccinated?

Tim Dellit:

So, first, I think we all have to be patient, even with vaccination, we can't change our behaviors for the next foreseeable future. At least the next several months, while we get a large enough group of individuals within our community vaccinated. We have a travel restriction from work. We discourage personal travel, if there was an emergency and someone had to travel, as we've talked about before, I think you can travel safely on airplanes. If you wear a mask, you wear eye protection, you make sure that that middle seat is open and you wash your hands and avoid contact as best as possible. I think you can do that safely. It will be safer once you're vaccinated. Again, the risk is not zero. It's never going to be zero, but I do think that it goes back to those basic practices, foremost, even independent of vaccination status.

Anne:

All right. So, I've got a theoretical situation for you. So you're vaccinated and your parents are vaccinated, how soon could you gather together for a meal?

Tim Dellit:

It's an individual risk assessment. In general, we like to see at least two weeks for an immune response after the last dose of vaccine. And then if both people have been vaccinated, then that risk goes significantly down, right? Again, that's never a risk-free, but I think that risk goes down to where people I think can make informed decisions and likely be able to do that with close, again, watching the bubble and all of those other things, but I think it will be safe to do.

Anne:

Good. So, let's talk about hugs, would-

Tim Dellit:

I'm not a hugger.

Anne:

... you hug ... Okay, so maybe you're the wrong person to ask. Would you recommend, if not yourself, would you hug a vaccinated friend?

Tim Dellit:

If both people, again, are vaccinating, me personally, it's going to take a while before I change my behavior. I'll probably still be wearing a mask a year from now and keeping that distance. But again, I think if both people are vaccinated and they are careful, and again, washing their hands and all that

other sort of thing, then I think that risk goes down substantially. And I totally appreciate that need for human connection. So, not trying to discourage it, and again, it will be safer once we get to that point.

Anne:

If you have vaccinated grandparents, could they hug a non-vaccinated kiddo?

Tim Dellit:

That makes me still a little bit nervous. Again, depending on their underlying situation, are they going to respond to the vaccine the same way, depending on their age and medical condition? I'd feel better once we get to a point where they're both vaccinated, which is a challenge, right? Because the vaccines aren't allowed for kids 16 and under. I think, again, the better question is where are you within your bubble? And what's that exposure to that child. And if that's minimal, then it likely is a safer at least.

Anne:

Good. Thank you. We've got a number of questions that have come in around the potential of returning to in-person school. How do you feel about kind of that kindergarten through second grade group going back to in-person instruction?

Tim Dellit:

Yeah, I think that's one of the goals, obviously with the phases of the vaccine in trying to focus on the K through 12. Teachers although, again, it's split by age, right? Those 50 and older in the second tier, and then later for those under, and I say that because I worry more about the teachers in terms of that exposure, especially if they have underlying medical conditions. And while we think that kids in general have less symptoms, typically often have no symptoms, we still have seen sick kids as well. So even if they're going to that, I'd want to know what are the practices within the school?

Tim Dellit:

Are they following the Department of Health guidelines? The CDC guidelines around masking, distancing, which is challenging with children, particularly young children, as well as older children. But I would really want to see the protections that are in place. And again, it's a judgment, but I also appreciate the impact it has had on our learners not being in school. So, you have to weigh those risk benefits, and if the school is following that and the teachers are protected, then I think it would be safe to proceed.

Anne:

Do you see any differentiation by age, in your level of concern, like pre-schoolers, kindergartners, we've seen kind of stick with in person? How about if we get into like the third through sixth grade, is it still just about, are they following guidelines or is there a different concern as we see older kids?

Tim Dellit:

I mean, when I see the data it's often mixed out there and you'll see different recommendations. For a period of time, there was some more concern as you went into the high school ages. Again, I think you want to have those safe other practices in there. And I think the theme here is that we can't be only reliant on the vaccine to get us through this pandemic. We have to keep all of those other measures, but

I think the schools in general, they're looking at a K through 12 and block as opposed to trying to make that distinction. And again, some of it is hybrid. And what can you do in environments that are more outside or better ventilation to try to minimize that risk and keep it in smaller groups as well?

Anne:

Thank you. So, as I mentioned at the beginning, we're about 366 days into COVID 19 in our community. It's been kind of a big week for reflections in general. From where you sit, I wanted to give you a chance to share some of your reflections on the past year.

Tim Dellit:

Yeah. It's hard to believe it's been a year, right? I think for me, it's the people that come to mind first, I think about that first patient in Snohomish, the high school student who has identified by the Seattle Flu Study, and triggered knowing that we now had communities spread. The over 400,000 individuals who have died. I think of the impact, I had a grandmother in Iowa who died last March. We haven't had the funeral yet, because we haven't been able to get back and gather. I think of the children who haven't been in school and the impact on their lives. The exhaustion of our people yet at the same time, the amazement of watching our entire community respond. I mean, I truly have never been more proud to be part of UW Medicine.

Tim Dellit:

And we are so very fortunate to work with the colleagues that we do here and the response that we've had, not only within UW Medicine, but look at our community. There's a reason why we are in better shape than many other parts of the country, and we live in an amazing, and it's been great to see everyone come together. And it's also helped us as a system come together in response here. So, it's the people that most impact, I think all of us. That's why we work here. We work here for the people, right? You can practice medicine in many different places, but we're here because of the people, the environment and the commitment that we have to our community.

Anne:

Thank you, Tim. I really appreciate your words. And thank you for answering questions as always. With that, I'll kick it to Trish.

Trish Kritek:

I'm just going to say thank you. Thanks, Tim, for those words as well. Thank you to all of the panel for answering the questions as you have for a year now, which is sobering and inspiring to me. Thank you to all the people who send in the questions. We had more than 150 questions again this week. Thank you for the folks who give feedback on a regular basis. And thank you to everyone out there who keeps taking care of our patients, taking care of their families and what you have done for over a year now, taking care of each other. We'll see you back next week. I wish you all well. Bye-bye.