Trish Kritek:

Hello, everybody. Surprise. We're a minute or two late. Things are always a new adventure here at Town Hall. Welcome. We'll give everyone a minute to get online. Happy Friday. We're chuckling because technical issues often are blamed on D1. But this one, we cannot blame on D1. All right. Welcome, everybody. I know there are still folks coming online. I'm going to start by saying who's in the room and get us started. And then, we'll go from there.

Trish Kritek:

Welcome back to Town Hall. I'm Trish Kritek. It's a pleasure to see you again on the Associate Dean for Faculty Affairs. And I'm now going to introduce who's here with us today. So, it's my pleasure to see Santiago Neme, our medical director at UWMC Northwest, Tim Dellit, chief medical officer for UW Medicine, John Lynch, infection prevention and employee health at Harborview and the head of our medical technical response, Jerome Dayao, our chief nursing officer at Harborview, Cindy Sayre, our chief nursing officer at UWMC, and Tom Staiger, our medical director at UWMC.

Trish Kritek:

We also have Todd Burstain here, our chief medical informatics officer, who has joined us to answer questions related to-

Jason:

There we go. Sorry.

Trish Kritek:

And a guest appearance from Jason. It's all good.

Jason:

I didn't know we were live. I'm going to disappear now. Bye-bye.

Trish Kritek:

Bye. Todd, to answer question on D1. In case anybody thought that we were really a TV show, we're not. We're a bunch of doctors and nurses and tech folks putting on a town hall every week. And we're feeling it this week, which is all good. So, welcome back. You'll note that Anne's not here. And so, she's not here to give a well-being message. And that's because she is on vacation, which is outstanding.

Trish Kritek:

And as I was reflecting on the fact that she's on vacation, it made me think about the stuff that she and I have been talking about a lot lately, asking ourselves and each other, our teams those questions about, first of all, what do we really miss from pre-pandemic that we're looking forward to returning to? And I would put vacation high on that list. I would strongly encourage everybody to think about vacations for themselves and supporting their teams and having vacations. And when people are on vacation, helping them totally disconnect.

Trish Kritek:

So, if you need Anne in the next week... I'm not Anne. I cannot do everything that she does, but reach out to me instead. I'd rather her email inbox was less full. So, she's on vacation, which I'm totally excited

about. The second question that we've been thinking about is, what changes do we want to keep? And I would say, one of the things that we've started doing as a team is always checking in before we start a meeting, whether that's checking in about your weather, which mine was suddenly a thunderstorm a couple minutes ago, but now, the sun is coming back out, or talking about what brings us joy in April or talking about what books we recently read.

Trish Kritek:

Giana Davidson's reading about urban farming, things that I wouldn't have known if I hadn't checked in at the beginning of a meeting. So, I'm going to hold on to that post-pandemic. And then, talking about the things that we default to that maybe we want to change for the future. And I'm going to put this out there for everybody. I'm a big fan of 15-minute meetings. I'm going to try to change all of my meetings to 15 minutes, moving forward. I'm looking at Tim.

Trish Kritek:

And I'm hoping that that can become part of our culture. I'm going to start at one person at a time. So, Anne's not here for her well-being message. But I thought her not being here and being on vacation made me reflect on those questions. And I'm hoping to inspire other folks to reflect on those three questions as well as we move forward. With no further ado, we're all going to jump into questions.

Trish Kritek:

And I would say, I'm excited to have folks here to answer some questions about D1. But really, the majority of questions were about vaccines and the rise in cases in the local spaces. So, I'm going to start off going to Tim and ask Tim... maybe you can just talk about where we stand with vaccines within UW Medicine right now in terms of who we've given it to and who's eligible right now.

Tim Dellit:

All right. Thanks, Trish. And I also, though, first, really want to thank all of our community for the response to the Destination: One go-live. We knew this was going to be a challenging time. I am just so incredibly impressed how resilient all of our teams have been. They know there are issues. They're working through them with a positive attitude. They know things will get better. We've gotten a lot of positive feedback as well. And we're addressing the concerns.

Tim Dellit:

I also really want to thank our super users who have been incredible across the board and, in particular, the IT team for the responsiveness when these concerns are there. So, again, huge team effort. This is going to be an iterative process over the next several months as we optimize our... it is our... electronic health record. But thank you to everyone.

Tim Dellit:

Now, with respect to vaccines, big day, we just hit 200,000 doses administered at UW Medicine. It doesn't seem like it was that long ago that it was 100,000. And now, we're at 200,000, which is absolutely phenomenal. As people have seen at the state level on March 31st, they moved into phase 1B, tiers three and four. So, that included individuals 16 years of age and older with two or more underlying medical conditions, anyone 60 years of age or older, as well as, then, DOH-defined groups of individuals living either in congregate living settings or high-risk workers, again, as defined by the Department of Health.

Tim Dellit:

And then, people have also seen that Department of Health, with the governor's announcement, is going to open it up to everyone 16 years of age and older as of April 15. It doesn't mean everyone's going to get vaccinated at that time. We still have a queue here of 35,000 individuals currently in our waitlist. And the vaccine supply, people have seen some of the production issues that Johnson & Johnson have had. That supply is being reduced across the country by 80%.

Tim Dellit:

The next couple of weeks, there is going to be a relatively flat or reduced vaccine amount overall within the state. And so, again, we're hoping that will increase towards the end of the month, going into May. But it's a little bit of an unfortunate timing in terms of as everything... everyone is eligible now, age 16 and older, with a flat supply. So, we really ask people's patience. We will get everyone vaccinated. But it's going to take a little bit of time to work through all of the queues.

Trish Kritek:

Okay. So, what I heard was, as of April 15th, everyone 16 and older is eligible. And I heard something about a 35,000-

Tim Dellit:

Yes.

Trish Kritek:

... person waitlist. So, relevant to that, some of the questions that came in were, is there any prioritization of UW Medicine employees to get vaccinated when everybody's able to get vaccinated?

Tim Dellit:

I mean, we're really trying to be equitable in our approach to allowing everyone who is eligible the opportunity to be vaccinated. However, there's a difference in terms of how people get registered. So, for our UW Medicine employees, we asked them to use the online registration because it also incorporates the survey if they were going to decline. And we want to be able to track that.

Tim Dellit:

For our non-UW Medicine employees... so, whether you're employed by the university as a whole outside of UW Medicine or outside of the university... then there's a phone number on our website to call. You get placed on that waiting list. And then, depending on your preference, you'll either get a text or a phone call when it's your turn to go ahead and sign up. And we're using a new bot to help do this so that it... it's pretty slick, from what I've heard.

Tim Dellit:

But there is a waiting list right now just because... even when we went into tiers three and four, that's a large number of individuals. And so, while it's great that we're opening up very quickly, the supply is not yet there to meet that demand. And so, we just have to be patient as we move through this over the next couple of months.

Trish Kritek:

Okay. So, supplying out there to meet the demand, different ways to sign up. And it sounds like when you said we're trying to be equitable, it's not that the UW Medicine folks necessarily get to jump the line in terms of getting vaccinated. Is that right?

Tim Dellit:

Correct, correct. We just have different ways of capturing that information and registering.

Trish Kritek:

Okay. How about in-patients? Are we starting to vaccinate in-patients?

Tim Dellit:

Not that I'm aware of, other than the end of the day. But I can look to others if they've transitioned to doing that more.

Trish Kritek:

John? Yeah, John.

John Lynch:

Well, maybe I actually might be... Santiago could maybe speak to this even better. But I know at Northwest, they are trying to capture folks who have had their first dose held outside, if they're in-house, to get them that. And we would love to get a way to get first doses into people. It's just figuring out the coordination so that... if people are still there versus being discharged. But I know Northwest. Again, Santiago knows more. Do I have that right, Santiago?

Santiago Neme:

Yeah, yeah. We're slowly increasing that. So now, at Geria Psych, for instance, our folks in Geria Psych, they get a first dose. Some folks get the second dose if they're hospitalized. At Montlake, for instance, we had some transplant patients who are hospitalized. They have received the first dose outside. And now, they're in the hospital.

Santiago Neme:

So, we're finding ways with Cindy Sayre and Lindsay in the Montlake clinic to make sure that we do this. But that's definitely coming. It all has to do with supply. And a lot of it has to do with the operationalization of this because you have to consent. You have to inform. And you have to know about the vaccines as well. But it's coming.

Trish Kritek:

Okay. So, we're moving in that direction. It sounds like we're doing it in select circumstances where someone's due for a second dose. Or they're going to be there for a long time. So, I appreciate that. One more clarifying question, Tim. Are 16-year-olds getting vaccinated in our system? Is it really 16 and older? I know that's who's eligible. But do we vaccinate 16 and 17-year-olds?

Tim Dellit:

I'm pretty sure we have. Again, I can't say that definitively. But they would be eligible to be signed up to do that. And I know that they are through Children's and other places.

Trish Kritek:

Yeah. Certainly, they're eligible. I just want to make sure that if people are 16, they can come to our system. Do either of the nursing leaders know if that's the case?

Tim Dellit:

I mean, there's no reason they couldn't.

Trish Kritek:

Okay. I'm seeing it. It's coming in the chat to me. Yes, 16-year-olds are folks who are vaccinating in our system. Great. Okay. I will come back to vaccines in a little bit. I want to talk to John a little bit now about our current numbers. I think people have been hearing about numbers going up across the country, in other countries, and also here in our neck of the woods. So, I wonder where we stood in terms of numbers in UW Medicine and in King County.

John Lynch:

Yeah. Sure. So, within UW Medicine, we're actually a total of 40 patients. The last time I spoke to you, we're down in the teams across the system. And that was several weeks ago. So, we, over the last two weeks, have really had a brisk increase hit in the mid-40s and then stabilized there. And this is actually the first downward trend we've had in probably two weeks or so. So, that's much better than continuing an upward trend.

John Lynch:

Still, about two-thirds of those folks are in acute care and about one-third in their ICU. We have had a handful of people who... again, I've always emphasized this issue of the heart-lung bypass, the ECMO or ACLS. We've had a number of people requiring that, both from Washington State and outside of Washington State, coming here. We've had, unfortunately, a number of deaths also associated with that intervention. So, very sick folks, they were still seeing.

Trish Kritek:

Yeah. That's the highest level of life support that we can do, really. So, it had gone up. We heard about that while you were away. And now, it seems like maybe we've plateaued-ish.

John Lynch:

Ish, yeah. It's a day by day. We're just watching very, very carefully. And you had asked about what things look like outside of UW Medicine?

Trish Kritek:

Yes.

John Lynch:

And we've seen... and I think folks who have paid attention in the newspaper or elsewhere... there's a very brisk and steep increase in cases across King County and we know, to some extent, across the state. And so, one metric that you'll be seeing out there right on our faces is this number of cases per 100,000 people over the prior 14 days.

John Lynch:

So, again, going back to a couple weeks ago, we're in the mid-80s, 85 or so. And we've been going down and down and down. And then, we hit stability. And now, we're at about 184 per 100,000 people over the prior 14 days. And what that equates to is about 300, plus, new infections per day, happening every day. And we're starting to see that obviously in our hospitalizations across the county where about 12 people are requiring hospitalizations per day as a result of that.

John Lynch:

Now, we're also starting to see maybe some leveling off. But again, very, very early. This is day one of that leveling. And we're going to have to see how things go in the next week.

Trish Kritek:

Okay. Well, we'll be watching carefully, I guess. I'll take the optimistic that it might be leveling off. But I think you're pushing on the concern that this definitely has been going up to levels much higher than we were a month ago. Relevant to that, there are some discussions, obviously, about variants and people's concerns about variants.

Trish Kritek:

And one of the questions that came in is like, how accurate do we think our estimates are of the percent of those variants in Washington? I told people, periodically, we sample not every specimen. So, how do we get a sense of how much we have here?

John Lynch:

Yeah. So, a huge amount of credit goes to the UW Clinical Virology Lab and just the foresight and work they've done in this. So, as of today, they've sequenced over 3,500 samples. So, it's still not most, still not all. But as time goes, it's a better and better sample. And it's the best sample we have in Washington State. Yeah. So, I think that's a pretty good reflection of what's happening.

John Lynch:

When we look at the trend, which I'll talk about in a second, it's very consistent with what we expected. It is unfortunate that that trend I just talked about, with new cases in the county and hospitalizations, is what we expected in the background of a largely non-immune population. The phase three transitions in these new variants floating around. And so, yeah, I think it's pretty accurate. It's not perfect, but I think it's a good sample. And just on the tail of that, I'll just reel off the quick percentages here.

Trish Kritek:

Yeah, the numbers.

John Lynch:

Is that what you want, Trish?

Trish Kritek:

Yeah, yeah.

John Lynch:

All right. You know me. I'm just going to keep going. So, if you look at all the variants, right... this is the California variants that's the B1427, 1429, the UK variant, B117, and some of the other ones, the 1351 and P1... those now constitute about 70% of the sequence that are being seen. And really, the vast majority are the one from California, the 1429, and the one from the UK, B117. And each of those is floating around 30%.

John Lynch:

And so, just together, they're about 63% of all the variants. And so, what I'm basically saying is about 30% of it are the wild type, the stuff that's really been causing disease over the last year. And about 70% of them are these variants, most of them being the UK and California variants.

Trish Kritek:

Okay. That's a little sobering to me that, by far, the majority of them are variants. Now, half of them UK, half of them California variant, and the minority are what we started with as the original virus. One more question about the community before I talk about some employee health stuff. I know there's phases. But what would be the number... you know how you're talking about the number per 100,000?

Trish Kritek:

Well, what would be that number that we would say we're... I mean, zero would be normal. But when will we say like, "Oh, it feels like we could be more normal in life?"

John Lynch:

Yeah. And it's really a great question. Now, see, there's two different ways to think about this. And I'm not going to get super into the weeds on it, but just to give you some guidance. There's the governor's plan, right? So, there's the phase one, phase two. We're in phase three now. And there is a future phase four out there, right, and future phases. And those are linked to two numbers. One is that rate I just talked about, the number of cases per 100,000 people over 14 days.

John Lynch:

And the second thing is the number of hospitalizations per 100,000 people over the prior 14 days. So, right now, for the number of people infected, we're right on the border of having to go from phase three backwards to phase two. We'll see how that goes. But the governor wants to see both of those metrics go backwards. And our hospitalization rate is still less than... so, the threshold there is five per 100,000. And we're about three and a half.

John Lynch:

So, the big challenge is that hospitalization number is actually back... that number is only up to the beginning of the month. So, we're a bit behind. So, we'll have to see how things look next week. So, that's the external phases out in the world. Internally, what we're really looking at is our number is much lower than we're seeing now. We've developed a draft five-level phases, starting really at 100 people infections per 100,000. So, roughly half of where we are.

John Lynch:

So, we start looking at peeling back policies, what we call on the EOC, the Emergency Operations Center, demobilization. And that's everything from masking. I think you asked me to pass around things like eye protection. All of those things would be part of that gradual, incremental rolling back or demobilization.

John Lynch:

And we're going to really try to link it to these cases, the number of cases we're seeing in the community, using the same metrics and, obviously, hospitalizations, because some of it has to do with how many people are in the hospital. And some of it has to do with what's the risk for bringing people, like visitors, into the hospital.

Trish Kritek:

Yep. That's really helpful. So, it sounds like we're going to do a STEPwise approach. The first step, though, is at 100 per 100,000. And we're way over that right now. So, we need to get to that to get to the first step of demobilization. And then, we'll incrementally peel back stuff. And yes, I was going... I did give you a warning.

Trish Kritek:

I was going to ask about whether or not we were going to be able to be free of eyewear at some point, not like my regular glasses, but protective eyewear. And it sounds like maybe that's the case at one of those levels. Is that true or not?

John Lynch:

And I keep coming back to this. And Santiago and I have talked about it a lot, is that I keep pointing out... and many others have pointed this out, is that we've had no babies die from flu this year. We've had no flu in-patients. We've had no older adults getting sick and ending up on ECMO because of influenza and these other viruses, respiratory syncytial virus, human metapneumovirus virus that can make babies sick and so forth. And we don't have enough healthcare workers getting flu.

John Lynch:

And so, when we think about these tools... I'm not going to put away the idea of masking around patients, around... maybe eye protection during the respiratory virus season or something similar. So, don't throw out your Stoggles or your other comfy glasses because I think there may be some utility in this in protecting healthcare workers and patients. Is there a time in the future where we won't have to wear eye protection for every single patient encounter? I believe that's possible. Yeah.

Trish Kritek:

All right. So, there is a possibility we won't be wearing eye protection all the time. And there's a possibility that we will roll it out intermittently. I'm going to go with the first part of that as a little optimism because I agree with you. And yet, there are some challenges to these things too. So, I think it is a balancing thing as things get better.

Trish Kritek:

Okay. Speaking of risks to healthcare workers... and I actually don't know that much about this. But there were a couple questions that came in about an outbreak on Three West. And I was wondering if you could talk about that. I think the concern is, was that among vaccinated staff?

John Lynch:

Yeah. So, I want to be really cautious here because there are folks probably on this call who represent our members of that unit, who we met with yesterday. And I don't want to... I just want to be careful how I thread this.

Trish Kritek:

Fair enough.

John Lynch:

Yeah. So, we have an outbreak. We think it's tailing off on Three West at Harborview. It involves three patients and four or five staff. And we're doing a lot of surveillance, a lot of testing. Again, things are looking really good right now. What this probably revolves around is a patient who was admitted, had a negative test on admission, had a negative surveillance test, but was getting CPAP. That's the machine that people use who have things like obstructive sleep apnea and other... right, Trish? You're the-

Trish Kritek:

Mm-hmm (affirmative). I'm familiar with it, yeah.

John Lynch:

The thing that you put on your face that blows air in and out... now, I know this isn't for you. It's for everyone on the call. And basically, it's what we considered aerosol-generating procedure. But this patient had tested negative, negative, negative. And so, everyone was using masks and eye protection. And he subsequently developed symptoms about a week and a half into his hospitalization and got tested and was positive. And it's always very hard to figure out directionality on these things.

John Lynch:

But basically, when you look at the healthcare workers who are involved, who subsequently got positive on testing, they may have had no symptoms. Or they developed symptoms and got tested. They all worked with this one patient on the night shift when the CPAP machine was on. So, that's really summarizing that.

John Lynch:

Around the issue of vaccination... and again, I just want to be cautious about this. We have a few number of-. But I would say that vaccine status played a role in the fact that some of these folks got infected. And I think that if we had a completely vaccinated workforce, we wouldn't have seen as much of this happen. So, I'll just leave it at that.

Trish Kritek:

I understand that, and I appreciate that. And let's all appreciate the sensitivity to individual's health and trying to be sensitive to that as we have this discussion. So, it sounds like-

John Lynch:

I just want to be very, very clear that no one did anything wrong. None of the healthcare workers did anything wrong in this. They did all the right stuff. It was just a circumstance that, unfortunately, a lot of things lined up, and it happened.

Trish Kritek:

Okay. So, it sounds like three patients, four to five stuff, related to CPAP where there's aerosol generation, which we know has increased risk of transmission. So, I guess I'll say, people are still worried about the risk of folks getting infected once vaccinated. And I wonder if you have any more data on how many of our vaccinated employees have tested positive.

John Lynch:

Yeah. So, we are tracking that. Sometimes it's hard to collate all the numbers. But what I can tell you definitively is that the number is extremely small, right? So, we've vaccinated 15,000-plus patient-facing healthcare workers. And way less than .001% of them are getting infected that we know of. About half of them get picked up, like they're getting a procedure. And they get tested into surveillance as positive. And we don't even know where that might be a false positive.

John Lynch:

And then, about half have something like a sore throat or a headache. None of them have required medical care. None of them have required admission. And so, the vaccine is definitely working. We fully expected people who are fully vaccinated to get infected in the midst of a pandemic when we know a virus is circulating. But really importantly, it's a very small number. And they are doing very, very well, either they have no symptoms or minimal symptoms, which is what we've seen in all of the studies so far.

Trish Kritek:

So, our results are consistent with the larger studies that have been reported, which is very small numbers and not getting sick, not getting hospitalized. I really appreciate that. I'm going to ask you two more quick questions, John, before I do pivot to talk about D1 a little bit. And maybe this isn't an easy one. But I'll ask the current state of quarantine after travel because I led with Anne's on vacation. And I think there are a lot of people who are contemplating vacation, even if it's driving somewhere. I'm just wondering about quarantine when folks get back.

John Lynch:

Yep. So, just a quick update, I've talked before on the governor's recommendation on this 14-day quarantine that he put out in November of last year. That has been rescinded. So, that's gone. And so, what the Department of Health in Washington State is really relying on is the CDC guidance. And if you're interested and want to see this for yourself, just google CDC COVID travel. And it's nicely separated into whether you're vaccinated or not vaccinated.

John Lynch:

And to be clear, this is about your travel, not work travels. Tim can speak to that. But the basic idea here is the CDC is saying, if you're fully vaccinated and you need to travel, that's your decision, that... wear a mask, distance, hand hygiene, all those sorts of things. But you do not need to quarantine or test unless the destination requires you to do so.

John Lynch:

For folks who are unvaccinated, the CDC is recommending pre-travel testing, one to three days, obviously masking, distancing, and so forth, and then, on return, to get tested within three to five days

in their recommendation, not UW Medicine's requirement. But their recommendation is a self-quarantine for at least seven days, with the test, after returning.

John Lynch:

And you're going to see this. For those of you who have kids in school, a lot of the schools are putting that requirement in there as well, seven days plus the test, like after a spring break trip or something similar. And if you don't get the test, it's 10 days.

Trish Kritek:

That's super helpful. So, I'm just going to say again. No more state rules on this, or guidance on this one. We're using CDC guidance. CDC guidance says, if you're vaccinated, you don't have to do these testing or quarantine. But you should do the usual things, mask, handwash, distance. And then, if you aren't vaccinated, it's pre-travel testing, post-travel testing with a seven-day quarantine, or 10 days if you don't test. So, I think that's really helpful for people. Thank you for walking through that.

Trish Kritek:

I will say I just traveled. I think people know. I had said I was going to help take care of a friend in Boston, which I did. And I followed the CDC guidelines since I was vaccinated. I came back to work. So, I was appreciative of that evolution. Tim, I don't know if you wanted to say something about work travel. I think you could chime in real quickly about that.

Tim Dellit:

Yeah. So, people know we have had a restriction against work-related travel really to preserve our workforce, particularly given the surge that we had in the fall and winter. And that's what we also did in the spring. I'm anticipating that, likely next week, we will transition to following the University of Washington overall travel guidance, just because our numbers have been lower, although, again, we're monitoring this very closely, as what John said. But I anticipate that sort of transition.

Tim Dellit:

We held off in changing earlier in part because we had a scheduled time-off freeze related to Destination: One, which also ends on Monday. And so, we wanted to wait until we got through those two weeks after Destination: One. But that announcement will likely come out next Monday. And so, we are going to follow the university.

Tim Dellit:

Now, they do have some limitations, for instance, on international travel, but less so on domestic. But people should still follow and pay attention to those recommendations there with respect to work-related travel.

Trish Kritek:

Okay. So, following the greater UW guidelines as of Monday... and they're more open in terms of domestic travel, still some limitations around international travel... check it out on Monday, I think, is what I would suggest to people.

Tim Dellit:

Perfect.

Trish Kritek:

Okay. Thank you. All right. I have more COVID questions, but I'm going to pivot to D1. And I'm going to ask Todd to join us. And I'm going to begin by saying a thank you, just like Tim did, for all the work that all the people did to make D1 as much of a success as it was. I have to confess that I was not on service. I don't go on service until May. So, I'm super excited that everything's going to be wrinkle... all wrinkles will be sorted out by the time I go on service. But thank you so much for all the work. And thank you to the whole team.

Trish Kritek:

I did have just a handful of questions that I wanted to follow up with you. And they're really specific, but I figured it's good to ask. Last time on Town Hall, I asked about labs. And I thought it was lab results. And then, several people clarified for me that was not what they were trying to ask. They were trying to ask about lab orders and whether or not there was a way for providers to release lab orders directly to patients because, I guess, that people are ordering a lot of outside labs. And they're wondering if Epic has a fix to do that, to release those orders to people.

Todd Burstain:

So, that is part of the future development that we will be doing. So, right now, we have online scheduling for appointments. And in the future, we'll have the ability to do online scheduling of labs. And once we have that, then the patients can self-schedule themselves for the labs when they want to, once the laboratory orders are out there. So, that-

Trish Kritek:

And are those lab orders that they could use somewhere other than UW Medicine? Because I guess that's-

Todd Burstain:

No. Those will only be at UW Medicine facilities. For folks that wanted to get it elsewhere, we have to fax those or email those orders to those other facilities.

Trish Kritek:

Okay. So, it sounds like that's not a fix for that challenge right now, though there will be an opportunity for folks to schedule their own labs within the system. Eventually, that's coming in the future. So, those folks who would still like that fix, I don't think we have it yet. There were three or four questions about it. The other two questions, which I think are really quite interesting, is... one is with the use of the ways to communicate in Epic.

Trish Kritek:

Some providers, at least one provider, said that there were a cohort of folks who are getting semi-urgent messages while they were in the OR or when they were out of the hospital. And they were concerned about the fact that even though they listed themselves as unavailable, the message still came to them. So, I wonder if you could talk about that.

Todd Burstain:

Yeah. So, we have different types of communication. There's three basic methods that folks can use to communicate. On the lowest tier of stuff that is not urgent at all, just the FYI, you need to know, you can use the staff messaging functionality in Epic In Basket to send messages to any other Epic user. For things that are not urgent but you want them answered usually today, we recommend using Secure Chat.

Todd Burstain:

And that's what they were talking about with the available and unavailable. Even if it says "unavailable," the message can go through. You have the ability in Secure Chat to forward those messages to another user. There's the little gear box that's available in Epic that you can use to select who you want to forward those messages to and for how long.

Todd Burstain:

And then, for urgent messages, we are still saying that you should page the person. And the paging numbers are entered in due course. And they're now viewable in Epic under the Treatment Team that has a little pager icon beside it with the pager number. So, again, the three modalities, staff message for just FYI, Secure Chat where I need to know but it's not urgent, and then paging for urgent.

Trish Kritek:

Okay. So, I'm going to follow up on the Secure Chat part. So, it feels like maybe part of this is some expectation setting about the return on what gets messaged in Secure Chat across our community, because it sounds like those are things that you're saying, within the day, somebody should respond. And then, that part where you say "unavailable," but you could still have it come through, I guess it'll be interesting to see if best practice is to forward your Secure Chat, because that doesn't sound like that's necessarily been incorporated into our practice.

Todd Burstain:

Yeah. It is definitely recommended that when you, as the sender, are sending the message, do not send it to somebody who says it's unavailable because they're not going, likely, to read that. Now, when you do send a message on Secure Chat, it does have a read receipt. So, when the person does read it, it changes the color of their icon to let you know that they have read the message.

Trish Kritek:

So, the sender will know that the person hasn't read it because they're not available. Okay. I suspect there will be more questions about this functionality because I think it makes people feel like they're missing something important. And they don't want to do that, which, I think, is what's driving the concern.

Todd Burstain:

I totally get that. And we're doing a lot. We're over 20,000 Secure Chat messages a day now.

Trish Kritek:

Okay. So, I'll just leave it out there or something to keep following up on. The last question, which I'm channeling my inner Anne on, is a question from a provider... I think a physician... saying, "Now, I can

check everything all the time with Haiku on my phone. And people can message me all the time. And it feels like I'm more tethered to my work as opposed to less tethered to my work." And I'm curious if you have some kind of thoughts about how to put some boundaries on that for people as we think about their well-being.

Todd Burstain:

Yeah. It's a mixed bag that, I think, really takes some discipline, right? So, in one sense, having mobile access to the chart and being able to check messages and place orders and doing things is great in that when you're walking around the hospital or in between patients, or walking from the car or something else like that, you can be more efficient so that you can actually get home earlier. But the flip side of that is if you don't turn your phone off at night, you keep doing it all night long, right?

Trish Kritek:

Yeah.

Todd Burstain:

And so, it does really take some discipline. I use the analogy of you have to keep your kids off the video games and their screen time. It's the same thing for us at work, that we need to be able to take that phone and put it on do-not-disturb mode to get some downtime away from work.

Trish Kritek:

Yeah. So, I think some strategies about self-control and limits on using the device is what I'm hearing. And I hear you saying there are some benefits to the accessibility. I agree. I'm going to discourage walking and texting or looking at your phone. I think it's unsafe. I'm going to go off on a limb and say we shouldn't do that. But if you're standing in front of an elevator and want to do that, have at it.

Trish Kritek:

I think it'll be interesting to have more conversations about how this fits into our well-being. So, I appreciate you engaging in that conversation. And more to come on that topic. And thank you again. I'm going to pivot back to vaccines. I'm going to look at you, Tom, first, and then Cindy and Jerome. So, Tom, I had asked you because I had a question, if we know what percentage of the medical staff have been vaccinated. So, I know you tried to find that out.

Tom Staiger:

Yes. So, I was able to get a report from our Employee Health manager this morning. And it shows that 68% of our medical staff across UWMC and Harborview... this is inclusive... are vaccinated. Two percent have declined. Of our house staff, 73% are vaccinated, 1% have declined. And just for reference, out of our other non-medical staff's staff, the vaccination rate is in the 72% to 74% across our campuses. And declination rate is in the 6% to 10%.

Tom Staiger:

So, I saw these numbers. And I was surprised that they weren't higher. It's possible that we didn't capture all of the individuals who have gotten their vaccines. But I think that this is a pretty reliable system through Employee Health. So, I would strongly encourage everyone who works here, providers, non-providers, everyone, to avail yourselves of the vaccine availability.

Tom Staiger:

I signed up as soon as I was eligible. I had mild symptoms with my second vaccine. And I'm just so glad that I had the opportunity to get vaccinated. And I would strongly encourage everyone, as I'm encouraging my patients, my family, everybody I know, to get vaccinated.

Trish Kritek:

Yeah. I have to say, those numbers surprise me too. And I would have thought that the number would be higher than 68% of the medical staff. And kudos to the house staff and fellows for outperforming the attendings at this point in time on the vaccination. And the staff, actually, are ahead on those numbers too. Tim, did you have more detail on that that you wanted to add?

Tim Dellit:

I was just going to say a couple of things. One, as I've heard from other healthcare systems, some of them are in the 50s-

Trish Kritek:

Interesting.

Tim Dellit:

... in that range. So, I think it is lower than what we had anticipated. I think the other piece and what we need to do in terms of the next phase is that, while we are not mandatory, mandating vaccination, we do expect everyone to participate. And so, the next step is really going to be going through, say, that 20% to 30% for whom we do not have an answer and, really, again, wanting to offer and encouraging them to be vaccinated. But also, if not, then they need to decline so that we really know the status of everyone.

Trish Kritek:

Okay. Yeah. I hear what you're saying because what I heard was only 2% have actually said, "I decline." And so, there's a big gap there in some of these data. I don't know if anyone else wanted to add to that. John, did you want to add something?

John Lynch:

Yeah. I'll just say that all of these data, to get vaccinated, you have to get... your second vaccine, it has to get put into this separate employee health medical record track. So, there's a little bit of a delay. And I suspect we're probably a little bit better than we are. But even if, say, we're off by 10%, that's 78% and 83% for medical staff and, overall, probably around 80%. And I guess unlike, maybe, some other people on this call, I'm not surprised.

John Lynch:

About 20% of folks... I talk to folks. A lot of people are waiting to see. Some people get the first dose. And there's a bigger delay to get to the second dose for various reasons. And I just would caution folks that... I think a lot of people were asking to that normalization you were asking about, that demobilization, things like eating and meetings together. And I think people have this sense that we are well vaccinated.

John Lynch:

And like the data show, that about one out of five folks isn't. And when we think about demobilization and meetings and eating, you don't know who those folks are. So, that's our perspective when we think about a lot of these activities.

Trish Kritek:

Actually, for that message alone, it's really helpful to see these numbers because I didn't know these numbers. And I find it really interesting. And even if they're a little higher, there's still a big gap between everyone being vaccinated. It's interesting. And I thought they would be higher because I mostly get the questions from people saying, "When can I get vaccinated?" Which I love, but that's my bias on this one.

Trish Kritek:

Cindy and Jerome, I think Tom told us it's 72% to 74% for staff. I don't know if there's any other details to those numbers that you wanted to add.

Jerome Dayao:

At Harborview, the information that we have received from Employee Health is about 70%.

Trish Kritek:

Seventy? Okay. Seventy percent of staff at Harborview? And, Cindy-

Jerome Dayao:

Yeah.

Trish Kritek:

... what were you going to say?

Cindy Sayre:

Yeah. We're in 74% at Montlake and 72% at Northwest. And the declination is between 6% to 10%. And I think back to some of these points about... we're about 80% of staff, compliant with the programming. And they've responded in some way.

Trish Kritek:

Yeah. It seems like the, actually, staff, not medical staff, have been more compliant with responding in some way. And so, there's an opportunity, maybe more with the medical staff, but with everybody, to engage in some way and say which way you might go. And if you said that you didn't want to before, you could still say yes, if it feels better now. So, I guess that I would encourage people to do that.

Santiago Neme:

And, Trish, I would like to add-

Trish Kritek:

Please.

Santiago Neme:

... that I think that it would be great to take the opportunity to really talk about this with our staff. There's a lot of people who stay quiet and don't want to voice their concerns around the vaccine. And we're doing a lot of vaccine safety discussions. But I think if you work in a clinic where people know you and you approach the situation from a care perspective, empathetic, I think you'll be surprised at how you can help that person make the right decision, which is to vaccinate. At least, you give them the opportunity.

Santiago Neme:

I think I've had different experiences. One is, I approach the topic like, come on, you need to get vaccinated. And it was perceived as being too forceful. But then, if you reframe that and you approach it from a care perspective, I've been very surprised by the positive response.

Trish Kritek:

That's right. I think being curious and talking to people about it is a good strategy. So, be curious about your colleagues. Be curious about your peers and engage in a conversation about it. I think that's great advice, Santiago. Thank you. Cindy and Jerome, I want to ask about visitor policy. And I think John alluded to it. And interestingly, someone said, "Could we use a dial system with visitors like we did before?" And maybe that's where we're headed. So, Cindy, do you want to comment on where we stand with visitor policy?

Cindy Sayre:

Well, it's a really timely question because many of us on this call, we're on a visitor policy call earlier today. I just want to continue to recognize how difficult this particular piece of the pandemic response has been. Very heartbreaking, some of the stories. And so, we're all really sensitive to the desire to get back to more normal state of visitation. At this point, what we did today, we cleaned up a little bit of the language in the policy that was causing confusion. And that was really around end-of-life comments.

Cindy Sayre:

And this is not finalized yet. But this just went into draft form today. And a little bit more language about confusion, delirium, specifically. So, we are still looking for a decrease in the transmission... I mean, I look to John... before we really dial. And one of the other points is that, while it seems simple in concept that you could just slowly turn the dial, each decision that we make in that direction really opens the door to more people than you would think.

Cindy Sayre:

So, as we talk through each of those options... and that's partly because of the very high-end care that we provide. So, when you loosen that up a little bit, it really does have impact on the number of people in the building.

Trish Kritek:

So, the dial is harder to do in terms of visitors. And you're actively talking about it, some small revisions in language around end of life and delirium and no major changes right now because of the numbers in the community. Is that right?

Cindy Sayre:

Yeah. To John and Jerome for any-

Trish Kritek:

Jerome, did you want to add?

Jerome Dayao:

It requires that thoughtful consideration of what's happening out there and what's happening within the hospital. That's why we are working very hard in making sure that the policy is very clear so that all of our staff can feel comfortable when we start letting visitors in, because other places in the country have allowed visitation. But we are very careful in looking... our staff are safe and that the people that are inside the hospital that are vulnerable are also safe.

Trish Kritek:

All right. And I think you highlight that tension between the importance of patients and family to be there, which is important for our patients, and the need to keep our staff safe. So, I appreciate that tension, Jerome. John, you unmuted. I don't know if you wanted to add something.

John Lynch:

I know. I think Cindy and Jerome spoke really well about it. Just going back to what we talked about earlier is that we were actually on a trajectory to get to visitation. And then, the numbers really just started climbing really quickly. And so, we're really looking... I would say, just as a broad guidance, looking at when we get to around 100 or less cases per 100,000 over the prior 14 days, that's when we're really looking at those steps.

John Lynch:

And I think Cindy's pointed around, when you make a dial... just as an example, when we change the ambulatory visitor policy at Harborview... and this is probably true to other places... we basically doubled the number of visitors coming through screening and into our clinics. So, very small changes can lead to big differences in actual numbers. And so, we're just trying to be careful.

Trish Kritek:

I appreciate that. And I think everyone appreciates that. And people are going to keep advocating because I just served as a family member for somebody in the hospital. And I'd like to think it was really important that I was there. I don't know if it was, but it felt like it in the moment. So, I think it's a very real tension for us as family members as well as parts of the healthcare team. So, more to come as we keep talking about it.

Trish Kritek:

I want to try to hit a couple more questions about vaccines because... Santiago, I was going to turn to you. People were wondering if we go over the shortest time between doses and the longest time allowable between doses because they're definitely not exactly what we started with.

Santiago Neme:

Yeah. Just as roughly for Pfizer, the recommended time is three weeks, for Moderna, four weeks. The shortest interval will be 17 days for Pfizer. And the longest that CDC recommends exceptionally is 42 days. So, six weeks, that will be the longest. But by the book, if you look at the recommendations, it's three weeks for Pfizer, four weeks for Moderna. But you can have four-day wiggle room within those time frames.

Trish Kritek:

And someone actually asked about the 17 days specifically. So, for Pfizer, 17 days is okay up to 42 days. That's helpful. Thank you. The other question I got, which we've asked before but I'll ask it again, is, if you've had COVID, are you more likely to get adverse reactions when you get vaccinated? Because I think that might be making people hesitant to get vaccinated.

Santiago Neme:

Yeah. There are emerging data in terms of it, to answer this question. And not only the side effects, but also the immunogenicity of that first dose, is a lot more robust in someone who has had COVID. There's a study from Mount Sinai recently where they looked at Pfizer, where, although the local site... symptoms like the injection site pain was the same.

Santiago Neme:

The systemic symptoms, like the fatigue, the headache, the myalgias, those symptoms seem to be more common in the folks who had had the natural infection before, which doesn't mean that it's contraindicated. It just means that you obviously have encountered something similar in the past. So, after the first, more likely to have those symptoms. But again, lack of symptoms doesn't mean that the vaccine is not working. So, I just want to be clear.

Trish Kritek:

Yes. We know some of the people here who didn't have symptoms. And we know that they're feeling like they're still covered.

Santiago Neme:

Right, right.

Trish Kritek:

But I think it's important to say, yes, you may have more adverse symptoms. And you can take Tylenol or ibuprofen and treat those. But it shouldn't stop you from getting vaccinated.

Santiago Neme:

Yeah. I just wouldn't take anything before the dose. I would just take it as needed. Yeah.

Trish Kritek:

After?

Santiago Neme:

Yeah.

Trish Kritek:

Great. And one more question about that. People are concerned that if they get vaccinated and that they want to travel, they get tested for COVID, it will test positive. Will you test positive after you get vaccinated?

Santiago Neme:

No, no. It's a different test, right? So, the vaccine shouldn't really make your PCR or your testing positive. The antibody testing is different, and it's somewhat controversial. But when you travel, the test is the PCR or the antigen. In some cases, when you go to Europe, you need it before, four hours before you get on the plane.

Trish Kritek:

Okay. So, do not, not get vaccinated because you're going to get tested because you're traveling. Please get vaccinated. John, there's two other things that came up in the questions. The first one is there has been some data out about Pfizer... and I think actually, now, Moderna... having lasting protection up at six months' time. And in the setting of seeing that data, people were concerned that that's when it would end. And so, the questions that I got were, do I need a booster because it's been at six months?

John Lynch:

Yeah. So, I'm not an expert virologist/immunologist. But my reading of the literature is that, yeah, we have really good data now coming out, showing that these immune responses are lasting. Remember, we're not that far out from these big trials. So, a lot of people have only been vaccinated for six months. And what they're basically showing is the persistence of measurable immunity, easy-to-measure immunity, like neutralizing antibodies and antibody titers.

John Lynch:

And so, that's really good news. It is not telling us that's the end. It's simply saying that, so far, everything's looking great. And really importantly, when you start looking at some of the more hard-to-measure measures of immune response, like T cells and B cells, these other things that we generate to fight off infections, right, those are doing great as well. So, there's lots of other measures that are probably markers of immunity that last much, much, much longer.

John Lynch:

So, as it stands right now, I know that companies are working on boosters. Now, remember, there's two different kinds of thinking about boosters. One is the same vaccine again, right? So, having another one, another of the same Pfizer, right, and just boosting immunity that way. The other idea is boosting with one that boosts towards a different variant-

Trish Kritek:

Right.

John Lynch:

... right? And so, I think people are looking at both situations. But as it stands right now, there's no data that I'm aware of, in my limited review of all the literature, that tells us that we're going to need a booster in the near future. Excuse me.

Trish Kritek:

Okay. So, no plans for booster. It just says that, so far, we know it's six months. And we don't even know how much further beyond that. So, I want to reassure people on that. Thank you. The last topic is there's more and more discussion about vaccine passports. And do you think that that's going to be something that becomes a part of our lives?

John Lynch:

Oh, my goodness. This is probably one of the most controversial-

Trish Kritek:

In two minutes.

John Lynch:

Yeah, in two minutes. I'll say, I don't know. There's my answer. I think that there's going to be commercial entities and perhaps countries in the world that are going to require this. And to be clear, there's a precedent for this. For those who travel internationally, there's a yellow card that requires yellow fever vaccination. So, this happens already. And so, there's a precedent.

John Lynch:

And I think you're going to be looking probably a lot of this being driven from the commercial side, maybe cruise boats, maybe airlines, maybe countries, maybe restaurants and bars. As it stands right now, there's a lot of discussion going on. There's a lot in the ethical world around the pros and cons of vaccine passports. But at the very least, I don't think we're going to be really, honestly, earnestly talking about these until access is dealt with.

John Lynch:

And so, I'm hoping that... I really strongly hope that we not talk about vaccine passports until everyone has equitable access to vaccine in not only our country but other countries because that will severely impact how people live, going forward.

Trish Kritek:

Right. Because that could then exacerbate disparities if we used a vaccine passport before there was equal access or equitable access. Okay. So, more discussion about that. I'm confident over the next many months. And so, we may come back to it. As a little side corollary, can you go to Employee Health to get proof of vaccination? Or is it that you just should have held on to that card that you got?

John Lynch:

Yeah. So, we do track your vaccine, your vaccination in Employee Health. I don't know if we've actually given people new cards or something, to be honest. I'll have to go answer that question for you. All the vaccinations are being registered centrally at the federal level. So, I suspect it will be... if you lose your card, there's going to be a way to get it. But I don't know the correct answer.

Trish Kritek:

Okay. That's fine. We can come back to it. And I'd say, hold on to your card, if at all possible. Take a picture of it. I have it on my phone, personally, so I have it with me. Not that there's a passport need, but I just like having it.

John Lynch:

I laminated mine. I know there's a big controversy about that.

Trish Kritek:

Okay. That is really comical, and I love that. Okay. Kudos to you for having a laminator. I am going to now play Anne briefly at the very end, John. And I'm going to Ask an ID Doc with you. And I will absolutely pale in comparison to her ability to do this, but I'm going to give it a shot. And I picked you because a lot of the questions were about middle school to high school-aged kids. So, would you have your kids go away to sleep-away camp this summer?

John Lynch:

If they're vaccinated, yes.

Trish Kritek:

So, yes, if they're vaccinated. So, if they're less than 16?

John Lynch:

Well, I'm hoping that, by the summer, we're going to have access to younger kids getting vaccinated. So, just so everyone knows, my kids are 11 and 14.

Trish Kritek:

Okay. So, hopefully, earlier vaccination. And yes if vaccinated, no if not vaccinated? Okay.

John Lynch:

Yep.

Trish Kritek:

How about kids going back to school right now, how do you feel about that?

John Lynch:

So, my kids go to independent school here in Seattle. And their school is supposed to start on Monday. And a week ago, we were full on, "You're going to school." And my older daughter's like, "Why?" And my younger daughter's like, "I can't wait." And as of this weekend, my... we actually started yesterday. My wife and I are having very serious discussions about what the right decision is, to be honest. With those numbers, it's hard. It's a really hard decision to make.

John Lynch:

And so, we're actually talking about it every day right now, with the final decision to be made Sunday. We're also looking to what's going to happen with the phasing because the school we go to also relies

upon that as well. So, if it goes above 200, then they're going to not have school. So, it may not be my decision.

Trish Kritek:

I appreciate you talking about how challenging it can be to make these decisions, and how kids are different on how they feel about it as well.

John Lynch:

Well, it is the problem when you're the daughter of an infectious disease doctor who does this sort of stuff. She's like, "The rates are going up. Why would you do this-?"

Trish Kritek:

That's awesome. I love it.

John Lynch:

"Why? What's the plus? What's the benefit here? I'm fine in my room."

Trish Kritek:

What an intelligent, empowered young woman. That's awesome. If they go, would you make them wear eye protection?

John Lynch:

No.

Trish Kritek:

Okay. I note that. This one describes the-

John Lynch:

You really don't like the eye protection, Trish. I'm sorry.

Trish Kritek:

No, I really don't. I'm so not into it. I'm so not into it.

John Lynch:

Have you tried the Stoggles? They're nice.

Trish Kritek:

We can discuss about my progressive lenses and the challenges. We can have that conversation offline. This is early for you. But how about going back to college in the fall? I know that your kids aren't quite that age. Do you feel okay about that?

John Lynch:

Yeah, definitely.

Trish Kritek:

And would you let them live in the dorm?

John Lynch:

Yes.

Trish Kritek:

As long as they are vaccinated?

John Lynch:

Yep.

Trish Kritek:

And then, finally, last question, if folks go to visit their parents... they're vaccinated, parents are vaccinated... not just for a meal but go and stay with them, can they go and interact in the house not masked?

John Lynch:

Yes.

Trish Kritek:

Yeah? Do you feel good about that? Wonderful.

John Lynch:

Vaccinated, vaccinated, yes.

Trish Kritek:

Yeah, vaccinated, vaccinated. All right. That's all I got in terms of Ask an ID Doc. And I want to say that I was exactly on time because I can control the time, which is perfect. I also want to say thank you to all of our panelists. As always, thank you. We were a little bit rushed jumping on, on the air today. And I just want to thank your grace in that moment.

Trish Kritek:

I also want to say thank you to Todd, particularly, and the whole D1 team for all they've done, as well as everybody in our clinical teams who rallied after having a long... more than 13 months of challenges already. You made it through launching a new EHR. And I'm so inspired by all the members of our community for having done that. And then, I will just say thanks, as always, to everybody for continuing to take care of our patients and their families, even if they're not in the hospital yet. We keep taking care of them.

Trish Kritek:

And most importantly, we've gone through another hurdle. We're hoping that we're seeing things plateau. Keep taking care of each other. We'll see you back in two weeks. And it will be a pleasure to do so then. Bye-bye.