

Trish Kritek:

Welcome back to UW Medicine Town Hall, I'm Trish Kritek, Associate Dean for Faculty Affairs and it's great to be back with you. I'm going to tell you who's here with us. Anne Browning, our assistant dean for well-being is back from vacation. Santiago Neme, medical director at UWMC Northwest is back from, I was going to say, T-Mobile Park. John Lynch, our head of infection prevention and employee health at Harborview and head of our medical response for COVID. Keri Nasenbeny, Chief Nursing Officer at UWMC Northwest. Tom Staiger, Medical Director UWMC. Rick Goss, Medical Director Harborview Medical Center. Tim Dellit, Chief Medical officer UW Medicine. And Cindy Sayre, our chief nursing officer for UWMC. So thank you all for coming back today. Got a lot ahead of us but I'm thrilled to have Anne back and I'm going to hand it off to her for the well-being message.

Anne Browning:

Sure. Thanks Trish. It was just about a year ago we started getting our minds around what the duration of this pandemic might look like. And with that I think we started grieving the loss of the trips, the weddings and graduations that we had looked forward to and putting a name to that emotion, grief, was helpful. This week a new word has emerged in our lexicon. As folks are navigating the meh that many folks are feeling as we plod through the second spring in this pandemic, that emotion is languishing. Adam Grant and The New York Times wrote that languishing is like this void in the middle of the spectrum of mental health, between depression on one end and flourishing on the other. And really that languishing represents absence of well-being. So what can we do to push back on the sense of languishing if that's something that sense of being stuck is where you're at. West writes that you can really think about giving yourself the chance to be absorbed in a meaningful challenge, to get to a state of flow where everything else seems to fade away. As an athlete that's a state I can sometimes get to with physical challenge. For some folks that might be cooking a new recipe. For my surgeon pals they'll often talk about finding flow in the OR.

Anne Browning:

So how do we intentionally build some more time to find meaningful challenge as we move forward and shift and think about coming back to work as more and more folks are getting vaccinated and there's more hope on the horizon? I hope we can shift towards thinking about self-care, not just in terms of self-indulgence but more in terms of... Excuse me, self-care as really setting an intention for how we want to live, how we want to thrive moving forward. Pardon me for a second. Sorry you all. My screen went a little bit crazy there, I apologize. So as we're starting to build that intention really, as Trish modeled about two weeks ago, we're asking folks to reflect on what we can learn from the year behind us and what we can do to shift and what we want to think about moving forward.

Anne Browning:

So as Trish did, we want to ask some folks today, what is it that you want to keep from last year? What are the patterns and habits you want to let go of? And really what do you want to think about shifting? What are you looking forward to as you move forward? So we'll go around this week and probably in a couple of weeks as well and give folks on this panel a chance to really talk and say what do you want to keep, what do you want to let go of and what are you looking forward to as you move forward? So we'll start out by giving John the mic-

John Lynch:

Thank you, Anne. So in terms of things I would keep, I have developed some amazing relationships across UW Medicine this year. They've been absolutely phenomenal. When I went into this work last year and started working across the system, I basically was introduced in a rapid fashion to people throughout our system. And I'll just tell you there are so many remarkable people who can do so much. It just blew my doors off and it was... I'm so looking forward to maintaining those relationships and seeing how individuals can really impact our system. I think other folks have reflected in past sessions about how great the system is and how dedicated they are to it because of the work we've done. I think that's true. But a system is made up of people and those individuals are just... It's just amazing, we have here at UW Medicine. In terms of my letting go going forward, they're actually flip sides of the same coin.

John Lynch:

I would love to let go of a regimented Zoom existence. My days are many, many meetings of lots and lots of Zoom. And I think I speak for many people that I like to see a little bit less of that regimented sort of approach and a little bit less Zoom. And what I would like to see going forward is, as I said, the other side is a bit more spontaneity and a lot more of those in-person relationships. Even the past couple of days our own team here, I was working with Vanessa Makarewicz, so one of the great things as my partner in infection control is that we just work together constantly. We're almost like one person, one team and we think in a complimentary way. But a lot of that's driven by spontaneity and the opportunities that we have when we're just like, "Hey, what do you think about this? What do you think about that?" And I'm really looking forward to that sort of interaction going forward, not only with Vanessa and the team up here on the 12th floor at Harborview but all of my colleagues and the benefits that come from that spontaneity.

Anne Browning:

Awesome. Thanks, John. Keri, how about you? What do you want to keep? What do you want to let go of? And what are you looking forward to?

Keri Nasenbeny:

Yeah. Thanks Anne. It was interesting to think about these questions I have to say. And a lot came to my mind. I think as far as what I want to keep, personally I am... In the midst of this I realized I had to do things differently. I couldn't just keep not sleeping, eating really badly and drinking sometimes too much. I mean, not that I'm... That sounded terrible but you know what I mean? I think I needed to figure out some new routines. And what I really landed on is if I sleep right, I sleep well, I eat well and I exercise I'm a much better person. I'm almost like a kid. I have to play, I have to exercise, I have to sleep and then I can function. And if I don't do it, even just one of those things I suffer the next day. So I really landed on a pattern of taking care of myself that involves those three things.

Keri Nasenbeny:

So that's something that I definitely don't want to lose because it's really helped me become a better person I think both at home and at work and all of those things. I think, like John, there's a couple of things professionally that really this pandemic I think has helped us grow as a system and as a team. And come together and really draw and leverage all the different resources that we have across the system and that has been phenomenal. I think the other thing that I would highlight that's been really... I think this pandemic has really highlighted all the systemic racism and I think it's created a springboard from us to develop a lot of momentum to drive change. And that's something that I don't want to see us give up.

I really want to stay on this journey and keep that momentum. And I think we all feel right now. So that's something I'm both personally and professionally committed to keeping. The next question. Sorry, it just slipped out of my mind Anne.

Anne Browning:

Things you're looking forward to.

Keri Nasenbeny:

Well, travel for one. I think we're all looking forward to traveling. You learn so much when you travel and so personally travel. That is for sure something that I'm looking forward to. The other thing I think I'm looking forward to is just doing work that's not COVID related. We had just started on the Magnet journey here at Northwest. And I'm really looking forward to getting back to that journey, to working with our teams, empowering our teams, to really growing together and developing the staff and the care here at Northwest. They are a phenomenal group of people and really provide tremendous care and just super excited to stay or to start that journey with them or continue that journey with them. And then I think what I want to give up really, first and foremost, is the isolation.

Keri Nasenbeny:

I'm for sure seeing more people but like John Zoom is just exhausting. I worry endlessly about my kids who should be out there spending way more times with their peers than they do with me. And in fact, the opposite is true. Remote school has just been a disaster in my family. And I think professionally I worry so much about our patients not having their families at the bedside. It's just I see the impacts of that daily, whether that's somebody dying alone or that's somebody falling who might not have fallen because their family would have been there to help them, the loneliness, the anxiety. I think that's the part that is really... I'm ready to let go of, that type of isolation and get back to the more normal interactions that we have with people.

Anne Browning:

Thanks Keri. Last one for today, Tom, would you like to share some thoughts?

Tom Staiger:

Sure. Thanks Anne. Like Keri, in my personal life, the pandemic has made me think carefully about self-care. And so I plan to continue to focus on making sure I get enough sleep, get enough exercise, engage in activities outdoors and with other people that energize me and sustain me. And so plan to keep that going forward. At work, the pandemic as well as D1 have made me get out of the office and round with staff more than I used to and get a chance to get questions from people, provide information, thank them for what they're doing. So I plan to continue doing more of that going forward than I have in the past. Things that I plan to let go of, the whole pandemic experiences reinforced to me how precious our time is.

Tom Staiger:

And so I'm increasingly mindful if I'm going to call a meeting making sure we really need to meet, making sure we're using our time as efficiently as possible and focusing both professionally and personally on high value activities and giving up things that are lower value. And then going forward, both in the work environment and outside, looking forward to the day, in the not too distant future, when we can get together with people in a room without masks on. Share that camaraderie, that

community of our colleagues at work. Be able to have conversations that are spontaneous and not over an electronic environment. And as well, looking forward to being able to start travel again safely.

Anne Browning:

Awesome. Thanks you all. And since I missed two weeks ago when we had our technical glitch at the beginning, it was my turn to have a technical glitch and have my screen go totally haywire. So thank you for your grace as I reset that. And thank you all for your reflections. Trish.

Trish Kritek:

I wouldn't even notice you had a technical glitch. Thank you all. Thank all three of you for those reflections. So much of it resonated with me. And some of it we're going to hit upon later. I'll add, I miss coming together. And I was thinking, Tom, you're going to say with a beer. But I will say with a beer in addition to that. Okay. We have a lot of questions. We have stuff going on so I want to dive right in. John I'm going to start with you today because I think we got questions about... Concerns about numbers and concerns about changes in King county. So maybe you could update us on where we stand across UW Medicine and across King county to start with.

John Lynch:

Okay, I'll go quick. UW Medicine we are now up to 56 patients. 36 of those folks are in acute care, 20 in the ICU. Folks may recall from our last time we're in the low 40s and so we definitely continue to creep up. Most of those patients are actually at Valley Medical Center. 32 folks there, 24 in acute care. Harborview's got 15. Five people in acute care, 10 in the ICU. And just, again, I've always keep talking about these ECMO or ECLS patients. Four people are on ECLS, which is actually a remarkably high number and with COVID on ECLS. Northwest is at two folks, which is great. They're down a little bit. And Montlake's at seven folks, which is actually up a couple. So 56 overall, about 20 people ICU, four people on the heart lung bypass machine that I can talk more about.

Trish Kritek:

Before we go to King County, one question that came up a couple of times was, do we know the vaccination status of folks who are coming in infected? And I know that there's patient confidentiality issues there but I think if you could give a gist about whether or not we think people who are vaccinated are the folks who are getting admitted.

John Lynch:

So we're not tracking patient vaccine rates in terms of admissions. I can tell you that we are tracking healthcare workers' positivity rates. And we're investigating or asking about their vaccine status for every single one of them. And of the 20, 25 folks who have had breakthrough infections, again, I mentioned this last time, about half of whom, maybe a little more, have had no symptoms and other half with very mild symptoms. We have one person who has required hospitalization. So very, very, very rare. Not ICU but in the hospital.

Trish Kritek:

So one healthcare worker of the folks who are vaccinated been admitted. 25 have had infection, half have had symptoms. And I just want to... I'm going to follow up on this. You don't know the status of whether or not people who are infected were vaccinated. Okay.

John Lynch:

We're not tracking that, no.

Trish Kritek:

Okay. King County, yeah-

John Lynch:

King County quickly. Folks may have seen in the news that King County's numbers are definitely increasing. The two numbers that are increasing are case counts, so the number of cases per day continues to rise. And the number of hospitalizations also continues to rise. And those are the two metrics that we're using for the phases that we're in. And our next phase evaluation is about a week and a half. And so in terms of that phase, phase three to phase two for King County, we're over that number. In terms of the hospitalizations we're actually over that number. You'll see we're right on the edge but if you actually looked at the real numbers we'll be there in the next day or two. So a lot of conversations next week and a half. The good news though is if you look at all those metrics, the number of deaths, which is always a lagging indicator, always comes up later, still remains very, very low. And I think that's really demonstrating the impact of the vaccinations in our elders, folks living in skilled nursing facilities and so forth. Unfortunately just knowing what happens with patients on ECMO, we will see deaths as a result of this surge. We're clearly in a fourth surge. But that's going to be in people who are in their 20s, 30s, 40s and 50s and not that older population.

Trish Kritek:

So younger patients' been going up in King County, both in terms of hospital admissions and in terms of infections. And one question we got was, how does the ratio of infections to hospitalizations now compare to earlier surges?

John Lynch:

Yes. So the number of cases we have now is greater than the spring or summer surge, lower than the winter surge. And the number of hospitalizations we have now actually exceeds last summer surge.

Trish Kritek:

Oh okay.

John Lynch:

And last summer we were right around 40 and now we're up about 50. So we have more hospitalizations than the whole last year right now than we did except for the winter surge.

Trish Kritek:

So winter surge had the most people in house.

John Lynch:

That's right.

Trish Kritek:

I guess the question is compared to the numbers of infections, I think the thing that people are trying to understand is, is it possible there's more people getting infected who are younger, who aren't getting as sick and thus not getting admitted to the hospital?

John Lynch:

Yes, definitely. Yes. That's definitely true. And I think that probably the bigger disconnect is the death rate, which is something that's very easy to track, unfortunately. And that's definitely not rising at all.

Trish Kritek:

Okay. Yeah. So I think that would fit to lower numbers of deaths, probably lower proportion of people getting hospitalized. Thus it's probably a reflection of this younger population.

John Lynch:

And variance.

Trish Kritek:

And the variance. Thank you. Okay. So a couple of follow-up questions. One question is, do we know the demographics or the risk factors for people who are getting infected after vaccination? Is there something about those folks, that age or immunocompromised or anything like that?

John Lynch:

Of the healthcare workers who we're tracking, none that we can point out. They tend to be obviously healthcare workers, so younger people. They're obviously vaccinated folks. And I'm being very clear, I'm not pointing out this particular group but we do know when we talk to people they are gathering, they are traveling. And the issue around vaccination, and I just want to emphasize really quickly, is that these vaccines are amazing. We'll talk about it a little more later. They do great at protecting you at the individual level. But their real power, this is true for all vaccines, is the population level. So you take someone who's vaccinated and drop them into a population of unvaccinated people where there's lots of coronavirus, that person's going to be seeing a lot of coronavirus. And the chances of overcoming that level of immunity is greater. They see it a lot versus a highly vaccinated population. So the message I would say is stay the course. We know the CDC guidance out in the community about small groups of vaccinated people, that's all cool. But in terms of our regular activities just take it easy. We'll get there but we need to get more people vaccinated before we really start opening things up again.

Trish Kritek:

Yes. I hear that message about hold the course. I want to just make sure the answer to the question was it doesn't seem like there's a specific cohort of folks who are at more risk to get infected after vaccination. It's more about exposure after vaccination.

John Lynch:

Yes, definitely.

Trish Kritek:

I think the other question that's relevant to what you were just talking about that's come up is, are there specific patient populations that because they might not get as good of immune response from the vaccination they should behave differently than what the CDC is recommending?

John Lynch:

Yeah, definitely.

Trish Kritek:

The question came up specifically about people who are immunocompromised.

John Lynch:

Yeah, no definitely. And so I reached out actually to my colleague, Dr. Steve Pergam who's an infectious disease doctor, heads an infection prevention program at SCCA and he has actually written about this. And I think that the key take on here is there are a lot of people, our patients and our co-workers who, because of a medical condition like cancer or autoimmune disorder or because of treatments like chemotherapy or STEM cell transplant, the medications that are required to keep those things working, are immunocompromised. And what we are learning is that many of those people, not all but many, depending on the condition, the vaccines aren't really generating an immune response. Now how we're testing that is limited. It's like checking for antibodies.

John Lynch:

But we can definitely tell you there are people who have gotten like a kidney transplant who've gotten vaccinated and have no immune response to COVID-19. So the key messaging there is a few in fold. One is they're counting on us to get vaccinated, to protect them. So as a population, cocooning them and especially their household members really need to get vaccinated to keep them as safe as possible. And two, you're right, until we get to a very high level of immunity in the population they're going to need to take extra precautions, even if they're vaccinated. So maintaining the masking and the distancing and so forth. So again, when we think about vaccination, it's both about ourselves but everyone around us, including people who have no choice. They can get vaccinated all day every day and it's not going to change their immune status.

Trish Kritek:

Okay. So for the immunocompromised folks, whether it's from meds for transplant or immune disease or cancer, concerns that maybe they're not going to have the same robustness to response to the vaccine and some extra caution. And that's why we should all get vaccinated to be protective for them.

John Lynch:

And remember some of those folks we work side by side with. So as I start seeing people unmasking and eating together and things like this and just asking this question, remember not everyone wants to talk about their medical status. They may not be comfortable disclosing that. And just assume that those folks are working right next to you.

Trish Kritek:

Okay. Thank you. And I think that we gave that message before, we'll keep giving that message. I'm going to ask just a couple other quick questions before I pivot to Tim on vaccines. Have we changed our current quarantine policy for vaccinated staff after a COVID exposure? Or what is our policy right now?

John Lynch:

Yeah. So I'm going to... Because I know you want me to be brief here. So-

Trish Kritek:

Maybe.

John Lynch:

... it's a little complicated. The quick answer is yes. Our quarantine policy for vaccinated health workers is different. So if basically you're exposed at work and you're fully vaccinated then we are not asking you to stay home for quarantine. There's some subtleties if you're exposed in the community. And I'd say probably the biggest issue is if you live with someone who has COVID-19 right now and you're fully vaccinated, we are trying to find a... We have a policy to shorten your time on quarantine that involves testing. And what you really need to do is to reach out to employee health, let them know so we can walk you through those details. But the key thing is if you're exposed at work, these are transient exposures, unlike living with someone, if you're vaccinated you're not going to have to do the home quarantine.

Trish Kritek:

Okay. So if you're exposed to work you don't have to home quarantine. If you're living with someone, you should talk to employee health to figure out the quarantine. And if you're exposed in the community but not with somebody that you live with, what's the story there?

John Lynch:

If you're exposed it's a brief exposure, you don't have to home quarantine.

Trish Kritek:

No problem. Okay. Thank you. That's super helpful. I have more questions for you but I'm going to save them for a little bit and I'll come back to you in a little bit. Tim, can you update on where we stand with vaccines? I think particularly people are interested in what our waitlist is.

Tim Dellit:

Sure. Again, thank you everyone for joining us here today. And thank you, John, for being so brief. In terms of our vaccination status, we are now over 236,000 doses. And since our state opened up for everyone who is 16 years of age and older being eligible to be vaccinated on the 15th, our waitlist right now is about 30,000. And we're probably about a week between when people go on that list to when they're taken off of that list to be able to schedule. So it's about a week right now. I am a little concerned that some of the demand seems to be dropping a little bit over the last few days. And again, I go back to what John did say in all seriousness, we all have a personal and collective responsibility to keep everyone safe. And so I do worry a little bit about that drop off in demand.

Trish Kritek:

Yeah. So 30,000 on the waitlist, about a week and starting to see it come down, which is not in our opinion a good thing because we really want everyone to get vaccinated. I'm going to talk about rates of vaccination a little bit more in a minute. Was there much impact to our process because of the pause on the J&J vaccine?

Tim Dellit:

No, not for us directly because we really weren't anticipating getting much of that vaccine right now anyway. So it didn't have a significant impact on us. Good news though, I don't know if people saw, the advisory committee did just this afternoon recommend going forward with resuming Johnson & Johnson vaccine with a warning, particularly around clotting for women less than 50. They did identify nine more cases. So I believe the total now is up to 15. But still out of seven million individuals who received that vaccine. And they believe, as I do, that the benefit of that vaccination outweighs that potential risk. So it is going to be resuming with a warning.

Trish Kritek:

Okay. So little impact on us and now it's resuming. I actually hadn't heard that yet today. So thank you. And we'll have a warning but everybody who looked at it says, "Safe to move forward." And I appreciate your endorsement of it as well. One more question about vaccines. Do we do something to prioritize people on the waitlist or is it you're on the waitlist and you just wait till you're off the waitlist?

Tim Dellit:

Yeah. So first come first serve. And so the phone number that we've shared before and it's on our UW medicine.org website, non-employees. So UW Medicine employees we'd want you to use the employee online link to register. And then you can select decline or hopefully get vaccinated. Then that is a better path to allow us to track. For our non UW Medicine employees, including university employees or anyone outside of the university use that phone number. Get on the waitlist then the bot will contact you once it's your time to be vaccinated. I do want to hit these vaccination rates because in the state it's about only 38% have received a single dose. And I believe it's 26% are fully vaccinated.

Tim Dellit:

Now in King county it's higher, 57% have received at least one dose and 36% fully vaccinated. But that's still a minority, as John was talking about the need to continue to mask, physically distance and all of those metrics. The good thing is when you look at age 65 and older it's 88% have received at least one dose in King county. Which is why I think we're seeing a younger group that are now hospitalized because we're seeing that protective impact from the vaccine in our population over age 65. We still have some discrepancies, unfortunately, by race. And there is that disparity out there that the county and city and us are very actively trying to address. Maybe it's 88% overall for age 65, it's 78% in the black community. So we do have some work there but overall those numbers are positive, particularly for that high risk population.

Trish Kritek:

Pretty good, really good numbers I would say in the older population. If you look at the whole population, we're still pretty early in this phase. Better in King county than the state but we're still at the 25% fully vaccinated in the state and ongoing disparities, which I think we definitely will touch on more in a few minutes. You said there's two different ways to sign up. The other thing that I got questions

about is, do people who are non-clinical folks need to say they're vaccinated in some way? Do they have to notify someone or do they have to let us know they got vaccinated?

Tim Dellit:

I think we'd like to have that within our employee health record. And again, it's a shared database both between our hospital employee health service and I'll look to John but also EHS on upper campus. They all use that same database. So we would like that information. We don't require non-clinical people to actually decline. We do want that information for our clinical workforce so that we can really track and ensure ultimately as we go forward that everyone has participated. But it is always good to have that vaccination information within the employee health records, which again is protected. So it's not part of your regular medical record but it would be within the employee health record.

Trish Kritek:

Okay. Did you want to add anything to that, John?

John Lynch:

I might've missed the question but whatever Tim said.

Trish Kritek:

Okay. One last question about that. You should listen because it might be relevant. You might want to answer it too. If I get vaccinated through the UW system and I'm an employee, does it automatically get into my employee health record or do I have to do something different to make sure that's in my record?

John Lynch:

It goes into a separate employee health medical record. It's distinct from Epic. It's a non-Epic product and only employee health has access to it. It's the same record that holds your measles and mumps and hepatitis B vaccine status.

Trish Kritek:

And I don't have to do anything to get it there. It's just going to go there.

John Lynch:

As long as you get within the UW Medicine system it gets into employee health records.

Trish Kritek:

Perfect. So if you get vaccinated here it goes into your employee health record for folks who are asking that question.

Tim Dellit:

And if you get vaccinated elsewhere we really do want that information because, again, we really want to know from an employee health standpoint where we are in our overall vaccination efforts. Again, as our expectation on the clinical side is that everyone participates. So if you happen to get vaccinated elsewhere please let employee health know.

Trish Kritek:

Okay. So vaccinated outside the system, let employee health know. Vaccinated in the system, it's in your records. Thank you. Because people wanted to do the right thing and let people know if they're doing it. Thank you. Tom and Rick, I'm going to look to the two of you. Two weeks ago we talked about percentage of medical staff who are vaccinated. And I'm wondering if you have any updated numbers on medical staff or staff in general that are vaccinated.

Tom Staiger:

Yeah. So numbers as of this morning for medical staff across UW Medicine, 69% vaccinated. So an increase of only a 1% from two weeks ago. Declination rate of 2%. Our residents are 76% vaccinated, a 1% declination rate. And then numbers for staff are in the 73% to 75% and declinations of 6% to 9%. So better performance amongst staff and our health staff than our providers. And a follow-up to a question that you're probably getting ready to ask is what are we going to do about this? Which is that we've requested a report of medical staff who haven't responded or been vaccinated. And Rick and Santiago and I will be sending out something probably next week, as soon as we get those names and contact numbers. Just letting people know it's our expectation that they either get vaccinated or decline so that we can track that.

Trish Kritek:

Okay. So not a lot of progress, 69%. 76% for health staff, better. Staff, 73% to 75%. So we have an opportunity in all of those places for more people to get vaccinated and even if they're deciding not to, we want them to engage with the system and say that they're declining the vaccination. More to come from our medical directors across the system on that for the medical staff. Rick is there anything else that you've been thinking about or the medical directors have been talking about to encourage our healthcare team to get vaccinated?

Rick Goss:

Well, I think as we now have some numbers to guide us it does lead us to really want to put more of an educational campaign in place. And I do think that, like our other important vaccinations, there really is a responsibility to decline in a formalized way. And so we would want to be using that information to lead people to do that. Obviously you have the right to decline but we want it to be an educated, well-stated position.

Trish Kritek:

Okay. I appreciate that. And I think all of us are happy to talk, anybody who has questions about it I would just offer it up that anybody on the screen would be happy to talk to you. I'm going to pivot from vaccines for a little bit to one Epic question. I gave Todd and Eric the day off because I only got I think two total questions about Epic. But I'm going to ask you Rick because I know you were on service since Epic went live. And it's a really granular question, who is supposed to enter outpatient referrals for inpatients, what physician is supposed to do that? Is it the discharging physician, the consulting physician, who's supposed to do that? Do you know the answer to that question?

Rick Goss:

Well, it does seem a little of a non-sequitur compared to everything else we've been talking about.

Trish Kritek:

I know but I feel obliged to ask it because it's the one I have.

Rick Goss:

But it's a good question and-

Trish Kritek:

Good.

Rick Goss:

... I should just put it this way. We're not talking about D1 much today because of the surge in our concerns. But let's give ourselves that credit for just a phenomenal transition that we've gone through and just thanking everybody who prepared all of, of course our IT, all of our teams that have gone through this. This question is really a window into a much larger question, which is really transitions of care into this case the discharge process. And so what it speaks to is how are we really refining and reforming our workflow around that? And this question is, well, who's responsible for making those follow-up arrangements? And what I would say and I've had this pretty well validated, I chatted with Tom and a couple of others, is it's really the same core principle, which is the primary service is really the final pathway to make connections, to do reconciliation, to make those appointments. So that's a given, there's a primary service.

Rick Goss:

However, we all know that if a specialty service says, "Hey we've gone ahead and already made an appointment because we think it's really important that this person has a visit in a week." Then that is absolutely welcomed by those primary services that are otherwise going to try to make that same arrangement. But we know it's not practical in every case. So it's really a team effort but yeah, it's a primary team ultimate responsibility.

Trish Kritek:

Thank you for voyaging into that space of Epic. And I'll just echo what you said, which is, it's great that this is a minor part of what we're talking about today. I want to acknowledge that as well. And I'm going to hear what... I echo what you said or repeat what you said, which is, primary team's primary responsibility be collegial. And if someone wants to help solve those things they can help solve them. But at the end of the day it's the primary team's responsibility. Okay, excellent. Thank you. I think that Keri brought this up when she was talking about her reflections at the beginning. And we had a bunch of questions about families and family visitation. John already alluded to the fact that we haven't made changes to our visitation policy. But actually got a bunch of questions about this.

Trish Kritek:

I'm going to start asking them to Cindy and Keri but I'm going to invite other voices to this conversation. And I guess the first question and I don't know if one of the two of you want to talk to this and I know John will want to chime in. But I think we would like to understand how we're doing our risk benefit analysis on deciding about visitors coming into the hospital. And I think it eludes to the challenge of the rising cases and the challenge for our patients to not have family at the bedside. So Keri I don't know if you want to comment first and then I can invite other people in.

Keri Nasenbeny:

Yeah. I think this is a really difficult question that we're all grappling with. I think we all see the challenges on both sides. If you're at the bedside, you know how hard it is for patients not to have families. And we're just not going in the right direction. So there is still that risk to our patients and families and to our staff. And we've seen that risk play out in ways that I think have had horrible outcomes. And so I think we set a threshold and John, this is where I'm going to ask John to chime in, of a certain number and we're above that number, it's a rate, the cases per 100,000. And I can't remember off the top of my head where we set that, but I'll let John chime in there. But I do think this is an extremely difficult question because I do think we've seen falls that have happened that may not have happened. You'll never know but for sure anxious, agitated patients whose delirium probably has worsened because they don't see that person they know. So I think we all acknowledge that this is not without risk and harm patients not to have their families. And the flip side is also true. So I don't have a good answer. I struggle with this daily.

Trish Kritek:

Yeah. And I think John did say I think it was less than 100,000 or 100 per 100,000 before, is that right, John?

John Lynch:

That's our initial goal when we were back at around 85 cases per 100,000 over the prior 14 days, the threshold was a 100. And as we were planning on changing that visitor policy we quickly hit 100 and then it escalated ever since. It doesn't mean that... Thresholds are not meant to be fixed in concrete. But we think about them, we think about all the other parts. But that is the aim. We'd like to see numbers at least heading down rather than up.

Trish Kritek:

Okay. So we'd like to see numbers going down. I think people understand that, as we call this a new surge, I think people get that. I think that question is, who's at the table and how are we balancing concerns about staff with concerns about patients? And I would add equity. Because I think the other thing that came up in some of the questions is different people can advocate differently for the exceptions to have families coming to the hospital. So I don't know, Cindy, if you want to comment on that about who we're bringing to the table to balance these as we think about this.

Cindy Sayre:

I think the first thing I would say is that it is a constant conversation. I think it's happening several times each week by emails, by Zoom meetings, no in-person meetings. And it's a constant conversation, which just tells you how difficult this equation really is. I want to talk about your question around equity because I will say we have been very attuned to that at both the Montlake and the Northwest campus. And somebody's ability to write an email to the correct person in UW Medicine leadership does not determine whether that exception falls in the policy. And we have to be very mindful that we're applying the policy fairly across all of our patient populations. I think, again, I've said this before in this meeting, it is definitely one of the hardest pieces of our COVID response. So what I can say is, who's at the table, it's a multidisciplinary team that's talking all the time in many venues and we're trying to include as many voices as we possibly can.

Trish Kritek:

Okay. So interdisciplinary group, which I think means doctors and nurses and other voices.

Cindy Sayre:

Well, we're hearing things through our daily safety briefs and issues are being escalated from all our therapies. A broad variety of our team members are raising the issues. And then primarily I would say it's providers and nursing leaders at the table.

Trish Kritek:

Okay. And John I invite your hand-raised voice into the conversation.

John Lynch:

I thought that was a nod, no.

Trish Kritek:

No, that was a yes.

John Lynch:

And just so everyone knows, we do meet, a group of us meet with union representatives and leaders every other week for between one and two hours. And we talk about everything under the sun around COVID including the visitation policy. And we met just Tuesday and we share it with that group as well for distribution to their members. So we do try to bring everyone out and be as transparent as possible. And there's actually a sentence or two in this week's COVID message as well saying we're holding tight where we are.

Trish Kritek:

Okay. Holding tight, we had a threshold but really what I'm hearing you say is we want to see it going in the right direction and we're going to keep reassessing and we keep talking. We talked to the unions, we talked on an interdisciplinary team. Is there guidance at all, John, from the CDC on this topic?

John Lynch:

No.

Trish Kritek:

Okay. So that's going to be what we decide within. And then I guess I want to highlight what Cindy said, we're working on trying to pause and make sure we're doing this as equitably as possible. I'll just say from my personal experience when I was on service in the surgical ICU last time, we had a request for a family and the nurse manager when she talked about it with me, we talked it through, it was, well, do we think we're being equitable? And we paused to go through it. So I know that that's actually happening, which I just want to say from personal experience I've seen it. I guess the last thing I'll ask and Keri I'm going to come back to you is, what are we doing... You said we think some people have fallen, we think that there are issues around delirium. So are there other things we're doing to try to mitigate the fact that we don't have family at the bedside?

Keri Nasenbeny:

I see our staff doing this daily, from buying somebody a paper to help orient them just to sitting with them if they have the time. I think our staff are doing absolutely everything they can to mitigate this. Holding somebody's hand when they're anxious and nervous. It's really spending that extra time I think

is really what they're trying to do is giving them the gift of time. That's hard though. I mean, we're all stretched so thin and well, for whatever reason, all of our senses just went through the roof in March and in April. And so that's hard but I also think we're leaning into the strategies that we know work. So what are the evidence-based prevention methods for falls, for delirium, for pressure ulcers? I do and I applaud our doctors, our nurses, everybody, therapist. Everybody is doing this I think at every turn to bring that humanity to the bedside, to bring that caring and that compassion. And it's still heartbreaking. I think this is a really hard situation I think for all of us.

Trish Kritek:

Yeah. Thank you. So I think many different members of the team trying to spend more time in the room with the patient. I've also seen people use a lot of iPads and iPhones to try to FaceTime and stuff like that. And I think it's the people getting the paper, reading with somebody. I see folks being fed and things like that too, which obviously we would do anyway. But I think all those things that we're trying to replace it's not the same. We just want to all acknowledge it's not the same and it's hard. I told everyone here that I had a personal experience with this recently and I think it is particularly challenging. Okay. Thank you. And is there anything anyone else wanted to add about this? I think because it's going on so long people are feeling it more and more. And that's why we're seeing more questions about it.

Cindy Sayre:

Okay. I actually will add something Trish. I think that we need to make the best decisions possible. And then as a team we need to enforce the decisions. I think we're going to be stronger if we approach this as a team as opposed to any single one of us advocating for any single patient. We need to be approaching this as a system. So as difficult as that is because we are invested so much in our patients, I think we will be stronger if we stay together on this.

Trish Kritek:

Yeah. So teamwork on this. I think conversations are helpful. As a physician I think partnering with the nurse manager or the other nurses on your unit is really important. That we're not saying one thing to families and that the nurses are having to say something else that's harder like, "You can't come in." So we need to partner. And I appreciate it being brought into that conversation. So I think that that is something that's important to hear as well. Thank you, Cindy for saying that. Santiago, I have ignored you all day. I apologize. Earlier Tim talked about issues around disparities and I know that you've been doing some work around vaccine hesitancy. So I wondered if you wanted to talk for a minute about what we're doing as a system to try to address vaccine hesitancy.

Santiago Neme:

Yeah. Thank you Trish. So it's been an interesting journey because initially there was hesitancy and then there was poor access to vaccines. And then the efforts really were about let's provide vaccine information, vaccine safety, but then the biggest challenge was the access to vaccines. Was, do we have enough supply, are they coming? And UW has been exemplary in how they've done this. So the expectations were pretty clear although there were very little things we knew for certain. We knew that there was an entire team really pushing and getting the supply we needed. So I would say that midway it was a bit of both. You would provide some vaccine hesitancy advice and then you would help someone get scheduled. Now it's getting more challenging because now it's mainly hesitancy, what I'm seeing. I'm not getting calls about, can you get me an appointment to... Can you help me? I don't understand the language, can you help me get in? Now it's really about, I think I'm going to wait.

Santiago Neme:

I have concerns about infertility or maybe this vaccine may contain some fetal, whatever. So all these things are becoming more challenging. So now we're really confronting that the vaccine, UW actually has many appointments right now when you try to find a vaccine appointment for your patient. It's very easy to find today. But you'll have to talk to that patient and in filling the gaps of that information. And it takes more time than just saying, look, there's no appointments this week. Now we have the appointments but they don't want to take the appointment. They don't want to get it. I think, for me, the message would be try to engage your patients, their families and your co-workers into this discussion. 71% of medical staff really has been vaccinated. Our expectation is that that number is close to 100%. So turn around in clinic and engage and find out in a non-confrontational way, what are the doubts? What are the questions? Because it's been already four months. It's like, wait. How long are you going to wait?

Santiago Neme:

So what are we doing? So we have the four main clinics that Tim described across UW Medicine. Then we also have the mobile van from Harborview in collaboration with the Mariners that's going to different facilities. And then we have the neighborhood clinics efforts in Kent-Des Moines, in Lopez Island and in Shoreline that has really expanded. So we have multiple sites now including this mobile site. On Monday I'm actually going to a Des Moines correctional facility where Dr. Trish had done already. We're going to try to really help get prisoners vaccinated. And again, this shows you the breadth of the response at UW Medicine and the vaccine efforts that have been exemplary. I have to say I'm getting contacted by husbands and spouses of patients of mine who are not at UW Medicine who want to be registered at UW Medicine to get the vaccine with us because Kaiser or Overlake or the other systems are not offering vaccines as readily as we are. So again, I think that I'm very proud of that expansion and that outreach that we've done that's been very intentional.

Trish Kritek:

Okay. So the different clinics in different spaces, the mobile clinic, the outreach of our clinicians going into the community to talk about why it's safe to get vaccinated. And then I think your encouragement for us to talk to our patients, their families and each other about vaccines and listen to what people are concerned about and talk it through with them, which does take more time but I think it's time we want to spend. Thank you. So community level and local level. I'm going to end before I hand it over to Anne with a bunch of disjointed other questions that have come in. So I'm going to go amongst our ID docs with some of this. Santiago, I'll stick with you for one. Someone asks, do we know more about fomite transmission because I think there's been some communication from the CDC that says it's pretty unlikely? Is that correct?

Santiago Neme:

Yeah. It is correct. Initially the emphasis was all about cleaning and hygiene and obviously those are key things. But just the obsession with fomites and things like that, I think we've learned that few infections really happen through that mechanism. And the main mechanism is really droplets, when I am in front of someone.

Trish Kritek:

Okay. So the main thing is droplets. Less having to worry about washing everything all the time. But we still wash things, we still wash our hands.

Santiago Neme:

Of course. Yeah.

Trish Kritek:

But we don't think fomite transmission as a main cause. John, I was going to ask you this before but Santiago is saying that about droplet. One of the questions that came up and it comes up frequently, it has for many, many, months, have we reconsidered the use of N95s for care of all patients with COVID?

John Lynch:

Yes. So due to the hard work of our logistics and supply chain teams and working with our traditional suppliers, it looks like we're going to have a better supply of N95s starting in June. Exactly which week of June, isn't 100% clear. But it looks like we have a new contract with them, it we'll be able to move back to our 1860s, 1860 Small in combination with the other respirator models we have. What that means and as we've been saying for the last year and I've been saying on town hall, is that we are going to expand the use of N95s as a result of that supply chain clarity. And so, we don't have a definitive date, but our plan is to move towards conventional status of N95s. And I'll just say this out there right now. What that means is that healthcare workers taking care of patients with suspected or known COVID-19 will be required to wear a respirator, either an N95 or a PAPR.

John Lynch:

This is going to be a big change. I want to be clear that this doesn't mean that what we've been doing in the past was insufficient. We have the data and experience to show that what we've been doing is very safe. But this is the guidance from CDC, from the department of health, labor industries and others. And it's, again, what we've said we were going to do all along. And so as that supply chain is loosened up we are going to move into that direction. When I say it's moving towards it's not completely conventional, there's still some parts around the extended use. Where you go with one N95 for an extended period of time and over more than one patient. So in a perfectly conventional status that'll be just thrown in the garbage every single time. But because we're in this for source control that can be used a little bit longer. Yeah. That's the news. A lot more is going to be coming out next couple of weeks around education and communication and affirm date for when we're going to kick this off.

Trish Kritek:

Okay. So people who've been asking that question, it is going to change. And it's good to keep asking. And it's been being assessed this whole time. So what I heard you say was when we have the supply we're going to transition to wearing a respirator, an N95 or a PAPR, for care of suspected or known cases, patients with COVID. And I think this is going to be... There will be a bunch of questions about this. So we will put it out there now and say when we come back to town hall we'll spend some more time answering questions about that because people will want to understand the nuances of that. And it's not going to happen immediately anyway. Is that right?

John Lynch:

Yes.

Trish Kritek:

Okay. So I'm going to... More to come but it's on the horizon. John, before I have you mute yourself again, another question that came up around hesitancy actually was concerns that the J&J vaccine was manufactured from fetal tissue. Is that the case?

John Lynch:

So the J&J vaccine has no fetal tissue at all. No genetic material, no proteins, nothing from a fetal tissue is in the J&J vaccine. And I think this is consistent with religious organizations that have prohibitions around this have said, "The J&J vaccine is perfectly acceptable. There's nothing in there." What people are commenting on and latching on is that the J&J vaccine was developed, some of the work that was done to develop the vaccine and this is true for many medical products, lots of medical and other research, biological research, uses cell lines. These are cells that replicate in a test tube or are similar. These are called immortalized cell lines. They can just continue to grow and grow. Many of them come from things like fetal organs many, many years ago or things like people who have cancer. You might remember the Henrietta Lacks' story. This is a cell line that came from someone's cancer and has been in labs now for many decades. Same thing happens with some of the scientific development for the J&J vaccine and other vaccines is to use cell lines like that. But to be clear, none of that is in the vaccine itself.

Trish Kritek:

No fetal tissue in the J&J vaccine or any other of the COVID vaccines.

John Lynch:

Correct.

Trish Kritek:

And the confusion is about using these immortal cells to develop them, which were used in the development of this vaccine as it was in many others.

John Lynch:

Yes.

Trish Kritek:

Okay. Thank you. I think we're going to run out of time and I want to give Anne a chance to do a little bit of ask an ID doc. But I want to ask you one more, John, I lied I was going to pivot back to Santiago. Santiago you're off the hook. There was a publication by our OB folks about increased risk of death with COVID when you are pregnant. And so one of the things that people asked is, is it okay for folks who are pregnant to follow the CDC guidelines about getting together? Even if they're vaccinated, is it safe for them to get together or are they at increased risk of getting sick? Since they're in increased risk of potentially a bad outcome, should they not follow the CDC guidelines about getting together?

John Lynch:

So I'm not super up-to-date in this. And so maybe we should bring back some experts in this. But my understanding is that people who are pregnant can mount antibody and cellular immune responses just like non-pregnant people following vaccination. So I recommend that they follow the CDC guidance. I'm not aware of any specific guidance for pregnant people following immunization, that points to

something, some different actions like we're talking about with people who may be immunocompromised.

Trish Kritek:

So nothing that you know of that says that that's a different group like the folks who are on immunosuppressing medications. I think that's reassuring and we can come back to it as well. We can do that. Thank you. With that and thank you for all the questions. I know there were some more that came in that I couldn't get to. I'm going to hand it over to Anne to ask an ID doc.

Anne Browning:

Great. And I've got Santiago with me today. We'll go pretty quick. Pandemic fatigue is real. More folks are getting vaccinated, which is great. A lot of questions around what people can do. First line of questions, life outside. Somebody wrote saying that there's a lot of peer pressure to wear a mask while working out outside, would you wear a mask while you're exercising outdoors?

Santiago Neme:

So currently we have a mandate that says that you're supposed to wear a mask outside if you're in a public space with people around you. I would say that the science now is indicating that those are very safe situations as long as you're distant. So what you're seeing is you see people running with our mask right here and then they're ready to deploy it. And I would say if I were to do this I would probably put it in my pocket. And again, we're running and then if I'm stopping or if I'm going through a trail or where I'm about to encounter more people I would probably be wearing it. But I'm thinking that we're going to evolve in this regard and we're going to make it more clear to folks. There is some peer pressure around it that I see. So that's why I want to have my mask ready.

Anne Browning:

Good. This next one comes through from my mom who actually texted me to ask my Friday friends if she knows a vaccinated 70 something person can leave her apartment and go walk around without a mask on now.

Santiago Neme:

I think she's safe to do that. I would just probably have the mask handy just in case she encounters people.

Anne Browning:

Good. Thank you. Mom will be excited. Travel, folks are really excited to travel. We said that there are more opening up within the US. Some folks really want to get out of the country. Could you imagine yourself traveling internationally this summer for fun?

Santiago Neme:

Honestly I'm not ready for recreational international travel today. And I think it has mainly to do with what's going on in many of the countries that I would go visit, including my home country. Although that might change because my aunt unfortunately has COVID and my dad just texted me that she's in the hospital. So anyway, it's pretty dynamic but I wouldn't go to Argentina for recreation or to Europe right now or India. I would probably stay in the US. And I would say I feel more comfortable with the

protocols we have here and basically with the vaccination rates that we have in the US are superior. So to me it gives me a lot of comfort to remain in the country. And we have a beautiful country to visit. So that's-

Anne Browning:

Two more quickly. Folks are wondering about their kids' extracurriculars. One person asked, would you sing in a choir, fully masked and six feet apart indoors? I know choirs in Washington State-

Santiago Neme:

My voice is terrible, I would never sing. But I would never go to an event like that today. I wouldn't.

Anne Browning:

You wouldn't want your kids singing indoors in a choir?

Santiago Neme:

No.

Anne Browning:

Good.

Santiago Neme:

I treat kids as unvaccinated low risk folks. So to me that's not a low risk plan.

Anne Browning:

Good point. Well, the last one's from me. All parents are vaccinated, two families, kids are not vaccinated, okay to have unvaccinated kids hanging out with each other?

Santiago Neme:

Well, CDC will say that vaccinated folks can mingle with another household, unvaccinated low risk. I would say it depends. I don't have kids but I would say if I know the family, if I know that they're following protocols, I feel like you'll have two low risk populations mingling. And I think that's probably fine. But we know that kids acquire COVID and we know that they transmit it. They are low risk. We know that the rates of hospitalizations are extremely low. We know that they transmit but the question is, are they low risk? And I think they are. So if I know that group then I would feel more comfortable. Yeah.

Anne Browning:

Quick, yes or no, even though Trish's going to kick me in the shins from the chat, would you travel to Israel?

Santiago Neme:

I love Israel. I haven't been since I was 18. Israel will be a good destination.

Anne Browning:

Okay. Thank you. And Santiago thanks for doing this. I'm really sorry to hear about your aunt as well. So thank you for sharing that.

Santiago Neme:

Thank you.

Anne Browning:

Trish.

Trish Kritek:

Yes. Santiago, I'm sorry to hear about your aunt as well. And your endorsement of travel to Israel. I appreciate all of the sharing today. I want to end by saying thank you, like I always do. And I want to thank everybody on the panel as always for being here. I want to particularly thank the folks who did some personal sharing about how they're moving forward at this stage. And I appreciate that introspection and the willingness to share that with all of us. So a huge thanks to the three of you and I look forward to hearing from the other members of the panel in the future. I want to thank everybody who helped make D1 not even an issue today at this town hall, one question that's pretty remarkable. And so a big thanks to everybody who was the support of D1. I am thrilled to have been able to focus on other stuff.

Trish Kritek:

I'm a little concerned that we had to focus on rising cases. So I'm going to ask everybody to really keep holding true to the stuff that John said earlier, physical distancing, wearing your masks, washing your hands. Hang in there, we're going to get there. We're getting so much closer on the vaccinations. It's in sight so take care of each other. And I just want to say a big thank you for continuing to take care of our patients and families, which is hard right now with more patients and that tension with not having families. They're so appreciative of all you do for that. And this is where vaccination plays the biggest part. We have to keep taking care of each other. So think about that as you think about making decisions about vaccination. You have inspired me by how we've all taken care of each other over the last many, many months. And I think together we can get there. So thank you and we'll be back in two weeks. Take care.