Trish Kritek:

Welcome back to UW Medicine Town Hall. It's been over a month since we've been here. And it's good to be back. My name's Trish Kritek, I'm the associate dean for faculty affairs for the school of medicine. And with me today, going around my screen are Keri Nasenbeny our chief nursing officer at UWMC Northwest, Tim Dellit, our chief medical officer for UW Medicine, John Lynch, infection prevention and employee health, as well as med tech response lead for COVID at Harborview and UW Medicine. And Anne Browning UW Medicine, school of medicine - I can't even talk today - assistant dean for well-being, Jerome Dayao, chief nursing officer at Harborview. Santiago Neme, medical director of UWC Northwest. Tom Staiger, medical director of UWMC and Rick Goss, medical director at Harborview. Cindy Sayre is away today, but we have everybody else. And it's my pleasure to see everybody back again. We have a ton of questions to go through. I have a bunch of things to ping around, so I'm going to jump right in and hand it off to Anne for a quick well-being message.

Anne:

Sure. Hello everyone. We've been going pretty hard in pandemic mode for about a year and a half now. And it's exciting to feel as though we're pivoting away from COVID response and into whatever comes next for us in our lives or at work and I'm excited for what's on the horizon and new projects, et cetera. Let's be honest I'm also realizing that I'm tired. And even though I feel as though I'm excited, I'm moving a little bit more slowly and that I need some rest. I would encourage you all to think about taking a break and whatever would be meaningful to you when you can. For some that might be a stretch of time fully disconnected from work. For others it might just be a chance to cut back on long hours in the office or on Zoom or on the floor.

Anne:

We're spread across a spectrum of folks who are ready to jump into new work. And then on the other side folks who need a little bit of a slower pace after having sprinted a bunch of marathons in the last 18 months. I would just say, try to get folks at the other end of the spectrum from you a little bit of grace as we start to recover from the long pandemic call. I hope you get some time to rest and recover and reconnect this month. Good luck y'all. Start feeling better.

Trish Kritek:

Thank you. And I do think that we didn't want everyone to, if at all possible take those downtimes when they come, it's so important. Okay. It is a new chapter and there's some interesting stuff around Delta variant. So I'm going to actually start with you, John, and let's just start with numbers here and King County and the state. And then I will tell you that the most common questions were all about Delta variant, which I'm going to ask you a bunch about.

John Lynch:

Yeah, sure. Let's get into it. So as of this morning, UW Medicine has 13 patients who have active infection. These are folks in precautions, four of them in acute care and nine in the ICU. I'll just make a quick comment about that in a second. At Harborview, oh, you have five folks all in the ICU. At least two of those people are on ECMO, the heart-lung by-pass. Montlake has one person in acute care, one in the ICU. Northwest has one person in acute care, one in the ICU. And Valley, remember those days of 40 plus patients, 50 patients? They have two people in acute care, two in the ICU. So four acute care overall, nine in the ICU. And that's just, I think a reflection of UW Medicine's job to take patients from all over the state. So that's why we're seeing so many more ICU patients.

Trish Kritek:

Yeah.

John Lynch:

Moving on to King County. Sorry, Trish-

Trish Kritek:

No, no. Go ahead. Keep going please, King County.

John Lynch:

I'm moving onto the county. About two weeks ago, we hit our kind of 2021 nadir. So the lowest rate of new infections were about 61 patients. Geez, I can't speak either. It's contagious.

Trish Kritek:

Contagious.

John Lynch:

So we were got up to 61 new cases on average over the prior seven days. Unfortunately we're now back up to 125 cases on average, over seven days. And that's just in a two-week span, hospitalizations have been pretty stable. Again, that tends to be a lagging indicator as I've said and deaths have also remained stable. So about four hospitalizations per day in King County, about one death per day. When you look at our rates, I've mentioned these a whole bunch of times, many times over the past year. King County is now at 19 cases per 100,000 over the prior seven days.

John Lynch:

That was about two weeks ago at that same time. And now we're up to 38 for 100k. So unfortunately we're kind of swinging back up. Washington State is also gone up a little bit. We're at 455 new cases per day on average, which puts us at about 40 cases per 100k over the prior seven days. But I really, really want to emphasize that as we're seeing those transfers coming in, parts of our state are seeing much, much higher rates. Benton County, Walla Walla. I mean, I've seen an article in the Seattle Times this morning are getting hit really hard. Right now Walla Walla has more people in the hospitals with COVID-19 than we do in King County, which is a complete flip of where we've been for most of the last 15 months.

Trish Kritek:

I think you're reflecting what people are hearing in the news. And I think what's causing more anxiety as we hear about more cases across the country and then in parts of our state. And even, I guess, locally, I will say it was the first time I was just down in the NICU for two weeks at Montlake. And it was the first time I didn't have any patients with COVID during that two week time period, which was notable. I haven't had that since a year and a half ago, so that was palpably different. And I hear these numbers about things are creeping up here and in lots of other places. I think relevant to that, what we're hearing in the news and the question that the start of the questions is, do you have a sense of how much of that is Delta variant?

John Lynch:

Yeah. So I just want to bridge from your last comment, Trish, because I do want to also remind people, if you look at our total of patients 13 or so, there's another 13 or 20 folks who have dealt with their acute COVID illness, but are still in our hospitals and even in the ICU, or maybe even on ECMO. So the burden is still there for our healthcare workers whether they're acutely have COVID or in that COVID recovery phase. Yeah, so Delta, so Delta is one of the three big variants concern that we've been talking about. These and the one you've been hearing about in the news, I just want to remind folks that if you look at all the sequencing done at UW Clinical Virology Lab, all the sequencing is done at Washington Department of Health.

John Lynch:

The vast majority of all of the sequences out there, are one of the top three are the three variants of concern. So if you're in Washington State, you're getting infected, it is very likely for you to getting... Remember the P1? The B117 or the 1617.2 which is the Delta. So that's what we thought we're worried about, and it is what's come to pass. And as of the last couple of weeks, Delta's really taken the most majority. So right now, if you look at the state we're about 40% plus of all of the isolates are Delta and the UW Clinical Virology Lab is about 32%. And I'll point out that, so they do a report every two weeks, the prior two weeks a report, they were at 20%. So it basically doubled in a course of one and a half weeks.

John Lynch:

And remember even that sequencing data is offset by a couple of weeks. So it's looking at data from a couple of weeks ago. So I would anticipate right now that we're well over 50% of all the sequences in people with a positive test are Delta. And this just goes to the, supports the fact in the science that we know that this is a incredibly transmissible virus. And new data just came out showing that people with Delta infection have 1000 times more the viral loads in the respiratory track and is probably one of the major reasons why it's much more transmissible right now.

Trish Kritek:

Okay. So we're thinking we're probably, we don't have the numbers yet because the numbers lag we're probably at about 50% of infections are Delta. And as you said, it's more transmissible probably because people are carrying more virus. That was actually one of the questions people ask, which is in the kind of, we had said if you're in a room in close contact for 15 minutes or something like that, you're at risk of getting COVID. Is it like, you didn't need less time with people or can you make it tangible that way for folks?

John Lynch:

Yeah. So let me put it this way and I don't want to be a downer at all, but I would argue that for an unvaccinated person now in July 2021 is different than being an unvaccinated person in July of 2020, when we're all unvaccinated. If you're unvaccinated right now, you're dealing with a virus that is incredibly transmissible. And that has, I think, a very high probability of getting around some of the things that we've put into place. If you're in a tight quarters, in a poorly ventilated setting, I think a mask is going to definitely help, but it's not going to have the same power as it did last year. If you're wearing a mask or if you're not wearing a mask and it's unventilated, I think you're going to be in a much more difficult situation than we were a year ago.

John Lynch:

It's not that this virus, as far as we can tell, makes you sicker. It's just that it infects more people and the more people get infected, the more sick people we're going to see, more people going up in the hospital in the acute care, in the ICU, in emergency departments and clinics. And unfortunately because of the way vaccination distributions working, it's most more young people. And that includes little kids.

Trish Kritek:

Okay. You've led into a bunch of follow-up questions that I have. So the first one is just to summarize what you said, it is that this is so much more infectious that the usual things we do like masking and distancing aren't as effective potentially with this variant as they were before if you're unvaccinated. People did ask, are we seeing increased rates of infection in kids 12 and under the ones who can't be vaccinated? So do you have a sense of the numbers on that?

John Lynch:

Yeah, so I don't have the numbers on that. I did reach out to colleagues at Seattle Children's Hospital and our own Dr. Helen Chu, maybe I'll hear in the next hour or so via email. When I look at the state data, I don't get a good... I wasn't able to get a quick breakdown, but I'll keep looking while we're talking. But I know talking nationally to colleagues across the country, they are seeing this happen. And I think it just goes to the point that we're dealing with sort of a twin pandemic, a pandemic of Delta and a pandemic of the unvaccinated as Dr. Walensky who heads at CDC phrased it, if you're unvaccinated right now, whether by choice or because of age or medical condition, this virus puts you at risk.

Trish Kritek:

Yup. And worse risk than before. So I want to follow up on the other thing that you said and before I talk about breakthrough cases. Because I know that people are particularly interested in that, but just for clarity, is there a difference in mortality in patients who are infected with Delta compared to patients infected with the wild type or the original virus?

John Lynch:

So I would say that there's echo poise. We don't know the answer to that question. Right now it looks like that there isn't an increased mortality rate with this variant of concern. But I think the researchers, deputy meteorologists are still looking into it.

Trish Kritek:

Okay. So not definitively, yes. It doesn't look like it right now, but we don't know, we don't have enough experience to be definitive about that. Is that fair?

John Lynch:

Correct.

Trish Kritek:

Okay. And then do you get any different symptoms with the Delta variant? Are the people having different manifestations of COVID with Delta?

John Lynch:

So it looks like all of the symptoms are very similar. I think one of the things we're starting to get a handle on though, is that the rate with which people develop symptoms, maybe this is still early phase may happen faster. So instead of having a week or so from the time of exposure to the time of symptom onset, it seems like it's happening faster. And this may be linked to that exposure, the amount of virus it's coming from one person to the next. And so when you get a lot of virus, the chance of you developing an immune response and symptoms is just happens quicker. Again, still early days on this. But definitely it's implications because we know the symptomatic phases when you have the most virus and potentially the most transmissible, if that happens really fast after an exposure, you can see how this can amplify through a population even quicker.

Trish Kritek:

Okay. So same symptoms, but it seems like we're not sure yet that you might have them faster because you get more of a load that you're exposed to when you get infected. Okay. So I think we've heard that obviously in lots of different spaces that the vaccines are effective against Delta in terms of getting sick. I think we're also hearing about breakthrough cases. So maybe you can talk about breakthrough cases and the efficacy of the vaccines in general for Delta, because obviously we're now making people concerned and they were already concerned, but we want to talk about vaccine efficacy and breakthrough cases.

John Lynch:

Yeah. So just a reminder, these vaccines are amazing and they're doing a great job against all the variants of concern. The most important tool we can use to interrupt transmission of any SARS-CoV-2 virus, any of the viruses these variants that cause COVID-19 is to get vaccinated. They are very, very effective against all of the variants, including all the ones I talked about, including Delta right now. That includes both the mRNA products and the Johnson & Johnson vaccine. Maybe a couple of percentage points difference in terms of their efficacy, but when you're dealing with the level of efficacy and effectiveness of these vaccines, they're still fantastic. And so if we're worried about Delta, you want to be protected against Delta. The most important step you can take right now is to get vaccinated.

John Lynch:

And I'll just point out when you look at those, what we're seeing across the country with the big outbreaks, particularly in the Southeastern United States right now, which are predominantly Delta, 99% of the people in the hospital, I repeat that, 99% of the people in the hospital are unvaccinated people. And just again, supports in the real world how powerful these vaccines are.

Trish Kritek:

All three vaccines that we have are effective against Delta. 99% of the people admitted to hospitals are unvaccinated. And I'm going to ask you to talk about this a little bit, John. We hear in the press about the Yankees who were vaccinated, who got infected. We hear about people who have gotten infected. So do you have a sense of the rate of breakthrough cases? And then you can distinguish between cases and people who get sick and need to be admitted to the hospital post vaccination with Delta.

John Lynch:

Yeah. So we have, it is extremely hard to give you a rate because what you're looking for is the number of people who are vaccinated, who have COVID over the number of people who have been exposed to COVID and we don't actually know that number. And so what I can tell you is we look at healthcare

workers who have been vaccinated. The rate of infections is extremely low. And I think we've had one, maybe two folks in UW Medicine who have ended up in the hospital with moderate symptoms. No one in the ICU and certainly no deaths. When all the rest who have been infected have very mild symptoms sniffles, a cough, sore throat sort of thing. And fortunately gotten tested.

Trish Kritek:

So what we know is in our population, there have been some infections, but they've been in general, very mild, relatively rare, maybe two people who've been hospitalized, nobody in the ICU. So that ability to mitigate severe disease is bearing out here pretty clearly in our population. Is that correct?

John Lynch:

Yup.

Trish Kritek:

Okay. I'm going to ask you-

John Lynch:

And an important part of this as the more people get vaccinated if you didn't have the same proportion from getting infected, that proportion, that number gets larger, right? So in some ways it's just a reflection of how many people are getting vaccinated as well.

Trish Kritek:

Okay. I'm going to ask you two more questions and give you a break because there's a lot of these questions and I'll probably have some more follow-up later. But the first one is because of people's concern about Delta, there are a lot of questions about what about a booster shot? When should we get a booster shot? What are the data for booster shots? I'm worried about this is what I read in the questions.

John Lynch:

Yeah. Unfortunately Pfizer has sort of set up a bit of confusion. So as folks have seen in the media, Pfizer has applied to FDA for a booster shot on the public health epi sort of vaccine expert world that the folks I've spoken to and read about. There are no data to support the use of a booster shot. There's no plan to use a booster. And the CDC and FDA came up with the national communication, the exact same day that Pfizer submitted that FDA saying we do not recommend a booster shot. So as it stands right now, no recommendation from public health authorities or scientists to get a booster shot. Now, there are scientists at the University of Washington who are looking into this question, it's a reasonable question, but scientists should ask it and study it before we make any recommendations.

John Lynch:

And there, I probably think the most proximate, the most likely area where this may have some benefit and there's a signal are people who are very immunosuppressed. So folks, for instance, who have a solid organ transplant, a kidney transplant, a liver transplant, maybe some types of cancer chemotherapy or maybe, and or maybe some folks who have for instance, rheumatoid arthritis or getting a specific type of immune suppressor drug. So those are three possible groups and the CDC and their main group that looks at this are, I think, have public documents out, the data's out there for them to review. And I think

it'd be meeting on it in the next week or two to at least talk about it. Again, those are all available documents, but as it stands right now, no recommendation booster, and not even a signal that one is needed at this time outside of those very specific recommendations.

Trish Kritek:

Okay. So no plans for a booster right now for the general population. Studies ongoing, we'll learn about it as they do their studies. And the one patient population is the severely immunocompromised group where maybe a booster will make sense. And we'll hear more about that potentially soon. Last one, and I think this is the one that's making people really nervous is kids. So any updates on when we might think there's a vaccine available for the 12 and under folks?

John Lynch:

Yeah. I don't, I would look to anyone. My co-panelists here, I've looked and looked. I've heard stuff all over the board. I was really hopeful for it before the end of the summer. But it looks like now probably a bit later. It's been interesting when we look at Pfizer, Moderna particularly, all of a sudden you go from one week here and nothing to the next week saying FDA submission, and then that may happen. But as it stands right now, I don't see any strong signals that we're going to see action on that topic this summer. So alright folks I would love to happen, but I don't see it right now.

Trish Kritek:

Okay. Not yet. And I didn't see Tim or Santiago unmute to say something different. So I think the answer is it's still, we're still waiting to learn more and it doesn't look like it's imminently on the horizon, which I think is I get it it's just stressful for lots of folks right now.

John Lynch:

Yeah.

Trish Kritek:

Thank you for answering all those questions. And like I said, there's more that have come in. So I'll come back to it I think if I have time. Tim, I'm going to turn to you as we have this conversation about Delta. I think the tension people are feeling is we're also talking about wearing masks less. And one of the questions, many of the questions actually was about where can I not wear a mask within our UW Medicine system? And there's the whole kind of health sciences, is it okay? Sounds like union. If I'm not in a clinical space, if I'm in an office. So what's the guidance on masking right now across UW?

Tim Dellit:

Thanks, Trish. It's a very good question. As everyone has seen the University of Washington earlier announced that they were transitioning to where if you are vaccinated, then you don't need to wear a mask again, that was outside of the healthcare setting. And so within UW Medicine, we have our clinical environment, right? Our hospitals and clinics. We also have a large nonclinical environment, our school of medicine, particularly the research labs. And we have worked collectively with our infection prevention colleagues to help define those areas. But one of the key pieces here is that in order to be without a mask, we have to know your vaccination status. And this is a requirement by labor and industries here within Washington State. And so we're also trying to work on what is that process to be able to verify the vaccination status of our employees so that if you are in a nonclinical environment that

you potentially could be without a mask. It gets complicated because we still have a number of individuals within UW medicine who are not vaccinated.

Tim Dellit:

And when you don't know everyone's vaccination status, it's very hard to then say, "Okay, don't wear a mask." And so we're moving in that direction. We've been looking at updating our policies, the messaging, but the key piece is the process by which we know the vaccination status. Once we have that as an example, within the Montlake campus, it would be distinguishing between the hospital and where UW medicine or UWMC Montlake ends and where health sciences begins. And we do have detailed descriptions for that, and there will be signage, but the first step is really to know the vaccination status of individuals. I will also say because of this Delta, it's interesting watching around the country UCSF, just as an example reversed their decision about allowing vaccinated individuals to not wear masks, even outside of the clinical environment, where now, regardless of vaccination status, if you're anywhere on their campus, you have to wear a mask.

Tim Dellit:

And that's just because of what they're seeing locally and the concerns in California, LA County did the same thing with indoor masking now. So we're in this little bit of a period where I think we're all been looking forward to being able to gradually move in the non-clinical areas to not wearing masks, but we really got to pay attention to what's going on. As John said, we've seen a doubling in cases, now we're not seeing an increase in hospitalizations yet. We're not seeing a change in deaths. But it is something that we have to continue to monitor here. And we're not out of the woods with this by any means.

Trish Kritek:

Yeah, I hear you. Can I ask a clarifying question? We got an announcement that says, this is the policy now. So if a group is in an office space and they know everybody is vaccinated, and it's a nonclinical space, can they go without masks at this point in time?

Tim Dellit:

UW Medicine has yet to formally change their policy or provide that messaging because of waiting to have that vaccine verification. The other piece here is that we have to do it in ways so that the supervisors know of their individuals who is vaccinated or not. But we want to discourage from actually asking colleagues, "Hey, what's your vaccination status?" Right. So there's a tricky balance there that we're trying to walk. And in fact, if you look at the university overall documentations and FAQ's they say you should not be asking people what their vaccination status is yet at the same time, we have to know what that is to allow people to be unmasked.

Trish Kritek:

Okay. So I think the take home, if I'm hearing you correctly, is we haven't actually changed our policy despite the email that we got from the university, until we get to the place where we know if people are vaccinated or not, we should be sticking with the masking. Is that right?

Tim Dellit:

Yes. And I'm looking to John and Santiago, I think we're-

Trish Kritek:

And they're nodding.

Tim Dellit:

... We're getting close, but I think it's just, we've got to have all those pieces in place before we can truly make that transition, but we're optimistic here in the near future, unless the situation changes where we need to reconsider. But I'd like to maybe hear from John or Santiago to make sure I haven't misstated anything.

Trish Kritek:

John, would you like to comment?

John Lynch:

You've stated right. Yeah. So I'll just say that announcement you referenced, Trish, does say accepting health centers and childcare centers, and this issue around knowing everyone's vaccine status or a supervisor being able to say, "Yes, you may go unmasked in those settings." We don't have that piece in place yet. We will. But I have to say over the last week and a half, I want to just acknowledge that this Delta surge has moved much faster than I anticipated and is having a much bigger impact than I thought. And I am very concerned about what it's going to do to obviously our country, the rest of the world, but also our state and our health system. And I think we need to be very cautious right now. I understand that the enthusiasm, I want to take my mask off, I want to meet and all that sort of stuff. I think we got to be really cautious now and not back off too fast.

Trish Kritek:

I hear you. And I think that's really clear. I just want to say, if you walk into health sciences, it is as if the rule has changed already. So we probably need to make sure that we're really clear on our messaging everywhere we go, because in health sciences, people are not wearing masks. I think they're doing that because they heard, they read that email that you just said, John, as clinical areas or childcare spaces, but that is not the case once you cross further downstream in health sciences. And I think that's the feeling in a lot of spaces where people are doing research because it's not a clinical space and maybe we just need to be really clear in our messaging across UW Medicine where we stand on that one.

Tim Dellit:

Yeah. And I just want to emphasize it's a little bit tricky because I don't want the people who are in those labs to think that they're doing something wrong either because they're following EH&S. They're following who they normally follow for their employee health advice through the University of Washington. And it is in a nonclinical space. So although we're in some ways we're very focused on all of our individuals within the clinical space and what they do when they move back and forth between the clinical and the nonclinical. But there are individuals who've never come into the clinical environment and they are technically following the overall university process. It's a little bit of an uncomfortable situation now I get that, but I wouldn't say that they're doing anything that they're not supposed to be doing in the sense of following the overall university guidance outside of that clinical arena.

Trish Kritek:

Yeah. I think it's leading to some tension of kind of where we stand and I hear John saying, let's be on the cautious side. It's just, we're a little bit in a space of a mixed message for folks. But I think we can keep messaging as we move forward. And it sounds like we're going to know more about what's going

on with Delta in the near future. And that may impact things like it has in California. One more question, Tim, relevant to this before I move on to some other stuff. You said we don't know how to know if people are vaccinated. One of the questions people ask is, are we thinking about in any way identifying who's vaccinated in any kind of public way so people would know, is that something that's on the table or is that something that's not on the table?

Tim Dellit:

I think it is something that's on the table. We've been having some initial discussions both through our med tech group with leadership, with HR, thinking about how we potentially could do that so that it's more easily identifiable who is, or is not vaccinated. And that's part of the process and plan that John's alluding to in terms of do we have that in place before we formally change the policies.

Trish Kritek:

Okay. And would that be a way that a patient would know that you're vaccinated or is that a way that your supervisor would know you're vaccinated?

Tim Dellit:

Good question. I will look again at John just to make sure I don't mistake. It depends on how you identify those individuals and we've discussed different options. I'm not sure where we finally landed, or if we've gotten to that there been different ideas of, do you just have a certain color sticky that's on your badge that is kind of internal knowledge or do you actually have a button that says you have vaccinated?

John Lynch:

Yeah. And so Tim's right we're still in the discussion phase, working with the labor relations folks and our AG and human resources to make sure that we're doing everything-

Trish Kritek:

John is in Reno because his daughter is in it. You're kind of on a slow feed. So I just want to acknowledge that you're celebrating your daughter’s making it to nationals. And thus, you're doing this from your hotel room, which we really appreciate. And thus you sometimes sound slightly slower speaking than your normal self. So I interrupted you. Go ahead. What were you going to say? We're still sorting that out I think is what you said.

John Lynch:

We're still sorting, we're talking to human resources, labor relations, AGs office, everyone around how to do this. So conversation is ongoing.

Trish Kritek:

Okay. Well, I think we'll need, obviously we'll want to hear more about that. People are curious how we know, and I think people want to know, and also we want to be honoring people's privacy and trying to figure out where that space is. So thank you for sharing. I'm going to pivot to Santiago and I'm going to ask Santiago vaccine clinics. I'm going to ask, first of all, this, and I'm going to go out of order of what I had planned, but are all our vaccine clinics now closed or are they closing? And if so, when?

Santiago Neme:

Yeah. Thank you, Trish, first of all, a big shout out to our vaccine teams all over the system. Really amazing effort in vaccinating greater than 351,000 people which is insane and in a great way. So thank you so much to Cynthia Dold, Jenny Brackett, Shireesha Dhanireddy and everyone else, all the managers. But yeah, we've been in the process of closing down and transitioning what we've been calling decentralizing this operation and early this week, for instance, we closed the Montlake clinic, the Northwest clinic. Harborview remains open on Saturdays. And the plan is to really decentralize and already at this moment, we have more than 20 clinics across our system that are all of the primary care clinics, some specialty clinics at Harborview and Montlake the ID clinic, for instance, at Northwest my clinic where we're doing this. And this was the first phase and there's going to be a next phase where we continue to expand the vaccination process at more clinics.

Santiago Neme:

And so a lot of work on that and that's gone really well. Thanks to the work of Jenny Brackett and the whole operations team. So that's currently where we're at. I understand that some folks, we're talking about boosters, we're talking about potentially needing more vaccines, more boosters in the future. So thankfully our vaccine has really come up with contingency plans. Should that need occur? If anything we've learned from our vaccine team is that it's extremely agile and focused on making this work. So I have 100% confidence in that we will have a mechanism to get everyone revaccinated if that's what the data and the recommendation show.

Trish Kritek:

Okay. And I'll add my kudos to the vaccine team. And so basically everything's closing down other than Harborview of Saturdays, and we're decentralizing, I'm going to come back to that in a minute. But if I was a staff member who now says, or an employee of UW Medicine who now says, "I would like to get vaccinated." Where should I go?

Santiago Neme:

So we have the clinics again, all of the clinics. And then we also have the ability to go through employee health as well. Yeah.

Trish Kritek:

So I could go through employee health if I decided I was ready to get vaccinated.

Santiago Neme:

Yeah.

Trish Kritek:

Okay. That's important for our staff to know. I'm going to pivot, I'm going to come back to you in a second Santiago, but I'm going to pivot to Tom and Rick and ask about inpatient and outpatient asking for vaccines or more importantly, perhaps having conversations with patients and then deciding they want to get vaccinated. So I guess I'm going to start with you, Tom. Maybe you could talk about if you have an inpatient and that person says they would be willing to be vaccinated, what we do. And then if you were in clinic, because you have an outpatient practice, how you make sure that patient gets vaccinated.

Tom Staiger:

At UWMC Montlake this week, we just started a process that the physicians, medical staff can contact either a nurse care coordinator if they have one on their team to make arrangements to have someone come up and do a vaccine, or they can email Lindsay Boyd who's done just a fabulous job in helping us with our vaccine effort to have arrangements made for a patient to get a vaccine. And that was sent out to all of our medical staff this week and will be an update in a couple of hours. My understanding is something similar has been, or is soon to be started at Northwest. And that Harborview is in the process of making similar arrangements.

Trish Kritek:

Before we go to the outpatient, Rick, do you want to comment on inpatient? Is that right at Harborview?

Rick Goss:

Sure. Yeah. Pretty similar. At Harborview, if a medical team wishes a patient on the inpatient to receive a vaccine, there is a contact on the continuity of care team who will work with the clinic staff who will then on an individual basis, go from outpatient to inpatient and provide that I believe five days a week, all the while, while we're building that infrastructure to have it done more routinely through the inpatient.

Trish Kritek:

Okay. So it sounds like right now we have kind of backup systems to try to make it happen. And I want to encourage everyone to look for the emails from the leadership at both the hospitals to know how to do that, because there are opportunities to get folks vaccinated when they're inpatient. I think there's more opportunities in the outpatient setting. So, Tom, outpatients at UWMC how would they get their vaccines now?

Tom Staiger:

So there's, as Santiago said, there's 20 clinics across UWMC, UWMC Harborview that patients can obtain COVID vaccines from three routes that I'm aware of. One for patients 18 years old and older can make appointments through their MyChart app. There's a phone number that we've been using for a while for vaccination appointments, 844-520-8700. Or people can go to the uwmedicine.org/schedulevaccine portal and schedule there and failing all of those, they can ask the front desk of the clinics and then they'll steer them in the right direction.

Trish Kritek:

Okay. So it sounds like a lot of different ways to schedule it through MyChart, through this number that I'm typing into the chat right now. And I hope I'm typing it in correctly. And someone's going to tell me if it's right and as well as online, all those are options. I think this is one of those things that maybe we have an opportunity to share with our whole community. Because I got a bunch of questions from providers saying I want to get my inpatients and my outpatients vaccinated. And I think listening to John earlier talking about it's about being vaccinated. I want to just make it as easy for our providers as possible to get those done. I will just tell you my personal experiences, I was on in the NICU and I had a patient who we persuaded to get vaccinated who was vaccine hesitant, and then we couldn't figure out a way to get the vaccine to her. So I really think it's super important that we share this with everybody.

Santiago Neme:

Trish, one thing to that.

Trish Kritek:

Yes. Please.

Santiago Neme:

Just because it's so dynamic and for instance, yesterday, I was talking to Michael Alwan our director of pharmacy at UWMC, there's a lot of planning to really improve the fluidity and the flow are those administrations. So since it's pretty dynamic I'm wondering whether we can talk to Glen about having that on the huddle or something posted rather than the emails. So then we know the current status because it's going to continue to improve.

Trish Kritek:

That's a great idea, Santiago, and I know they're working on an Epic billing. I'm going to talk about Epic in a minute for a second. But before I leave this topic, I want to actually ask you, I said, I had a patient who was vaccine hesitant, and we got a camp full of questions about what do we think are the best resources to share with patients to use and talking to patients who are vaccine hesitant that have data or other information? So I'm wondering if you want to share and that if anyone else has other information that they are using for patient education and patient conversations, that would be great.

Santiago Neme:

Yeah. So the huddle actually has a nice layout where you can see the data first and then you see an FAQ. Now there's a document that doctors Lisa Chew, Shireesha Dhanireddy and the equity, the vaccine equity group had put together that's a really detailed FAQ that we use as one of the guidelines whenever we go to a prison or a jail or somewhere, and we talk about vaccine safety, it's an excellent document that keeps getting updated. So I was talking to Lisa Chung, and we're going to ask Glen if he could post that on the huddle as well. Again, these are changing topics, but I would say that the most important message is the fact that you see that 99% of the patients being admitted are unvaccinated and the vaccines are effective at this Delta variant and all the variants of concern as John said, and the fact that we have seven months of data on safety, including pregnancy and their babies. So I think that it's something that we should all engage and spend some time because it's really worth it.

Trish Kritek:

Yeah. I hear you. And it sounds like we're going to try to post some more resources on the huddle for folks. Are there any external websites that you think are particularly useful or John or anyone or Tom or Rick, if maybe you've used them in patient interactions?

Santiago Neme:

CDC has some great materials too that maybe we can link to that and actually multiple languages. Dr. Walensky has some beautiful videos. They're short, they're only in English, but closed caption. So maybe we can work with comms and make sure that we upload those.

Trish Kritek:

Okay. That's great. Thank you. I appreciate it. I think we have a lot of folks in our community who want to help the effort to just answer the questions, listen, try to understand and want the resources to help that. Thank you. Keri and Jerome, I've ignored you for a really long time. I wanted to ask you about visitors and actually the questions that I got were about children and visitors. I'm not sure where we

stand with children and visitors. So Keri, I'll ask you first and then maybe I have a follow-up question about visitors.

Keri Nasenbeny:

So the policy, as it stands now, children are allowed to visit. They have to be with an adult though, so they can't visit on their own. So we have one to two visitors, so it really kind of depends on the space that that patient isn't on the inpatient side. So if it's a patient in a double room, we're still only allowing one visitor. So, and that space, we probably wouldn't have children visiting because they can't be unaccompanied and a private room where you can have one to two visitors, potentially your child could come visit with their parent. In ambulatory settings it's still just one visitor. And so I think potentially you could have a child come with an adult in that setting.

Trish Kritek:

Is that okay if the adult is the patient, can they bring their child? Is that within our guidelines right now?

Keri Nasenbeny:

Our guidelines are a little bit vague. And so actually I looked at others, but that's my understanding is that you can bring one person with you.

Jerome Dayao:

Right. For as long as the child is within the control of the person that's bringing this child. I mean, what we're trying to avoid here is what Keri is saying is that the nurses or the clinicians aren't the one that's going to manage an additional visitor through the child. I mean, as the visitor, so that's what we're doing.

Trish Kritek:

Okay.

Santiago Neme:

And the child over two needs to be masked.

Keri Nasenbeny:

Yes, thanks Santiago. That's exactly right.

Trish Kritek:

Child over two needs to be masked. Can bring a child if they're under the control of the parent as two people on the inpatient setting, but maybe even in the outpatient setting, if the child's with the parent who's getting care if they're under their control, they could bring them. Is that right?

Keri Nasenbeny:

Mm-hmm (affirmative). That's my understanding. Anybody feel free to correct me on this.

Trish Kritek:

Nobody is correcting you so I'm going to go with that. Someone will type in something into the Q&A or chat if we're wrong. Jerome, I'll ask you this. How about incorporating vaccination status into visitation? Is that something that you've talked about as part of the visitor policy or is that something we're considering?

Jerome Dayao:

Well, I think all of us are in one of four that we'd like to continue to explore that, but right now, as it stands, it's so difficult for us to validate who has received vaccines outside our own employees. I mean, even just validating that within our own employees is already one of the challenges that we know and recognize to be very real as we implement this. We are however, looking into other innovations, such as the electronic at the station that would be coming out pretty soon so that people or individuals may be able to self-test and do that before coming into the campus. But more work is happening on that. But with regard to your question about vaccination, it's just so challenging, Trish, to determine who has vaccines and do they show their proof? I mean, what kind of proof all of those other questions need to be answered.

Trish Kritek:

So it sounds like logistically really challenging to do it that way. Sounds like self-testation is on the horizon for visitors. So we'll be looking for that to be rolling out in the near-ish future, maybe. Okay. I'm actually going to ask Keri and Jerome, after I ask Rick, there were actually a handful of questions about Epic, which I know is totally different than what we've been talking about, but I want to honor the questions that we get. So Rick, and then Keri and Jerome the same question is going to go to you. Where do we stand with updates or changes to Epic to make it easier? Because I think we said we were going to do updates and there's going to be the next iteration. So do you have a sense of where we stand with that?

Rick Goss:

Sure. Well, I'll give you my impression and just as we're in this ever-changing landscape, that is COVID, we're also going through major changes in our adoption of Epic. And I think we've all gotten through that first major rollout and are anxiously working on this term optimization and upgrades and so forth. There are a lot of categories. There are a lot of buckets of activity we're working on cores and the white board, there's validation questions. There's the in-basket and documentation and charge capture, and many others. I think what I would just say, I think from my standpoint, I think representing a lot of the leadership, medical leadership and others is that whenever I speak to our IT leaders Dr. Burstein in particular for me, whom I talk to probably a couple of times a week, one of the things I'm aware of is that team is really hearing those concerns.

Rick Goss:

So whenever I say, this is what I'm hearing, I'm reassured to know that Dr. Burstein and others has heard the same thing. And in virtually every example, I get the answer. We have a team, we're meeting, we have dates, we have goals and more is going on than even I'm aware of until I ask those questions. So I think if there's a barometer that we are in fact working toward optimization, that's the way I gauge that. And then of course, we're always looking for those milestones, those breakthroughs. I'm optimistic, even though I know this takes a good while to sort through.

Trish Kritek:

Okay. So a lot of work going on behind the scenes, people are hearing about the challenges. I'm going to ask a follow-up question, but Keri and Jerome, are there areas that you know that they're particularly emphasis for nurses? Because I think some of the questions were about nurses and all the clicking that they have to do right now.

Jerome Dayao:

Right. So there is an active group that meets regularly on optimization with regard to the processes and work flow. In fact part of the optimization efforts, I see we have the whiteboards optimization infusion, GI endoscopy, training, security and analytics. And these are the bigger buckets that are being worked on and looking at the timeline I mean, it's a very robust report that the Epic group produces and gets sent. It talks when do we expect to have all of these optimization and what are the upcoming optimization? That includes surgery, procedure, suites discharge processes. So they have all of these sorted in buckets. And from that timeline, I can see until the end of the year, we have a lot of these efforts on building a pathway.

Trish Kritek:

Okay, Keri, did you want to add something? I don't know if you want me to-

Keri Nasenbeny:

I guess just the only thing I would add is that there's also a lot of work going into the upgrade that's going to happen this fall. So there's a major upgrade where we're going to skip forward three iterations of Epic this fall. And so a lot of resources, and I think that will fix some of the bugs that we have and issues we have and help move the system forward. So that's the other, and the only other piece I would add, I would echo everything that Rick and Jerome said a ton of work going into stabilize, optimize and improve the system.

Trish Kritek:

Tim, I'm hoping you're going to tell me when this upgrade is going to happen.

Tim Dellit:

I also want to say that the EHR is not a static thing, meaning it's going to be continuously improved as we go forward. There are absolutely a number of what we refer to as sprints, where we have committed teams focused on whiteboards or focused on infusion or GI endoscopy, where we know there are issues, transplant is another good example. The upgrades, I believe are going to be occurring in the fall I think in the November frame, they are not going to be nearly as big of a change as the goal life was. I don't want to alarm individuals. Much of this is just upgrading to newer versions, not a lot of noticeable differences. There'll be some things, and we'll certainly message on those. But for many of those it will be things that people won't even see honestly, but we need to do that to be able to catch up so that we have the most current versions as we're going forward.

Trish Kritek:

Okay. So big upgrade in November, which I'm going to cast as it's going to be a good thing and nothing like rolling out and maybe make things better. How about that? And lots of teams that are ongoing work and rolling stuff out to improve things as Rick talked about and Keri and Jerome alluded to. So I guess, and people can keep telling us if there's issues that they have. Yes. Is that true? I'm going to say it's true. Keep sharing if you're having issues.

Tim Dellit:

And I can tell you, I meet now weekly with the Epic leadership back in Madison on some of the issues around our charge capture, what's happening on the inpatient side, radiology, the OR. So we absolutely have their support and attention and they realize some of the challenges. Now, again, a lot of this is not unexpected, right? I mean, this is just part of any go-live. Each organization has some unique challenges but we actively are addressing all of those. And we very much appreciate some of the challenges that people have had in these different areas.

Trish Kritek:

Yeah. It sounds like a lot of concern to work in the areas that are the hot spots, more to come and an upgrade in November. Thank you. I'm going to hit John for a couple of quick questions before I hand it off to Anne for ask an ID doc. So John, these are just some random ones that came in. What about, where do we stand with eye protection, which I think hasn't changed, but the question is here, and I'm just curious if there's any intent to change that at all. And then we can decide if we keep asking.

John Lynch:

Yes. There is an intention to do that. We're redrafting the policy now to transition to requiring eye protection based on a patient's transmission-based precautions. What I mean by that is if a patient is in aerosol contact precautions, like for COVID, if they're in droplet contact precautions, like for influenza that eye protection would be required in those settings, just like it always has. But I always want to remind folks that in standard precautions, routine precautions we use for all patients at the beginning, that eye protection is also required when you may be exposed to a blood or body fluid. I'd also say if you're doing a nebulizer, if you're doing any type of procedure where you may be exposed at any aerosol droplet, anything, wearing our protection is really important. So places like the emergency department, probably really good idea to wear eye protection all the time, because you never know when it's going to happen.

John Lynch:

You don’t know what the symptoms are that are bringing people in. Similarly in primary care, it makes a good sense there too. Or any specialty where you routinely unmasked patients, right? Where that could happen or you're looking in their mouth or their nose or similar, these are all settings that are consistent with standard precautions. I just always like to remind people of that because we've historically seen challenges that we recognize that people hate eye protection. And we recognize that we're just not seeing people do it. And so instead of me walking around asking everyone to put their eye protection back on and spend the rest of my life doing that, we're going to try to find some pragmatic solution and roll back to it the way we've historically.

Trish Kritek:

Okay. So we're going to be rolling back eye protection, but you still have to be thoughtful about the fact that there are lots of places where eye protection is important. And so I think in all seriousness, I still have mine and I wear them. And I think people will be happy to hear that. I want them to also hear your guidance, that there are reasons to keep thinking about eye protection in many different settings. So thank you for answering that. Last question for you is have we changed the spacing requirements, like in break rooms? Have we moved to having more people in spaces or are we still staying with the same constraints on numbers of people in spaces?

John Lynch:

Yeah, so I think this may come up as well with the University of Washington upper campus guidance, where they said distancing is no longer required. I just want to remind everyone for clinical settings. And when I say clinical settings, that's like the hospital and everything in the hospitals, the UWMC footprint, the Harborview footprint and so forth. Regardless of what's being done in different rooms. Those footprints are regulated by labor industries and department of health. And it is very, very clear that they're still expecting us to distance as part of our normal practice when possible. Things like masking are and other tools, ventilation are all mitigation tools. And distancing is one that when possible is still a requirement. So yes, no changes.

Trish Kritek:

So distancing stays the same, numbers per room stays the same, just to be really clear about that.

John Lynch:

Correct.

Trish Kritek:

Thank you for clarifying it. I'm going to answer one question myself, because I asked everyone this last time and no one could answer. So I took it on myself to try to answer it. Health Sciences shuttle. I had a nice conversation with their manager today and here's the deal, masking is going to be required and actually they are going to let up on their distance thing. So they're going to let more people on the shuttles. There will still be three shuttles that go from on the Health Sciences route, which is down one from their four. So it's still a 20 minute shuttle, but they think there'll be more capacity. South Lake Union is two shuttles here and from Montlake to SLU and one from Harborview, that's one less than usual for the UW route. And they think they probably will go up on that route, but not yet.

Trish Kritek:

So some improvements, not back to totally normal yet. They're going to see how much business there is, and then they will move back towards totally normal if they need it, if they don't have to have as limited seating on the certain shuttles. And I really appreciate John who taught me a lot about the Health Sciences shuttle today. Thank you. And with that, I'm going to pass it to Anne for ask an ID doc.

Anne:

Sure. I get to hang out with Tim here for the next little bit. It seems like a lot of the questions that are coming in are ones we've heard asked before, but what we live with is this changing context. So I'm just going to put this out as kind of three overarching questions for you Tim. And the first one and note I will kind of be like, what do you think going forward with Delta will be the follow-up. So we'll start just, how are you living now? Are you going out to restaurants? Are you traveling? Are you masking? What are you doing right now as things have reopened?

Tim Dellit:

Yeah, I haven't changed a whole lot. There are some things, for instance when I walk now with a dog, I don't always have a mask in my pocket like I always used to. I think I'm more comfortable with small groups where I know people are vaccinated. I still, if I'm going to the grocery store, I'm wearing a mask. If I go into other public buildings, I'm still wearing a mask. I tend to do more takeout from a restaurant.

I'd probably be more open to eating outdoors, but well-ventilated. Sometimes when they put in these plastic huts outside, I'm not sure the ventilation's any better if not worse than inside the restaurant. So I'm still a little more on the cautious side. I have because of family matters recently flown back to the Midwest wearing a mask, felt pretty safe on the airline doing that. But I will say if you are traveling, know the vaccination status of where you're going.

Tim Dellit:

I happened to go back to where I grew up in Iowa and I know their vaccinations rate and it's not ours. So wherever I went there in grocery stores, I was the only one wearing a mask because no one is wearing a mask there, vaccinated or unvaccinated. And I know they're not all vaccinated. So I think if you are traveling, which I know more and more people are doing, for me, I think the airlines are safe. I think the airports are really crowded. So you still kind of got to watch that but know where you're going and what's happening in terms of cases and vaccination rates, because parts of the country right now are starting to see increases surge, especially in that Midwest Southern area.

Anne:

Yeah. One of the followups in the Q&A was kind of a question around would you fly to Missouri right now? Sounds like you would probably try-

Tim Dellit:

I flew to Minneapolis. I'm not sure. That's on the Northern side of Iowa as opposed to the Southern side which is bordering. And actually when you look at Iowa, I'll just go off tangent here. But the Southern counties of Iowa are starting to see some increased activity compared to the Northern side where Minnesota is a little bit lower. So again, these are maybe it's my paranoia, but there are things that I look at again, in terms of just wearing masks, particularly when I'm traveling somewhere else.

Anne:

So I'm looking at the same kind of New York Times comment around this, the pandemic of the unvaccinated, Delta, et cetera. Do you have a prediction of how you might shift your behavior if we start seeing more Delta kind of variant and some surges here?

Tim Dellit:

Well, like John said, if you're getting infected here, it's going to be one of those three most common variants of concern. And I think the Delta is here. It's probably 50% or greater of our cases just based on sampling from the virology lab. So I'm not changing my pattern right now. And again, the vaccines I do think are very efficacious, even against the Delta. They may be a little bit less in terms of preventing mild disease or asymptomatic disease, but still extremely good about preventing severe disease or hospitalization. So I still feel comfortable with that, but it gives me pause and we continue to monitor this.

Anne:

Cool. Thank you. Last one, we had a bunch of questions about kids, especially for kids under 12 who can't yet get vaccinated. And a lot of parents just wondering what should I feel safe during... What precautions should I put in place in this moment? Do you have any thoughts there?

Tim Dellit:

I think it's a balance, right? Because that socialization is so critical as well. And I think increasingly as families know other families and they know both behaviors or vaccination status of at least the parents, I think you're going to see more and more gatherings. I think large gatherings, particularly with large numbers of children that you may not know as well, do give me some pause. You get, kids are less likely to be severely ill, but they are unvaccinated. And so I still would be cautious in that, but I also think there's a balance, right? I fully support trying to get back in person in the schools in the fall. I think there are a lot of mitigation steps that can be done and have been demonstrated across the country to be able to do that safely, even if they aren't vaccinated.

Tim Dellit:

So I think, again, it's a balance. We need to allow that socialization, that education in person for kids. I know there are questions around camps. And I think a lot of the camps are really focused on either ensuring those who are eligible are vaccinated or doing testing of those who are may not be eligible for vaccine. And so I think they're trying to figure out how to do this safely, recognizing that value, because we've seen that impact particularly on children and adolescents, especially over the last year and a half. It's really been devastating for many of those individuals.

Anne:

Tim, thank you as always. Back to Trish.

Trish Kritek:

And thank you to everyone. Thanks to our whole panel for answering questions. We're a little rusty because we haven't been here in over a month and I was shocked when I read John's email yesterday that said something about 40 town halls. I didn't even know that. That seems like a crazy number. And I don't know if he counted himself or what, but that's a lot of town halls. And we've been reflecting on what we should do with town hall as we move forward, we're going to be back on August 13th. Well, we're here to talk whenever there're stuff. And if we need to come back sooner, we'll be back sooner. We'll continue to respond to the temple of town halls that make sense for our community, but we'd like to hear from you. So we've added a question to our Q&A that where you put your questions every month, week, day, whenever asking you what you'd like to see happen with town halls.

Trish Kritek:

These are for you. I have learned so much from doing them. We have changed what we do in our hospitals and our school of medicine because of the input from you. You have been instrumental in our response and instrumental in us learning. So we want to keep hearing from you and we want to do what's useful for you. So if you're having a feeling about town halls and what we should do as we move forward, please take a minute and click on the link and give us your input because we really appreciate it. And they're really, this was an organically designed thing from you for you.

Trish Kritek:

So with that, I'm going to say, thank you for coming back for our July town hall. It's been a pleasure to hear the answers from all the folks as usual, a big thanks to everybody who did all the vaccine work. I want to re-emphasize that because it has been a colossal, colossal effort as we wind down the big clinics, a huge thanks to everyone involved in that. And I know there were tons of volunteers. And then finally a thank you to all the members of the UW Medicine community. Again, for all that you do to take

care of our patients, their families. And as we think about this next phase and taking care of each other again, continuing to take care of each other. Thanks, and we'll see you back in August. Bye-bye.