

Trish Kritek:

Welcome back to UW Medicine Town Hall. I'm Trish Kritek, Associate Dean for Faculty Affairs. And with us today we have Tim Dellit, Chief Medical Officer for UW Medicine. It's my pleasure to have Seth Cohen back, he's the Head of Infection Prevention for UWMC, Anne Browning, our Assistant Dean for Well-Being. Keri Nasenbeny, Chief Nursing Officer at UWMC Northwest, John Lynch, Head of Infection Prevention Employee Health at Harborview. Jerome Dayao, Chief Nursing Officer at Harborview, and Cindy Sayre, Chief Nursing Officer at UWMC. All of our medical directors are on the lam this week, so other folks will chime in to answer their questions. Welcome back. We've got a lot of questions again so I'm going to jump right in and hand it off to Anne.

Anne Browning:

It has been a week. We are in the final day of school at home with my kiddo. For now, fingers crossed. There hasn't been any transmission across her classroom that we know of. And there's been a lot of learning in this week and a half. I now have a five-year-old who can mute and unmute and move herself in and out of breakout rooms, which is way faster than my parents picked up anything around the norms of Zoom during this pandemic. For the most part as her chief Zoom-clicking link officer I mostly kept my cool and only once did I find myself saying, and for the first time in the pandemic, "If you find yourself needing to use a whiny voice maybe you should put yourself on mute," but I might actually need to use that again at some point.

Anne Browning:

Overall, though, I've been struck by the number of folks who have been in contact with me and have mentioned that they too have had kids who have been in situations in classrooms with exposures and/or schools that have had exposures. And I think it is pointing us in the direction that we're in for a pretty tough autumn. It's really tough in that a lot of the resources we usually leverage in terms of friends and family and backup care when we're in quarantine, those are off the table. Again, we're going to try and talk about some options and some resources, but this is just going to be a really big challenge.

Anne Browning:

And one thing we can do is try and bring as much grace and compassion and understanding to folks who are in disrupted situations, so thanks to my colleagues for being willing to put up with a five-year-old jumping into Zoom calls for the week. But overall it's I'm continually amazed by our ability to be adaptive to what needs to happen and to see a kiddo thriving in an online environment in a classroom. The fall will be hard, I'm pretty sure we will get through it and I cannot wait for our opportunity to vaccinate our little people. So, hang in there, take care of each other as we get through this. Trish.

Trish Kritek:

Anne, thank you so much for that message. And I think you're underestimating how well you managed this week, I think you've done a fabulous job of it. Anne, I'm waiting for you to use that whiny voice line on me, so I'm ready. Okay, John, let's start with you. And maybe we can start with numbers here in King County state levels.

John Lynch:

Yeah, sure thing. Thanks. If we look at UW Medicine overall we're at 73 patients, which is down quite a bit from where we were when I last spoke to everyone, we were around the 90s, so that's fantastic news. The numbers remain fairly high at both Valley and at Harborview. Valley is at 26 patients and

Harborview at 24. Northwest is at nine, which is down a little bit, which is great. Again, this is at 6:00 AM this morning, things may have changed. Montlake is at 14. I'd say just one other thing to see is that our acute care population is 34 patients and the ICU patients is actually 39.

Trish Kritek:

Wow.

John Lynch:

The last few weeks I've talked to everyone here, we've had more acute care patients which has been different than it was in the last year and it seems like we're shifting back maybe to more folks in the ICU and I think that has to do with the question I'll be asking me later around length of stay, but also just how much this is impacting people. I can also tell... Thanks for reaching out to Seattle Children's. They're down to four patients. Three are in acute care, one in the ICU. This is down from 12 patients about one half weeks ago, which is great news obviously, but their positive test rate remains high, around 4%, which is about 100% higher. They were around 22% before Delta and it still remains high.

John Lynch:

In terms of what we're looking at in the county and the state, it looks like in terms of case positivity we may have hit a plateau, both in King County and at the state, still very high levels. When I say plateau, still high numbers of case counts, in the mid-500s in King County. One thing I would say, and I mentioned this last week is with school, with more indoor activities, a lot more fairs and other group events, I said to be cautious. And when you look at both the state numbers and the King County numbers, it's hard to know because it's incomplete data but there seems to be maybe just a little tick up, not a huge one but just a little tick. And so I think we may be looking again, at least at a plateau, and at worst maybe a delay in that downward slope.

Trish Kritek:

Okay. Our numbers are better which I think is a good thing. And at the county level it's stably really high. Kid numbers coming down, still people testing positive, though, all over, actually. I also noted that change in more patients in the ICU so I will follow up with a question you already foreshadowed before I ask another demographic question. Which is, someone wrote in asking about the average length of stay for patients when they're in acute care or in the ICU and I wondered if you had those numbers.

John Lynch:

Yeah. I'm not sure how to answer your questions specifically. Dr. Burstein, if you're out there listening I did try to use the slicer dicer and this is my best shot here. I appreciate all your help on this. When I look at the last six months it's about 220 patients with COVID-19. About 40% of those folks, 46% of those folks were in our hospitals for less than seven days. About 26% of people were here for two to three weeks. About 11% of people here from two to three weeks. And then really this is really important, 16% are people, so 35 out of those 216 were here for more than three weeks. And I think we all know from our experience that most of the folks in the ICU are really the ones who are here for those many, many weeks.

John Lynch:

And so around 20% of people and maybe around 30% are here for more than two weeks. And when we think about, just for everyone out in the audience, when we think about average length of stay out in

the world in healthcare, most places it's a few days. In some places that have high-acuity patients, Montlake and Harborview, it's gets closer to a week, five to seven days. And so when you start talking to three or four weeks, that's way off what is the typical stay for people even with complex illnesses.

Trish Kritek:

Yep. I think 30% of people at two or more... more than 30% of people at two or more weeks is really quite long and a month in the ICU is a long time. Keri and I in our former life were partners in running critical care at UWMC and we would call people who had been in the ICU longer than a week. We'd call them long length of stay because we're worried about how long they've been in the hospital. I think the answer is there are some people, 40% of people who are there less than a week but a lot of people there for quite a while. And I think you're right, that shows why we have longer stays in the ICU, particularly, so those numbers stay up longer. Thank you. I appreciate it and I think Todd would be very proud of your slicer dicer activity.

John Lynch:

I tried.

Trish Kritek:

There was a question last week from Paula Houston in the chat and I wanted to follow up on it out loud today about the demographics by race in terms of numbers of patients who are testing positive for COVID. We know there have been disparities in this pandemic and I'm curious what we're seeing now.

John Lynch:

Yeah. And those disparities persist, we recognized this very early on. I think anybody involved with the social determines of health would have fully expected to see how this would play out. We are still seeing disproportionate numbers of cases in particularly communities of color, communities that have had barriers to access to care. I did pull out the numbers for King County, and again I use slicer dicer for UW Medicine, to look at some of the hospitalization rates. Trish, if you want me to just run through those quickly.

Trish Kritek:

Sure. Yeah, go forward.

John Lynch:

There's just a bunch of numbers here but just to give you a sense, when we look at hospitalizations across King County, folks who identify as white are about 45% of people, although they constitute 58% of people of our population, so slower, lower numbers proportions in the hospitals. Among people who identify as black, that's about 12.4% of hospitalizations although that same community is about only 6.8% of King County population, again, double the disproportionality there.

John Lynch:

Folks who identify as Asian, about 14%, although they're 19% of the population. Folks who identify as Hispanic are 16.6% of hospitalizations, although they're 10.3% of the population. Native Hawaiian Pacific Islanders are 4.8% of hospitalizations, although only constituting less than 1% of the population in King

County. And then individuals who identify as American Indian, or Alaska Native are 1.4% of hospitalizations, although they're 0.6% of the population in King County.

John Lynch:

When I look across UW Medicine, we're seeing the same things. I think just to call out some of the biggest numbers here. Again, folks who are Native Hawaiian Pacific Islander, these are UW Medicine patients, are 2% of our hospitalizations in the last six months. In Alaska, excuse me, American Indian Alaska Native population is 4% of our hospitalizations. And again, both those groups are less than 1% of our King County population so you can see just the huge, huge impact of these disparities.

Trish Kritek:

I appreciate you going through that. And just to reiterate briefly, it's that we're seeing disproportionately higher admissions to the hospital of folks who are Native Hawaiian and Pacific Islander, indigenous folks across this country, black and Hispanic patients. I think state and our institution it's worth us continuing to think about the social determinants of health and the disparities that ongoing systemic racism resulting in this pandemic, so thank you for going through those. Couple more questions, I'll come back to you for real today, John. Numbers of staff testing positive and their vaccination state.

John Lynch:

Yes. Vaccination state, there's a lot of activity going on right now around healthcare worker vaccination. Overall we're still around that 90% rate. There are some groups that are much higher, there's a few groups that are a little bit lower. But I would say that it's stable to slightly improved since the last time I talked to you, we were around 88%. When we look at testing, in the last 24 hours 104 health workers have been tested. And these are only, to be clear, people testing at UW Medicine. There may be even health workers who tested outside of UW Medicine. Out of the 104, two are positive, that's 1.9%. In last seven days I have 511 folks who were tested, 17 are positive, that's 3.3%. And you look over the entire trend of the pandemic, our median there is 3.5%. Seth, he's been doing this work in the weeds much more than I have, so, Seth, anything to add or correct, let me know.

Trish Kritek:

Okay. He seems to be shaking his head, no. It looks like we're tracking with where we've been in terms of staff testing positive.

John Lynch:

Yeah. And throughout the pandemic in general, when I try to trend all this, it looks like our healthcare worker population tends to be at or below the community percentage. And I see Seth nodding, so again, he's been looking at these data a lot more.

Trish Kritek:

I remember that from before and I think that's somewhat reassuring.

John Lynch:

Definitely.

Trish Kritek:

I'm going to ask you one question. I'm going to pivot quickly to Tim because they're interrelated. There's a bunch of folks who send in questions about the impact of what's happening in Idaho and the fact that Idaho is now a crisis standards of care. I'm going to start with just a broad question, John, and I don't know if you know this. Were you able with your tools to identify how many patients we have with COVID who are from out of state?

John Lynch:

Yeah. I went through Northwest, Montlake, and Harborview populations. I don't have an electronic record and I didn't have time to ask the Valley team so if anyone's has so Valley pieces of information, please let me know. Interestingly, at Harborview we only have one patient who's out of state, so out of those 24 we have one person who's in Alaska. And at Montlake, I'm pretty sure, Seth, out of the 14 people there, there's only one person and that person's from Montana, and I didn't see anyone from Northwest who's from out of state.

John Lynch:

I mean, as you're alluding to, these crisis standards of care, these huge numbers of folks that we're seeing in Alaska and Idaho, Montana, Oregon, are having enormous impacts which I'm sure Tim can talk more about. But the farther away you are the less, slightly less impact it has in. I would say the important thing for us in UW Medicine to understand is that we're definitely here to serve those populations as we always have been, but we're not seeing huge impacts. Where we're seeing in terms of the patients we're seeing in our hospitals are people from our neighborhoods, from Seattle, from King County, from Eastern Washington, Western Washington, and in the Peninsula.

Trish Kritek:

I think that's really helpful and I think people are worried about it. They want to be helping and they're also curious about the impact on what it might do for us here. Tim, I am going to turn to you. My first question was going to be, what's the impact on our census of folks coming from Idaho? John's kind of answered that, but maybe you could just reflect on the fact that the State of Idaho is now at crisis standards of care and what that means for us in interacting with folks in Idaho, Eastern Washington, Alaska.

Tim Dellit:

Yeah. Now, thanks, Trish. And I would say again our thoughts go out to everyone in Idaho right now. That is a very difficult state to be in and one that quite frankly I never thought that we would actually see in this country and I really sincerely hope that we don't reach that state in Washington State. Previously last week, I believe, they had already gone into crisis standards in the Northwest Panhandle and now it's been across the state.

Tim Dellit:

What that means is that they really are no longer able to deliver what we would consider standard of care, and they are in a situation where they are having to allocate scarce resources, whether that be staffing, beds, or equipment such as ventilators. They are in the scenario where they are trying to do the greatest good for the largest number but unfortunately that also means that unlike our normal process they are having to make decisions on who is most likely to benefit from those scarce resources. And that is really difficult and it's not only impacts those who are presenting with COVID-19, but that's anyone

who presents for medical care. And so it has an impact across the entire health system, not just for COVID-19.

Tim Dellit:

I also want to just really acknowledge we have faculty in Idaho, we have house staff in Idaho who are actively engaged in caring for patients there and are really part of this very challenging scenario, so our hearts really go out to them. As John alluded we may not have as much direct impact in terms of patients from their being admitted to our facilities but there's a ripple effect. And so those patients when there is this overflow, if you look at what's happening in Spokane, Eastern Washington is really impacted.

Tim Dellit:

And that affects all of the state because if Eastern Washington, and we're already again across our state at high capacity. So as Eastern Washington even goes up higher that impacts their ability to provide care, shifting potentially more people over to the west side of the state. Again, as a state, we don't want anyone to reach that level, it's really an older nut, and so it is having some indirect impact anyway on our state and certainly for members of our community who are actually based in Idaho.

Trish Kritek:

Yeah. I think, in fact on the folks that we know, care about, work with in Idaho, they're at crisis standards of care, we're not at crisis standards of care. We're not even close to crisis standards of care here, I just want to say that out loud. I think most of it has been staffing and some beds in Idaho and not things like ventilators which is I think a good thing actually because they're kind of slightly different but still sobering. And there are impacts on us and there's definitely impacts on folks in Spokane and Eastern Washington, so thank you for walking through that. Do you know if we're sending any healthcare workers out to help in Idaho?

Tim Dellit:

No. Other than those that are based there, I'm not aware that we're actually sending additional individuals right now, but again, because of the way our programs are fought across the WWAMI states we have a large number of faculty who are based in Idaho, as well as again trainees who are actively responding.

Trish Kritek:

Yeah. Just this morning, Tim and I were talking to a colleague who's delivering care in Idaho and it's sobering. And I'll just echo your thanks to everyone there and tell them that we're thinking of them and want to help however we can. I'm going to shift gears. Last time we talked about people coming back to on-site work. And I guess my question is, and people were asking, how is the return to onsite work gone? And is it, are we changing our ideas about whether or not we should keep doing it?

Tim Dellit:

Again, the university is committed to returning it to on-site activity. In those units that I'm aware of things have gone relatively smoothly because people both not only are the vast majority of vaccinated, they're all masked, but they're also doing it mostly through a hybrid model to decrease the density of individuals and so not everyone's there on the same day. And I've also heard a lot of positives where people really appreciated seeing people in-person for the first time, sometimes for 18 months. I think

there was also some real happiness there. There's certainly, and again I don't mean at all to minimize a lot of anxiety around returning to work as well, but I think for those who have done it I think they've also seen some positive aspects of, again, just being able to have some contact with our coworkers aside from Zoom.

Trish Kritek:

Yeah. I actually met someone I hadn't met in 18 months the other day because it was the first time we were in-person together. It was awesome. Okay. Vaccine exemptions, I'm going to start with you and then I'm going to pivot to the chief nursing officers. Do you know how many requests for exemption we've had and what percentage of them were approved?

Tim Dellit:

And again, I look to Seth and John who really I want to thank because they have done a tremendous amount of work with colleagues from upper campus to really have a consistent approach. And in fact, they are participating together to review the medical exemption set as an example. Overall, I think we've had just over 60 medical exemptions, around 300 religious and probably about a third altogether that have been approved.

Trish Kritek:

A third of all exemption requests across those two categories have been approved?

Tim Dellit:

Correct.

Trish Kritek:

Okay. So-

Tim Dellit:

Now, keep in mind as we talked about before there are a number of steps in that evaluation. On the medical side it's a very narrow number of contraindications to receiving the vaccine. It's really did you have a severe reaction after the first dose or severe allergy to one of the components of the vaccine. Other things, and we have this on our form, such as autoimmune disorders actually are not a contraindication to being vaccinated. Those are really big reviewed and it's a relatively small number of individuals in that category.

Tim Dellit:

On the religious side, again, we absolutely do not question anyone's faith or belief, that is not the question. Then the question really is, can we accommodate those individuals? Particularly when you look into clinical settings, so those patients, those individuals, sorry, employees who have direct patient care or indirect patient contact, the question is can we actually accommodate those individuals when you think of not only the PPE requirements but it's really the twice daily testing, the inability to care for anyone who's immunocompromised, not being able to be on units that are at congregate settings such as our psychiatry units.

Tim Dellit:

It becomes very difficult if not impossible to accommodate those, and so the proclamation from the governor does allow a denial of those requests based on hardship and inability to make those accommodations. And so, again, it's not that we're questioning at all your beliefs but it's really in that clinical setting, can we accommodate those? And that's why the majority of those are being denied.

Trish Kritek:

Okay. It sounds like a total... I know he's going to say not twice daily testing.

John Lynch:

Yeah.

Tim Dellit:

Or twice weekly.

Trish Kritek:

I was going to get to it.

Tim Dellit:

You know what I mean?

John Lynch:

Yeah.

Tim Dellit:

Twice weekly.

Trish Kritek:

I just want you to know that we're listening to everything you say Tim-

Tim Dellit:

Yeah, thank you.

Trish Kritek:

... so we notice when you say something crazy like twice a day testing.

Tim Dellit:

Okay. I appreciate it. Thank you.

John Lynch:

Can I ask to jump in there just really quickly?

Tim Dellit:

Yeah.

John Lynch:

Seth put a huge amount of work in this but also Dr. Nindidamani has just done hours and hours, day, night. Nicki McCraw, Jennifer Petritz, who leads up Human Resources. It has been huge amount of work and I just want to give good credit where it's due. Thank you.

Trish Kritek:

Okay. Thank you. Kudos to the human resources team as well as our infection prevention teams for looking through all these. I heard a total approved of 60 medical and 300 religious and that's about a third of all the requests that were...

Tim Dellit:

Those were the number of requests.

Trish Kritek:

Oh, those are the number of requests?

Tim Dellit:

And a third of those have been approved.

Trish Kritek:

Okay. That's actually really helpful. Thank you for clarifying, I misunderstood. So 60 medical requests, total, and 300 religious requests, total, and of that 360, a third of those have been approved. Thank you for clarifying. It's actually not super, super high numbers but that's a lot of work for people to individually go through those and work with people, so I appreciate the team's efforts on that and I appreciate you clarifying what would count as a medical exemption.

Trish Kritek:

Cindy, Jerome, and Keri, as you can imagine there were many questions in this current setting of our staffing shortages, what is going to be the impact of folks who can't, won't be a part of our staff. We heard some numbers and I'm just curious what's your sense is about the impact on our inpatient and outpatient staffing. Carrie, I'll let you go first.

Keri Nasenbeny:

Yeah. It's something that we've been huddling around and doing a lot of work around, I would say for weeks, in addition to everybody from infection prevention teams and HR managers have also put a tremendous amount of work into this effort, meeting with our staff, trying to surround them with support if they have got questions. And then also really trying to anticipate what the future impacts would be, if many. For Northwest, they're not huge numbers onesies, twosies here and there, though all of that is impactful and I think it's something that we care deeply about and so trying to put in plans for mitigation, whether that's travelers, posting positions, if we really believe that that individual is going to choose not to be vaccinated and we weren't able to accommodate their exemption, at least.

Trish Kritek:

And thank you. So it sounds like individual spots where you were coming up with different strategies to fill in. Jerome, I see you on mute and I'll ask for your thoughts and also maybe thoughts on how you are accommodating people if you are able to do so.

Jerome Dayao:

Right. I mean, it's the same approach that we've done for Harborview. In fact, earlier today I've met with all of the inpatient managers just to go over the list and I'm pretty confident and comfortable with the numbers that we have in there. I mean, as what Keri said. I mean, it's about 100% compliance to very high 90s that we would be able to find replacements for those individuals. A lot of those that have submitted religious or medical exemptions that were denied have opted to receive the vaccine, which is promising, so that is truly helping us. But in preparation for those that we might lose in critical clinical areas, we have elicited the help of the traveling agency so that we can replace the staff as necessary. That's what we've been doing.

Trish Kritek:

I want to highlight two things that I heard Keri saying, really working with people and trying to support them through this. And then I heard Jerome say a lot of folks who have opted to go ahead and be vaccinated and I think that's another part of. It sounds like using travelers. Cindy, did you want to add anything to that?

Cindy Sayre:

Yeah. The only thing I wanted to add is what came up in one of our meetings this morning. There are some employees who believe that there's an appeal process. For example, they received a declaration of their exemption requests and they're telling their managers, "I'm going to appeal." And based on our conversation with HR this morning there is really not an appeal process so I want to be clear to people that are just waiting, hoping that they're going to get a different decision and appeal and agree with Jerome that we have vaccinated staff this week and we're just going to keep trying to communicate the message. I was so happy we brought some J&J vaccine in so people can meet this deadline. As an optimist I am continuing to have a lot of hope that we can vaccinate even more of our staff.

Trish Kritek:

Thank you, Cindy. And I did see that email that we have some Johnson & Johnson, so that's an opportunity for folks, which is great, and I appreciate all the work that all of you have been doing in this. I'm going to shift gears and talk about visitor policy because I talk about visitor policy with you every week and it's evolving. Jerome, I'm going to start with you, the current visitor policy at Harborview.

Jerome Dayao:

Ours is straightforward, we're not allowing any routine visitation at Harborview right now with a few exceptions that are also posted in our intranet. And these are with regard to being a caregiver, primary caregiver to the patient, patients with mental needs and those kinds of needs, including those that are actively dying or in that face of needing to have some family members around. We currently do not allow any routine visitation at Harborview.

Trish Kritek:

Okay. I think that is, you're right, that's the easiest. The exception is end of life and supporting patients in that phase so I think that's important to keep reiterating. Cindy... Actually, I'm going to Keri first

because I'm going to ask you a follow-up about specific. Well, actually, it doesn't matter. Go ahead.
Montlake, Cindy.

Cindy Sayre:

Yeah. At Montlake, our visitor policy is unchanged. We still have the one to two visitors allowed and it's the same in our outpatient and inpatient. And the OB, I think there was a specific question about our OB visit-

Trish Kritek:

Yeah.

Cindy Sayre:

... is also unchanged at this time. We can have a visitor and the doula available. So, yeah.

Trish Kritek:

Yep, that was going to be my follow-up question but then I realized there's L&D at both places. Keri, I'll ask you what the policies are at Northwest.

Keri Nasenbeny:

Very much the same as Montlake, so only two visitors and including in our OB area where they can have one visitor plus a doula. And then the only one exception is our adult psych unit because that unit has experienced, I think at least two, if not three, two significant outbreaks and so they have restricted visiting. They do have visitors if there's a therapeutic need or if that makes sense for that patient's plan of care, but because of most of those patients are over 60 and we do have a couple of unvaccinated patients still there. So there's really no routine visitation on that unit unless it's in that.

Trish Kritek:

Okay. I appreciate that. Montlake and Northwest, one to two patients, not one to two patients, one to two visitors per patient as it has been including on L&D with the exception of the geropsych. And I am going to ask specifically about outpatient. Jerome, is your visitation policy for outpatient spaces as well?

Jerome Dayao:

No, outpatient is unchanged. This only applies to inpatient. And this is primarily to the reason of our communal spaces at Harborview, and we're trying to reduce foot traffic within the inpatient so that we can reduce community infections.

Trish Kritek:

I appreciate that. Communal spaces seem to be the thing that's changing how we have visitors and I think we heard that at two places. I will ask a little bit more about outpatient. There's lots of folks who are concerned about air circulation and small spaces, that many of our exam rooms are small spaces. The question really was, are we thinking about changing our visitation policy for outpatient spaces and maybe raising the bar about having folks accompany someone to the clinic? And I'll take anyone who's open to answering that. Cindy.

Keri Nasenbeny:

Well, we haven't talked about it. I mean, here's what I would tell you that we have a group that meets regularly around visitation. The visiting policy that I was just going to pull it up that my understanding for outpatient is one visitor, it's not one to two because they do have smaller settings. I think the one thing that I would offer is that we're looking at, and I believe it applies to outpatient, John, correct me, or Cindy or Jerome if I'm wrong, but looking at requiring proof of vaccination or a negative test for visitation. And I just started to review that policy and a proposed policy I should offer and I thought that that also applied to our outpatient areas as well, but I would welcome anybody to correct me about that.

Trish Kritek:

Okay. Does anyone have a good sense of, is it one or one to two? I thought it was one, as well.

Keri Nasenbeny:

I think it's one. I was just going to...

Cindy Sayre:

Me I have it stated. Yeah.

Trish Kritek:

Okay. We'll clarify. We'll clarify it. And I think what I heard was on the horizon maybe proof of vaccination to accompany. All good. And then I want to clarify one of the things for the two UWC spots. Is it one to two per day or is it one to two total? On day one I go in. Can tomorrow Tim go in and on Wednesday Seth go in? Different people.

Keri Nasenbeny:

Here's, I'll tell you what? I just look at the policy. Outpatient is one visitor, one person to accompany you. Here at Northwest we have no ability to enforce that and so what we really try to do is, and when we restrict patients or we're restricting talking to patients, both patients coming in for surgery or through the ED or as they're admitted, is really trying to recommend that it's one or two designated visitors. But if I'm the nurse today and it's John tomorrow, there's no way of knowing that and we don't personally have a way to track that just due to who's manning our check-in, et cetera. And I think maybe Montlake is a little bit different. What we really try to do is just on an individual patient level, talk that up and the why, why that's important. I will tell you though that I think it is probably often different, sometimes different visitors.

Trish Kritek:

Okay. I think that's really helpful. I think the goal is that patients have designated visitors so that there's decreased exposure and that's something we're communicating patients on a regular basis, individually. That's not something that we're policing, so to speak, because it's logistically impossible to do that at this point in time. And I think just so that we all are at one visitor for outpatient setting and perhaps proof of vaccination in the future. Thank you.

Trish Kritek:

Lots of questions about visitors. It's an evolving space so I probably want to keep asking them on it. All right, Seth, you had a 30-minute hiatus but now it's your turn. Lots of questions about third doses and

I'm seeing in the chat that maybe there's evolving news about their doses. But my broad picture question because there are so many questions about it is where do we stand in terms of third doses, not for the immunocompromised folks but for everybody else?

Seth Cohen:

Yeah, it's a very hot topic. I think John and I are on the same page on this one where, the simple answer is first doses are way more impactful than third doses and so we want to make sure that we are prioritizing first doses whenever we can. But people probably know that an FDA panel did meet today and recommended boosters for people over the age of 65 or people with risk factors for severe disease, which I don't think has been well-defined quite yet. But they stopped short of recommending boosters for all-comers. There's going to be additional meetings next week. Regardless of what they decide we will be ready with our mass vaccination sites to boost employees according to CDC-approved criteria, which will be determined.

Trish Kritek:

Okay. We're ready to do it and right now what we've heard from the FDA panel was 65 or older, but more conversations before the final recommendations come out. Is that just for Pfizer or is that for Pfizer and Moderna?

Seth Cohen:

Pfizer is the only one that filed so far. We're waiting on news for Moderna. And I also see a lot of questions in the chat about pregnant people and I don't think we know the answer to that yet. Hopefully that'll be defined next week.

Trish Kritek:

Okay. We don't know for pregnant people, that was one of my questions, they beat me to it. And we have enough supply to give folks the vaccines if it was a broader indication than 65.

Seth Cohen:

Yep.

Trish Kritek:

That's great. This is the tension, one tension is there's a whole world that needs to be vaccinated. A lot of people said, "Well, what about the rest of the world?" And I think that's part of it. You express the greatest benefit is in the first dose and there's probably added a benefit to getting more, but who knows exactly how much that is? Are there risks to getting a third dose?

Seth Cohen:

So far based on the data that Pfizer files we haven't seen any increased risk of side effects. We look forward to the CDC summaries, but I don't see a significant downside to getting it other than we really need to prioritize those first doses. It's this alignment between public health and self-interest. We're not vaccinating everybody in the world, we're going to go through the entire Greek alphabet before we're done with this.

Trish Kritek:

Yeah. And I just want to acknowledge that many of our people who sent in questions had very much that global mindset and their questions about why would we do a third dose before lots of other people get a first dose? What I'm going to say is more to come on that, it's obviously rapidly evolving. I'm going to pivot to the flu shot. "Last year we had almost no flu," someone wrote and said, "Why do we need to get flu shots this year? Do you really think flu is going to be a problem this year?"

Seth Cohen:

I think this has been one of the silver linings of COVID. Flu is completely unpredictable. It is very susceptible to all of our non-pharmacologic interventions like masking distancing. And the Southern hemisphere has relatively little flu, and that's all good, but what's different about this year is we're not in lockdown and schools are back in session. And so I think it is a really, really good idea for everybody to get their flu shot. We're going to be giving them out through our mass vaccination sites and through employee health. Our flu campaign for employees starts on October 4th and you can get both doses at the same time. There's no concern about splitting them up.

Seth Cohen:

And Trish, I know we skipped over pregnant people briefly, but I just want to be really clear, just come back to that for a moment if I can. I know our OB colleagues feel very similarly but there is clear consensus that pregnant people need to get vaccinated for COVID and all of our sectors and gynecology colleagues are recommending this for their patients. We're seeing a lot of pregnant people in the hospital who are very sick and it is often completely preventable.

Trish Kritek:

I'm going to summarize that by saying the clarity is, we are recommending pregnant people get vaccinated. The question was about a third dose and I think that's where there's any gray. And the same way with the third dose is great for a lot of spaces at this point in time so thank you for making that clarity. And I also heard you say October 4th for flu, you can get both vaccines at the same time. And we think that there probably will be flu because there's more people out and about and in school and things like that, so get vaccinated. I'm going to shift to monoclonal antibodies. Are we expanding our reach with monoclonal antibodies, are we working to get them out to L techs or skilled nursing facilities, or clinics? Where do we stand with monoclonal antibodies?

Seth Cohen:

Yeah. And happy to let John speak to some of this since he was on a call recently. We have expanded our access to monoclonals and thanks to Santiago and Shireesha and Rupali and many, many other people, we have been able to offer monoclonals at Harborview, Northwest, Valley and at other sites. The challenge is that allocation for monoclonals will now be going through the state, John, you can correct me if I'm wrong. And so there are some questions about our supply. Right now monoclonals are good for a very highly-selected population of people who are at risk for developing complications due to COVID, but they're not something that everybody can count on and they are extremely resource-intensive. And so getting vaccinated is highly preferable in our minds than relying on monoclonal antibodies. John, are there any other comments that you want to make about that?

John Lynch:

I would just say that UW Medicine is engaged with a lot of stakeholders across the State Department of Health, coalitions, other healthcare systems, around how do we best use this now even more finite

resource. We have challenges with the actual amount now which we didn't even a week and a half ago. And, as Seth said, delivering this medication to people takes a lot of resources. It takes a place, it takes a person, takes movement. And so we're working with the state as to whether there can be delivery to people's homes, whether those can be infused there. There's lots of barriers to access. If you have a disability you have barriers to transportation and so forth. Whether we need mass fusion sites or similar. A lot of conversations ongoing.

John Lynch:

Some significant challenges that we just learned about in this last week and a half. But I would say just the important thing, and Seth may have mentioned this, but just to emphasize, we are trying to this, we've had expanded access and provided more access through all of our sites within UW Medicine over the last several weeks, thanks to the extremely hard work of a lot of folks.

Trish Kritek:

Okay. What I heard is logistically challenging and continuing to work on it, now at a state level because that's the way that it's going to be distributed, and the logistics of that are also trying to address disparities and access. And I think I heard Seth earlier say, "I want to highlight it." And it's way better to get vaccinated than to get infected and try to go through the logistics of getting this drug because we're actually only giving it to a small portion of folks who are getting infected as it is. I think those were the take-homes that I heard through that so thank you both for that collaborative answer.

Trish Kritek:

Seth, last little bit of questions before I actually go back to Tim, that's a warning. How are we doing on supplies for testing and access to testing? Because there are a lot of people who are positive and people having to wait to get tested.

Seth Cohen:

Yeah. It's a very good question. We actually just had a respiratory viral summit with our lab colleagues.

Trish Kritek:

Wow.

Seth Cohen:

Yeah, yeah. And I was just reminded how lucky we are to have true world experts on virology and laboratory diagnostics here at UW, so they are doing a lot of planning around this. Our hope is that we should be okay for supplies. They have a number of different platforms that they use, and we're also doing our best to expand testing and the Department of Lab Medicine, as you know, is running a number of different test sites around the city to help with capacity.

Trish Kritek:

Okay. It sounds like we think we're okay and we're always strategizing about having adequate supplies, a kudos to the Lab Medicine team on that. And we're working to expand. Is there any place particular where we're trying to expand that you know of?

Seth Cohen:

Well, we have a lot of open positions right now for our Northwest site and also the Harborview site is also trying to ramp up capacity. And part of that is because we want to be able to test families of our employees or people who have kids who may have been exposed. We really want that to be a resource, both to help keep everybody healthy but also keep people at work. Those are some areas of focus.

Trish Kritek:

Okay. We're ramping up for families, kids, and our employees, particularly at both Northwest and Harborview. Thank you. I appreciate that. Tim, I forgot to ask about this but I want to come back to it. Came up in the Q&A too today. I think last time I asked Tom or Rick about surgeries that were rescheduled, and maybe it gives us a lay of the land, the impact of the surgeries that we've had to reschedule both financially and when we're getting those people back in to get their surgeries done.

Tim Dellit:

Yeah. We originally postponed non-urgent surgeries that would require hospitalization through September 19 and we have now extended that until the end of the month through October 1st as we continue to monitor the situation. We did that initially when we were at really extreme capacity and we needed to create bed capacity for those patients who really required a more urgent hospitalization. Different from what we did very early in the pandemic, we're still doing those outpatient procedures that don't require hospitalization, because again, the goal is to preserve those beds.

Tim Dellit:

And I would say in each of those cases the surgeon is reviewing the situation for that patient and making an individual determination, is it safe for that patient to have their surgery postponed initially for four weeks? If it would cause medical harm to the individual, then we are not postponing that. An example, if you are having surgery to resect the tumor for an oncologic or cancer diagnosis, those would not be delayed. And so again, it's each case is being reviewed on an individual basis because we really want to make sure it's safe for patients to be postponed.

Tim Dellit:

Now, the impact of that, if you look in August, I believe Harborview had about a 5% reduction in their surgical volumes when you look at inpatient and outpatient together. UWMC, the combined two campuses, about a 10% reduction in cases. Harborview probably a little less impacted because of their trauma volumes that have to come in. Northwest campus especially has a greater number or proportion of non-urgent surgeries and so they probably impacted a little bit more. So we are going to see some impact with volumes and from our finances, but not nearly what we saw. If people recall back in the spring of 2020 there was a 65% reduction in all volumes, so not nearly at that extent.

Tim Dellit:

We need to watch these trends. John mentioned earlier we're down in the 70s now. That's reassuring but we still have very full hospitals. Leadership will have to make a determination where we are at and whether we can resume. Some of those surgeries now after October 1st, or if we need to push that out and we haven't made that determination yet, so again, we're continuing to watch the dynamic situation.

Trish Kritek:

Okay. So it's currently it's October 1st, an individual case-by-case decision making based on necessity of the surgery, and five to 10% decreases in surgeries compared to 65%. So some fiscal impact but we don't think anything like the fiscal impact from before.

Tim Dellit:

Correct.

Trish Kritek:

Thank you. I think really helpful. Okay, John and Seth, before I hand over to Anne in a little bit, I'm going to pivot back and forth between you with some questions. John, first question is, any discussion about going to N95s as our standard mask? We've been talking about this for a long time and I'm just curious if there's any evolution in that space.

John Lynch:

Yeah. We're actually talking about that and we've had several conversations this week in the MedTech group as to whether we should move in that direction. I would say that we're... At Harborview specifically we've had a few outbreaks associated with our congregate settings, as Jerome mentioned earlier. And in those settings we're seeing transmission from healthcare workers to patients, healthcare workers to healthcare workers, and patients to healthcare workers, and trying to figure out what steps can we possibly take to improve the safety of those situations, and increasing our respiratory protection is definitely one of them.

John Lynch:

In those settings right now we are expanding our use of respirators, N95s, but we have to recognize there's still a lot of challenges around those. If you're wearing an N95 for extended periods of time we know that health workers have struggled with that, with the discomfort of wearing it, skin issues. People who can't wear those have to wear PAPRs and interference with just their activities at work. That's one tip to the point, the point of the spear right now we're really focused our activities.

John Lynch:

But we are definitely thinking about, do we need to expand N95s either like we have done in emergency departments? Hey, if you want to use an N95 you can go ahead and use it, or should we move to something more required. And I think all those levels are being discussed and being thought about on a day-by-day basis right now. Seth, did I capture about right.

Seth Cohen:

Yep.

John Lynch:

Okay.

Trish Kritek:

So no change right now, but-

John Lynch:

Well, some changes. We're doing some changes in these congregate areas, strictly part of you right now, but expanding me on that is a daily conversation.

Trish Kritek:

Okay. Thank you for correcting me. Changes in congregate areas because we're seeing transmission between patients and staff and staff and staff and patients and patients.

John Lynch:

Yeah.

Trish Kritek:

And discussions about maybe this would be an option for people and even discussions about this is what we're going to require. Those two we have not gotten to yet but it will keep coming back to this because it's an ongoing conversation.

John Lynch:

Correct.

Trish Kritek:

Yeah?

John Lynch:

And I just want to reiterate, N95s are great, masks are great, but they only work when you're wearing them. They only work when the patients are wearing them. You can wear N95s all day but if you go into another room and have lunch with three or four or five people and no one's wearing masks, it defeats the purpose.

Trish Kritek:

Yeah, I get it.

John Lynch:

We keep coming back to the Swiss cheese model, respirators work, masks work when they're on you, when they're on the other person. As soon as we start taking those things apart is when we start taking increased risks.

Trish Kritek:

Yeah. Masks work when you wear them, that's the take-home on that one. And I personally, it's hard to wear an N95 all day, so I'm going to have a vote, which I don't at all, I'm voting for the optional N95. Okay. I haven't asked this in a long time, but eye protection. Seth, or you want to start John?

John Lynch:

Seth, you go. No, no. People are tired of me.

Seth Cohen:

Yeah, it sounds good. As people know, across the system we are dealing with a number of outbreaks and we have dealt with outbreaks previously at all of our sites. We think that eye protection is an important part of the PPE bundle. And there is just something that is different about Delta that is making it highly, highly contagious, so I think we want to do everything we can to protect our healthcare workers. And so there was the subtle move away from required eye protection and we are moving back in that direction for required eye protection for patient-facing encounters.

Trish Kritek:

Eye protection, I got it here on my desk when I'm interacting with patients, not patients with COVID, just in general I'm going to start wearing this again when I go back on service on Monday. Yes?

John Lynch:

Yeah. Remember when we rolled it back for vaccinated people, it was maintained for unvaccinated healthcare workers and now we're going to go back to everyone.

Trish Kritek:

Okay. Everybody we're going back to eye protection for everybody starting now, wish if not now. Okay. John, any thoughts on providing patients with a surgical mask, giving them a surgical mask when they come into clinic as opposed to relying on the masks that they wear into clinic based on masks work when they're on you and fitting well?

John Lynch:

So many hot topics you're hitting on today, Trish. Yes. That is another thing where... yes, I know, I know. That's just the way you roll. Yeah, Seth and I and the rest of the MedTech groups are talking about going to... Our operational teams are leading the screening at the doors and seeing whether that would be an option. We need the supply, we need the tools to have those conversations. We definitely, I think all of us agree we want to move away from buffs and bandanas.

John Lynch:

We did that earlier, but it's hard to keep that up and I think that we need to re-engage in those conversations and then get the operational pieces in place in discussions with our CNO leaders around this possibility. But I think we from the MedTech perspective would love to see everyone in a surgical mask. A well-fitting mask is definitely superior than some of the cloth, one-layer buffs and handkerchiefs we're seeing out there.

Trish Kritek:

Okay. On the horizon we're working on potentially a logistics supply, stuff that would go into being able to have everyone wear a surgical mask. I think that's reassuring to people, particularly people who work in outpatient clinics who I think are feeling that one a lot.

John Lynch:

Yeah.

Trish Kritek:

Seth, last question before I hand off to Anne. It's a tough one to give you at the end but I'm going to do it anyway. I didn't get to this last week, there were people asking about ivermectin. It's been in the news a ton about, do we treat people with ivermectin? What's the story with ivermectin? I think my question is, is it part of how we treat patients with COVID? Let's just go with that as a simplistic question.

Seth Cohen:

Short answer is, no. I think there's something about this pandemic that has people searching for miracle cures which I completely understand. It would be wonderful if we had a pill that was super effective against COVID. We don't. The evidence for ivermectin, a lot of it has either been retracted or discredited or in the process of being retracted. The short answer is, I don't know any ID doc or critical care doc who recommends ivermectin, unless somebody is at risk for reactivation of Strongyloides, which is a worm, which ivermectin is very effective against. But even Merck, the company that makes ivermectin and stands to make a profit from it has come up very strongly that they do not recommend ivermectin use for COVID.

Trish Kritek:

Yeah. And I would say my whole critical care community would strongly endorse what you just said, we don't treat COVID with ivermectin. I lied, I have two questions I need to ask and I'm sorry. I apologize, bad timing. John, physical distancing. Are we still encouraging physical distancing because we're seeing people come back to have some in-person meetings and conferences?

John Lynch:

Yeah. It's a great question and it came up in the Q&A as well, is I think the bandanas, the buffs, that the eye protections, I think there's this a lot of drift that we've seen. And I think what folks like Seth and I are asking everyone is that we need to re-engage with all the practices that we've all been doing for the last 20 months. We're all tired, but the most important things we can do, good masks, physical distancing, and to answer your question directly, still super important. Vaccinations, staying home when you have any symptoms at all, getting tested, thinking about exposures. All of those things are probably more important now than ever.

John Lynch:

Because as I think Seth mentioned you have schools-in-place, public events occurring. And I think everyone down here, every healthcare worker who I'm speaking to right now knows that the public doesn't have the same perception of the state of the pandemic as we do, as all the people on this call do right now. I know this is more than... but yes, physical distance is still critically important. The farther you away from someone else the less risk there is to you.

John Lynch:

Now, the reason we have masks, and we do the daily out of situation and all those sorts of things, is to allow us to get a little bit closer and have some of those in-person sessions. It doesn't mean we can't have meetings, it doesn't mean we can't have in-person learning. We just need to when possible create those distances, it's still an important part of it.

Trish Kritek:

It was more than I asked for, but it was great. We have to go back to keeping physical distance, super important. Wear your mask, wash your hands, all those things that we've been... and bring back the eye

protection so we all stay safe. I think it's really important. I'm going to stop there and hand it off to Anne so she can ask you a few questions as I asked the ID doc. Anne, it's all yours.

Anne Browning:

Sure. Thanks. John, we'll keep you on the hot seat.

John Lynch:

Sure.

Anne Browning:

This week I'm just going to ask the questions pretty much as they were written and flowed into us in no particular order. Here we go. Would you take a spunky 81-year-old immunocompromised mother to a football game? She has had three shots of the vaccine.

John Lynch:

Only if she had a lot of distance and everyone around her was masked. I have heard some reports from some of these situations even where masking is required that it is not as good as we hope it should be.

Anne Browning:

Good. Would you let an eight-year-old with asthma play recreational soccer if most folks are masked but masking has not been mandated?

John Lynch:

Only if the eight-year-old groups are small. If you had a massive group, 20, 30 kids out there, there'll be a problem. If there's 4, 6, 8 kids, distance outdoors, I think that's not unreasonable.

Anne Browning:

Good. Would you go to an indoor concert if folks were all vaccinated and masked at the concert?

John Lynch:

I'm not there yet.

Anne Browning:

Okay.

John Lynch:

Biologically, probably some pretty low risk, but I'm playing the Tim Dellit card here, I'm still a little conservative about really going indoors and crowds.

Anne Browning:

That's fair. Would you let out-of-state vaccinated grandparents come visit you if you had kiddos in your house who are under 12 and therefore unvaccinated?

John Lynch:

Oh, yes, I would.

Anne Browning:

Cool.

John Lynch:

Because I'd ask them to mask. I think planes themselves are pretty safe as long as they continue to mask, they're vaccinated and they're going to follow my rules when they're at my house. Yeah.

Anne Browning:

Yes. So you'd have grandma and grandpa mask up indoors if there's any-

John Lynch:

If they visited? No, as long as they mask the rest of the time on the plane and how they're behaving in their own homes.

Anne Browning:

Got it. Thank you. Would you let unvaccinated kiddos have play dates with each other?

John Lynch:

Oh, only very small pods. I mean, if you're under 12 you don't really have a choice, do you? And I think in kid context it's critical. I would just stick with the pod system that probably you, Anne, have been doing and that I was doing earlier pre-vaccine for my kids.

Anne Browning:

Would you hang out with an unvaccinated family member if they had had COVID and recovered a month or two ago?

John Lynch:

It's actually a lot of parts to your question-

Anne Browning:

Yeah, anyway.

John Lynch:

Because any adult that I know who's not vaccinated and I'm not so sure I'm ready to talk to. Yeah, I'm torn about that, I'd have to think.

Anne Browning:

Later.

John Lynch:

If they're really, really nice and they had maybe an IPA or something like that then we're going home.

Anne Browning:

So in the right circumstances.

John Lynch:

The right circumstances. Is this possible? Maybe outdoors.

Anne Browning:

Would you hang out indoors with another vaccinated couple?

John Lynch:

I do that right now, so full disclosure. There's a few families that we embed in our pod and they're vaccinated and we hang out with them indoors.

Anne Browning:

Good. Would you go shopping for clothes or other non-necessity items in-person or do you think that's too risky right now?

John Lynch:

I think that's okay. These are not places where people are spending hours and hours, you're just moving through. It's like a grocery store.

Anne Browning:

Last one for you. As the weather changes, would you eat indoors at the hospital cafeteria?

John Lynch:

I let Seth and others speak to the other cafeterias, I said, "Harborview, I know the airflow there." The airflow is outstanding. We have great ventilation, great filtration, and I go through there every day and make sure there's no more than two people at a table. Trust me, I do it and I disrupt any lawbreakers. And so, yes, I think it's reasonable to eat in that situation. But to be honest, I eat at my desk because I'm on Zoom pretty much all day. But if I didn't have to I probably would spend 20, 30 minutes eating down there. I love seeing my colleagues down there, is one of my favorite parts of my job.

Anne Browning:

I do love that you played home monitor and break up people at tables as well.

John Lynch:

Yeah. I have zero discomfort with that anymore. No problem.

Anne Browning:

Right on. Thank you. Trish.

Trish Kritek:

No problem. And, John, we'll work on getting a little badge to wear so you can wear it when you go down there into the cafeteria. I want to say, thank you. Thank you to the whole panel. I wanted too

thank you because I sat and listened to all the thanks from people in this panel today. And I heard thanks to the various ID teams that have been doing a lot of work, our HR teams, our healthcare teams, the folks who've been our nurse managers, so many folks. I heard a really deep-felt thanks from Tim to our colleagues who are working in Idaho, our trainees who are in Idaho and Alaska and other places are particularly taxed. And I think it's really heartwarming to me to hear everybody here keep thinking, folks, and I just want to say I'm appreciative of that.

Trish Kritek:

I wanted to hollow out something that Tim said, which is people did come back to work onsite this week and it was hard for people. I think it caused a fair amount of anxiety, and there were joys. I had people showing up at my door to say hi that I hadn't seen in a really long time and I personally felt that joy. I think we're still in these challenging times, there are small moments of joy that are really important and we're all pushing through some challenges too, and I just want to highlight Anne's message of grace for each other.

Trish Kritek:

And with that, I'm going to close this week. I'm going to tell you that we're not going to be here next week, we'll be back on October 1st and we'll answer all or as many of your questions as we can then. So please send them in over that time period and we'll see you back then. Thank you again to everyone out there for taking care of our patients, their families, and really keeping taking care of each other. Bye-bye.