

Trish Kritek:

Welcome back to UW Medicine Town Hall. I'm Trish Kritek, associate dean for faculty affairs. It's my pleasure to welcome back this week, Santiago Neme, our medical director at UWMC Northwest, John Lynch, head of infection prevention, employee health at Harborview, Tim Dellit, our chief medical officer for UW Medicine, Anne Browning, assistant dean for Well-Being, Cindy Sayre, CNO for UWMC, and Rick Goss, medical director for Harborview.

Trish Kritek:

A few folks are off on a vacation. Jerome is getting ready to come in around at night, so they're not with us today. We have a special guest this week. Joining us on town hall this week is Dr. Paul Ramsey, our dean and CEO of UW Medicine. It is our pleasure to have you join us today, Paul. I'm going to hand it over to you right off the bat, because I know you have some words, and Anne has handed off the Well-Being message to you for this week. The floor is yours.

Paul Ramsey:

Thank you, Trish. Good afternoon, everyone. The story behind my being with you today is I had asked to have a chance to thank everyone. I'd like to especially thank, to start, the panelists for today. Tim, John, Santiago, Cindy, let's see, Anne and Rick are the panelists, and then a special thanks to the outstanding host of this series of town halls, Dr. Trish Kritek. Trish, I greatly appreciate your leadership of the town halls in this extremely important communication across UW Medicine. Most especially, even, Trish, beyond thanking you, I want to thank everyone, all of the participants in the many town halls, all of our workforce.

Paul Ramsey:

I understand how hard everyone is working, and I greatly appreciate your commitment to all that you do to support our mission, to improve health for all people. Thank you to everyone. When I asked to join, I didn't realize that I would be put to work, and I'm not sure whether Anne Browning is responsible for that or Trish. I think it was Trish's idea that I'd be put to work, so thank you, Trish. I am very happy to talk for just a couple minutes about wellbeing. Wellbeing is what we're all about. It's our mission to improve health for everyone.

Paul Ramsey:

We, as healthcare professionals, cannot improve the health of others unless we pay attention to each and everyone's individual wellbeing. With Trish's request for me to say a few words about wellbeing, I tried to condense my thoughts. Many of you know I'm a primary care physician. I used to have a large number of patients. I now have a small number of patients. So over the years, I've given a lot of advice to patients about wellbeing. I also have thought about it more for myself and others on our workforce these last few years than ever before.

Paul Ramsey:

We clearly have a very long list of activities and behaviors that have been demonstrated to contribute to wellbeing. I thank Anne Browning and many others for assembling a menu of options that are available to our workforce of activities that can be available for wellbeing. When I think of this long list of activities and behaviors, my simple mind focuses first on three basics, sleep, diet and balance are my three basics. By balance, I mean balance among priorities, balance among time with family and friends, time for one's self, and of course, the professional time, which is so demanding for all of us today.

Paul Ramsey:

Beyond these three basics of sleep, diet and balance, that's where there's a very nice, long and comprehensive list that creates a menu for us to each choose activities that can promote our wellness. I guess I would leave you with three points that I use myself as the key points for continuing to focus on my own wellbeing. You need to be a little bit selfish with this. It is focused on each other's individual wellbeing. And of course, as team members and workforce, we can help to support one another.

Paul Ramsey:

The three key points that I focus on are, first, what works for the individual. In my case, of course, what works for me as an individual? Just like all aspects of medicine today, we should not treat a patient based on what works on average. We're in the era where we're trying our best to do precision medicine. I have recently, and recently as the last couple years, been thinking more and more about precision wellbeing. How do we tailor? As a primary care physician, how do we help a patient tailor a wellbeing program for the individual?

Paul Ramsey:

As members of a workforce, how do we help each other tailor individual approaches to selecting the activities and behaviors that will promote each individual's wellbeing? My first keypoint is try to focus on precision wellbeing for each individual, and share what works. My second point is that an approach to wellbeing, just like a medical treatment approach, should not be static. Conditions evolve. Each individual evolves, and the approaches to wellbeing, I think, we need to continue to evolve.

Paul Ramsey:

As I think back over my last two, three, four decades of trying to keep myself well to focus on my own wellbeing, I think I've used trial and error. I have tried different things. Some work. Some work better than others. Some don't work at all. Some don't contribute to my wellbeing. I think it's important to begin with selecting a program, but then just like we do when we're prescribing a treatment, have to evaluate how it's working, and use trial and error to create your own individual wellbeing program.

Paul Ramsey:

The last keypoint, which I think is more relevant the last two years during the pandemic than perhaps before, but it's always been relevant. That is, I think, you need to schedule. At least I need to schedule my wellbeing activities and behaviors. You need to schedule the basics. You need to schedule sleeping and eating. Sometimes eating is deferred. One of our panelists was just eating as we start this town hall, but you need to schedule the basics.

Paul Ramsey:

I say this is perhaps more important now because of the extraordinary time of rapid change in medicine, and the unpredictable, uncertain nature of what we're doing, the uncertain nature of the pandemic, the uncertain nature of our equity, diversity and inclusion of progress. We are in an era where we have to do our best to define what we can do, and do it. That means in this time of uncertainty and time of rapid change, scheduling provides some control for ensuring that some of the most effective activities that work for each individual are scheduled, so they work.

Paul Ramsey:

For me, that bottom line is the balance, the time with children, grandchildren, scheduling that time. For me, exercise is a big part. Many of you know that I schedule that exercise at 5:00 in the morning. So usually, Trish is not calling me at 5:00 in the morning, or Tim Dellit sometimes tries to call me, but not Trish. Then making sure that there is a balance of the professional activities, and I'm setting the priorities for those activities so that I can have that balance with friends and family and some time for myself and time for exercise.

Paul Ramsey:

My message is please schedule, please focus on your individual precision wellbeing, and don't keep it static. Keep it fresh and new, and try some new activities. Thank you, Trish and Anne, for your leadership in this. My best wishes for wellbeing for all of our workforce. Thank you.

Trish Kritek:

Paul, thank you so much. Really appreciate your time. We know you have to run off, but we appreciate you coming and saying a few words about wellbeing. It's meaningful for all of us. Thank you so much.

Paul Ramsey:

Stay healthy.

Trish Kritek:

Thanks. Bye-bye. All right, we're going to jump in. John, I'm looking at you. I'm going to start with you, and we're going to start with UW Medicine, King County, numbers if that's okay.

John Lynch:

Sure. Is it okay if I snack while we're doing it, or just-

Trish Kritek:

Evidently, yes because we want to get to your focus on your diet. I do not... You cannot take a nap during town hall. You have to stay awake.

John Lynch:

Total patients across UW medicine are down a little bit. I think that we continue to see a very slow decline as we talked about in the last couple of sessions. As of 7:00 this morning-ish, we had 58 patients across UW medicine, 24 in acute care, 34 in the ICU. Valley's numbers still are on the higher end at 24 people split evenly between the acute and ICU. Northwest is down, which is wonderful, two and two. Montlake is stable, around 13 with eight people in the ICU. Harborview is at 17, which is getting...

John Lynch:

I don't know why, but I look at each 20 to 30, 10 to 20 as a good number, and we're less than 20, so happy with that. We do have 12 of those people in the ICU, and we have two people on ECMO. I don't know, Santiago, if you know the Montlake ECMO numbers right now. I didn't get that information today.

Santiago Neme:

I don't, but Trish might.

Trish Kritek:

I think it's one patient. I'm actually on service in the ICU.

Santiago Neme:

Right.

John Lynch:

I just want to point out that the number of people on ECMO just remains extremely high. We have four total at Harborview and then more at UWMC. I also want to just point out that this continues to impact many different populations. Montlake, for instance, they have a person on L&D right now who has COVID.

Trish Kritek:

Thank you for showing the breadth of folks that are impacted by ongoing disease. I am encouraged that we're down into the fifties. I think that that is an optimistic note, which I'm excited about. We've talked about it before... Actually, do you want to talk about King County in the state? How are we doing there real quickly?

John Lynch:

Sure. I also forgot to mention, and thanks to you, Trish, for sending me those numbers. Seattle Children's also continues to see cases. They have between six and 10 kids, both in the acute care and the ICU at any given time over the last couple of weeks. It's the whole spectrum of age groups. Across King County, the numbers continue to trend down slowly. As of 9/27, so a couple of days ago, which is normal, we're just about 450 cases per day. That puts us at a rate that still is very high, about 145 cases per 100,000 people, but that trend is slowly coming down, so heading in the right direction.

John Lynch:

Fortunately, we're starting to see the same trend in Washington state.

Trish Kritek:

Which is great.

John Lynch:

The absolute number of cases going down, but also the absolute number of hospitalizations. We always think about cases first and then hospitalizations and unfortunately deaths as lagging. They take time, so to see hospitalizations go down, and in King County, starting to see the deaths due to COVID go down really makes me feel very confident that that trend in the number of absolute cases is very real. I think probably you've seen in the media, this is true across the United States. The case counts by CDC are going down, and our death rate actually drops for the first time since June across the United States.

John Lynch:

We know we have lots of problems in different parts of the U.S., including different parts of Washington state, but the overall trend is in the direction we are all hoping for.

Trish Kritek:

Which I think is encouraging, so I'm going to take that as a moment of optimism. Relevant to that, are we seeing a decrease in numbers of employees who are COVID positive?

John Lynch:

Yeah. I'll just tell you the numbers. In the last... As of this morning, yesterday, about 70 people got tested. Two are positives, 2.8% of folks, so small absolute numbers. Over the last week, 16 positives out of 393. These are, again, folks only tested in UW Medicine, which is about 4%, which is a little bit higher than our baseline, but is very similar with what we're seeing out in the community. We don't have a good sense of what the test positive rate is in the community, because there are some snafus on the data collection side.

John Lynch:

Hopefully we'll be able to give an update maybe not next week, but the week after when I get to see you.

Trish Kritek:

That's great.

John Lynch:

That's still low, nothing outrageous at all.

Trish Kritek:

I think one of the things that folks have asked is are most of those breakthrough cases for our employees since so many people are vaccinated? We've talked about this before. I think the answer must be yes.

John Lynch:

Yeah. I mean, I say when you look across King County, I say we just hit another threshold there. I think it's greater than 80% of all eligible people in King County are now vaccinated.

Trish Kritek:

Wow.

John Lynch:

It's not surprising that when we see positive cases, we're seeing them among vaccinated people. When you look across the entire United States, when you look at the hundreds of millions of vaccinations out there, there's going to be a lot of people who get infections. What I can tell you though is based on what we know in UW Medicine, these folks aren't ending up in the hospital, right? These UW Medicine, vaccinated health workers, some of them are positive while being vaccinated, but they're not getting sick enough to end up in any elevated level of care.

Trish Kritek:

So infected breakthrough, not getting super sick. I'm going to pop over to boosters, because people are asking a lot about that. But before I do, do we know if there's more likelihood to break through if you got a Johnson and Johnson or Moderna or Pfizer?

John Lynch:

It's a really hard question to answer. The reason is that it takes time from your fully vaccinated status. For Moderna and Pfizer, that's two vaccines when you got that. Then we had this additional challenge of when were you in a peak? And then was it during a Delta peak, right? Obviously, the most recent one, we had a big peak. We had it during Delta. We had people vaccinated back out in December and January. Other people vaccinated in August, in September. It's a little challenging to piece this all apart that we're probably going to see some differences, but I would say that the take home here is that even when we look at those differences, we're looking at very small differences between them.

John Lynch:

There may be some difference between the Moderna versus Pfizer. Maybe one shot of J&J is different than two shots of the mRNA vaccines. We may be seeing some activity around those things. But even when you take those all together, and you look at the infection rates, the separations between them are very, very small. My confidence in getting any of the vaccines now remains extremely high. They are very effective, very safe, and they are keeping people out of the hospital.

Trish Kritek:

So take home is they're all good, which we said over and over again. I do think I heard you say maybe J&J isn't quite as good as the mRNA vaccines, but maybe that's not definitive even as well.

John Lynch:

It may be that it's not that the J&J is not as good. It's just that one dose of the J&J may not be as good as two doses or a dose of that sort of thing. I think-

Trish Kritek:

Or the mix and match or something.

John Lynch:

Yeah, which a lot of people are working on right now.

Trish Kritek:

Let's talk about third doses or second doses or boosters. How many boosters or third doses in non-immunocompromised folks have we given? I'm going to say it really slowly, because you're looking up the data. Have we given across UW medicine so far?

John Lynch:

I almost forgot to bring that up. Huge thanks to Jenny Brackett, who's been one of the amazing champions in keeping the vaccination program functioning. When I look across total, as of... Let me see here. It looks like... Oh shoot, I'm sorry. There's two different... Third dose data, 11,300 doses.

Trish Kritek:

11,300 already, that's a lot.

John Lynch:

They're amazing, aren't they?

Trish Kritek:

That's amazing. That's wonderful. Those are all people-

John Lynch:

Third dose, that's immunocompromised and boost.

Trish Kritek:

That's people who got it earlier because they're immunocompromised, and now, there are healthcare workers who are getting their third dose of Pfizer.

John Lynch:

It looks like an estimate's around 6,000 booster doses. To be clear for everyone, a third dose right now is the standard series for a person who's immunocompromised, three doses. It's three doses. A booster is when you're going outside the series, right? So maybe associated with durations of time from the last vaccine, or may have to do with the season, right? That's how we're looking at third doses for people who are immunocompromised versus boosters right now.

Trish Kritek:

I got my booster on Monday because I'm a healthcare worker, and that was approved, right?

John Lynch:

Correct.

Trish Kritek:

Just in case someone asks, I did feel kind of crappy, but it was short lived and felt totally fine the next day. A lot of people are asking about, "I got Moderna. Can I get Pfizer as my booster?" I want you to answer that question, but also respond to the fact that there are some studies about mixing and matching.

John Lynch:

No. Right now, the answer's no. The current recommendation is this first wave is for Pfizer only, so you had Pfizer vaccine series. This is a Pfizer boost, and we don't want to go outside of that right now. I fully anticipate to see additional updates in the near future around Moderna, and hopefully stuff on mixing and matching, whether it's J&J plus an mRNA. These are all in the works. Researchers here at the University of Washington are doing a lot of this work as well as our colleagues across the planet. I'll say just to be very, very clear that I got Moderna.

John Lynch:

I am not stressed about this time to a booster. I feel very confident in this. I'll just share my wife is a nurse. She also got Moderna. She's in UW Medicine. She's not stressed. These vaccines, the two-dose series are highly effective against protecting us. The third dose provides an incremental benefit, may have some help with longevity of the duration of immunity, of a very high level immunity, but two doses keep us safe. And so if you're really, really worried, please talk to your primary care doctor.

John Lynch:

Reach out to me or Santiago. I won't put everyone else here on the list here. I just want you to feel confident that it's okay to wait. I have not got that additional boost, and I feel very safe.

Trish Kritek:

Okay, so the answer is if you got anything other than Pfizer, there's not a booster available for you now.

John Lynch:

Not you. Yep.

Trish Kritek:

There will be in the future most likely, and we're just waiting for that to happen, and we feel good with two doses. To be honest, I felt conflicted about getting my booster. I'll just say it out loud when lots of people haven't gotten a first dose. I think it is an interesting space for all of us to navigate, and there's a lot more to come. We'll keep talking about it as more information comes out. How about if you're a pregnant person and you're trying to figure out when to get a booster?

John Lynch:

A booster?

Trish Kritek:

Well, you got vaccinated, and you're like, "Is there a better time during the pregnancy to get the next dose, or should you just get it now?"

John Lynch:

Actually, I got just late breaking in the last hour or so, the American college of Obstetrics and Gynecology just came out with a very strong recommendation that all pregnant people need to get vaccinated now. It's not ambiguous, not guidance. This is what you should... This is the expectation. This is the standard of care, and the vaccinations are safe in pregnancy. There's no specific timing, first, second, third trimester, any time during breastfeeding. All good, so you should just continue to follow the recommendations as for folks who are not pregnant.

Trish Kritek:

Okay, so follow recommendations the same as everybody else, and the recommendation is stronger from the organizations about, "Go ahead and get vaccinated."

John Lynch:

Yep.

Trish Kritek:

Now, let's pivot to small people. Any news on when we might get the vaccine for five to 12 year olds?

John Lynch:

I want to go back a few months. Who said this? I think I said something around the end of October, back in the summer, and I think-

Trish Kritek:

We have them recorded, so we could find what you said.

John Lynch:

I think you should go back and look, Trish. It looks like we might have... I think it's been submitted. Someone might be able to put it in the chat, but I believe that we're moving ahead towards possible evaluation by the end of October, which is fantastic.

Trish Kritek:

Super exciting. We're thinking optimistically towards the end of October. Will we at UW Medicine be offering vaccination for children?

John Lynch:

Yes. I did confirm with Jenny that... Right now, we do 12 and above, and the plan would be that whatever the next age, group five to 11, that UW Medicine would be doing those groups as well.

Trish Kritek:

Okay, so I think that's really important. I got a bunch of questions about that. We'll be doing vaccination.

John Lynch:

I can see everyone getting more and more excited.

Trish Kritek:

Well, we have several weeks to get revved up, so soon hopefully and across UW Medicine. I think that's good. I'm going to give you a break for a little bit. Thank you for answering all of those questions. I'm going to pivot over to Tim. Tim, I'm going to talk to you about vaccine exemptions and the vaccine mandate, because there were many questions about that that came in through town hall this week. I think one question people ask is like, "How are we being equitable and how we're assessing people for medical exemptions across the system?" Is there some standard process for assessing those?

Tim Dellit:

No, that's a great question. We're trying to be consistent not only across our different hospitals within UW Medicine, but within the university as a whole. As an example, all the medical exemption requests are reviewed by a group that includes individuals from EH&S, which is upper campus as well as representatives from UW Medicine. Collectively, they're reviewing those together so that we have a consistent response. Similarly, on the religious exemptions are all being evaluated through HR, so there's really a lot of focus to have consistency.

Tim Dellit:

Now, again, there's still some recognition of what can be accommodated within a clinical environment where there's direct or indirect patient contact versus non-clinical environment, but the process we really try to have a consistent approach across the university.

Trish Kritek:

Across the university, across all of UW Medicine, but across the whole university, which is great collaboration, I think that that's helpful for folks to understand that we're trying to use one clear standard on these. How many of our employees, I'm going to do with the positive of this to start with, have been vaccinated and maybe you know where we stand in our different categories on that?

Tim Dellit:

This is I think really tremendous. When you look at our staff across our medical centers, we're at roughly 97% vaccinated. That is phenomenal. I would say our medical staff, we're probably 99% plus. We are doing extremely well. We still have people who we're trying to outreach to. We continue to want to offer and educate around vaccination, and continue to work on those areas where either we haven't gotten a response or we also... The good news is that when we see people who have applied for exemptions, if they are denied, we've also seen a large number of those individuals go on to start their vaccination series.

Tim Dellit:

We're in really good shape there, and we just got updates from our school of medicine, so including all of our staff, we're at about 90%. Some of that is just we're still getting information. For instance, we have shared individuals, our pediatric faculty as an example. We've developed a process to be able to get that verification information from Seattle Children's, and are in that process. Again, that's a very conservative number even within the school. So overall, I think we are in really good shape in terms of moving towards that October 18th deadline.

Trish Kritek:

That's an incredible number. 97% is really remarkable. 90% in the school is really remarkable. Thank you to everybody who has gotten vaccinated. I know there's still people who are really struggling with this, and it sounds like there are opportunities to talk about it. I asked this before, but the question came up again, so I'm going to ask you again. Is there an appeal process if the exemption is not granted?

Tim Dellit:

No, there's not an appeal process. Again, there's a very consistent standardized evaluation, but if that exemption is declined, there's not an appeal process because the facts around what led to that declination are not going to change.

Trish Kritek:

Okay, so there's no appeal process because we think we have the standard process of looking at it, and we don't think that there's going to be gray that needs to be clarified. Do you have a-

Tim Dellit:

And if there is, there's always... We can get more information prior to making that determination.

Trish Kritek:

Okay, so we're reaching out prior to it so that we make the most informed decision as possible. Do you have a sense of the impact on our workforce of the folks who have chosen to leave or will lose their jobs based on this at this point?

Tim Dellit:

We don't have those numbers yet. In part, we know how many exemptions, and I'll just tell you. For the medical centers, we've had 360 requests for exemptions for religious reason, and about 64 medical. Of those together, about a third have been approved and two thirds have been denied. Again, as I mentioned, many of those who have been denied are now starting their series. We won't yet know until next week. Now, next week is an important date because we're two weeks prior to the 18th. So by that time, we'll know who will not meet that requirement to be fully vaccinated, but then there are a number of different pathways just as an example.

Tim Dellit:

For instance, if someone starts their vaccine series prior to the 18th, they may not be able to work after the 18th. Again, depending on the circumstances, they may be on leave. Again, it's a little bit complicated in terms of whether it's unpaid or whether they're using vacation or other accrued leave, depending on the circumstance of where they are, either the denial or vaccination process, but that complicates knowing the final number until we hit to the 18th.

Tim Dellit:

But by next week, we will know who won't be fully vaccinated. So on the clinical side, that's important because then we know where we have to potentially mitigate holes in the workforce, so to speak.

Trish Kritek:

That seems like around 300 people that might be in that space, and we'll understand that more after there are some more opportunities for conversation and potentially some decisions to get vaccinated. Have you been part of any conversations on campus since we're collaborating with upper campus a lot on this about rapid testing? Are we going to do more testing across campus?

Tim Dellit:

There's a little bit of a distinction. We haven't been changing it. John and Santiago can correct me in terms of our approach within the clinical environment. Again, in the upper campus, particularly with return of students, they have a Husky testing program, which is really supported by the Seattle Flu Study, so a little bit different than our laboratory medicine colleagues. They communicate obviously in terms of overall coordination around testing strategies, but I think what you're referring to is really focused on the upper campus population.

Trish Kritek:

Probably. I mean, I think people are curious about it feels like there's lots more people around, and I think that's causing some anxiety in our environment, and people are wondering about, "You just don't know," so are we going to test people more often?

John Lynch:

We are doing a pilot at Northwest in the Geropsych unit. Santiago, I'm not sure if you know off the top of your head, but I don't believe it's found anything. That's a congregate unit where there's a higher risk. Older adults, they're not wearing masks, and healthcare workers, all moving around. So far, it's not really finding anything, but it doesn't mean we won't expand that, but we're looking at data.

Trish Kritek:

It sounds like we're piloting doing some more testing in special spaces. No evidence that that's revealing a lot yet. More to come. Is that about right? Okay, thank you. Last question, Tim, before I move on, are we going to make boosters mandatory?

Tim Dellit:

Not at this time. Again, the proclamation is really focused on for Moderna and Pfizer, those initial two doses, or Johnson and Johnson, the single dose. Boosters are not part of that requirement in terms of meeting that by the 18th.

Trish Kritek:

Okay, so not boosters. Obviously, I mean, right now, it couldn't be for the 18th because there are some types that we don't have boosters for yet, so thank you for clarifying.

Tim Dellit:

Exactly, and so I think some of this will sort itself out as we go forward, I think. There is a tension, as you mentioned earlier, between being eligible for a booster or certainly, the immunocompromised definitely should be getting that third dose. I would encourage those who are eligible for the booster to do that, but there is that tension of availability here and the ability to do that versus when you look worldwide, and you see areas that just don't have access to the vaccine.

Tim Dellit:

That's a very real tension that I think many of us, including I think people when they were weighing this through the FDA and CDC, they were really feeling that tension as well.

Trish Kritek:

I think that's part of why we saw a split boat and as people weighed that, so thank you. I'm going to pop around a bunch now because there's a bunch of different types of questions, and so Rick, Cindy, Santiago. Rick, I'm going to start with you. Are we planning to resume all surgeries next week? What is the plan with the surgeries that have been rescheduled? Are we continuing to reschedule or where do we stand?

Rick Goss:

Great. Thanks, Trish. Good afternoon. Pretty simple answer here that we are resuming the full schedule on the operative environment effective next week. Many patients have been rescheduled, and for the most part, they will be accommodated in very short term, and the schedule will resume.

Trish Kritek:

That's great to hear. I think lots of people have been worrying about those patients who have been maybe waiting a bit for their surgery, so thank you for that. That's good to hear. Cindy, visitor policies. Question about... We had some evolution specifically asking about proof of vaccination and whether or not we're going to reconcile, so our visitor policies are the same across sites again.

Cindy Sayre:

Thank you. We are continuing to have a lot of conversations moving towards wanting validation of vaccine or a negative test for visitors in the medical centers, for sure. That is all progressing, still questionable about what exactly we're going to do in the outpatient setting. That's still to be discussed. What was the second question?

Trish Kritek:

Let me just... What I heard was unclear what we're doing with vaccination status in outpatient setting, moving towards vaccination status on the inpatient setting. Harborview is not having visitors. I know you're not at Harborview, but maybe you know where we stand with reconciling the policy across sites.

Cindy Sayre:

Well, I think what we want to do, we standardize to the degree that it makes sense, right? But then we also recognize that we have three very different buildings, and so we want to be adaptive to our environment. That means that necessarily, there's going to be some differences between the policy and how it's operationalized at the different medical center. At this time I think, we want to standardize where it makes sense.

Trish Kritek:

At this time, they're going to stay different, I think, is the take home there.

Cindy Sayre:

That's basically it.

Trish Kritek:

Because there's different populations and different risk factors, and we're going to keep adjusting based on those, so thank you. I think the proof of vaccination will be something that people are interested in hearing more about as we move forward with that.

Cindy Sayre:

Yeah, and there's lots of details to work out about exactly what that's going to look like, but I do want people to know that's coming for the inpatient side.

Trish Kritek:

Okay, so on the horizon for the inpatient side. Santiago, how are we doing with antibody treatments, and how are we prioritizing who gets antibody treatments?

Santiago Neme:

Thank you. Good afternoon, everyone. There's been an evolution on this, because first, you have an EUA, an emergency use authorization that was very broad in terms of criteria. Even for instance the criteria for weight was a BMI greater than 25, which is a lot of the population, right? We started with those very broad criteria at UW medicine. We adopted that to include some demographics, some issues around equity, race, ethnicities, et cetera, but then we heard from King County who actually, I think, helped start a conversation around supply across the region.

Santiago Neme:

It was identified that although we had pretty good supply, other healthcare systems had a more limited supply, so then the idea was given that we have less supply, let's have a central distribution just like vaccines. We're all getting some but not a system getting more than others. At the same time, this also coincided with really limiting the criteria for the use of monoclonals. So for instance, in the past, we used to take 10 days from the onset of symptoms until the monoclonal. That was our timeframe. Now, it's seven days.

Santiago Neme:

In terms of who are the vaccinated patients really who qualify today, only if you're over 70 years of age or you're moderately or severely immunocompromised, very different criteria from the EUA. Now, we're working with that county-defined criteria, all of the hospitals. It's caused a lot of frustration, I have to say, because we changed gears because we had to, because supply is different, and that's what we're facing today. We're still...

Santiago Neme:

We've treated over 110 patients since we expanded on August 29th, and the program is robust. We have multiple spots, but it's evolving and it's being adapted based on supply and also on potentially new products. I would say if you are getting frustrated because you're no longer qualifying, you would've qualified three weeks ago. It's because the criteria that we go by is set by King County.

Trish Kritek:

I think the big take home there is the way we're prioritizing them is based on the criteria that King County puts forward, which have become stricter because we're controlling the... There's a limited supply, and we're controlling it at a state level. Some things I heard was seven days of symptoms. If you're vaccinated, over 70 or moderate to severe immunocompromised, but people can look at all those and understand they're coming from King County.

Santiago Neme:

It's on the website. It's on the website. And then just as a reminder, we still review all of the positive tests of UW Medicine, and we still have the REDCap surveys for internal providers and external providers and employees. We have all those avenues.

Trish Kritek:

So you keep the same routes to try to sign up for it. Relevant to testing, I got actually a bunch of questions about feeling like there was a wait time for employees to get in, and curious about are we thinking about expanding testing people are feeling if they're waiting several days to get a slot in our testing system as employees?

Santiago Neme:

I think part of it is really knowing the correct route to request that appointment. Because for instance, one, we think that the phone number is the easiest thing, and this is where you encounter typically a wall when you sometimes call. But if you go through REDCap... For instance, two days ago, I had a surgeon call me and say I can't get in. I was like, "Did you go through the REDCap survey?" He says, "No." Well, there were 30 available appointments at Northwest that day for staff, so I would encourage folks to use the REDCap survey.

Santiago Neme:

There's also a phone number. I can put them in the chat, but it's really important to go through the REDCap survey. That way, we can track. Family members are also welcome to... For family members, you call the phone number, even if the exposure of your kid happened to have nothing to do with the hospital. So basically-

Trish Kritek:

So use REDCap, and kids can use it even if the employee was not exposed.

Santiago Neme:

REDCap is only for staff. The family is the phone number. But what I'm trying to say, if there's someone in your household with symptoms or exposures, get them tested. I'll send that info on the...

Trish Kritek:

People want to have the REDCap information sent out again. REDCap is for employees. Phone number is for kids, but kids, even if the employee was not exposed, can use our system.

Santiago Neme:

Yes.

Trish Kritek:

Correct?

Santiago Neme:

Correct.

Trish Kritek:

Thank you for clarifying that. I'm sorry if I made it more confusing.

John Lynch:

The contact center should be overbooking for family members.

Trish Kritek:

Sorry. Say it again, John.

John Lynch:

Contact center who answers the phone for family members should be overbooking preferably on the same day. That's our goal.

Santiago Neme:

Exactly. And then the other thing I want to say, if someone is getting, for some reason, difficulty, just call one of us from your respective... No seriously, from your campus, either Seth, me, John, whoever from our teams, because we really want to emphasize the safety of those families and the staff.

Trish Kritek:

Thank you. I think it's really important because there's lots more kids getting in places where they're exposed and want to get tested. Use the phone number if it's a kid. They should be overbooking. If you're running into boundaries, then talk to the folks in the infection prevention employee health offices like Santiago, John, Seth, et cetera.

Santiago Neme:

Chloe, et cetera.

Trish Kritek:

Chloe. We could list lots of names. Thank you very much. Rick, I'm going to pop back to you. I asked Santiago about antibodies. One of the questions, which we haven't had in a really long time, but I wanted to re-ask it was I'm going to ask you to wear your internist hat. They said, "When should a patient who's positive seek care in the hospital? When should someone come in and be seen?" I'm curious what your advice would be to your patients about that.

Rick Goss:

It is a question that has come up. I think with so many changes in the overall surges and treatments and options, I think people still ask that and wonder. I believe that the core principles that have always been in place really remain, and that is that the vast majority of people that acquire COVID will be safely managed and will recover while being home and being isolated, monitoring their symptoms and using symptom management. The biggest worrisome signs are shortness of breath and, of course, just feeling worse, a deteriorating set of symptoms and conditions.

Rick Goss:

There, we do want people to stay in touch with their providers. There may be that threshold where we do ask that the patient come in, who may then need to be admitted. There's the discussion we just had about monoclonal antibodies, where there may be some criteria that people will be eligible for. They're, again, staying in good touch with your provider. There's also a website available that people who may not have a primary care provider in our system can also access.

Rick Goss:

Obviously, open as well to the experts, but from the primary care view, I think really those core principles, knowing that the vast majority of people can continue to be safe and get through this, whether you're vaccinated or unvaccinated, open to others.

Trish Kritek:

Well, first of all, you're an expert in that, and so I think that that concept of the vast majority of people are fine at home. But if you're feeling short of breath or progressive shortness of breath, that would be a good time to, a, be talking with your primary care provider, and, b, potentially come in. I like the communication with your primary care provider. I don't know what that website is where other folks can get that information, but maybe we can share that in some way if that is feasible.

Trish Kritek:

Cindy, I'm going to pop back to you. People are still worried about our staffing situation, so wondering where we stand with what we're doing to try to retain the folks we have. Obviously, they're a priceless resource in our community right now.`

Cindy Sayre:

100%. I am one of those people that are concerned about nursing, the number of nurses that we have in our system. What I can tell you is that we are talking about it every day, and there are lots of things in the works. We are in active negotiations with some of our labor partners, and so that limits what we're able to say right now. The best I can say is that we're talking about it every day. There are plans and trying to make sure that this is the best health system to work for. If I can say one other thing-

Trish Kritek:

Yeah.

Cindy Sayre:

It is tempting when you see a big sign-on bonuses at other places, and some systems just have a lot more money. That is just the truth, but what I can tell you is that our ratios are very close to standard most of the time throughout our health system, which you can't say about other places in our area. There are other considerations than money. I continue to feel like we are just doing such a great job of leading through the pandemic on the clinical side, keeping our staff safe and doing everything we can to push resources to the bedside.

Trish Kritek:

There's stuff in the works. There's conversations on a daily basis. I can't get into the details of all of that right now, which I appreciate. I think just for people to understand, staffing means... The ratios means how many patients to a nurse, and that our nurses... Go ahead.

Cindy Sayre:

Well, I do acknowledge that it's not... There are sometimes when nurses are taking an extra patient than they would've normally taken. I think I am saying that most of the time, we are within our ratios and certainly doing much better than other systems in our area.

Trish Kritek:

I think that's a form of support of our nursing staff that you're highlighting, and I appreciate that. I'm hoping that we'll hear more about that as we move forward. Thanks. This is kind of... Well, I'm going to pivot up to John, but it's you and John, Cindy, a lot of questions about people not wearing their masks in public spaces in our institutions. The reason I'm including you, Cindy, is a lot of them had to do with the third floor of Montlake, but also in hallways and things like that, maybe because they're drinking or eating.

Trish Kritek:

I just wanted to hear from a couple people about what's our guidance on that? How are we helping people keep their masks on, but also be able to eat and drink? I don't know who wants... John, you can go first.

John Lynch:

I can jump in a little bit. Just broadly, and then Cindy can certainly address Montlake. We've been at this now for 20 months. We have lots of great masks, surgical masks, multi-layer masks that have excellent data supporting their safety. I think we've gotten the routine of using these in any indoor space, right, including at work. We high policy and we really strongly, strongly support all health workers who come into the facility with their cloth mask or any other type of mask that's not like this, needs to go to their work site and exchange it for one of these.

John Lynch:

If you forget to bring your mask in the morning, then just go through the visitor entrance. They all have masks. We actually want all visitors be wearing this level of mask as well, and we'll work on operationalizing that. I just say as an infection prevention person here at Harborview, and I'm sure Santiago and Cindy and everyone else feels similarly at Montlake and Northwest, we want to see all healthcare workers in our facilities wearing one of these multilayer medical surgical procedure masks, and not wearing the cloth masks that they're used to.

John Lynch:

If they really, really, really have some issue with cloth masks or these types of masks, these masks can go over the cloth mask, but what I'd ask you to do is to talk to employee health, because we have other varieties that may be more comfortable that may not have the same reaction or similar. Is that good?

Trish Kritek:

That's a start. That's a great start, so employees, wear a surgical procedural mask. John is showing it, and we're in the process of operationalizing it for visitors. I think... That was a question that came up. Is that... I just want to follow up that one thread real quickly. Is that true for outpatient settings too that we're going to operationalize having surgical masks for patients?

John Lynch:

Well, our goal is to do this for all screening spaces, so where all patients get screened, and visitors get screened. That would be the thing. To be honest, we had it in place, but you got to maintain it. You never... In infection control, we just know you can't ever take your foot off the gas. You just got to keep talking about it. Keep reminding people. Buffs started to sneak back in after being really clear about not having them, and it's just natural human behavior.

Santiago Neme:

And-

Trish Kritek:

Go ahead, Santiago.

Santiago Neme:

No, I just wanted to add the common thing that's happening is that people are not wearing their mask, and staff feel like they don't want to talk to that individual and correct that. I would really ask everyone to try to do this because I don't think it's what we're saying. It's just how we're saying it. I think there are

polite ways to approach this, but it's really about our safety, and it's about the safety of our coworkers, our patients and our own.

Santiago Neme:

No one should feel embarrassed or concern or self-conscious about having that conversation with the person, because at least most of the time, I think they go pretty well, and people acknowledge that they should be doing something different.

Trish Kritek:

I think the things I heard were all healthcare workers should be wearing a procedural mask. We're moving towards all visitors wearing a surgical mask, even if it's over a cloth mask. It's part of our responsibility with each other to speak up when we see people not wearing their mask. I want to acknowledge that it's not always easy, because there's lots of different power differentials within our environment. I think where it feels like you can do that, do so.

Trish Kritek:

If you can't, then speak to your supervisor and have them help you, because that is a challenge, but please be a part of the community as much as possible is the message I heard. John, I'm going to ask you a couple last questions before I hand it off to Anne. If I lost my vaccine card, how do I get a replacement?

John Lynch:

Actually, I looked at this. There's a bunch of different ways. First thing I want to say is if you get your vaccine card, take a picture of the front. Take a picture of the back, right? Treat it like a credit card. That's the first thing to think about. Treat your vaccine card like a credit card, so don't misplace it. Stick it someplace. You want to really have it. The second thing you can do is you can go... If you just Google vaccine card replacement DOH, Department of Health, it'll bring up a whole website.

John Lynch:

It actually has recommendations around what to do. But if you don't even want to do that, just go to myir.net, M-Y-I-R.net, or just Google MyIR. That's the Washington State vaccine tracking program. You can find your vaccine. You have to register, but you get it on there. You can get it on your phone. It's MyIRMobile. It'll be on there. These are all acceptable with the upcoming King County requirement, so physical card, a picture, the MyIRMobile. All of those will work, and you can order another vaccine card through them.

Trish Kritek:

So MyIR.net, take a picture of it. I took a picture only of the front. I'm going to go take a picture of the back later, and treat it like your credit card, or better than I treat my credit cards, because I lose them, so keep track of it. Flu shots are starting next week. I think people are already getting them. I got mine when I got my COVID booster. Do you need to sign up for the flu vaccine, or can you show up?

John Lynch:

I think there's a whole variety of mechanisms. Our amazing employee health teams have over the years worked and distributed the expertise for administering vaccines, the rolling carts and stations and all

kinds of things. The goal here is to make it as easy as possible. That includes getting your full vaccine or your COVID booster at the same time. I think the employee health teams are really... Their goal is to make it accessible and easy.

John Lynch:

No scheduling as far as I know is needed anywhere. You'll be seeing flu vaccines just like you have in the past.

Trish Kritek:

Last question before I hand it over to Anne. What about when I go outside of the hospital, do I need to keep my mask on then?

John Lynch:

My routine is yes. I just continue wearing it until I get to my... I drive to work until I get to that car. If I was for instance, taking a bus, I would just keep it until I got home. These are really wonderful masks. To be honest, as we think about being in public situations, the ability to buy a box of this level of mask at Costco, at Safeway, at all these places is pretty reasonable. They're all out there, CVS, whatever, Walgreens, Fred Meyer. I would consider using these when I'm out and about. I'm not sure what I said.

Trish Kritek:

I just want to give you credit for acknowledging every place you could buy them, and not just being a Fred Meyer person or a Bartell person.

John Lynch:

Bartells, Target.

Trish Kritek:

I got it. Buy some surgical masks.

John Lynch:

These are what I wear all the time.

Trish Kritek:

So do I.

John Lynch:

I don't wear a cloth mask. I would just wear it as soon as I get home, and then it goes in the garbage, and then I get a fresh one.

Trish Kritek:

The recommendation is you have to wear it outside. You don't have to, but the recommendation is to do that. Anne, the floor is yours. Save me a minute or two at the end.

Anne Browning:

Absolutely. I've got Santiago on the hot seat. Welcome, Santiago. We had a bunch of questions come in. We'll see how many we get through. I'll also say that in the chat, I put in some resources around our peer-to-peer program. We would like to normalize that as something we do when things are hard or we have a difficult experience, and we can refer ourselves or refer a colleague. I also put in a link to our mental health support services as well. Thank you to the person in the chat who mentions the challenging moment that we're in.

Anne Browning:

I also put in a link to our soups. We have been collecting soup recipes, and posting them from folks across our community, so please check out the soups and submit your own. Santiago, I'm going to start mostly with questions for you and how you're living right now. Returning to in-person work, would you feel safe working next to a coworker with a divider between the two of you?

Santiago Neme:

If I'm working with a coworker, I'm going to be masked whether I have a divider or not. I don't think that the divider would add extra safety. I would say I just don't put the divider as part of my safety. I would say we would both be masked, so I would be comfortable, but we would be masked.

Anne Browning:

Good. Do you worry about getting a breakthrough infection?

Santiago Neme:

I do, and I think the equation changes for me then. I actually had this conversation with my husband who's not a healthcare worker, and the impact on me is greater. Why? Because I'm seeing patients because I work in an environment where the workforce is precious, and we're pretty short in different departments. Really, it's different. I could potentially have an asymptomatic infection, and give it to my patients, and I happen to treat vulnerable patients for the most part.

Santiago Neme:

I would say the equation for me is I'm trying really hard not to get a breakthrough infection, so I would say I worry about the possibility.

Anne Browning:

Thank you. I feel like that's a very real concern, I think, many of us are grappling with. Do you still worry about sanitizing everything around you? Are we still freaked out about surfaces?

Santiago Neme:

Not really. I would say normal hygiene, normal infection prevention. You want to clean surfaces and things like that, but we really know now that the main issue is just air. It's just droplets, and the virus is in the air rather than surfaces, but you want to clean obviously normal like we have been, but I've been really obsessed around masks more than anything.

Anne Browning:

Good. Thank you. As John mentioned, it looks like numbers are coming down a bit across the country, maybe even a little bit locally. Do you think any of your own behaviors will change if we do see this continued downward trend maybe in terms of socialization and et cetera?

Santiago Neme:

I can see how that would change. Actually in July, they changed, and then we had to readapt. In July, I got to see my family. We had a little get together. That was July. That was alpha, vaccinated, right? Then we learned that there were more breakthrough infections. The case has changed. My behavior adapted to that. I'm hopeful that we'll be again in a spot where we can do more things.

Anne Browning:

Good. Would you go to hot yoga right now?

Santiago Neme:

I would never go to hot yoga because I don't like the heat. I know it's strange for a South American but I-

Anne Browning:

I know.

Santiago Neme:

I like yoga, but not hot yoga. I would say no, not even yoga. I would not be indoors exercising.

Anne Browning:

Thank you. Would you go to an indoor concert even if you could be all masked up? Not right now?

Santiago Neme:

No, and even if it's Radiohead, I wouldn't go.

Anne Browning:

That may have been the actual question people were asking. Last one I'll have for you before I pitch it back to Trish. For folks asking about family gatherings, about kiddo stuff, don't worry, we're going to keep doing this as long as we need to over the weeks. The last one, I thought this was interesting. John may have alluded to part of an answer. If you're going to be on a plane or a bus or in a grocery store, what kind of masks are you wearing right now? Are you doing cloth or going more hardcore?

Santiago Neme:

I never used cloth. I'll either use this. Lately, I would say when I've been on planes, I've used the KN95, which I find to be comfortable. They seal my face really well. It's an extra. It's five layers instead of three. I don't know that they're much superior than what we have, but I would have to say that I take that precaution when I'm in a plane with... More than a plane, it's the airport. It's everything around you. I would say I use that. I don't think it's required, but when I fly, I'd typically use that, not that I've flown that much.

Anne Browning:

Good. Santiago, thank you. We're definitely going to answer more questions in the weeks to come.
Trish.

Trish Kritek:

Thanks, Anne. Thanks, Santiago. Thanks, everybody. I want to end by saying last night, a group of doctors and nurses from UW medicine spent about an hour listening to this story of a critical care doc in Idaho. I was privileged enough to be a part of listening to that story. It was super sobering. It was heartbreaking at times to listen to it. I listened to lots of friends who are in New York and Louisiana. It was similar. Maybe not as crazy numbers, but there were some things that were different that were really hard to listen to and gave me pause.

Trish Kritek:

The first was the amount of conflict over vaccination amongst staff, amongst patients and families with staff, and really hard things that are going on. Some of that in a smaller degree, but a very real degree is happening in our system right now. It is something that people have been struggling with. There's tensions among colleagues now that's different. There's tensions that have been part of families for a long time.

Trish Kritek:

We are actually already had planned to have next week's town hall be like Schwartz Rounds, where we're going to hear from clinicians in our community who have been in the midst of those challenges, and hear a little bit about how they're navigating those challenges, how they're getting through those challenges. We'll have a member of our ethics team join us. We have on our website already a place for you to talk about those challenges that you've experienced as well as any questions you'd like to ask our ethics consultant.

Trish Kritek:

It'll be a little bit different town hall. It will be a live one, so we want people to tune in if at all possible. We know that's not true for everyone. But because we want to honor the bravery of people talking with us about those challenges, that's the style that we'll do for that town hall. I want to thank in advance all the people who are going to be participants. I think it will be a very special event, and I think one that reflects on the challenges of the moment.

Trish Kritek:

The second thing that was super sobering to me, and actually heartbreaking, like I said, was listening to this physician say that they had gone months with nobody saying thank you to them. She said that very organically, and Paul was already planning to come to say thank you today. It just reinforced for me how important it is for us to say thank you to each other all the time, and so I appreciate that Paul came and said those words to all of us today. He sought that out of his own volition, and wanted to be here to say that.

Trish Kritek:

I have a very cynical friend who's covering for me right now in the ICU who I'm going to say thank you to for covering the ICU while I'm in town hall. I will say his text he sent to me. He said, "It does actually make me appreciate UW." That's just as a ringing endorsement of this place as I've ever heard from him, and it's because we do say thank you. I'm going to end the way I always do, and I'm going to encourage

all of us to think about how we thank the folks around us, because it's really through working together that we will continue to get through this.

Trish Kritek:

I want to do a special shoutout to our EBS workers. I missed Environmental Services Week, but thank you to the town hall person who wrote in to tell me that I missed it and that I should specially thank the EBS workers, because they're essential members of our team, so important. A big thank you to our whole EBS team. then as always, thanks to Paul for joining us today. Thanks to all the panelists. Really, we can't say it enough.

Trish Kritek:

Thank you to all the members of our community, each of you, for what you do every day to take care of our learners, our scientists, our students who are all coming back, and we're seeing them again, our residents and fellows, our patients, their families even in moments when it's hard, and keep taking care of each other. Thank you, really, from the bottom of my heart. I think I can speak for the whole panel. Thank you very much. We'll have a special town hall next week, and then we'll be back with regular town hall the following week. We'll see you soon. Bye-bye.