Trish Kritek:

Welcome back to UW Medicine Town Hall. I'm Trish Kritek, Associate Dean for Faculty Affairs. We're back to regular town hall this week. With us are Tim Dellit, our Chief Medical Officer, Anne Browning, Assistant Dean for Well-being, Keri Nasenbeny, CNO at UWMC Northwest, John Lynch, Head of Infection Prevention and Employee Health at Harborview Medical Center, Jerome Dayao, our Chief Nursing Officer at Harborview Medical Center, Santiago Neme, Medical Director at UWMC Northwest, Tom Staiger, Medical Director at UWMC, and Cindy Sayre, Chief Nursing Officer at UWMC. And yes, I got them all without messing it up.

Trish Kritek:

I am happy to have Anne back, and I'm going to hand it off to her right away for a well-being message.

Anne Browning:

Thanks. Last week was interesting. I got to be in a very different role and I got to be somebody who actually just sat back and had an opportunity to listen and hear stories that folks were sharing about how challenging working right now it is, how it's challenging to remain kind of empathetic and dealing with the challenges of still navigating COVID in our environment at this point. Almost 20 months into the pandemic. It was really amazing to hear folks be vulnerable and open. As you know, we didn't record that session, but a number of folks were just asking for a bit of some thoughts. And so for the well-being message today, I just wanted to share a couple of things that I heard that I took away.

Anne Browning:

It was interesting. One person just said, "This was supposed to be over by now." We've had the vaccine for nine or 10 months, and there's frustration that we are still sitting here in this really hard fifth wave. But folks were also sharing kind of what helps them get through it, and this really nice comment around perspective taking and recognizing that folks with vaccine hesitancy are operating from a place of kind of real fear, real concern. And there are many reasons why people are choosing to be vaccinated or not. That perspective piece is really helpful.

Anne Browning:

One person said, "I don't like what this has done to me." The hard and honest challenge of being challenged to be empathetic when doing incredibly hard work. Same person though then mentioned, "This is what we do. We are still taking care of people." I think there was this really lovely line of recognizing each other's humanity. That is one way in which people are really kind of thriving even in a time of real challenge in this work.

Anne Browning:

One person mentions just that the stress is so palpable and kind of calling out folks who were unmasked in a public transit situation, and at the same time kind of mentioning that there recognizing that they're holding onto anger and that they really needed to pivot and start leaning into love. I thought that was such a lovely reflection of recognizing what we can control and what we can't and when we can in trying to let go of anger and really lean into love.

Anne Browning:

With that, recognizing that we're kind of managing this fifth wave that we didn't necessarily think we'd still be in and recognize that we're kind of managing this as a chronic situation at this point or a chronic condition, but with kind of this perspective taking, with recognizing each other's humanity, there's a way we can kind of continue to show up with compassion for each other that is really powerful and will help us kind of continue to get through this.

Anne Browning:

So thank you to everybody who shared last week. It was a real honor to listen. And for those of you who weren't able to attend, I hope sharing a couple takeaways is helpful.

Trish Kritek:

Thanks, Anne. Thanks for your reflections on it. I also want to give a repeat thank you to the folks who were honest and vulnerable enough to share with our whole community and acknowledge that we didn't record it to create that space to allow them to speak really freely from their hearts and how much we all appreciated that.

Trish Kritek:

We have more challenges coming, and that we're still continuing to navigate. Next Monday is going to be one of them. So Tim, I'm actually going to start with you today to kind of talk about the impact of October 18th and the kind of implementation of the vaccine mandate.

Tim Dellit:

Yeah. Thank you, Trish. First, I also want to just thank you and Keri for just really a very powerful session last week. It was really impactful and I think very much needed by our community. So I'm very grateful that you were able to do that and it was so well received. So thank you.

Tim Dellit:

The last two weeks have been challenging as we lead up to October 18th. I think when the governor put forward the proclamation requiring vaccination for all healthcare workers and then all individuals in higher education, so essentially all of our University of Washington community, I don't know if we really understood the challenge of how to implement that and how much work it was going to take. And so, I'm really appreciative of all the work by our HR teams, our employee health teams, members within our School of Medicine departments, teams within our clinical environment within the medical centers.

Tim Dellit:

The amount of work to do this verification of everyone's vaccine status has been daunting. But just like any other challenge, our team has rallied come together. I'm really pleased to say that we're at 99% vaccination for UW Medicine.

Trish Kritek:

Wow.

Tim Dellit:

That includes the school, that includes our UW employees within UW Medicine. That is phenomenal. I can tell you it's the highest vaccination rate of any healthcare system within our state. So, tremendous

work by everyone. Really proud of the team. At the same time, this is really challenging. This is the largest kind of termination event that the university has ever been involved with. There's a lot of anxiety, right? People have different views around the vaccine. It's difficult to watch colleagues who may no longer be with us. We recognize the impact on those who may be leaving us and making that decision. So, there's a lot of mixed emotions here as well. So, very good outcome on one hand, but also recognizing just the impact that this has on our community as we go forward towards this October 18th date.

Trish Kritek:

Yeah. So, a remarkable vaccination rate amongst our employees and students. Really, 99%. Wow. And an enormous amount of work, as well as a lot of sadness and I think anxiety about Monday for folks and the impact on teams as you said. People ask specifically how many people will be losing their jobs and if you know those numbers and where we stand with that.

Tim Dellit:

Again, these numbers continue to fluctuate a little bit as we continue to verify individuals. But roughly, when you look at staff across our medical centers, we have about 220 staff who are currently not in compliance. We have about 10 faculty who are not in compliance, 13 staff within the School of Medicine who are not yet in compliance, and we had one resident who has not been in compliance. And so, even though we're at 99%, because we're so large, it still impacts a significant number of individuals. Again, much less than what it potentially could be, but again, we realize the impact for those who won't be with us after the 18th.

Trish Kritek:

Yeah. So 220 staff is a lot of people. 10 faculty, one resident, and 13 staff within the school. They're all parts of teams who are impacted by not being a part of that community any longer. We'll come back to this for more discussion a little bit when we talk about staffing.

Trish Kritek:

There were questions about what we've done when folks have asked for a religious exemption and if we've been able to find accommodations for some of those people in our community.

Tim Dellit:

Yeah. And so, the proclamation allowed individuals to request either a medical or a religious exemption. With the religious exemption, our approach has been, again, not questioning anyone's religious belief. We believe that's a private decision by the individual and we absolutely respect that. The real question is, can we accommodate that within the clinical environment versus if someone is in a non-clinical environment. And our approach has been that if someone is in a direct patient care area, direct contact with patient or even indirect patient contact, we aren't able to accommodate that religious request in that setting. It is just an undue burden which is allowed by the proclamation.

Tim Dellit:

Again, our ultimate goal here is the safety of our patients, the safety of our staff. We need to preserve that, particularly given that we care for a lot of immunocompromised patients, right? I mean, it is really challenging. Even those where they may have gotten a medical exemption because they had a severe reaction, those accommodations then require twice weekly testing. They can't work with any

immunocompromised populations. They can't work with populations in congregate settings such as our psychiatry populations. So it really is becomes very limiting in terms of where they would be able to practice in that sort of setting. And so that's been the approach that we have taken.

Tim Dellit:

I would also say that we have taken a consistent approach across the university. That's one of the things that's been really important that members of our teams have been working very closely with colleagues on Upper-campus to ensure that we have consistency in approach as we review these exemption requests.

Tim Dellit:

As I mentioned before, we've had over 400 exemption requests. About 1/3 of them have been accepted and about 2/3 were denied. Those that have been denied, I would say the majority have gone on to start the vaccine process, which is also encouraging. And so, that is also, I think very good news.

Trish Kritek:

Okay. It sounds like we're being pretty... I'm going to use the word strict in saying "If you're a direct patient care or indirect patient care, it's likely there wasn't an accommodation possible because of the patient populations and the care settings that we have." So most of those people did not get accommodations. And for people who didn't get the exemption, many of those people were subsequently vaccinated.

Trish Kritek:

I'll ask one more follow up question and I'll clarify something that came in the chat in a second. How are we managing folks who might have at the last minute decided to get vaccinated but aren't going to be fully vaccinated come Monday?

Tim Dellit:

Individuals who start that vaccine series prior to the 18th will still be on leave. They'll be on unpaid leave until they complete that. They have, I believe for us within UW Medicine, until November 17th to complete that. Now, if they submitted a exemption request and if that was denied, then they're being given 45 days. And that goes out to December 2nd. In that situation, they can use either accrued leave that they may have or unpaid leave.

Trish Kritek:

Oh, good.

Tim Dellit:

So there is a path for those who have decided at the last minute that they want to start that vaccine. We're having them out of the work environment until they meet the requirements, but there's a path for them then to be able to return to our community.

Trish Kritek:

Okay. So folks who are using leave, accrued leave or unpaid leave, with a date of November for everyone if you had an exemption that wasn't approved, you have a longer time period so that we can

keep those people as part of our workforce. The last thing I'm going to ask is I saw this come up in the chat. When you say 99% vaccinated, you mean 99% vaccinated, not 99% vaccinated plus people who have exemptions?

Tim Dellit:

No, I mean vaccinated, which again is exceptional. Absolutely exceptional.

Trish Kritek:

Yeah, that's unreal to me actually that that number is so high. So thanks to everybody and all the members of our community who have gotten vaccinated as well as all the people who've helped make that happen. Thanks, Tim. We'll come back for more questions in a little while.

Trish Kritek:

John, I'm going to turn to you and ask kind of where we stand with numbers in the system and in King County.

John Lynch:

Yeah, sure. As of 6:00 this morning, we're at 52 patients. We actually had gotten... It's kind of where we were when I spoke to this group last week. We got up into the 60s in the middle of the week and then came back down again. 17 of those patients across the four hospitals are in ICUs. We have about three people with COVID on the ECMO, the bypass, I know at Harborview. I'm not sure if there's any additional at UWMC. I don't think so.

Trish Kritek:

No.

John Lynch:

So three people total. And then we have 35 people in acute care. So folks who are outside the ICU, but still requiring care. And as I always like to remind people, there's probably about the same number of people who are out of isolation or precautions for COVID who are still recovering from COVID 19. So it's still a lot of people.

Trish Kritek:

So, people who are in our hospitals and receiving care, but 52 total that we would kind of compare to what we had before went up and came back down. We're at 50ish now.

John Lynch:

Yep.

Trish Kritek:

How about in King County? What are our numbers like?

John Lynch:

Yeah. So the slow, slow, painful trend is continues, but it's in the right direction. So downward. It's about 12% decrease this week compared to last week. In the last seven days, it's been about 420 new cases per day. So that's good news. Over the whole week, we're about just under 3,000 cases compared to the week before, we're about 3,200 cases. So heading the right direction. Around hospitalizations, it's actually gone up a little bit in the last seven days. We're about 15 hospitalizations per day in King County specifically. And then deaths, in good news, continue to trend down. We're about three deaths per day in King County. So that's about a 30% decrease. So about 37 deaths in the last 14 days compared to about 52 deaths in the two weeks before that.

Trish Kritek:

Okay. So downward trend of death. Downward trend of infections. A little blip in hospitalizations.

John Lynch:

Yeah.

Trish Kritek:

One of the questions that came in was like, "Why isn't it going down more quickly?" In this county where we're so vaccinated and we have a mass mandate, why is it taking so long?

John Lynch:

Yeah. I'd say two things. I think there's a lot of unknowns and there's a lot of speculation we can make, but I think there's two things. One is, King County is not a fixed place, right? There's no walls around us. So we're really part of a larger community that goes well beyond our county borders. We know that different counties in our state and in our region are being hit extremely hard. You go to some of the counties around, we're seeing... Instead of seeing 140 per 100,000, they're at 300 cases for 100,000. And particularly in some parts of Eastern Washington. A lot of hospitalizations in Yakima and the Tri-Cities and so forth. So that's one part. We have unvaccinated folks in other parts of our state and some of those folks are here in our county.

John Lynch:

The other thing is, even though we've achieved very high levels of vaccination, and I wrote down some of these numbers, I think 82% of all eligible, so 12 and older, folks in King County are vaccinated. But that's 1.6 million people out of 1.95 million people, which means there are 350,000 eligible people who are not vaccinated. And if you take just all people, that's 667,000 people in our county who are not vaccinated. So 3/4 of a million people, which means that they are... I don't know how many of them have ever had seen COVID. I'm hoping that none of them have, but some of them probably have. But I would say it's probably the majority of them have no immunity. Which means that this Delta variant, whenever they go out, especially if they're not masked, especially if they're in grouped indoor settings where there's mixed populations of vaccinated and unvaccinated, or mostly unvaccinated people, they're going to get COVID. And that's what we're going to continue to see.

John Lynch:

So even in places that have high vaccine rates like us in King County, the numeric, the large number of people who remain unvaccinated is still very large. And that's I think was part of it. And then the last part is, I'm not calling out any specific activities, but you think about things like fairs, big sporting events,

concerts, these are places where if you're not masked and you're not vaccinated, COVID is going to move around. And that's probably blunting some of that downward trend.

Trish Kritek:

Okay. So the things I heard are; we're part of a state and the rates in different counties nearby are still high. There's not like a wall around the county. Two, though the percentage of vaccinated folks is really high, the absolute number of people who are on vaccinated is also quite large, and that we still keep going to big events where there's probably a higher risk of spread in things where large groups of people are gathering. Thank you. I think it's frustratingly slow for so many of us to watch. I know that's true for you as well.

Trish Kritek:

I'm going to pivot to asking questions about vaccines because there were lots of them. So do you have any updates on, let me start with vaccines for children and when we think that they might be approved? Because we ask this all the time and it feels like it's really close.

John Lynch:

Yep. I'll give you the good news that I got just a few minutes ago is that... So the way it works, we've all become very familiar with how this vaccine approval process works and we're watching like hawks. So there's the FDA approval part. And then that goes to the CDC's Advisory Committee on Immunization Practices. And then that gets signed off by the CDC Director, Dr. Walensky. And so, the first step, the FDA part, is going to actually happen. It's scheduled now for October 26th.

Trish Kritek:

Wow.

John Lynch:

For the under 12s. The way this has work recently, it goes... And that committee's called the VRBPAC. It's got a long name. That happens usually week one, and then the second week, ACIP. And usually by the end of the week, they get signed off by the director. So once it happens, it's about a week. Someone put in the chat, "Under 12 or five to 12?" I think it's five to 12, but I'd have to verify that.

Trish Kritek:

I think it's five to 12.

John Lynch:

I've seen a lot of nos. I think it's five to 12.

Trish Kritek:

Yeah.

John Lynch:

So that means that 10/26 plus, a week and a half, we may be given vaccines. And I'll just say UW Medicine is prepared for that to give.... Yay! For five to 12 year olds. So that is fantastic news. As a parent of two teenagers who got vaccinated earlier this year, I recognize that happiness.

Trish Kritek:

Okay.

John Lynch:

-the younger ones.

Trish Kritek:

We're looking early November, feeling like we're getting closer and closer to locking that in for the five to 12 year old.

John Lynch:

Yep.

Trish Kritek:

So that's really optimistic. We will be vaccinating kids and we're ready to do it. So thank you. Do you know if the dosing is going to be different for kids?

John Lynch:

I don't know.

Trish Kritek:

Okay. I'm going to shift. We can find out for the future folks.

John Lynch:

Thank you.

Trish Kritek:

I'm going to shift to updates on boosters because there's been lots of talk about Moderna, and J&J, and mix and match. So where do we stand on boosters for folks who've been vaccinated with Moderna and J&J?

John Lynch:

Yeah. So that first FDA community, the VRBPAC met yesterday. I'll just give a quick shot out here. Dr. Steve Pergam, one of our own at UW Medicine and Fred Hutch docs, who's one of the members of that committee has been a really great and helpful expert to give our own teams information on this. So yesterday, the VRBPAC met and talked about... We'll talk about that in a second. The chat there. Yesterday, they recommended a Moderna booster for folks six months or out. It's a half dose in that case. So half dose of Moderna for folks six months or more after their second vaccine for Moderna. And then, is it okay if I talk about J&J?

Trish Kritek:

Go for it.

John Lynch:

So J&J just got approved today. It looks like they're going to recommend a booster at least two months after the first dose. When I look at the media around this, what I understand is that I think they're probably going to move towards, "It's not a booster. It's just a two dose version of J&J going forward." So people who get J&J in the future would just get two doses separated by some amount of time. They also did comment on that they are looking at reviewing, considering, the idea of J&J plus an mRNA vaccine, but gave no timeline on that.

Trish Kritek:

Okay.

John Lynch:

I know there's clinical trials going on about this. There are some data out there. I know this is a big question for a lot of people to get a J&J. And it's tough right now because you're like, "Oh, do I just get the J&J because it's been a couple of months? Or do I wait?" I don't have an answer for you. So that's where we are.

Trish Kritek:

Okay. So what I heard is, Moderna, very close to the fully approved for half a dose at six months as a booster.

John Lynch:

Yep.

Trish Kritek:

J&J today, second dose at two months, but not really as a booster, as a two dose vaccine, and more to come on the mix and match. No recommendations on that right now.

John Lynch:

Right.

Trish Kritek:

The only other thing I'm going to ask about this is the folks for whom it's indicated. Can you just refresh? Because people were saying like, "Is it all employees in UW Medicine or is it only patient-facing employees?

John Lynch:

Yeah. I think it's the same indications as the Pfizer, so everything we used last time. So folks in occupational health settings. Again, this still has to go to the ACIP next week. And remember, one of the recommendations the ACIP actually voted against. And then Dr. Walensky reversed that. So my understanding is we'll probably go along with the exact same groups including occupational risk as defined by the CDC as we did with the Pfizer-BioNTech product.

Trish Kritek:

Okay. So occupational risk or the folks that are 65 and older are the folks that we would be talking about most likely. And all these things aren't done yet, but they're getting close, is what I would say.

John Lynch:

That's correct.

Trish Kritek:

Okay. One not vaccine question, we might have time for more vaccine questions because there's a bunch of them, is the change in masking in clinical spaces. So there've been a bunch of emails recently. Maybe you could just clarify where we stand with what masks everybody should be wearing in our clinical spaces.

John Lynch:

Yeah. People probably remember over a year ago now, me demonstrating how to wear these on town hall.

Trish Kritek:

Yeah.

John Lynch:

I think we're all familiar with it. What we're asking people to do across UW Medicine is to use a medical/surgical mask. That doesn't matter whether you're in a clinical space or a clinical footprint. We really want all UW Medicine personnel to be as safe as reasonable, be expected in all of our settings. We need everyone who's in an office space or clinical space to be safe as possible. What we've learned... And I'll just put the caveat out there. Doing mask studies is extremely hard, but given that, multi-layer masks, I think we can say pretty definitively are better. Masks that fit more snugly are better. The real challenge is when we... Sorry about the Harborview noise back there.

Trish Kritek:

It's giving ambiance to your answer.

John Lynch:

Yeah, at least it's not a helicopter. And the issue really is that we... So we know all of these are multiple layers. We know that they can fit really well. And if anybody has any trouble fitting, let me know. There's a great CDC video on how to make it fit better with knots and so forth. The flip side is that the cloth mask, I don't know. They're all over the place. Some of them we made at home, right? Remember over a year ago, the surgeon general showed us and made a t-shirt out of this. The problem is bandanas, buffs, these are single layers. We don't know the cloth masks out there. A grandparent may have made one or a friend. What we really want to know, it's really I can't tell when I look at that as I'm screening or so forth, is that I know all of these are multiple layer masks that can fit really well against your face.

John Lynch:

And what we really want to do is to get people into this everywhere, our patients, our visitors, and all of our healthcare workers, as opposed to sort of the kind of huge spectrum of cloth things that we're using for face coverings.

Trish Kritek:

Okay.

John Lynch:

And you can wait. It doesn't have to be at the front door.

Trish Kritek:

Okay.

John Lynch:

You can go to your workspace and get it up there. You can get it on your unit. You can come in with whatever is your face cover, your cloth face cover or one of these, coming in. You don't have to go through screening. You can get it later. We just want you not to be sitting in your workspace for the whole day wearing a buff, a bandana, or a cloth mask.

Trish Kritek:

Okay. I think I got it. Everyone should wear a surgical mask.

John Lynch:

There you go.

Trish Kritek:

That includes our patients and all the employees. You can wear your cloth mask to wherever you're going to get your surgical mask, but then put a surgical mask on. I appreciate that. Thank you. I think that's a big change for us. So it's going to take some getting used to.

John Lynch:

Yeah, and it takes time. It took us time to get comfortable with all of these things. We'll get there.

Trish Kritek:

Okay. I appreciate that. I'm sure we'll get questions about it as we move forward. And people... It's a change. Change can be disruptive. All right. I'm going to give you a break. I'm going to look over to Tom.

Trish Kritek:

Tom, we got a bunch of questions about kind of how busy our hospitals are. I asked our nurses about this and nursing leaders as well. But specifically for you, a couple of questions. One is, how are managing we transfers into our institutions from both in-state and out of state when we're kind of bumping up against maximal census day in and day out right now?

Tom Staiger:

Yeah. We've been dealing with this a lot lately. We have been prioritizing patients for whom we provide unique services, our mission patients at our various campuses, people for whom we've got unique things to offer, and also patients with emergent and highly urgent needs when we've got the capacity to help them. So that's how we've been assessing transfer patients. Sometimes we've got a little more capacity and so we can take a somewhat broader range of patients.

Tom Staiger:

In terms of out-of-state patients, there's discussions about whether to create an added review at the medical director level process for out-of-state patients who don't fit that mission, highly urgent, emergent patient population. And so we may be introducing some additional layer of approval for certain out-of-state patients, but that hasn't been finalized.

Trish Kritek:

Okay. So based on the mission of our institutions and emergent settings and where we stand with our current census with a question of, for out of hospital, out-of-state folks, maybe an extra layer, but that's not the case right now.

Tom Staiger:

Yes.

Trish Kritek:

The other part of that is, what else are we doing to minimize boarding? Because I think people are feeling the tensions of boarding in all of our hospitals right now.

Tom Staiger:

Yep. We're doing our best to low level across our four hospitals. We've got communication that takes place every day at a regular time to do some low leveling. We've got internal meetings. I'm most familiar with the Montlake meetings that are taking place multiple times a day to figure out flow, how to improve flow, how to overcome barriers to discharge. And those are taking place at our other hospital campuses, Northwest and Harborview Valley, et cetera. And so, trying to improve outflow, trying to assess and regulate the inflow of patients. So under worst case scenarios, when we're really bumping up against the safe limits of our boarding as the last resort, we have sometimes rescheduled some of the somewhat elective procedures and things that are going to occupy beds. That's a last resort, but that's one of the things we're doing as well.

Trish Kritek:

Okay. So load leveling across institutions, strategizing on how to move forward disposition of folks. And then occasionally in the far end of that spectrum, canceling procedures that are not emergent. Relevant to that, how have we done with catching up on surgeries that we have postponed?

Tom Staiger:

We started allowing non-urgent procedures and surgeries that require an overnight stay to begin again on October 4th. There were some that were scheduled that week. My understanding is there were greater numbers scheduled this week. That said, there's more patients that fit into that category than we could fit in in this first couple of weeks. So the surgical schedulers were looking for the people who were on the more urgent end of that spectrum. We've made some progress, but we didn't do those not urgent procedures for about five weeks or so, so we've not fully caught up on the ones that had to be delayed.

Trish Kritek:

Okay. So we're still in the process of trying to catch up. So there's still folks waiting. And we're trying to prioritize the ones that are more urgent of those ones that weren't urgent, urgent.

Tom Staiger:

Right.

Trish Kritek:

I appreciate that. We'll keep checking on that because I think people have been asking about that a bunch.

Trish Kritek:

I'm going to just turn to our chief nursing officers. I think the other side of the tension around the census is staffing. Again, we've had a bunch of questions about staffing. I'll start with kind of what are we doing to retain staff. It's notable to me that there are bunch of people who ask, "We've talked about nurses, but what about other parts of our staff like PCTs and other important members of our healthcare team?" Maybe, Cindy, do you want to start us off on what we're doing to focus on retention?

Cindy Sayre:

Yes. It a major priority for our leadership. That's the first thing I can say and something that we're talking about every single day. I want to just say I share the concern, not just on behalf of the nurses, but all of our teams as we move forward. We're working... We have different phases of negotiations going on with our labor partners. That's one piece of it. I think that we are continuing to try to support the teams through the programs that you help us with, Trish, in peer support to make this a safer place to work emotionally and physically. And then using every pipeline that we can think of to hire into these physicians. And that includes traveler agencies. We've talked about that before. But also looking at partnering with schools. For example, I'm talking to the respiratory therapist group today. "Can we bring in, I'll just use the term externs, or people that are in their training programs just like we would a nurse tech to help grow some competencies that we need here?" It's a very complex environment that we're working in. So a lot of challenges in these.

Trish Kritek:

Yeah. So ongoing negotiations. Jerome, go ahead. You're unmuted.

Jerome Dayao:

No, I would just like to add as what's Cindy saying, this is a true priority. I just want to give a national landscape. I mean, for instance, for nurses, there's about 140,000 permanent full-time positions in the country that are open right now that hospitals are trying to fill. So we are competing against national hospitals, local state hospitals with regard to these nurses. We're engaging the traveler agencies. We recently signed a contract with this organization called Incredible Health that's going to help us bring in here permanent workers to help with that.

Jerome Dayao:

In addition with that, we're also actively negotiating. There's lots of incentives currently at the table to keep and retain the staff that are already here, not only the ones that were trying to attract to come work for us at Harborview. So these are just some of the ways, and of course, the resilience you worked that you have been very instrumental with, and Anne, and all of these other resources that we have for every employee here at the Medical Center.

Jerome Dayao:

And just to give a numbers perspective, we are also looking at turnover, overall turnover. Like for instance, for nursing staff at Harborview, it's about 8.5% turnover in the second quarter. Whereas, the national comparatives I was just reviewing the data earlier today, it's about 16 to 22% percent nationally turnover of nursing staff. We're also closely monitoring some of those numbers.

Trish Kritek:

Jerome, I appreciate that context. This is a national problem. It's a state problem and it's a local problem. And maybe it's worse than a lot of other parts of the country. And we're still really feeling it. So the strategies around supporting people, but also negotiating, and that negotiation has implications for retention of the staff that we have as well as using travelers. I think Cindy pointed out partnerships with schools and other organizations to work towards getting more permanent staff hired into the positions that we have. So thank you both for going through that.

Trish Kritek:

Keri, I'm going to invite you in. The other aspect of this that people brought up is like, "What are we doing to make sure that patients are safe in these times?" So part of it is working on the staffing, but people worry about safety when it feels like people are stretched and our teams are stretched.

Keri Nasenbeny:

Yeah. I think that's a really important question. I'll let Jerome and Cindy speak for what they're doing at their campuses. But here at Northwest, we're doing a couple things, I think, to really address patient's safety. One is, we're really reinvigorating our shared governance councils and trying to reengage our staff who care for our patients in this work again. And I think that's a really important part, is to have their voice at the table. Have them help us understand what's the work we need to do, what will work, what won't work. So that's, I think, a big part of it.

Keri Nasenbeny:

We're looking at systems that can help us be smarter, I think. So looking at, for example, the Telesitter Program. That's a program that will help us keep eyes on patients who are at high risk for falling. So how can we work smarter and not harder, and how can we integrate some of our systems together. Just hearing about a new Pyxis upgrade that will really help us with some medication safety thing.

Keri Nasenbeny:

So I think really one of my goals is to think how can we do a better job integrating technology, especially now as we have Epic to help our staff make the right choices to know what the right thing to do in an easier, less time consuming way. I think that's one of the directions we really have to think in. But I do think the other piece of it is really engaging our staff in this work. I think that brings them some... Think about retention, connection back to the work, and feel good about the work that they're doing. But it's really mostly important because they know it best and they know what will work and won't work.

Trish Kritek:

Yeah, it's easier to find that sense of purpose when your voice feels heard. So structures to hear the voices of the folks who are taking care of our patients and incorporating that input, as well as it sounds

like using technology and other strategies to make the work more efficient and effective instead of harder to do.

Trish Kritek:

Jerome or Cindy, did you want to add anything to that?

Cindy Sayre:

Well, I'll just add that we are making staffing decisions sometimes on every four hour basis. Looking across all of the staff we have available, all the needs that we have and making sure that we're making the best possible decisions about how to assign staff to certain areas.

Cindy Sayre:

I want to give a shout out to our teams because one of the things I've really seen especially in the last couple weeks is incredible teamwork where units will help each other out for short periods of time when they can. People are really collaborating and rallying around providing the very best care. I just appreciate the collaboration and the professionalism that we've seen from all of our teams.

Trish Kritek:

Okay. So a shout out to the collaboration across units, as well as that kind of nimbleness of just in time strategies to address where we need the staffing right then. Thank you. Jerome, since you're not unmuting, I think you're going to go with like, "That sounds good. And those are the things we're doing at Harborview too." Okay. I appreciate that.

Trish Kritek:

I think it's obviously... I'll just tell you. We get questions about it every week because it's something that people are feeling deeply. And I know the three of you are feeling it deeply as well. So thank you.

Trish Kritek:

Santiago, I'm going to have you wear your ID doc hat today. I have a bunch of more ID doc questions, but not ask an ID doc. One of the things that people ask about every town hall actually is, what's the difference between natural immunity from being infected versus being immunized and why don't we think that natural immunity is just as good as being immunized?

Santiago Neme:

Yeah. Thank you, Trish. Natural immunity basically relies on the T-cell immunity, on that cellular response. The problem is that initially, you would think that a natural immunity gives you protection, and it does. But then today we actually have data that shows that natural immunity plus vaccines is much more protection than just natural immunity. Plus, COVID has shown us that... I mean, SARS-CoV-2, that it's a pretty dynamic virus. I mean, we've already had multiple variants. We're dealing with Delta, which is the most transmissible variant we've seen. So it's pretty dynamic and changing. So it depends what was that infection you had. So yeah, you would have some protection, which is mainly cellular, especially after the first three months, but we know as a fact that if you get vaccinated, you're getting more protection.

Trish Kritek:

Okay. So you've talked before about cellular immunity and humoral or antibody immunity, and you're saying the vaccine's going to give you both of those, whereas natural exposure is going to be mostly the T-cell type of immunity. And it's going to be to whatever version of the virus that you got infected with, as opposed to more broad protection.

Santiago Neme:

We actually saw that, right? That we had many people who had the alpha variant got exposed, got sick, and then re-infections became more common. Initially, re-infections were super rare. But then re-infections became more common. So that gives you a sense of how natural immunity, when you just got infected, will give you the antibody response, will give you that of course, but it will wane. And this is why we're vaccinating and re-vaccinating, right?

Trish Kritek:

They both give you both, but you're worried that they're going to wane and it's going to be targeted to that specific variant that you got initially infected with.

Santiago Neme:

Exactly.

Trish Kritek:

And there are studies that have looked at this.

Santiago Neme:

Mm-hmm (affirmative).

Trish Kritek:

Thank you for going over that. The other thing that people ask a bunch about is long COVID and what do we about who is developing long COVID. Is it related to how sick you were when you got infected or not?

Santiago Neme:

Initially, it was thought to be related to the severity of your illness. Most of the studies were basically quoting that you had moderate, severe COVID, and therefore you're going to have more long COVID. But then we've learned that even people with very mild symptoms have had, after eight months, at least one of the symptoms they had when they were having acute COVID. Long COVID is technically defined by symptoms that persist over after four weeks. And then the problem with the severity is that you also have the ICU syndromes. Just being in the ICU, right? So after the post ICU syndromes that may be conflating. Is it COVID? Is it the ICU state? Is it the mechanical ventilation? I mean, you're an expert in that area, but I think the answer is that everybody can get long COVID, even mild symptoms. And the best tool is to be vaccinated because we know that the vaccines... Actually, people who are vaccinated and get COVID have less long COVID.

Trish Kritek:

Okay. I'm going to highlight that last point. People who get vaccinated and get COVID are less likely to get long COVID. I think that's an important message. And you don't have to have had really severe

symptoms, maybe it's more common in those people, but you could have mild symptoms and have long COVID symptoms after four weeks. And then the last one was, when people are really critically ill in the ICU, often they have lots of symptoms downstream after that. It takes a long time to recover. And whether that's long COVID or being in the ICU, it's hard to distinguish. So thank you for that. Really thoughtful, comprehensive answer on that.

Santiago Neme:

Trish, quick thing. So UW Medicine has a post COVID clinic that's led by Rehab Medicine.

Trish Kritek:

Yeah.

Santiago Neme:

It's an outstanding clinic and it's multi-disciplinary. If people are suffering from long COVID, which is again very common unfortunately, please make an appointment or talk to NOS so we can guide you.

Trish Kritek:

So please reach out about the Rehab Medicine long COVID clinic. Thank you, Santiago. Two more questions for you before I hop back to John for a couple. Why did we originally say don't get your flu shot and your COVID vaccine at the same time, but now we're saying you can get them both at the same time?

Santiago Neme:

Yeah. My understanding, that it was mainly because these were new vaccines. Whenever you have something new, if you're basically given two interventions at the same time, and then you have side effects, which one is it, right?

Trish Kritek:

Mm-hmm (affirmative).

Santiago Neme:

But traditionally, an idea we say, that when you get one vaccine, you can get multiple that day, right? When you go for a travel medicine appointment, you get several vaccines.

Trish Kritek:

Yes, you do.

Santiago Neme:

With this one, we just didn't know whether there would be an issue of interaction, which was less likely. But then we wanted to carefully assess the safety and the side effect profiles.

Trish Kritek:

Yeah. I think that's a really good point. In general, we think getting multiple vaccines at the same time is fine. In this case, we didn't know that much about the new COVID vaccine. So we tried to isolate that

exposure so that if you had a reaction, we'd know it was to that. And we didn't know how things were going to go. So I appreciate that. Now we're saying, "You can get your flu and your COVID vaccination at the same time." I did. Just as a person speaking up about that for my booster.

Trish Kritek:

The last question I'll ask you, I'm going to ask you to kind of think about this and we've talked about equity a lot of times before. I think there's a bunch of individuals who said, "Is it right for me to get a booster, if I fit into the category, when so many other people in the world haven't gotten a first shot?" So I'm a healthcare worker here. Should I go ahead and get a booster when other people haven't gotten?

Santiago Neme:

It's a tricky answer. I basically would say follow the recommendations and assess your own risk. But I would say I'm pretty comforted by the policy that the US has had in terms of expanding access globally. My home country, like I said, now it's getting a lot of Moderna doses, Pfizer doses. That has really helped many places in the world. And if anything, the Biden administration is doing a lot towards that. I would like people to get... Honestly, I would prefer... If you tell me that your dose is going to go to someone who hasn't been vaccinated, I would rather give my dose there, because I feel like the booster is a bit less important for me right now. I'm also a Moderna guy so it's not available.

Trish Kritek:

Thanks for the full disclosure.

Santiago Neme:

Right. But yeah, that's what I would say. The benefit for me is not that great. If someone hasn't been vaccinated and we didn't have vaccines, absolutely, do first doses. Yeah.

Trish Kritek:

In the grand scheme of life, first dose is way more important. So if we had to choose, we're going to give the first dose to someone. We think that we're doing better at getting vaccines out to the world, which I think we're still behind it. I think all of things you read would say were still behind, but we're moving in that direction and we have the doses here. So you may step forward and use it potentially. I think your faith in saying we have good protection from the first two doses is also something I heard in that message. So thank you.

Trish Kritek:

Okay. John, a couple of last questions. Some of them are about policy. What is our policy around eating in group settings?

John Lynch:

Don't do it.

Trish Kritek:

That's an easy one. So let's not-

John Lynch:

I'm trying to channel you, Trish.

Trish Kritek:

I love it. So stay six feet apart and don't come together and eat together in our healthcare settings.

John Lynch:

Correct.

Trish Kritek:

What am I supposed to do if I have cold symptoms? It's about to be cold and flu season.

John Lynch:

Yeah. We have an answer for this in some places and not as great answer in other places. The first thing is, check yourself, right? If you have very mild symptoms that are consistent with, say you have a history of allergies and it feels like allergies but you're not sure, we do have rapid testing for employees at Montlake and at Harborview, in the employee health teams. We can do a rapid test. You can sit either in the clinic or in your car. A test goes back in 60 minutes. We've done this at Harborview now over 110 times. It's been great. We've caught like three pauses. The rest of those people were able to go on with their day and work. So that's 110 shifts that we were able to preserve. A little bit fewer at Montlake, but they're still working on it. I would love to see this everywhere, but this is where we have it right now.

John Lynch:

If you do have those symptoms, what we really need people to do is get tested. If you don't have something that responds to, for instance, your allergy medication or other medication or a treatment that maybe you have a history of these symptoms, you got to get tested for COVID. I'll just let everyone know. So far, no flu in the community. We don't have to worry about that right now. Get your flu shot, but you got to get tested. Just like we've done for the past 20 months.

Trish Kritek:

Okay. So if you have symptoms, you got to get tested. There's a small group of people where you're like, "It's really allergies." You can come in at Harborview or at Montlake, get a rapid test, and then potentially go to work. But in general, get tested. I think that's the take home.

John Lynch:

Yep.

Trish Kritek:

Are there people who test positive for a long to time after they've been infected have a long tail of still testing positive?

John Lynch:

Oh, old school test. This is an old school question, Trish. Yes. Once you test positive, you really don't want another test for at least 90 days no matter what happens. Because you will have kind of the

skeleton of the virus continues to hang around. The RNA, which is what we pick up, it can be up your nose and just be lying around. These tests are so sensitive, so good, that they will find, they will dig up that skeleton. They will find it. And it'll be positive even though you are not infected anymore and you are not infectious. You can't give someone else COVID 19. So in our hospitals, even in patients who are very ill, we take them out of precautions and we do not retest them for at least 90 days. Because if I test them, it's very likely it'll still be there even though they are very safe to have out of precautions.

Trish Kritek:

Thank you. It is the circle of life of questions, because all questions come back again.

John Lynch:

I love it. This is great.

Trish Kritek:

Someday I'll ask you about whether or not we should be masked. But anyway. I appreciate that answer. Yes, exactly. Thank you. It does feel like the old days. But for people, if you test positive, high likelihood you're going to keep testing positive. So don't be tested again for 90 days I think is the take home.

John Lynch:

Yep.

Trish Kritek:

Last one for you, and then I'm handing it over to Anne. There are some people who are saying, "I'm hearing lots of stories about people having reactions on their booster shot or getting sick after their booster shot or having some kind of flu-like symptoms after their booster shot. Are people having different reactions to the booster than they had earlier?"

John Lynch:

I haven't heard a lot to be honest. I think it's just like a lot of vaccines, sore arm. Some people are a little bit tired. I have not heard sort of the stories of being out for a day or anything like that. But again, it's just the Pfizer folks and only a subset of those. Even though we have these actually available to a lot of people, actually a minority of the eligible population has gotten a booster.

Trish Kritek:

Okay.

John Lynch:

And so I don't know. I saw Santiago nodding. I don't know anyone else. I haven't heard any outstanding issues with the reactions to the booster.

Santiago Neme:

What I read is that it's more similar to the second dose for some people, but we don't have enough data as John said. CDC only released preliminary data.

Trish Kritek:

Okay. So we don't have enough data.

Cindy Sayre:

-

Trish Kritek:

It sounds like... What'd you say?

Cindy Sayre:

I was just going to say I got mine and no side effects.

Trish Kritek:

No side effects for Cindy. I felt like after the second dose personally. And so that rings true for me. But I also did get my flu shot then too. Who knows? Okay. Enough about me. It's time to hand it over to Anne to do Ask an ID doc.

Anne Browning:

Excellent. And I get to ask questions with Tim today. We've got a bunch, but I'll try and fire through him pretty quickly.

Anne Browning:

There were a lot on this theme of family, especially with kind of holidays around the corner. I'll start with some specifics, then I'll ask you some general ones. Would you allow vaccinated family members visiting from out of town to stay with you for a couple days?

Tim Dellit:

Yes.

Anne Browning:

Cool. Would you feel good about gathering to eat indoors with like 20ish vaccinated folks?

Tim Dellit:

No.

Anne Browning:

What number do you feel kind of comfy with?

Tim Dellit:

I like to keep a 10 or less.

Anne Browning:

10 or less. Right.

Tim Dellit:

I'm still more of a small number. Again, that's not based on any evidence. Just my comfort level. I just worry as you start to get into larger crowds.

Anne Browning:

I appreciate that. I think a lot of folks are like, "How about six? How about eight?" So if your threshold is 10ish before you start to get too nervous, I think that's helpful to hear.

Anne Browning:

Let's see. Holidays in general, I would say we're about six weeks out from Thanksgiving. Do you have any kind of general ways you're thinking about precautions or kind of central considerations for folks?

Tim Dellit:

No, think again, now this year we have vaccine, so it's different than we were at last year, right? My own approach would be, if we were going to have individuals over, I'd like to make sure that everyone was vaccinated. But I think we're in a different position than we were last year because of the vaccine. So my approaches and thoughts around it are a little bit different. Whereas last year was much more of a virtual family gatherings. I think there's the opportunity to have those family gatherings. But again, my own preference is to ensure that everyone's vaccinated.

Anne Browning:

Excellent.

Tim Dellit:

At least those who are eligible.

Anne Browning:

What do you think about traveling through airports? Flying over the holidays? Would you do that?

Tim Dellit:

I actually feel fairly safe flying. I think the air flow in the airplanes is actually quite good. My worry around the holidays is just the large volumes of crowds in the airports, but I think it's doable. Again, I flew over the summer when it was a little less crowded. I was going back to Iowa, and no one goes there. So it was very few people. But I think that's the only hesitancies. That the airports will be very full. There's going to be a lot of people. And so, as you're standing in line, you just have to try to keep your space. Everyone should be masked. And again, people, if you're vaccinated, I feel pretty good about that. And have the hand gel with you.

Anne Browning:

I've seen a lot of saggy masks in airports.

Tim Dellit:

I know. That's the thing. I kind of moved back from those individuals.

Anne Browning:

Yes. Segueing on to kids. I'll actually start with another on the theme of travel. Would you fly with an unvaccinated kid around the holidays?

Tim Dellit:

No.

Anne Browning:

More on kids. Would you trick or treat in Pierce County?

Tim Dellit:

Yes. I actually think trick or treating, again you're outdoors. You could have a mask on. I actually think enjoy Halloween this year. Don't listen to John.

Anne Browning:

Say you had a newborn, would you let unvaccinated cousins who are masked up, come to meet the newborn?

Tim Dellit:

No.

Anne Browning:

Would you let an 8-year old go to a bouncy house birthday party with their whole class?

Tim Dellit:

If it's the same cohort of students for which they've been around during the day, I probably would be okay with that, because they've spent the whole school day with them. They're outdoors with them. I think that cohort, I think I'd probably allow that.

Anne Browning:

Cool.

Tim Dellit:

I'm not sure if it's any more risk, I guess.

Anne Browning:

I got one around vaccine. Somebody has a kiddo who's 11, will be 12 in a couple months. Would you recommend, if you had an 11-year old, would you wait so that they could get an adult dose in December? Or would you go with the 1/3 kiddo dose as soon as John gives us the thumbs up in a couple weeks here?

Tim Dellit:

Yeah, that's a really good question. I would probably go ahead and get them vaccinated if it were available simply because we're into respiratory virus season and we still have a lot of COVID-19 within our community. If we were at a different time of the year where the rates were lower, maybe you could

think about that. But I still worry and I'd rather have them be protected sooner rather than later. So I would probably go ahead and get them vaccinated once it's available.

Anne Browning:

Good. Thank you. I think that's helpful to hear. Next series is just on life. If you were a senior citizen, would you do lunch indoors with other senior pals if you were all vaccinated and boosted?

Tim Dellit:

Yes.

Anne Browning:

Would you go to a movie theater?

Tim Dellit:

No.

Anne Browning:

Would you go bar hopping for Halloween?

Tim Dellit:

No.

Anne Browning:

Not ready to bar hop? This one came in-

Trish Kritek:

Just wouldn’t go bar hopping. Full stop.

John Lynch:

You know you're talking to Tim, right? You're talking to Tim Dellit?

Anne Browning:

No questions. No bar hopping.

Trish Kritek:

That's just like the craziest thing you've ever said.

Anne Browning:

Tim, one more. They came in in the Q&A. If you were boosted, would you go to an indoor concert?

Tim Dellit:

I think you can. The reason is because I think a lot of those places now, they're checking vaccination status, right? People are going to be masked. I think you could do that.

Anne Browning:

Okay. Interesting. So things are... I get this sense that-

Tim Dellit:

See, I'm on the edge. I'm on the edge.

Anne Browning:

Yeah, you are living on the edge, but Tim is giving me a little bit more permissive state. So thank you as always for jumping into the hot seat. It's great to hear your recommendations. Trish.

Trish Kritek:

Thanks, Anne. Thanks, Tim. Now, the recommendation is everyone travel to Iowa for the holidays. It's the safest place to go. Just to get there.

Trish Kritek:

All right. I appreciate all the questions and all the answers. As always, thanks to everybody who sent in questions. I went back and looked at the questions from the preceding week so that I could try to incorporate them all. We obviously didn't get to all of them as always.

Trish Kritek:

I want to say a couple special thanks. Last week, it was National Healthcare Supply Chain week. I had no idea, but now I do know. I don't think lots of us know how essential our supply chain folks are. They are the reason we are able to now have surgical masks for everybody and so much else that goes on. So a special thanks to our supply chain teams across our system.

Trish Kritek:

I also want to thank everybody who's been involved with all of the vaccine mandate work, which has been really hard and quite emotional as we try to navigate these waters together. So a deep thanks to those folks into the teams that are all being impacted and the individuals who are being impacted.

Trish Kritek:

And then, I'm going to do a preceding special thank you to Tim who's going to moderate next town hall because I'm going to be gone. This will be a first for town hall. I think it will be special viewing. So Tim, thank you in advance. Everyone tune in.

Tim Dellit:

Well thank you for trusting me. We're going to do our best to get through.

Trish Kritek:

I think it will be outstanding. All right. And with that, it's the end of our weekly town hall. I want to say a huge thank you to all of you for tuning in. Thanks to the panel for their wisdom as always. I'll end as I always do. Thank you for continuing to take care of our patients, their families, and each other as we move into this next few weeks of the end of October. Thanks so much. I'll see you back after that special town hall. Bye.