Trish Kritek:

Welcome back to UW Medicine Town Hall. I'm Trish Kritek, Associate Dean for Faculty Affairs in the School of Medicine. And with us today, we have Santiago Neme, Medical Director at UWMC Northwest Anne Browning Assistant Dean for Wellbeing, John Lynch, Head of Infection Prevention and Employee Health at Harborview, Tim Dellit, CMO for UW Medicine, Tom Staiger, Medical Director UWMC, and Cindy Sayre, CNO for UWMC, and Dr. Shaquita Bell, who's, as I told, here returning based on much demand to answer more questions about kids. She's a clinical professor of pediatrics, and the interim senior medical director of the Odessa Brown Clinic. So thank you for coming back to join us, Shaquita. We're going to start off as we usually do with a wellbeing message from Anne.

Anne:

Thanks, Trish. So I'd hope to be zooming in from Dublin with a lot of jet lag to say hello to everyone, but less than a week out from that trip, it ended up getting canceled, given what we thought were some problematic numbers within Ireland, but also that we had four colleagues from South Africa traveling in for that global convening. And with Omicron emerging and being detector identified within South Africa, once those four folks couldn't travel up, we decided to postpone, and it was hard. It certainly has not been the first time we've had global travel wildly disrupted by yet another unpredictable step in COVID and in this pandemic.

Anne:

But I sat on the meeting, at some meetings this week with some of those South African colleagues, and sat with what just felt like just these really tough inequities around travel restrictions and vaccine distribution that are continuing to kind of drive and keep us all in this interconnected way within these patterns of disruption that are really, really hard to sit with. And it's something I want to make sure we are all continuing to pay attention to, because this is a global pandemic by its name.

Anne:

As we think about where we're at, we had a ton of questions coming in this week around Omicron, and what does that mean for our plans for this month for different holiday gatherings that people are thinking about? And I'll ask John at the end, and I'll ask our friendly infectious disease doc, some of those questions that we're rolling in. It is tough to be sitting with this kind of level of uncertainty, and yet I just want to say that I'm really glad to be in community with all of you as we're kind of navigating through yet what is another really tough moment within this pandemic. So thank you.

Trish Kritek:

And thank you. I know it was hard to be here and not be in Ireland. You and I have had multiple conversations about that this week, and it does feel like there keep being these things where there's this, and I think that was one for you. So thank you for sharing that moment. I'm actually going to start off with John and talk about where we are here locally, and we will talk about, for sure, Omicron before we get into all of that, because I think that's actually the thing we had the second most questions, most about kids, second, omicron. John, where do we stand within our system with patients with COVID right now?

John Lynch:

Yeah, sure thing, Trish. We're now at 30 patients as of 6:30 this morning, which again, is a trend very much so in the right direction. We have 18 folks in acute care, 12 folks in the ICU across UW Medicine

hospitals, but every hospital in our system right now has less than 10 patients with COVID, which is pretty amazing. UW MC Northwest actually got to zero for a day or two this week, Santiago, right, and now has two. So it's great. Really, really good news.

Trish Kritek:

Yeah. That's awesome. And I think super exciting. I watch the numbers every day, and I'm like, "That feels good," and I think people are feeling that.

John Lynch:

Sorry, one quick correction. Sorry. Montlake's at 12. Sorry. They're just above 10, but every other one less than that.

Trish Kritek:

We're just waiting for someone to put in the chat, "No, we're at 12, John." So-

John Lynch:

Okay. I'm sorry. I know it was coming. So I wanted to make the correction as quickly as possible.

Trish Kritek:

Good catch. Okay. But still 30 across the system is really different than where we were at, and we were kind of stuck for a while at the 50-ish, and now we're actually seeing it start to come down, which is great. Do you know what percentage of the folks that we see that are hospitalized now are vaccinated?

John Lynch:

Yeah. Actually, let me just run the numbers for you because I think the numbers are quite compelling. At Harborview, of the folks we have, this is when we looked actually this afternoon, five of six patients who were in the hospital are unvaccinated. At Northwest, when I again pulled the numbers, at that time, there was one, and that one person was unvaccinated. Montlake, of all their patients, seven are unvaccinated, including one of the ... Just a note, one of the patients was on ECMO, they have two people on ECMO due to COVID there, was a previously healthy person who's now on ECMO, and is unvaccinated.

John Lynch:

There are four people who are vaccinated at Montlake who have COVID, but three of them are people who have had transplants, so are pretty immunocompromised. And the last person was actually admitted for a non-COVID reason. It was found on screening and is asymptomatic. So what I would ... to take home, when I look at those numbers is the vaccines are working fantastically right now, and it really continues to be a real problem for folks who are unvaccinated.

Trish Kritek:

So vast majority of people are unvaccinated who are admitted to the hospital, or the few that are vaccinated, the majority of those are people who have significant immunocompromised.

John Lynch:

Yeah.

Trish Kritek:

I appreciate that. People ask that pretty much every week. So I think it's good to kind of go over that. As I said, there were a lot of questions, and I'm just going to start with a kind of really broad question, and maybe encapsulates a lot of the questions, which is how much do you think we need to worry about Omicron?

John Lynch:

I think the most important thing, I'll just make two quick points. One is we got to keep an on Delta. Delta is the thing that's causing the problem now. Every single sequence that we've done in Washington state is Delta, and those cases continue to be the ones in the hospital and hospitals across our state. So we got to keep an eye on the ball there, and we're still early days in winter. The second thing is around how much am I worried about Omicron. Again, the take home point here is, I'm not sure just yet. The questions that are coming up are, is it more transmissible? Does it cause more serious disease? And is it going to be able to get by our vaccine needed immunity?

John Lynch:

And the thing is I can make speculations about some of them. There's some data on each one parts of those things. It gets pretty complicated, but the answer really is, we're not sure just yet. It may be immediate transmissible, it may not be as dangerous for folks, and there may be an impact on vaccination media immunity. But it's going to take us a little bit more time to get to understand where we're going to be. So my take on this is we should prepare for something like Delta Delta Plus in healthcare and in our society. And when I say prepare, I mean reinforce the things that we know already work, get vaccinated, get boosted, wear a mask, stay home when you're sick, get tested, distance when possible, because we know those things will work for Omicron just like they do for Delta, as they did for every other variant before that.

Trish Kritek:

Okay. So here we're still seeing all Delta, and we really don't know about all the things, which I think you're right, are the things people asked about, severity of the disease, transmissibility, and are vaccines going to not work against it? And I think the answer is we don't know yet. The one thing that I'm going to follow up on those three with you though, is there have been some reports that maybe it's milder disease. Does it seem like there's a signal that it might be milder disease?

John Lynch:

Yeah. So when we look to our colleagues who have got the most experienced with this, it's colleagues, scientists and physicians in South Africa, particularly in this one province in South Africa where the surveillance experts first picked up and reported this. And I apologize to anyone out there, I don't know how to pronounce the province correctly. I think it's Gauteng province, G-A-U-T-E-N-G, which includes Johannesburg, and where they have really great genetic surveillance.

John Lynch:

They are reporting, again, this is anecdotal reporting, not in case reports, not in peer review literature, they're reporting milder disease. But you have to think about who's getting infected, right? We have big issues around vaccine equity, vaccine access, vaccine uptake, right? They are all completely big issues. But one of the big things you have to recognize is a lot of people who aren't vaccinated are younger

people, right? And if they're getting infected more commonly with Omicron, we know people with fewer comorbidities, healthy adults tend to have less serious disease.

John Lynch:

So we have to just be cautious. I definitely want to ... That's great news from multiple south African colleagues that Omicron infection may be associated with mild disease. Fantastic news. But again, I'm being very cautious about that and waiting for a little bit more to get some more data.

Trish Kritek:

Okay. So maybe some early signal that it might be mild disease, but there might be some things that confound that, that we'll have to see play out over time.

John Lynch:

Exactly.

Trish Kritek:

You said that we are seeing all Delta. What percentage of the variants in our state, and are we actually testing to see what kind of variant it is?

John Lynch:

I can give you a couple of quick statistics. One is I just talk to Dr. Alex Greninger, one of our leaders in the UW clinical virology lab, and he's estimating that about 100% of all the positives right now, positive tests in UW Medicine Clinical Virology are being sequenced, or I shouldn't say sequenced, being tested for what are called S gene dropouts. You guys, we talked about this back with Alpha variant. It's just a way on our PCR platforms to do sort of a quick screen for things like Omicron. So Omicron's another S gene dropout, unlike Delta. And so they're basically testing every positive test on that platform to look for S gene dropouts.

John Lynch:

I know Dr. Roychoudhury, who also is a scientist in that area, mentioned this morning on social media, they've tested about 1,500 samples so far this week, and that was probably as of yesterday, and I bet you it's even more today. So they're screening everything and doing amazing work. So I feel very confident in our clinical virology colleagues and their surveillance program that they're going to find Omicron if it shows up.

Trish Kritek:

So that's super helpful, because before we talked about, we were sampling and doing only some tests to see what variants it is, but because you have this kind of more rapid easier screen, we're screening all of the samples for what would give us a signal that that's Omicron.

John Lynch:

Right. So if the sample comes out as one of these S gene dropouts, then it moves on to sequencing where they actually look at the whole genetic sequence.

Trish Kritek:

Yeah. So this would be like, "Hey, do more testing and prove that this is actually Omicron."

John Lynch:

Right.

Trish Kritek:

That's really helpful. I'll ask you two last questions before I pivot to Tim. The first one is I love the person who wrote this question, was like, "Delta is number four in the Greek alphabet. Omicron is Greek letter number 15, and someone's going to tell me I got it wrong. Were there variants all in between there that we just didn't hear about?"

John Lynch:

Actually not 100% sure, but I believe, yes. Do you guys remember there was new and new?

Trish Kritek:

Yeah.

John Lynch:

I don't know all my Greek letters, to be honest, but I'm pretty sure we had a whole sequence of them through this. Some of them were not present in the United States here. Here, we had a lot of Delta, we had a lot of Alpha, but we didn't see Gamma that we saw in South America, or some of the other variants in other parts of the world. So it's actually one of the big take homes that I hope maybe we could touch on later, Trish. It's a pandemic. That means it's everywhere. And what we see here in Seattle, Washington state, the United States is different than other parts of the world and what they're seeing. Margaret Griffiths is saying they skipped Nu and Xi. I didn't know that was a ... Oh, sorry, Xi. There we go. Thank you. They skipped a couple.

Trish Kritek:

I appreciate the feedback from the viewers. It's always appreciated. I actually had to Google Omicron and to find that it was actually a Greek letter. So I feel like I'm learning all this accessory knowledge from this experience.

John Lynch:

Yeah.

Trish Kritek:

But I think your take home point was there are a bunch of other variants, maybe not all of them, all those letters, and we don't necessarily see them all here in Seattle or in the United States. Okay. One last one, there's been a lot of talk from the Biden administration about home testing. So people asked again, how should I be using home testing, particularly in light of Omicron?

John Lynch:

Yeah. So first quick point here is the home testing or antigen test, which pick a different part of the virus up, it's actually a protein, rather than the gene that we use for the molecular tests. And all the antigen tests will work for Omicron in the same way they work for Delta and Alpha. So that's one important

thing. Where I think the antigen tests really have a great role, right, is that we know they have lower sensitivity and lower specificity compared to molecular tests. But where they really could, I think be really great is if you are at home, or your kid is at home, or a family member's at home, and they have symptoms, a cough, a cold, a sneeze, and they do an engine test, a rapid test, and it's positive. They've got COVID, right? You're all done. You don't need to go on and get additional testing.

John Lynch:

Now, if they have all that syndrome and their antigen test is negative, you might be missing COVID, but that would be a trigger then to go on and get regular testing or PCR test. And I think that's a place where they're really, really good. There are some data where doing sequential tests for asymptomatic people could be very useful, but I don't know what the exact magic number is. Is it two? Is it three? Is it four? But that could be a potential place as well, and you're seeing that it's done in a lot of schools and sports, where they do sequential antigen tests, and I think that's a pretty rational for someone who's healthy, no symptoms. But where their greatest power is in a symptomatic person, easy test at home, and that test is positive, you're kind of done then. You know that you have COVID, and if you're doing well symptomatically, you can stay home and isolate and follow all the protocols.

Trish Kritek:

Okay. So particularly useful if you're symptomatic, it's positive, you have COVID. If maybe also in serial testing show that you're negative and people were asymptomatic, but I think you clarified, you clearly delineated those two. So thank you. I appreciate that. All right, Tim, first question is, are we prepared if there's a surge associated with Omicron because people are worried that we're about to enter into this next phase again?

Tim Dellit:

First, I just want to acknowledge and thank Anne for raising the issue that she did around our global community, because again, it really does highlight while we're very fortunate to have quite high vaccination rates here locally in King County, as long as there are areas of the world that have low vaccination rates or lack of access to vaccine, we continue to run that risk of the emergence of new variants. And so again, it really does highlight that global community.

Tim Dellit:

In terms of our surge planning, again, we still have our incident command structure. We've done a lot of work over the now two years around search planning, and all those plans would be ready to implement, should we see a need? And again, we don't know enough around Omicron yet. I do think that we likely will see some increase in cases. I was anticipating that even prior to the emergence of Omicron, just because of as we go into winter season, I wouldn't be surprised if we start to see some increase. We were seeing that across the country, right? Look at the Midwest as an example, even in the Northeast prior to Omicron. So we do have those plans and they are ready to implement.

Trish Kritek:

Yeah. Plans already kind of already anticipating there might be a surge, and we'll see what happens with Omicron. Relevant to that as well, there's been a big push to say, you should get a booster, you should get a third dose. And people asked, are we going to mandate that people get that booster or third dose?

Tim Dellit:

John included this and his message earlier this week around Omicron. And currently, we don't have plans to require that. We do strongly encourage it, just as the CDC does, and we're starting to track that, particularly for our healthcare workers or those individuals who use our hospital-based employee health services. And so if you've got vaccinated within our UW Medicine vaccine clinics, we have your information in our employee health database. If you got vaccinated in a clinic as a patient, or you got vaccinated in a pharmacy, or outside of our system, and work in our healthcare environment, we would encourage you to submit that, as in John's message so that we can track that. That's helpful both in terms of exposure investigation, but also should we, depending on what happens here in the future, need to really look at that issue around booster vaccination, then we have that information already. But currently, it is not required. Strongly encouraged though.

Trish Kritek:

Strongly encouraged, not required, not out a mandate. And if you got it somewhere, not in our system, let us know, so we can have it as part of our records. I think the last thing about preparedness is people are asking, are we going to go back to people spending more of their time working remotely? And then do we have plans for changes to onsite work in light of this?

Tim Dellit:

Yeah. No, that's a great question. Right now, we're not changing our practices. We believe what we're doing currently is creating a safe environment. We're continuing to watch and learn as Omicron evolves, but right now, there's been no change in our current. And again, what we're doing, that combination of efforts that John alluded to earlier, we believe is creating a safe environment.

Trish Kritek:

Okay. And I think the other encouraging thing is we're actually at lower numbers than we've been in a really long time. So trying to balance those two things. Okay. In a lead up to going to Shaquita, I wanted to add you, how many pediatric doses have we given out across UW Medicine for vaccines?

Tim Dellit:

So we've given out 21,000 doses. That includes mostly first. There are some now seconds, because we just started this at the beginning of November. And so that three-week period, there some second doses in there, but 21,000. And the good news is that previous waiting list that we described is gone.

Trish Kritek:

Oh, that's great.

Tim Dellit:

So we've been able to move through that for children. Now, for boosters, because of all the emphasis now, particularly from the CDC and in the media, we do have a waiting list of about 16,000 there. However, we're doing about 12,000 a week. So we will move through that. But the boosters, there is an increase in demand right now, which is good to see. But people have to be a little bit patient, and check both within our system, and we should get you in in the next couple of weeks, or if it's available elsewhere as you each check pharmacies and everywhere. But there is an overall increased demand in boosters, which is good to see.

Trish Kritek:

So I'll start with that one. Lots of people wanting boosters and a waiting list, lots of kids who've gotten their first dose, now some are getting their second dose, and no more waiting list. Do we have adequate supply for our pediatric doses right now in UW Medicine?

Tim Dellit:

So my understanding, and Shaquita will have more information, is that the supply has gotten better, and that's allowed us to now get through our previous wait list. So right now, people can get their children in, I think pretty easily.

Trish Kritek:

Okay. That's great. And actually, thank you for giving me a nice segue over to Dr. Bell. So Shaquita, maybe if we can start off with giving us a sense of the data and how we're doing locally with vaccination of our five to 11-year-olds.

Shaquita Bell:

Yeah, absolutely. So to answer the earlier question, yes, we have good steady supply. Now, obviously, going into the winter months, we all always worry about inclement weather impacting supply. So I've been telling people not to wait to go ahead and get vaccinated right now while we do have supply. But the good news is that it stores, the Pfizer, Moderna, and J&J vaccines all store really well. So even if we have some mountain passes closed, we should have some supply for a while.

Shaquita Bell:

So in the state of Washington, there is 677,000 children between the age of five and 11. About 116,000 folks have started vaccinating their children in that age range. That's about 17% of the population within the five to 11-year-old group having started. Obviously, it's only been about four weeks, so we have very few people who have had their second dose. That's only about 1,000 folks, but really, really good start here at 17,000 kids being vaccinated, or 17% of kids being vaccinated who are eligible. And I'm hoping now that the supply is better, that we'll see much better outcomes as well.

Trish Kritek:

Yeah, that's great. So 17% of the kids that would be eligible and hoping to kind of ramp up as we have the supply, which is adequate right now, which is great. Do you have a sense of how we're doing in being equitable in that distribution of vaccines?

Shaquita Bell:

Yeah, great question. And one of the really amazing things about our state is that we actually track this information. This is something that the state of Washington, the Department of Health in partnership with UW specifically started tracking to earlier than most states. So there is a website that you can actually look at COVID data through the Department of Health, and you can also look at it through Public Health, King County. And what we know right now is that relatively our state is doing pretty well overall. So around 77% of folks who identify as black and African American in the state are vaccinated. Hispanic, Latino, Latinx is about 75%, and American Indian, Alaskan native are at 95%. It's hard for me not to smile at that one because that's pretty amazing. You can-

Trish Kritek:

That is pretty amazing.

Shaquita Bell:

Yeah, you can break it down by region, and that's where we start to see a little bit more disparity. So Seattle actually is not doing super great in terms of black and Latinx populations. We're still below the 70th percentile for the vaccine overall percentage, and other parts of the state, those are above, and that's what pulls up the overall vaccine rate for the state based on race, ethnicity, and language. So we're continuing to try to do outreach in the city of Seattle to reach communities. And some of that's through mobile vaccines, partnering with local places of worship, schools, the state to do mobile vaccines and reach people where they're at. So there's still work to do in Seattle proper, but the overall state numbers continue to look really good.

Trish Kritek:

Yeah. So we're like 75 to 77% state-wide, little lower for blacks in King County. Really good for our native American population.

Shaquita Bell:

Yeah.

Trish Kritek:

That's for everybody, not just for kids, right?

Shaquita Bell:

That's 12 and over. We don't have the data for five to 11 yet just because it hasn't been long enough for people to be fully vaccinated.

Trish Kritek:

Yeah, okay. We might have to have you back, and we'll revisit that as we get more experience, just a little warning to you. The thing that we got a bunch of other questions about is, what are we seeing in terms of adverse events? People are understandably still worried about that. So now we have of more experience, you just told us about all the kids who've been vaccinated. So do you know how often children are having adverse events?

Shaquita Bell:

Yeah. I was telling the group that one of the beautiful things about being on this Town Hall is that one, people read their email, and they either watch live or they watch afterwards, because I got a lot of outreach after the Town Hall, and a lot of really amazing colleagues who sharing data with us. So I'm actually going to share some information that Dr. Margaret, one of the UW epidemiologists emailed me, which is really wonderful. So this is looking at people with reactions, comparing adults to children. And what you'll see is about 3% fewer folks reporting severe reactions, and that includes pain, redness, and swelling, and less than 1% of kids. Then I'll scroll down for fatigue, fever, headache, chills. I think everybody can read their slides. I hate when you're in a presentation and somebody like reads every single line. So I won't do that to you all.

Shaquita Bell:

But this is also looking at efficacy or how well it works, and this is just demonstrating the efficacy of the vaccine. One of the other people who reached out to share data with me was Dr. Michael Portman, who is one of our cardiologists, and who is part of the overall study for looking at the myocarditis associated possibly with a vaccine, definitely with COVID. We had a total of 27 cases of vaccine-induced myocarditis, and only one of those people were assigned female gender. And it looks like all of those cases happened in the first couple of days after the second dose. So we're a little too soon to know whether or not we'll have any myocarditis signal with a five to 11-year-old dose. But again, of the cases that we have had, all of those people have been over the age of 15.

Trish Kritek:

Okay. So the older kids in the kid range are the ones who've had the myocarditis, almost all of them identify or are genetically male. And then the other part of that was you snuck in slides, which all the people on the screen right now are saying, "Trish, you never let me use slides."

Shaquita Bell:

Oh really?

Trish Kritek:

Oh, yeah. And-

Shaquita Bell:

Well, see, that's part of being a special guest star, is you don't know what you're doing.

Trish Kritek:

Yes. Yes. All of them are going to remind me of the fact that you're ... I'm going to hear like, "Shaquita got to use slides." So anyway, I want to encapsulate what I saw there, which is the adverse events were a lot less likely in children. And so let me follow up with that, because there's a question that's coming through the Q&A now, and that is, how is it then, how do we balance the fact that, well, adverse events aren't that common, but severe disease isn't that common in kids. And so how did that balancing result of yes, you should get vaccinated?

Shaquita Bell:

Yeah. I don't need a slide for this one. Right? I think it goes without saying that if any child had a severe reaction or death from an infection that's preventable via a vaccine, then the vaccine is warranted. I mean, it's the same reason why we vaccinate for all childhood illnesses. While they're uncommon, they are severe and deadly and preventable, and that's the point. So I think what we know about COVID demonstrates that it is not worth the risk, and that the safety of the vaccine is in and of itself so safe that we recommend getting the vaccine.

Shaquita Bell:

The other thing I'll remind folks is that we're thinking about a pandemic, and a pandemic really means that it's bigger than Seattle, it's bigger than the state of Washington, it's bigger than the United States. This is all around the globe. The more we can do to eliminate this infection in our population, the better all of us will do on a population level. So preventing infection in our children is going to prevent infection across all of our population and make everybody healthier. So it's the same sort of logic of herd

immunity, the dreaded term that started out at the beginning of this pandemic. But the reality is our children can get COVID, and they can spread COVID, and they can die from COVID. So we have ample reason to vaccinate our children against COVID.

Trish Kritek:

I really appreciate that. And so it was like, it's about this child. We don't want them to get sick and die from COVID, and it's about our community, and that's our global community in the midst of a pandemic. I really appreciate how you walked through that, and I hope people heard that, because I think you could use that same message when you're talking with people who are worried about vaccination for their kids, and why it seems like there's ample evidence that we should proceed. Last question for you for right now is, do you have a sense ... because now we got five to 11, so now the questions I get is, how about the younger kids? So do you have a sense of when we might have vaccines for the folks who are under five?

Shaquita Bell:

I'm going to point at the Bell-Lynch phenomenon, and I will not predict it. I haven't gotten any update about any submission to the FDA for EUA from any of the vaccine companies. So that means it's still months away before we'll have, at the earliest, months away before we'll have a vaccine that you even has an EUA approval.

Trish Kritek:

Okay. So we don't know yet. It's still going on. People can keep asking the question. It prompts me to ask-

Shaquita Bell:

Yes, absolutely. And I'm happy to not share a slide, but an email when we hear it's submitted.

Trish Kritek:

I loved it. It was great. And somebody who sent you that is so happy that they got to share that with the community, because they wanted to share it with the community. So thank you for doing that. It was great. And thanks for the person who sent it to you.

Tim Dellit:

Just don't ask for permission. That's what I'm learning.

Shaquita Bell:

I guess that's the lesson.

Trish Kritek:

Clearly, that was the take home message. Okay. Santiago, welcome back. It's good to see you. I wanted to ask you a few questions about booster shots, because I've asked you about boosters before. One of the questions, people who have gotten vaccinated, and then gotten COVID asked commonly when should they get their booster? And this one was very specific, was like, "Will I have more side effects if I do it quickly after I got infected, or should I wait a little longer, and I'll have less side effects?" Do you know anything about timing of booster and side effects if you have been infected?

Santiago Neme:

So I didn't know the answer to this question, and I asked around, and no one could come up with a study or anything that looked into this question. What I would say is that we've been saying the same thing for almost two years, is let's not waste an opportunity to vaccinate, and do it as soon as possible. It is unclear whether you're going to have more side effects or less side effects, but we know that the side effects, if they occur, they're transient, and we know that the getting the vaccine, getting that booster is extremely important. So I would say let's not waste that opportunity. And the same thing for some of the questions that we receive pretty often, which is, "I've gotten the mRNA vaccines, should I switch?" I always say, just get the vaccine that you can get the sooner. If you can get Pfizer sooner, get it. If you can get Moderna, get it going to get it, because the truth is that we really need to get that extra protection.

Trish Kritek:

So thank you. I think the take home is no data to say that there's better or worse side effects with any of those specific timing. Thank you for looking into it, and asking people. So when you have the opportunity, get the booster. And I think the second thing, you started to answer my second question, which is this kind of mix and match question. And what I think you said was take what you can get. If it's there, take it. If you go and they have a choice, would you recommend the mixing and matching at this point in time?

Santiago Neme:

I would say the mixing and matching, as we've said here before that I strongly recommend is going from a J&J to an mRNA. That mixing and matching makes a lot of sense. Mixing and matching between Pfizer and Moderna is ... I don't know. It's a bit negligible. This is where I think it's like a couple weeks ago we had kind of a shorter supply of Moderna. People would have to wait a few days. Well, get Pfizer. That's a simple, very similar products. So I would say, but the recommendation to cross platforms is for J&J, at least most of the experts are recommending this.

Trish Kritek:

I think that's a nice, clear guidance. If you had J&J, boost with an mRNA. If you had mRNA, take what they have when you get there. And most importantly, if you have the opportunity to get a booster, get a booster, because the last question about boosters for you is, who are we recommending get boosters now?

Santiago Neme:

Yeah. It's basically the CDC is recommending now that everyone over the age of 18 should get a booster. It changed. I think John alluded recently, it changed from a can or may to should. And this is why we really want to this point, it's really important for all of us to stay as healthy as possible, particularly as healthcare workers, right? We want to prevent even those asymptomatic and mild infections because of the transmission potential to our family members, our patients and coworkers. We know that we've had significant staffing challenges. Let's just maximize our protection as much as possible.

Trish Kritek:

Yeah. So the recommendation is now 18 and older. 18 and older, am I saying that right? Or older than 18, 18 and older?

Santiago Neme:

Older than, yeah. 18 and older. And then remember, it has to have been six months from dose two.

Trish Kritek:

Okay. Six months after your last dose, 18 and older, now you should get a booster. My sister had texted me and said, "Should I get a booster?" I was like, "You can, don't worry about it." And then I was revising my previous text, things are evolving. So I think that's how this has been all along. All right. Last question, Santiago. I have to look at my notes because I can't say it, but someone wrote in about the mechanism of action of Merck's new drug, which I believe is called Molnupiravir, but that might be totally wrong. Does it predispose to more variants, based on the mechanism of how that drug works? Tim shared with me how that mechanism of the drug works, and it took me a better part of 10 minutes to try to understand it. So you don't have to explain all the details of it, but is there a risk that we could end up with more mutants that would be a problem with this drug?

Santiago Neme:

Yeah. So this was a concern when this drug was first submitted the paperwork to the FDA. But when you think about this drug is, the mechanism of action is similar to some of the HIV meds, in that the main goal here is to disrupt what we call the viral RNA replication process by introducing these errors. Whenever you introduce errors, you may, in a way trigger some resistance. But when you look at the data that Merck, at least submitted in their slides and their presentation, they really didn't find that to be the case. Although this is a very new agent and new application, and we live with COVID, which is an ongoing changing landscape. So as of today, and I discussed this also with Shireesha and Rupali who, again, know about this much more than I do, and I think for now, it seems like it's reassuring in terms of triggering or inducing new variants or resistant forms, but it's soon to tell. It is too soon to know, as John was saying about Omicron, and we just have to see.

Trish Kritek:

Okay. So early data doesn't suggest it, but we're very early. It does work by inducing errors and viral RNA replication, which could allow new variants, which could be resistant to appear. So it seems like we need to study it more over time. Yeah. Okay. Thank you for that, and thanks for talking to folks about that one as well. Cindy, I'm going to jump to you. I ask you always about visitor policy. So I'm going to actually ask about the visitor policy that's rolling out at Montlake and Northwest. And one of the questions that came in was, why is the policy going to be one way for inpatient and another way for our outpatient settings? And how did we come up with that decision making? Maybe you could comment on that.

Cindy Sayre:

Yeah. Well, like so many things during this pandemic, we have late breaking news. We have had the vaccine requirement or the testing requirement at Harborview who were ready to roll that out at Montlake in Northwest, but we've hit a couple of barriers. So I'm not where's that date of exactly when that's going to go live. It's still a little bit uncertain.

Cindy Sayre:

In terms of how we made decisions around having this protocol in the inpatient setting versus the outpatient setting, part of it is just logistics. We have central entrances here in the medical center. It gets a little bit more difficult when you get to the clinic spaces, because we don't really have registration staff. For example, in the Roosevelt clinic downstairs, we have to set up new structures. My

understanding right now is, I think we will get there. I think we'll get there. I think this is a phased approach, and right now we are going to focus on the inpatients.

Trish Kritek:

Okay. So I think what I heard was my might not be going live next week with the visitor policy, and not like in Northwest, because there's some things that still need to be sorted out.

Cindy Sayre:

Yeah.

Trish Kritek:

It will be an iterative process, and eventually probably go to the outpatient setting as well. And the reason we're not starting there is, A, because it's a phased approach, but B, also because of the logistics and the challenges of it. Is that right?

Cindy Sayre:

That's my current understanding. And I literally have a meeting at 4:30 to talk about the policy and how it might happen and might not happen here on Monday, so we're-

Trish Kritek:

Okay.

Cindy Sayre:

Things are in development.

Trish Kritek:

If nothing else over the last 20 months, we've learned that things evolve over time and that there are things that change, and so we talk about it that way. So thank you for sharing that.

Cindy Sayre:

Okay. And I think just one more sentence is, we want to get it right, and that's why sometimes these things are delayed because we've hit some kind of barrier, and we want to make sure we're doing this correctly.

Trish Kritek:

Okay. I appreciate that, and I think sometimes a day or two more, or a week more is better to get it right, or as close to right as we can. The other thing I question about visitors that came in, and it came in last week, and last time I failed to ask it was, do you have thoughts on people notice visitors in our common spaces who aren't necessarily fully wearing their mask, they're doing the kind of below the nose mask wearing. John has shown me these various ways of wearing a mask before. What are we doing to try to help people keep their masks on?

Cindy Sayre:

Well, I think this is really the job of all of us, the entire team as we move through the medical center. There are messages everywhere, and we all know that those written messages really only have limited utility. I would say about 50% of the time that I walk through the lobby, I am asking somebody to put their mask on, and mostly people are very compliant. One of the pieces of confusion we have is our visitors will be eating sometimes in those common areas. And when I say, please put your mask on and they'll say, "Well, I'm drinking my coffee." And then I have to say, "We're actually not allowing that in these public spaces."

Cindy Sayre:

And so far, I think people have been respectful of that message, and they'll put it up. I just think it's going to take the entire team continuing to reinforce. And I will also say, some of even our colleagues, we're needing to remind people. And so I have found my script for saying, "Would you please?" I think this is Santiago taught me this move, "Would you please put your mask up?" And people do it. So yeah.

Trish Kritek:

Yeah. I appreciate you saying, it's kind of all of us working on it together. It can be a hard conversation. So we need to support each other in those conversations, and lead with some curiosity about why maybe they don't have their mask on, and then clarify that we actually don't eat in the public spaces. So I appreciate that very much. I have taken to doing it myself when I go on my daily walk to see the kids lined up to get vaccinated, which gives me great joy. So I try to fit that in everyday at some point in time. And so I think that's for us and for visitors not eating on the third ... not on the third floor, but in other common spaces.

Cindy Sayre:

Right, those are not safe areas for us to be eating, or for patients and visitors to be eating.

Trish Kritek:

Thank you for reinforcing that.

Cindy Sayre:

Yeah. Thank you.

Trish Kritek:

Last question. I have never had this question before. When are we going to return to valet parking?

Cindy Sayre:

Yes. Well, valet parking went away when the pandemic was in its early stages. There was some infection prevention concerns, and we also really had stopped our elective surgeries for time, so we didn't have as much need for that. In our executive team meetings for the Montlake campus, we are just now starting to talk about it again. The issue is that we have really limited parking, as I think Harborview does and other places, but we have limited parking, and we just don't want our patients to bear that burden of driving around and around when they're trying to get to an appointment, but we are in the very early stages of revisiting this.

Trish Kritek:

Okay. So someone asked the question, and actually you're starting to talk about it. So that's great, and we'll hear more about it over time. Thank you.

Cindy Sayre:

Yeah.

Trish Kritek:

Tom people are asking, are we still experiencing really high census, or is that getting better as our COVID census is going down?

Tom Staiger:

Yes, we are continuing to experience very high censuses. We did get a little bit of a reprieve as we generally do over the Thanksgiving holiday. But by the end of this week, we are, again, exceedingly full across all of the hospitals in our system. So we remain very full. I don't get the sense that those volumes are growing, and maybe there's some signals that we aren't across the system boarding quite as many patients routinely, that's a little less clear. But we are certainly remaining very full.

Trish Kritek:

Okay. So maybe a little less boarding, but overall, still super full. And it sounds like not because of COVID, it's because of all other types of reasons that people are being admitted.

Tom Staiger:

Right. There's a COVID contribution, both the census, as John mentioned at about 30 today, as well as patients who had COVID and are no longer infectious, but are still in the hospital that are occupying beds. But this is not predominantly being driven by COVID at this point.

Trish Kritek:

I think so that's helpful. And I think that that other point of we have patients who are no longer on precautions, but were omitted because of COVID and aren't ready to be discharged yet. So that is part of the strain, but not the predominant cause. And the other question that also often comes up is people asked about, where do we stand with rescheduling elective surgeries? This was very specific. It was about elective orthopedic procedures. And I'm just curious, is there's something different with orthopedic procedures that we haven't caught up with those, or do you know? And maybe Santiago, maybe those happen more at Northwest, I'm not sure.

Tom Staiger:

If the question is, are we caught up with rescheduling the previously deferred orthopedic surgeries and other surgeries, I think by and large, we have caught up with those. And I don't know, Santiago, if you know anything about ortho cases that have some residual, please comment.

Santiago Neme:

It's not significant. I agree with you, Tom. The person who asked on the Q&A was more specific about a case. So I didn't get the sense that it was a trend. But if it's a trend, I'm happy to look up the issue, but I'm not aware of an issue involving multiple patients.

Trish Kritek:

Well, I will say if there was one in the Q&A, this one came in from the remote submission beforehand. So that might have been-

Santiago Neme:

I got two.

Trish Kritek:

... two. I don't know if that's a trend, or maybe it's the same person really wanting me to ask the question, which I did. So maybe the person needs to check in.

Santiago Neme:

Let's follow up for next time. Yeah. Next time we bring. Yeah.

Trish Kritek:

Okay, great. John, I'm going to sneak in a couple last questions with you before I hand it over to Anne. And the first one is, you said there were the people who were in-house were mostly unvaccinated, and there were some people who were immunocompromised. Do we think there's a fourth dose in the horizon for immunocompromised patients, or do we feel like we're there?

John Lynch:

It's already there. So for immunocompromised people who have that third dose, right, they are also eligible for a booster, so a fourth vaccine. That is currently already out there. I don't think the message kind of boiled out as much as the third dose did, but it is already in the recommendations from the CDC for immunocompromised people who get a three-dose regimen to get boosted following the same protocol.

Trish Kritek:

That's super helpful. I didn't understand that. So I'm going to say it back and make sure I got it right. So we made a really clear distinction between boosters and three doses, and we said, people who are immunocompromised should get three doses.

John Lynch:

Yes.

Trish Kritek:

And six months later, they should get another, a fourth dose as a booster.

John Lynch:

Right, for the mRNA vaccines.

Trish Kritek:

And for J&J, it would be?

John Lynch:

I hit this up and I can't find it now. And so for my immunocompromised experts out there, feel free to ping me on this. But I believe that it doesn't have the same sequence. If you get the J&J, there isn't the additional dose, but there is the recognition to get a booster.

Trish Kritek:

Still good.

John Lynch:

So I see Dr. Bell nodding. Thank goodness. So I think it would be a total of two for those folks. mRNA, it would be four.

Trish Kritek:

Okay.

John Lynch:

I think I got that right.

Trish Kritek:

Okay. All right.

John Lynch:

The reason you're asking this is because it's not super clear, and I recognize that. So talk to your primary care provider. If you are immunocompromised person, you got three doses. This is a good time to do that.

Trish Kritek:

Okay. I think that's really helpful. I always learn at Town Hall, but I just learned something else at Town Hall. So if you had mRNA three doses, get a booster on fourth dose at six months. And if you're doing J&J, look it up, so you get the right info.

John Lynch:

Yeah. Talk to your provider, because I think the issue is that the third dose recommendation came out less than six months ago. So really, that plan to get the booster hasn't really hit them yet, so to speak.

Santiago Neme:

And if that on OCCAM, there's actually the schedule that Rupali put on. So on our app, there is the schedule there.

Trish Kritek:

Oh, so for folks who use OCCAM, which is our online or app based kind of guidance for clinical care, you could look there because our infection prevention and stewardship teams and vaccine teams have put something together there. Thank you, Santiago, for highlighting that resource. All right. There are many more questions in the chat. I'm going to ask you one last one, John, and I'm going to hand it to Anne.

And this is kind of an existential one because I think it's what lots of people are hanging with, and it's asking your opinion kind of warming you up for time with Anne, do you think we'll get to what looks like normal again, like not wearing masks?

John Lynch:

Yeah. I think we will. I see, Tim just leaned back with listening here. I do think so. Whether it will be back to normal all the time is the part that I'm not clear on. I think when I think about a new normal, I think of periods where COVID activity is higher, and then there's periods where COVID activity is lower. Obviously, variants may make an impact. If something like Omicron has mild disease and displaces Delta, we may be looking at the next wave of COVID is being more flu or minor flu, like a bad cold, particularly for vaccinated people, but maybe still some serious immunocompromised people and very young, less than five.

John Lynch:

And so I would say that what I'm looking at envisioning is maybe periods where things are pretty much back normal, and periods where they're not. I'm prepared for masked winters, so to speak. I'm prepared for indoor gatherings during those times of the years as requiring things like maybe vaccinated populations and masks or similar. I see air handling, ventilation as being a really important topic, not only for COVID, but for all respiratory viruses going forward, and that never going away. But I do see periods where something like pre-2020 summertime outdoor concerts as being entirely possible.

Trish Kritek:

I'm going to end with that optimistic note of yes, and maybe some changes at times, responding to what's going on in the environment, and that's my synopsis of that one with that. I'm going to hand it over to Anne, and I always say for ask an ID doc. But I noticed earlier today she said ask a friendly ID doc. I don't know if she was trying to imply something about how you should be today, John or what, or if she's just a much kinder person than me, but Anne, the floor is yours.

Anne:

Thank you. All right, John. OMG Omicron is kind of the broad take of questions. And I'm curious, I'll start just since we don't have Omicron here yet that we've identified, to clarify, folks want to know, has being boosted changed your behaviors?

John Lynch:

Nope, not at all.

Anne:

All right.

John Lynch:

I feel more confident in my ability as I move through my day with Delta still circulating pretty widely.

Anne:

How are you feeling right now about eating indoors and restaurants all boosted up?

John Lynch:

I'm not eating in indoors in any restaurants.

Anne:

Okay. Omicron might be around us already. It's hard to imagine that it's not going to show up at some moment. Would its presence shift any of your behaviors, do you think?

John Lynch:

I think, yeah. As I mentioned earlier, I'm withholding judgment. Right? I'm waiting to see where there's actually data and more information from our colleagues in other parts of the world to inform us about what it really means. I fully expect, as it sort of implied in your comment that I fully expect we're going to see Omicron any day, could be tomorrow, could be next week, could be a month from now. But I fully expect that to happen, and I'm not going to ... I mean, I think the things that we are doing now, the vaccines that we're doing, the actions that we're taking on masking and so forth are going to be very effective against Omicron, and I'm going to continue practicing that way.

Anne:

Cool. Lot of questions around upcoming holidays. Would you travel for the holidays?

John Lynch:

Yeah, following the same things I always do. Someone put in the comments around seeing some variation with masking, not only in our hospitals, but also on planes. I have taken flights. I plan on taking flights this winter with my family, and we have a way we do it, we wear masks, we bring food. Either we eat before we get on the plane, or as soon as we take off, we eat food that we have, and then mask up for the rest of the time. Because I know as soon as that travel cart comes down, everyone's masks come off, and they nibble and chew for the rest of the time. And so that's my practice, but I believe that the air handling on planes, the filtration, and my personal choice and my family's choice around masking and vaccination keep us safe.

Anne:

Good. Thank you for that. Would you go to any holiday gatherings with any unvaccinated people this winter?

John Lynch:

No.

Anne:

If you-

John Lynch:

Aside from those under five, obviously, if there's little babies, which is probably maybe your next question. Sorry, I just want to be clear.

Anne:

That's all right, that'll come up. For holiday parties, would you do any indoor unmasked holiday parties with vaccinated boosted folks? We're talking like 10 to 15 people.

John Lynch:

Yeah. Yeah. I mean, if they're people I know who have risk assessment that's similar to mine, boosted ... Excuse me, vaccinated, plus mine is boosting. I'm not as hard line about the boosting part, but fully vaccinated is really important. Now, did you include the under fives in that question? I might have missed it.

Anne:

Not yet.

John Lynch:

Okay. There we go.

Anne:

We will get there. We will get there.

John Lynch:

Yeah, and I'd probably cap out, I think 15's probably right above my max. Right?

Anne:

That was going to be my follow up of what hits your threshold of this doesn't feel safe anymore, since I think a lot of folks are trying to navigate that size space, how many families bring together, et cetera? I feel like talking about choirs can be a little bit triggering around here, but folks want to know 65-year-old vaccine boosted, could they join a community choir to sing indoors masked?

John Lynch:

I think that is reasonable. So masked folks, everyone vaccinated, pretty reasonable, right? So the risk of those vaccinated people transmitting while masked is pretty low. The risk of you acquiring vaccinated while masked is pretty low. I am a human, like every other one. We want to engage in communal activities. I think it's pretty rational. I remember size of the group's important, but really, really important, and I always try to channel my colleague, Dr. Jeff Duchin, our health officer here in King County. You have to make a personal risk assessment. What are you willing to do? What risk are you willing to take? And that ultimately comes up to you. I think it's probably okay. If you have serious heart disease, serious lung disease, immunocompromised, probably not a great choice right now. It's kind of a risk assessment.

Anne:

I think that's a good point for me getting in a boat and rowing underneath was a risk I was willing to take for my own wellbeing, and I think that's something being in community choir might be we're sitting in a mask.

John Lynch:

I go to a climbing gym several times a week. I think I've mentioned it before. It is so important to my mental health. It's my social circle. I do it multiple times a week, and that is a risk assessment I take. My kids go to the same place, and it's so critical to my mental health, my wellbeing, but that's something I do and choose to do.

Anne:

I agree. I agree. Thank you for that. This is the holiday kiddo follow up. How would you feel about having that kind of zero to four plus kids in the house visiting maybe extended family members who flew in? Are you okay with that unvaccinated younger group kind of being in and out of houses?

John Lynch:

Yeah. I mean, I think in general, are they well? What is their school or daycare situation like? I've been amazed with learning about how these kids have adapted to masking, and follow rules, and keeping their hands clean, and how many do daycare settings are doing a great job. But I think all those parts need to be assessed. Right? And so if you're a stay at home little kid, vaccinated parents, vaccinated siblings, that's going to be very, very safe. If you're a daycare kid where there's low numbers of COVID, everyone's following the rule, I think having those kids into my life, and again, it goes back to that risk assessment and what I need. What do I need as a human being as a family member? Hey, if I really want to see my niece or nephew who's that old, and I haven't seen him in two years, and they're doing everything right, I think that's a reasonable risk assessment. If it's something that's less than that, maybe a little less so. Right? And so I'm not answering your question perfectly well, but that's the way I approach it.

Anne:

Good. I have one specific one around travel, a person who is 10 years out from a transplant is boosted, wants to take a two to three hour flight. How do you feel about that? I know you mentioned vaccinated folks who had had transplants as being a concern.

John Lynch:

Yeah. This is a really important question that I think has to be done on an individual level. What was very clear is that the level of a person's immunocompromised state is virtually infinite from extremely immunocompromised to moderately immunocompromised or mildly immunocompromised. Is this someone who's experienced, what's called an opportunistic infection, an infection that happened because you were immunocompromised, or is it not? And so yes, I believe that can be done safely. I believe that they're handling on planes, being masked, having vaccinations can make you safe, reasonably safe. It's not zero, but it's not either end of the extremes, but I think it can be done safely. But if you're someone who's recently had a bad opportunistic infection, or has had more than one, or is on treatment for one of those things, or is really close to their transplant, right, those risks might be a little bit too high. And so it really depends upon all those variables.

Anne:

Cool. I'll sneak in one last one, before I hand it back to Trish.

John Lynch:

We'll be fast.

Anne:

This came in as an actual question. John Lynch, how was your Dune movie experience and what type of mask did you wear?

John Lynch:

Dune was so good. It was so good to see on the big screen. Dr. Bell saw it. It was so good. It was worth seeing on big screen. So it was great. Everyone was masked. There was lots of space where I was, everyone was vaccinated. I went after the vaccinated thing, and I wear a surgical mask. I believe in surgical mask. If a K95 fits you better, or an N95 fits you better, go for it. But these fit my face, my cheeks or something really well, and so I feel very comfortable with these. I don't know. This is my whole family wears.

Anne:

Awesome. Thank you, John, very much. And I'll hand it back to Trish.

Trish Kritek:

You heard it here. Dune is great, and John has cheeks that fit well in a surgical. I want to say a huge thank you to everyone who's here on the panel, as always for answering the questions. A special thank you to Shaquita for joining us again, and I do think you'll be back again. So plan for it. I want to also give a special thanks to all the people who kind of ... I love that we have Town Hall and have a conversation here, but it bleeds out, and people are answering questions. They're emailing Shaquita with data, they're reaching out to Santiago, so he has stuff to answer his questions. It's Tim sending me links that say, "Trish, you should really know how this drug works. Why don't you learn about it?" But Town Hall is great, because we come together as a community, but it's also great because of all the conversations that come from it. So thank you to all the people who share your knowledge and help us answer questions, but also help us all learn.

Trish Kritek:

A final thank you to all of you, as always for your questions. They push us, they ask really important things, and I so appreciate all the questions that you keep sending in. And I'll end as I always do by saying thank you to all of you for continuing to take care of our patients, their families, and most importantly, continue to take care of each other. There will be some stuff that we'll learn over the next few weeks about Omicron, and we'll keep coming back together to tell about it. See you soon. Bye-bye.