Trish Kritek:

Welcome back to UW Medicine Town Hall. I'm Trish Kritek, associate dean for faculty affairs in the School of Medicine. And we have lots of folks with us today to answer your questions. Santiago Neme, medical director at UWMC Northwest. Tim Dellit, chief medical officer for UW Medicine, Anne Browning, assistant dean for well-being in the School of Medicine. Keri Nasenbeny, CNO at UWMC Northwest. Tom Staiger, medical director at UWMC. Rick Goss, medical director, Harborview. Cindy Sayre, Chief Nursing Officer, UWMC. John Lynch, head of infection and prevention and employee health at Harborview, and Jerome Dayao, Chief Nursing Officer at Harborview.

Trish Kritek:

And I'm happy to welcome back again Dr. Shaquita Bell. She's a clinical professor in the department of pediatrics - I almost put you in medicine. And the senior medical director of the Odessa Brown Clinic. So Shaquita, thanks for coming back because we do have lots of questions about little folks.

Trish Kritek:

Anne is going to interweave her well-being message into her questions with Santiago at the end. And so Santiago now knows that he's on the hot seat later. So we're going to jump right into questions so that we can maximize our time. That is not to say we do not prioritize wellbeing. You'll hear more about it as we go.

Trish Kritek:

I'm going to start off with you Tim today. I think a lot of folks heard Jay Inslee yesterday saying that he was calling up the national guard to help. And there were a lot of questions about what does that mean for UW Medicine. And I thought maybe you could answer that question in the context of where are we right now in UW Medicine?

Tim Dellit:

Yeah. So we as a healthcare system earlier today have 194 patients within our hospitals, again about 80% on acute care. And we have about 600 of our employees that are out either with infection or quarantine.

Tim Dellit:

So when you think of our response, moving from that conventional routine everyday practice to contingency that we talked about last time, we're still in that contingency place and all of you are feeling it. I know you're caring for patients in different places. We do have patients in hallways, we're using other boarding areas that we often normally would not use.

Tim Dellit:

We have impacts on our staffing as well. And so we still are in that contingency phase right now in our response. And I would say our healthcare system and all the healthcare systems, particularly in Western Washington are really stressed right now. All of the healthcare systems are over 100% capacity. So it's not unique to our system. It's what we're feeling in Western Washington.

Tim Dellit:

And now what we're seeing and John will talk about this more, I'm sure, we're starting to see that increase in Eastern Washington as well. So the entire state, healthcare system really is under a lot of stress, both from a capacity standpoint and the impact on our staff.

Trish Kritek:

Okay. So we're at contingency in terms of staff and space and that's common across the region. I'm going to come back to supplies in a second, but before I leave that, what are we going to get from Jay Inslee? Are we going to get anything from Jay Inslee?

Tim Dellit:

Well, we've been having a lot of conversations with the governor's office, as well as department of health in terms of how we can best support the healthcare systems specific to the national guard. The hospitals are going to have, my understanding that national guard in terms of helping them within their facilities are going to be Providence Everett and then facilities in Yakima, Wenatchee, Spokane.

Tim Dellit:

There was mention of national guard setting up a testing site near Harborview. I think, at least for me, we're still trying to understand what that means. And so we need to have some more coordination with them, whether that is to augment our current existing site or potentially utilize those individuals within our current site, or is that a completely separate site?

Tim Dellit:

So, I think some details still need to be worked out. So short answer is, there's not a lot of direct impact from the national guard. We are still working with the governor's office, DOH, and other agencies around those patients who don't medically need to be in the hospital and really trying to think creatively around alternative sites of care and ability to care for them to be able to simply free up capacity in the hospitals. But it's a challenge, but not directly from the national guard.

Trish Kritek:

Okay. So no national guard coming into our hospitals, maybe this augmentation of testing at Harborview, but we're not clear yet. And really, the emphasis for us is can we come up with the resources with the government's help for discharge of folks who don't need to be in acute care any longer.

Tim Dellit:

Right.

Trish Kritek:

I think that you said we're contingency in terms of space, people in different places, and staff, we're still down a lot of staff. The other thing people ask about, are we having shortages of supplies right now?

Tim Dellit:

John may have a better sense of this. My sense is we're still in contingency where we are using extended use of our respirators and some of our other supplies, but John may have a better current sense with supply chain.

Trish Kritek:

John, do you want to add to that?

John Lynch:

Yeah, sure. So we're actually doing really well. Our supply chain team has worked extremely hard on making sure that we have enough PPE. When we think about that, it's high protection, gowns, gloves, and all the stuff that we're used to. It's the surgical masks, although we're using them a little bit less than we once were. We have plenty of those on hand and the different levels of surgical masks.

John Lynch:

Where we're really spending a lot of time and focus and the supply chain team is working very hard is on respirators. These other tools where we level up our respiratory protection in all settings, and obviously, respirators in the care of people with COVID-19 known or suspected.

John Lynch:

We're doing really well right now. We just met with the supply chain team earlier today. And I think thanks to their work, we have a broad array of different respirators. One part of this is that some parts, some of those models may not be as well supplied as others because of manufacturing decisions, not supply, not us purchasing them. We're trying to buy them, but they're just not maybe making as many as they once did. And so we're looking at fit testing to fix that. But the major message, we're doing really well.

Trish Kritek:

Really well on supplies, including respirators though you might have to be fit tested for a different one based on which ones we have.

John Lynch:

Yep.

Trish Kritek:

Thank you, both. Okay, Tim, I want to come back to you for a couple more questions. This question was super common. Do we think we're near our peak?

Tim Dellit:

If you look at the King County dashboard, it's a straight line up. We're up to about 1,800 cases per 100,000 over the last seven days. And we're seeing 6,000 to 8,000 new cases and that's an underestimate we know. So we have not reached, I don't think, that peak yet. The estimates are hopefully sometime towards the end of this month, it does seem to be compressing in terms of moving closer and closer.

Tim Dellit:

But I would, in my mind, still thinking towards the end of this month previously had been mid-February, but I think that's been moved up. Keep in mind, even when we see the peak of cases that lag then in terms of the peak in hospitalizations may still occur. So I think we still have to brace ourselves that the

next several weeks are going to be really challenging for our system and all the other healthcare systems.

Trish Kritek:

Okay. Still going up, maybe the rate of rise isn't quite as fast, but still going up and hospitalizations are going to lag behind infections. And that raises the question that honestly was the most common question we got, which is, are we all just going to get COVID? And if we're all just going to get COVID, should we just get it over with? There were several questions about COVID parties like chickenpox parties.

Tim Dellit:

Yeah. I think it's a great question. And there have been some estimates, for instance, in Europe, well, 50% of the population get it. We've heard estimates of 60% of the population, but we can't all get it at once or we're going to overwhelm the healthcare system in all honesty.

Tim Dellit:

And so, I do think we're all feeling it closer to home. At least I think in earlier searches, we would know of people maybe who got COVID-19, but maybe it wasn't directly in our pot. Maybe it wasn't directly in our household. More and more, I think all of us, if not ourselves, have experienced within our household, within our family, fortunately again, most of those cases have been mild, at least among our healthcare workers and their families. Quite frankly, because they're all vaccinated. Most are boosted. And there are some differences in Omicron being more upper airway than in the lungs.

Tim Dellit:

But the sheer volume can overwhelm the healthcare system as we are already experiencing. And so I really would encourage people not to intentionally expose yourself. Doesn't mean that you may not acquire COVID-19. And as John said, that has no reflection on you or anything that you've done. You can do everything perfect right now, but this is so transmissible and so prevalent in the community that you may well get it or members of your family will get it. And we have to keep supporting each other through that. So, I'm not sure it's inevitable, but I think we're all feeling it much closer to home right now.

Trish Kritek:

Yeah. So it's a reality in all of our lives in a different way. And you can get infected, even if you do everything right. And if we all get infected right now, we're going to fully overwhelm our healthcare system. So I think those are the big things I heard from you. Do you think that we're going to see further waves and are we on the way to it being endemic?

Tim Dellit:

Two years into this, I am not in the predicting business. I never saw Omicron coming. A year ago, we were vaccinating and thinking we were going to see the light at the end of the tunnel in the spring. So I don't know. There is a sense in just my own wondering here. If we really get such a large proportion of the population infected with a more mild version, recognizing it's not mild for everyone, we still have people with really severe illness. So I don't want to minimize that.

Tim Dellit:

But there's a part of me that wonders of will this be what pushes us from pandemic to endemic? We won't know until we get to the other side, but there is a part of me that wonders about whether this as painful as it is going to be right now, whether this will get us to that other stage.

Trish Kritek:

Okay. So we'll keep talking about that because there's lots and lots of questions about that. I appreciate your thoughtful and nuanced answer about it. Tim already gave you some preview numbers, John. But maybe you could give us a little bit more detailed numbers about UW Medicine and then maybe the state because Tim had said things are evolving in the state.

John Lynch:

Yeah. Thanks very much, Trish and Tim. Yeah. So right now UW Medicine, I should say right now as of six o'clock this morning, we're at 194 patients with COVID-19. Just again, to level set here, we were at our biggest number in the past was in December of 2020 at 124. So well over that maximum.

John Lynch:

Of the 194 folks, 154 are in acute care and 36 in our ICU. I always like to mention a couple call outs here. Someone did need to go onto the ECMO machine at Harborview as a result of their COVID-19 infection two days ago. So we have two people on ECMO that are linked to their COVID infection. So it is happening.

John Lynch:

We have a patient on the OB service at Montlake who has COVID-19. So we're starting to see that. We tend to see that with higher numbers as well. The other takeaway across this is that still huge number of cases, particularly in our acute care service, but slowly increasing on the ICU service.

John Lynch:

The question I know that you've asked in the past, Trish, is around vaccination and other things. I started to dive into that data. One is it's really hard to actually get the vaccine information on a lot of patients. They just don't have the information or they're early enough in their hospitalization that we don't get a lot of info.

John Lynch:

It looks like a lot of our patients are vaccinated. Not many of them are boosted, but we still have a lot of people who are not vaccinated. And when you separate those out, definitely people who aren't vaccinated are the ones who are having more severe disease. That continues to be the case.

John Lynch:

In King County, if you look at the patients here, if you are not fully vaccinated, you're still 11 times greater risk of ending up in the hospital, and 18 times greater risk of dying from COVID-19. And that's in the absence of boosting. So that's not the boosted numbers.

John Lynch:

I also looked at the breakdown of age and comorbidities and Tim looked at this. And when we looked at the biggest group of people in the hospital with COVID-19, it's still just like it was with Delta, aiming for

people with other medical problems. So we have this thing called the high-risk comorbidity registry. So it's a collection of patients in our medical record system who have high-risk medical problems and they are the largest group of patients we have in the hospital with COVID. So that's a really important thing.

John Lynch:

The other thing is I pulled the data of patient age distribution over the last 30 days and we're still seeing older adults. So the important thing here is that Omicron is still happening in the patterns that we saw before with Delta. It is causing less severe disease. The vaccines continue to work. But it is still preying on the same distributions of communities in the hospital and really important, the communities outside the hospital that continue to have barriers to access, to care, to testing, and information.

Trish Kritek:

Okay. You said a ton. Thank you for all of that. I'd say big take-homes that I heard were still many more people in acute care than critical care, but slowly rising numbers in critical care and a couple patients on ECMO now, which is different that the majority of folks have some other health risk, high-risk group that puts them at risk of getting sicker. And we're seeing more of that.

Trish Kritek:

They're an older population that's in the hospital and that we're actually seeing folks who are vaccinated and unvaccinated. I agree with you. I tried to spend some time with these data this week too, and it's really hard to parse it and we're still working on getting those data for everybody. But very few people who are boosted, who are in the hospital.

John Lynch:

Yeah. That boosted population is really different than the other groups.

Trish Kritek:

Okay.

John Lynch:

If I'm allowed to, Trish, I'm not sure, but I just want to make two more points-

Trish Kritek:

Please.

John Lynch:

... to fit on this. So, a little glimmer of hope. So I'm going to invoke the bell rule here. No forecasting. I cannot tell you what's going to happen next week or the week after or a month from now. So I'm in the same boat as Tim, I don't forecast.

John Lynch:

But if you look at the data from public housing county, there's a couple of little glimmers here. And one bit of data from UW Medicine, one is we're seeing a slight blunting in the absolute number of cases over the last couple of days. So we seem to have topped out around 40,000 cases per day.

John Lynch:

Now, that is with a caveat that testing access is limited. We're not tracking all the cases because of that limitation and also a lot of use of antigen tests. But it is much better than what we're seeing, where it was just continued exponential increase. That's one good note.

John Lynch:

The second thing is, if you look at syndromics around, so looking at what's called COVID-like illness in our emergency departments in King County, that's also taken a slight dip down over the past couple days. So I would say those are two somewhat promising. I'll just say maybe they're stable rather than exponentially increasing. And when you're ready, when I talk about employee infections, I have one more bit of data there too that may be helpful.

Trish Kritek:

Okay. So the glimmer of hope you're giving us is that maybe we're stable on the number of infections and COVID-like illnesses.

John Lynch:

Yeah.

Trish Kritek:

We'll wait to see more. We're not going to put all our eggs in that basket right now.

John Lynch:

Yeah.

Trish Kritek:

Do you want to comment on how Eastern Washington is doing?

John Lynch:

So this is a big issue. So it's always hard when you talk about predictions and what's going on is like, it really depends upon what you're talking about, what population you're talking about. We may be looking at a peak in the King County area, maybe even a peak in the metropolitan Puget Sound Region. We are not looking at a peak in Washington state. We're actually looking at a big increase in cases, if you look at our whole community across our state and indeed across our region, Oregon and Idaho are following suit right behind Western Washington.

John Lynch:

We are seeing increases in cases in pretty much all counties in Eastern Washington. And we're going to see hospitalizations as a result, both that, remember we talked about last week, the width and four, all of those are going to be problems. And in addition, the community is going to be hit. That means the schools and the healthcare worker populations, just like our own are going to be seeing COVID-19 infections and exposures at, or maybe even greater than the rate we're seeing here because that vaccine coverage is definitely different in different communities in our state and in some places, much, much lower.

John Lynch:

So I think Mark Taylor and Steve Mitchell who run the WMCC and others have told us that they're starting to see a lot of activity in Houston and Washington, and that's going to be a big problem for our state because all the Western hospitals are pretty much full. And our usual patterns of moving people in our state are going to be sincerely, seriously challenged going forward as the health worker population is impacted and their number of inpatients goes up.

John Lynch:

The data has been a little bit off for the past couple of days because of just the program they're using is not working at the moment. But my recall is they're probably over 2,100 patients in Washington state who are hospitalized right now, which is a record.

Trish Kritek:

Yeah.

John Lynch:

It's going to get big.

Trish Kritek:

So big take-home I heard was going up in Eastern Washington, lagging us, and we're worried that it's going to go up a lot more there both in terms of staff and in terms of patients being infected and that they don't have the pop-up valve of coming west, if we're already full. So, more to come on that. And partly maybe why some of the resources going to Eastern Washington with the national guard.

John Lynch:

Yep.

Trish Kritek:

I have a bunch of other questions, but one that I didn't put out and warn you about, but it's coming a bunch of times in the chat is, do we know about death rates so far with Omicron in our spaces?

John Lynch:

Yeah. In our own spaces, it remains remarkably low. We are not seeing deaths anywhere where we are seeing them in the past. We have had people pass away. I do want to offer my condolences, anyone has lost someone. I'm not trying to decrease that awfulness, but we are seeing much lower rates of death really in that COVID-infected population that we did in the past.

John Lynch:

Now, if you look at the King County dashboard, it has actually gone up substantially, but it may be actually a reflection of data collection and timing. And it may be just stable because of a dip in the December time period. I actually reached out to our public health colleagues and Dr. Duchen around this and he feels it's more of a stabilization than a true increase. So those of you looking at the King County dashboard, just be cautious in that interpretation.

Trish Kritek:

Okay. So seeing a lot less death and I appreciate your sensitivity of saying if it's in your family and someone you care about, that doesn't matter if it's someone you care about. But in a population sense, we're seeing less death with this, which I think is good thing for us to hear.

John Lynch:

Yep.

Trish Kritek:

Where do we stand in terms of numbers of staff who are on quarantine or isolated right now?

John Lynch:

Yeah. Again, this is a difficult situation as Tim mentioned, we're dealing with a lot of people who are on isolation and quarantine. So just over 500, so about 502 health workers in UW Medicine are in isolation, it means they're infected and their home as a result. And we have about 100 folks who are in quarantine.

John Lynch:

Almost all those folks who are in quarantine at home are home because they live with someone with COVID-19. And so that's a group that we try to keep a very close eye on. The glimmer here, and again, I get it. It's a lot of people, it's an impact on those individuals, their families, their whole lives, as well as their coworkers is that the numbers have actually come down a little bit. And if you just look at our graphics, they're pretty stable. It's a lot of people, I would love to see those numbers continue to trend down, but they are definitely not growing.

John Lynch:

And so when I look at that COVID-like illness, I look at the case counts in Whatcom County. I look at healthcare workers in our own population, a highly vaccinated population. I am seeing some glimmers of stabilization, at least right now.

Trish Kritek:

Okay. Yeah. So 500 in isolation, 100 in quarantine, but that number's down and maybe that's another sign towards stabilization, which is great. And a little bit of hope. I appreciate that.

Trish Kritek:

While we're talking about isolation and quarantine, where are we now with the guidance on isolation and quarantine? I'm going to start with UW Medicine and healthcare workers.

John Lynch:

Yeah. So this is something that's in evolution. So one of the biggest issues we have right now, and I would look to Jerome, Cindy, Keri, and Tim, and others to speak to this is that our staffing is really challenged. It continues to be highly challenged. Going back to that point, we had 322 health workers who tested positive this week. That's still a lot of people, even though those numbers are down, they're still very large.

John Lynch:

And the impact on healthcare delivery, bedside care, all the support that leads up to the facilities, engineering, janitorial, everything that we do is being seriously tried with this.

John Lynch:

And so we are looking at ways to get the workforce back to work a little bit sooner based on the much more mild disease and rapid evolution. So people getting infected, those who have symptoms and have symptoms for shorter periods of time, they tend to be much more mild.

John Lynch:

We have a much more robust PPE infrastructure right now. We rolled back visitation yesterday. So we have more space in our facilities. And as a result of all of those things, we are looking at a day-by-day basis of moving our return to work policy, the isolation and quarantine policy to maybe move close to the CDC recommendations for staffing when things are challenged.

John Lynch:

What that basically means is shortening the time for return to work based on symptoms. And this is coming under the advice of our public health colleagues, Seattle King County, and potentially bringing people back in some of those quarantine situations back a little bit earlier with more testing.

John Lynch:

So the basic take-home here is if we're looking at people who are asymptomatic or people who are symptomatic, we're looking at bringing them back to work earlier for their normally scheduled shifts. Not making them come back on day X, just getting them back into their normally scheduled shifts a little bit earlier than we are now. And then looking at that quarantine group when we can bring some of those folks back with more frequent testing, which we now also have access to in the form of imaging testing and PCRs.

Trish Kritek:

Okay. So if I were going to say, right now, it hasn't changed.

John Lynch:

Correct.

Trish Kritek:

But next week or in the future, in the near future, we're talking about potentially bringing people back, whether they're infected or quarantining earlier, the quarantining people with more frequent testing.

John Lynch:

Correct.

Trish Kritek:

Is that right? So I guess what I'm going to say to everybody is keep your eyes out for this evolving.

John Lynch:

Yep.

Trish Kritek:

Last week we talked about how, EH&S was thinking about evolving the criteria for the folks who are in the rest of our UW Medicine, like school of medicine folks. Do we know if that has changed?

John Lynch:

Yeah. And I think last week, what you caught me on was that I didn't know the right answer. And then I came back saying that there was like three different answers. And so yes, they have finalized their approach. I have it up.

John Lynch:

And so one point here is that UW, upper campus, that sort of academic world there applies to school of medicine, other folks that's EH&S, environmental, health, and safety. So that's their website. That's for those folks.

John Lynch:

UW Medicine, clinical folks, that's employee health. So it gets a little confusing and you're right. So they have finalized their guidance. It's available. If you go to UW EH&S, environmental, health, and safety, COVID, has the top of their page. It's got a very nice flow chart.

John Lynch:

And the basic take-home here is for folks who have been exposed, and if you've been vaccinated, you don't need to stay home. If you haven't been boosted vaccinated, it's a five-day quarantine.

Trish Kritek:

Okay. So five-day quarantine for exposure, if you're not boosted for EH&S. And by the way, I wasn't trying to catch you. I was just asking the questions.

John Lynch:

You were totally trying to get me. I know.

Trish Kritek:

I appreciate you looking into it and I appreciate answering all the questions I ask you. So thank you, really, in all seriousness.

John Lynch:

No problem.

Trish Kritek:

Okay. I'm going to ask you two more questions before I go to Shaquita. And actually, it's just one question altogether. And that is, a lot of people ask, are masks still valuable? We keep changing the recommendations and is it valuable for us in the hospital? But also, is it valuable to be wearing a cloth

mask in the community? Because we're asking all of the folks in the community wear masks. So maybe you could just talk a little bit about masking at this moment.

John Lynch:

Yeah. So the brief answer here is yes, masking matters. And I think of it like I think about everything else as a sort of a continuum. Out in the public, it's really about the more people we can get a mask on, a cloth mask, a surgical mask, any other mask, the better. The more people, in a group context, the better off we are. Because it just decreases both those ballistic droplet transmissions or the stuff you can see when you sneeze and cough and the stuff that you can't see, the aerosols that stay in the air and get around the sides at vast.

John Lynch:

So the more people who wear those, the more powerful they are. And so that's one area. And if you think of the other pole where we're dealing with constrained circumstances where people aren't wearing masks, for instance, patient care. Wearing a more robust mask or a respirator and I put in that bucket, the KF94s, the K95s, the N95s and higher, those provide much higher level of protection where I can say that person is safer in an environment where other people aren't wearing masks.

John Lynch:

Like patients who are maybe very sick and can't wear or tolerate a mask. Or in Dr. Bell's case, a small person who isn't capable of wearing a mask because of lots of issues, their age, or so forth. And so, the way I think about it is where there's a lot of people, if a lot of people are wearing masks, that's great. And if it's cough mask, that's the best that can happen. Okay. I'm okay with that. I'm better with surgical masks, even better as you ramp them up.

John Lynch:

Where circumstances are less controlled or where you have people without masks, that's where I really want to ramp up those masks. That's where the level-up idea comes from where we're eating and drinking or maybe around people who aren't wearing masks.

Trish Kritek:

So extra protection in the clinical settings where there might be people who aren't wearing masks. And then for the whole population, they're decreasing the load of Omicron that's getting out into the spaces around us through droplets or aerosol is protective to the greater community. And that's why we're still continuing to say, "You should wear a mask, whatever level of mask you can wear."

John Lynch:

Yeah, exactly.

Trish Kritek:

Okay. Thank you. I think it's hard because it's like, everyone's getting it, I'm wearing a mask, everyone's still getting it. And so people keep asking the same questions, which I-

John Lynch:

They're good questions, Trish. And I understand. I sympathize with everyone. I get it.

Trish Kritek:

Yeah. Okay. You're off the hook. Shaquita, John gave us numbers for a bunch of institutions, but he didn't give us numbers for Seattle Children's, and a bunch of people wanted to know what's happening at Seattle Children's. So let's start with that if you can.

Dr. Shaquita Bell:

Yeah. So we've been averaging around 25, 30 patients. Although today it looks like we have 21 total, 16 on acute care and 5 in the ICU. For the most part, we're seeing much higher rates of COVID infection in children than we've ever had in this entire pandemic. So 58,000 children in the US tested positive with a new diagnosis COVID last week. This is astronomical rates.

Dr. Shaquita Bell:

I will say the vast majority of the children that I reported just now that are at Seattle Children's, most of those kids were diagnosed with their clearance swab to enter the hospital. So most of them were not admitted with COVID.

Dr. Shaquita Bell:

However, we are seeing a lot of kids who have both COVID and RSV or COVID, and group RSV is still really, really dominant in the community. There was a question about influenza. We're still not seeing a lot of that at Seattle Children's and in our clinic here at Odessa, but a lot of RSV. In fact, it was still outpacing Omicron about 10 days ago, the last time I looked.

Trish Kritek:

Okay.

Dr. Shaquita Bell:

So lots of COVID, but lots of other things, too.

Trish Kritek:

More kids than ever being admitted, I think, and most of them are incidentally found to have COVID. A lot of them have other respiratory viruses like RSV and are most of the kids who are being admitted have other risk factors that make them high-risk to be admitted to the hospital.

Dr. Shaquita Bell:

Some of them do and some of them don't. And we're really seeing the age spectrum. In fact, one of those people on the ICU, it's a stretch to call them a kid.

Trish Kritek:

Okay.

Dr. Shaquita Bell:

They're in their mid-20s. So, it has been variable, but the ICU level patients tend to be people who have other conditions that make them higher risk for COVID.

Trish Kritek:

Okay.

Dr. Shaquita Bell:

And sorry, somebody in the question-answer, just asked what RSV is. RSV is respiratory syncytial virus. To you and I, it's a cold, maybe a runny nose, but to kids, it's very dangerous. It's one of the highest causes of respiratory distress and arrest in the United States in children.

Trish Kritek:

Thank you for adding that. I appreciate that. Do you know, are we seeing a difference in the kids who've been vaccinated versus the five and under or the kids who can't be vaccinated? And I'll ask both at children's, but maybe also in your practice, what are you seeing in your practice?

Dr. Shaquita Bell:

Yeah. We're still seeing, it's what we see on the adult side that vaccine both makes it less likely to get COVID, also makes you much less likely to need hospital-level care. The other thing we've seen, which I put in the questions is that we've had a 75% decrease in MIS-Cs. So kids who are vaccinated and yet still get COVID do not, for the most part, overwhelming majority do not get MIS-C. So if there was any reason to get vaccinated it's that you won't get myocarditis and MIS-C.

Trish Kritek:

So I think that's really important. So MIS-Cs is this systemic syndrome that kids have where they're all over sick after COVID and can be critically ill. And we're not seeing that in the kids who've been vaccinated.

Dr. Shaquita Bell:

Correct.

Trish Kritek:

That's wonderful. That's actually great news.

Dr. Shaquita Bell:

It's very good news. And that's just new this week is when I heard that.

Trish Kritek:

That's great. So, in your clinic, are you seeing mostly kids who are asymptomatic, mildly symptomatic? What are you seeing?

Dr. Shaquita Bell:

I'm seeing probably what most people on the front lines are seeing everybody has COVID. Everybody has COVID. Some of them, for the most part in the clinic, are not severely ill. I think I've sent one or two kids to the ER in the last two weeks, and both of them ended up having RSV and croup.

Dr. Shaquita Bell:

So for the most part, not really severe COVID although obviously the fact that 20 kids to 30 kids a week are in the hospital with COVID is pretty concerning. All of those children also have to be on a special unit, which takes up increased staffing, which is another strain on the hospital system.

Trish Kritek:

Yeah. So I think you're feeling the same strain around staffing.

Dr. Shaquita Bell:

Yes.

Trish Kritek:

And I would just say mostly mild, but obviously again, just like we said, people can get sick and kids can get sick with this as well. We were talking about vaccines. Do you have any news or updates on vaccinations for kids zero to four?

Dr. Shaquita Bell:

What I know is probably most of you have heard this, the vaccine went into a third dose for the first series. So they had to introduce a third dose, which usually takes about a month to get everybody who's enrolled in the trial to get that third dose. So this pushes it out a little bit. Again, I'm going to do the bell curve and not guess when, but we are still a ways out before that vaccine is approved.

Dr. Shaquita Bell:

And again, the study is six months to five years. So that would still mean that six months and under would not be vaccinated. So that's another reason I stress the importance of the vaccine is that there will forever be people who are unable to be vaccinated for one reason or another. So you getting a vaccine helps prevent or protect those people who are not able to get one.

Trish Kritek:

Yeah. And so we won't ever have everyone vaccinated because the littlest folks will not be in that spectrum. The vaccines on the horizon still, I think is what I would say.

Trish Kritek:

One of our questions was asking you to comment on a recent CDC paper about linking COVID and diabetes. And I wondered if you could... I feel like it's a pretty complex thing, but maybe you could comment briefly on that.

Dr. Shaquita Bell:

I sure can. And I'm happy to put in the chat the paper. It is actually maybe a lot disconcerting. We're seeing a dramatic increase in both type 1 and type 2 diabetes, which is interesting because those are totally two different illnesses. And the pathophysiology between those, I just sent it to us on this. That's helpful.

Trish Kritek:

We can deal with it after you finish talking about this.

Dr. Shaquita Bell:

But, so, yeah. So type 1 and type 2 diabetes, what children's have seen just at our hospital over the last three years. So our rates of new diagnosis diabetes in 2019 was 245 in the entire year. In 2020, it was 327, and then 2021 was 431.

Trish Kritek:

Oh, wow.

Dr. Shaquita Bell:

And what you see in this paper is a 2.44 risk ratio of getting diabetes after COVID infection. This is in a pediatric population. And it appears that the diabetes is diagnosed approximately 30 days after the infection. So obviously, really concerning another reason to vaccinate your children is this is a lifelong illness. Diabetes is that is not something that is going to go away after your 10 days of quarantine.

Trish Kritek:

Okay. So we're seeing an association of increased new diagnosis of diabetes and kids after COVID seems like the numbers at Seattle Children's have shown that increase in new children diagnosed with diabetes. So I like that you're staying on message, which is still get vaccinated.

Dr. Shaquita Bell:

Yeah. And I think the other thing that this puts into context too, is that we have to think about... Remember when we started to talk about high-risk patients and people said patients with obesity for instance are high-risk . And we didn't entirely understand what all the drivers were. This is a good example of now two years into this pandemic, we're seeing why there are some medical conditions that put you at higher risk for negative COVID impacts. And we still don't understand all of the medicine behind it, but the data is certainly playing out despite our best efforts to understand.

Trish Kritek:

I appreciate that sense of we're learning as we go. And we're seeing more of those associations. Okay. Three more quick questions for you. The first, they're all ask a pediatrician that I'm going to do some that'll take Santiago off the hook for later. So, what type of mask, if you were sending your kid off to school right now, would you have them wear?

Dr. Shaquita Bell:

That's a great question. I've been telling everybody to wear two masks. I like three-ply and above personally. If the child can wear it... Now, remember, we don't recommend masking under two years old because the risk of choking. So two and over masking. And if you can do a medical mask, a three-ply ideally, and a cloth over, that's the most ideal. The other thing I have been diagnosing a lot of in-clinic is posterior-like behind-the-ear dermatitis. So if you can have one of those masks tie behind the head, that's really helpful as well.

Trish Kritek:

Okay. So you're saying two masks, a surgical mask with a cloth mask tying one, if you can so it doesn't pull on your ears. How about N95s? Are you saying like-

Dr. Shaquita Bell:

For kids?

Trish Kritek:

Yes.

Dr. Shaquita Bell:

That is not an official recommendation.

Trish Kritek:

Good. Okay. That's helpful.

Dr. Shaquita Bell:

I don't think they fit them.

Trish Kritek:

Fair enough.

Dr. Shaquita Bell:

I guess if your 12-year-old is the size of a 25-year-old then maybe, but the N95s were not developed to fit a child's face.

Trish Kritek:

That's great. I think we're talking about the whole value of it is that it fits your face. And if you have a tiny face, it's not going to fit. Wow. Really loud noise outside my window. Would you limit the movement of your five-year-old right now? Would you keep them closer to home?

Dr. Shaquita Bell:

Oh, it's such a good question. So I get this question on a daily basis and it's very complicated. And to be quick, I would say it really depends on your situation. I think there's so much about COVID that's individual in a family. Do you have the ability to keep your child home? Is that even an option? What is your childcare option? Is that a safe option?

Dr. Shaquita Bell:

I think all of that needs to be taken into account for myself, who's working 60, 70 hours a week. I would honestly have to have my child in childcare right now. Otherwise, I wouldn't be here with you all. And I wouldn't be here with my patients and families.

Dr. Shaquita Bell:

However, if I was working at home, writing a book, or I don't know what else people do, who have more ability to work from home, I would definitely consider it. I saw a family on Wednesday who both parents are working from home and they asked me their opinion. I said, "If you guys can do it, I would do it. I would swing it." If you can reassess in a month, I don't think you have to make the absolute decision today. And you can always do it week by week as well.

Trish Kritek:

Okay. So I think you actually answered my last two questions. So the highlights I heard you say is, it depends if you had the really luxury of being able to do it, you might consider doing it for now. It's not forever, and you'd continue to assess the situation. But the reality is for many of us, we're going to continue to have kids in childcare because we need to do that to keep doing our jobs. So I appreciate the thoughtful answer. And I appreciate you coming again. And maybe that I come back to you, who knows it's crazy these days. So thank you.

Dr. Shaquita Bell:

I'm trying to get in the Q&A too.

Trish Kritek:

I'll send you the Q&A. Awesome. And I'll take Santiago out of Q&A to answer a few questions. Santiago, I've meaning to ask this for two weeks. How well do we think that the rapid antigen test actually work for Omicron?

Santiago Neme:

Yeah. So this has been a hot debate and especially this past couple weeks where there's been more evidence, not only about the type of test, but what you should sample. Should you sample the mouth? Should you sample the nose?

Trish Kritek:

Yeah.

Santiago Neme:

I would say in general, we're pretty comfortable with how these tests perform analytically in terms Omicron, but again, there's emerging data that seems to point out that you detect Omicron first in the mouth and fairings and then in the nose. So this has led to some discussions on med tech. And I don't know if John will cover this piece, but basically, we're looking into whether we should do a two-site sampling mouth and nose, for instance, to increase the sensitivity.

Santiago Neme:

But in general, I would say rapid tests, antigen tests have been really, really helpful, especially as John pointed out last week. If you have symptoms and have a test and it's a positive test, that's a confirmed infection, even in terms of Omicron, families should be using these tests.

Trish Kritek:

Okay. So it does detect Omicron. If it's positive, you should say that's positive. We're talking about whether or not swabbing the throat. And people asked about this in addition to the nose is something we should do to increase the sensitivity of finding it. Sounds like we're considering that right now.

Santiago Neme:

Actually, John, correct me if I'm wrong, but I think we're proceeding with validation in the next couple days, John.

John Lynch:

Yep, that's correct. We're looking at validating our rapid test machines in our hospitals right now.

Trish Kritek:

Okay. So we may be evolving to nose and throat. Is there a best antigen test, Santiago?

Santiago Neme:

Over the course of the pandemic, there's been some brains that have had issues. And you could recall that the most popular tests has been BinaxNOW, but there was a brief period where there were concerns and then they fixed the test. And I would say, I would get anything that's FDA authorized and there are more tests available now, if you don't necessarily look for the BinaxNOW, which is the most popular one.

Trish Kritek:

So BinaxNOW, yes. And if you see something that's FDA approved, it's probably good to go. Okay.

Santiago Neme:

Yeah. Authorized, not approved.

Trish Kritek:

FDA authorized. Thank you for clarifying that. Two more questions. I think this is on PCR test, but what does it mean when the result is inconclusive?

Santiago Neme:

Yeah, those tests used to be more common, but fortunately, our lab has had the capacity to rerun the sample through a different instrument. But the way this was explained to me is that it typically means that the amount of virus is very close to the detection level. So what I would say the most common question is how do we interpret that? And it really depends on the situation. Why?

Santiago Neme:

If we're living in our current time, which is one out of three tests are positive, then there's a high incidence of infection. And also if you're performing this test on asymptomatic individual, then I would conclude that test is positive, and I would stop.

Santiago Neme:

If for any reason I'm using this test as asymptomatic screening or something different, and you have the ability to repeat it, then you could consider repeating the test, especially if it has repercussions, let's say a healthcare worker who needs to see patients tomorrow.

Santiago Neme:

So that's the framework that I would use. But in talking to the lab, we have the ability, if you get an inconclusive result to run it through a different instrument and then conclude whether it's detected or undetected.

Trish Kritek:

Okay. So right now it sounds like with all the Omicron around, and if you're around folks and you're symptomatic, we're going to call it positive, but there's ways to give further testing on it if we need to do that.

Trish Kritek:

Okay. I might save the other question. I might come back to you in a little bit. So, I'm going to save it for right now. I'm going to pivot to Cindy, Jerome, and Keri. There are a bunch of questions about, are we going to go to no visitors? We have gone to limited to very select circumstances for visitors. Cindy, what is our policy right now in terms of NICU visitation?

Cindy Sayre:

Yeah. So the NICU has not changed their policy. They are accepting the birthing parent and then a supportive second person have to be asymptomatic or test negative.

Trish Kritek:

Okay. So same rules as before, a birthing parent and another support person. Is that right?

Cindy Sayre:

Yes.

Trish Kritek:

That's for the NICU. Not for L&D.

Cindy Sayre:

Neonatal ICU. Yes.

Trish Kritek:

Okay. Neonatal ICU. Okay. So otherwise, we're saying we're really bringing down visitors a lot. And so Keri and Jerome, I had two spectrums on this that I heard questions about. The first one is, are we going to actually go to outpatients and procedures and also make those no visitors? So Keri, I'll ask you that question. We talked about what we're going to change for outpatient visits and procedures.

Keri Nasenbeny:

Yeah. At the moment, the policy has not changed. So outpatients can have one visitor. Though. We're really, really trying to encourage that just to be in the cases that somebody needs a caregiver. So somebody like me would be encouraged not to bring a visitor with me, but perhaps my elderly mom might need to bring my dad with her. So really trying to encourage just caregivers.

Keri Nasenbeny:

As far as procedures, those folks often need somebody to drive them home. And so in that situation, we definitely need that person there with them to help get them home safely.

Trish Kritek:

Okay. So policy is the same, trying to limit it. I won't tell your mom you called her elderly and in procedures, we often need someone to drive you home. So that's a really important thing. So that has not evolved. And I'm going to say, because you always do say this, we'll continue to assess it. But if you need someone to drive you home, you need someone to drive you home.

Trish Kritek:

Jerome, the other end of that spectrum was like, when are we going to go back to having visitors? And are we going to be any different about the rules when we let visitors back into the hospital?

Jerome Dayao:

That's a great question, Trish. And as you've heard, Dr. Dellit mentioned earlier, the numbers are still going up and the weekly, we do meet the task force for visitation. I'm a part of that. And so as other members of this team to always discuss, look at the numbers where we are at consult with med tech, the experts for infection control to see, can we bring visitation back because it is also important to us. We believe that visitation is crucial to the healing and the education of the patient. So we'll like to bring it as soon as we can safely. That is our threshold.

Trish Kritek:

So we're watching the numbers. And are we going to change anything about the 72 hours for a test or anything about vaccinations?

Jerome Dayao:

There's current discussion right now that that three days is going to be shortened to a day because of the new variant.

Trish Kritek:

Okay.

Jerome Dayao:

So there is no current policy yet, but that change is coming.

Trish Kritek:

Okay. Thank you. So potentially when we go back, we're not there yet, we would narrow the window on the testing. So I appreciate that. Cindy, how do we... Oh, go ahead, Keri.

Keri Nasenbeny:

I just say the other thing we're looking at is requiring a booster as well.

Trish Kritek:

Oh. And potentially requiring-

Keri Nasenbeny:

So saying fully vaccinated includes that booster.

Trish Kritek:

Changing the definition of fully vaccinated to include booster. Thank you for clarifying that.

Keri Nasenbeny:

Yeah.

Trish Kritek:

Cindy, how do we stand? We've talked about how tough it is in terms of staffing. How are we doing in terms of having the ratios that we see, and that means how many nurses to how many patients in our hospital, at least at UWMC?

Cindy Sayre:

Yeah. So at the Montlake campus, we are in contingency staffing. And the way I would describe it as variable. So we have some shifts again that are really challenging. Where we are, we might be two nurses short in the unit, and then other times when we are in ratio. So we're really in a contingency phase right now.

Trish Kritek:

So it sounds like it's variable at various times in different units. And sometimes up to down two nurses for a unit, for a shift. Jerome is that... Sorry, Cindy.

Cindy Sayre:

I just want to say what we are doing is really looking across the whole medical center and we will float staff so we don't have just one unit that's in big trouble while another unit is overstaffed, for example. So we are load leveling staff just to make sure our patients get care.

Trish Kritek:

Okay. So you're really moving people around to try to mitigate that as much as we talked about last week. Jerome, is that similar at Harborview?

Jerome Dayao:

Very similar at Harborview. And in addition with that, we also like to create awareness to our entire team where we are. So we publish our daily ratios in the ICUs and in the med search area, so that they're aware of that. And it's really stretched because another thing that you have to factor there, Trish, is not only the ratios, but the acuity of the patients and the people in the hallway.

Jerome Dayao:

Harborview functions at the 120% capacity for instance today. So that is also exacerbating that condition and we're doing everything that we can to have staff, including having our managers be part of staffing so that we can mitigate some of these challenges.

Trish Kritek:

Okay. So I think, Jerome, you raised great issues, it's not just our staffing ratios as well, it’s also how sick are folks in the hospital and where they are. We know that our census is crazy across sites. And so I think

you're highlighting that really nicely and a big thanks to all the people who are pitching in, in all the different spaces to take care of our patients and collaborate.

Trish Kritek:

One last question for the three of you. Many people asked if we're considering outdoor heated tents for eating. Is that something we're considering at any of our sites right now? No from Keri.

Keri Nasenbeny:

Turns out tents are actually, as I've talked to Pam, who's our facilities associate administrator for facilities. It's just really not that simple. And there's a lot of challenges that come with them. So really, I think we're looking at alternative spaces within our building. Staggering breaks to the degree possible and create safe spaces within our facility tents. I think we've asked her that question a million times if we've asked her that once.

Trish Kritek:

Okay. So you're asking the same question lots of people are asking.

Keri Nasenbeny:

Yeah.

Trish Kritek:

And it sounds like it's not so easy and maybe not so safe. So now we're going to really keep working on spaces within our buildings. And maybe we have some more space now with fewer visitors in the house hospital. Okay. Thank you all very much.

Trish Kritek:

Tom and Rick. Rick, I'm going to start with you. Lots of people are asking relevant to what John was talking about before, about how many people we're bringing in as transfers into our hospital. So, on average, how many transfers are we bringing into Harborview and Tom can add for UWMC.

Rick Goss:

Sure. Well, that's a great question, Trish. So we've been working extremely well with the transfer center in a lot of coordination across our sites at UW medicine, with our medical directors' involvement, great work by transfer center, and the WMCC among others.

Rick Goss:

What that's done is that's allowed us to be very focused on our core, most specialized, highest acuity cases, where we can provide that expertise as well as then work with the WMCC, and look at cases on a more individualized basis and actually find other options for them.

Rick Goss:

So over the last number of weeks, I believe we have some similar trends. I know the actual number of patients coming into Harborview through the transfer center is down from maybe average 5 to 10 down to about half of that. And those are highly selected, very appropriate cases with safe plans for the others.

Trish Kritek:

Okay. So a lot of communication. Oh, sorry.

Rick Goss:

Yeah. I was just going to turn it over to Tom.

Trish Kritek:

Yeah, please.

Tom Staiger:

Sure. Similar at UWMC, we historically average around six patients coming in a day work at about half of that right now. So because of capacity, because of heightened scrutiny on who the people that really require our services, we've had around a 50% reduction over the last couple of weeks in patients coming in.

Trish Kritek:

Okay. So about half the numbers across it's on sites and that a lot more communication and collaboration to try to really bring in the people who need us most. The second question that I got a bunch of was have we started using moonlighters or backup pools or providers to care for folks? And Tom you're unmuted. So maybe you can answer that.

Tom Staiger:

So yes, on some of our services, like the hospital service at Montlake, we've started bringing in resident moonlighters to staff on weekends, some night shifts. I expect our ed by next week, we'll be bringing in moonlighters. And the department of medicine has recruited faculty to be available, to be back up for if we need to call somebody in. So we've got that activated. Though, I don't think we've had to bring in anybody yet out of that pool at Montlake or Northwestern.

Trish Kritek:

So hospitalists and ed, with more people who are volunteered, and maybe we'll start to use some more of those folks over the next week or so. Okay. I promised Anne six minutes. So I'm going to try to fit in really quickly, a couple quick pings, and it's going to be quick.

Trish Kritek:

John, a lot of people have asked about, can you get reinfected? Are we seeing people get reinfected with Omicron if they had Delta or Omicron and if they had Omicron?

John Lynch:

We definitely are seeing people who have had Delta get infected with Omicron. It's been clear from very early in the surge. I've not seen any data on people getting reinfected with Omicron. So we've only had Omicron. It does appear that Omicron protects you against Delta. So if we were to ever have a resurgence of that, we do have it in that direction. But still early days.

Trish Kritek:

So you probably won't get Delta if you had Omicron. If you had Delta, you can get Omicron.

John Lynch:

Definitely.

Trish Kritek:

We don't know about Omicron, Omicron.

John Lynch:

Get vaccinated. If you had Delta and you're counting on that, get vaccinated and then get boosted.

Trish Kritek:

Okay. I'm going to ask you to put in the chat for me, what people should do if they get an alert on their phone about COVID exposure. Because I got that question 1,000 times. And then Tim, I'm going to ask you the last question before I hand off to Anne. Lot of people asking again, can we possibly go back to free parking when it's so crazy?

Tim Dellit:

Yeah. And I have been asking about this. We get this request a lot. Unfortunately, at this stage, we're not able to provide free parking. Keep in mind at UW Medical Center, the university really controls and manages the parking.

Tim Dellit:

The big difference now, compared to where we were in spring of 2020 is the volume of activity within our hospitals. Our hospitals are full so there's still need for that parking and on the Montlake campus, they're even more stretched because they had to close the surgical pavilion. So all that parking garage has to be closed because there's no power to that entire building. Because we had questions, "Could we park in the pavilion?"

Trish Kritek:

Yeah, I understand that.

Tim Dellit:

But there's no power, it's dark. And so from a safety standpoint, we just can't use that. So right now we're not able to provide that again. I really appreciate the questions. Personally, I do think, and others may have different views, but again, if you are on public transportation, mask up. That's the setting as John was describing, use the KN95. Use that respirator when you are in the situation where you are around other more individuals. And I do think that you can safely do that, wearing a respirator. That's the time where I really think you should use that out in the community.

Trish Kritek:

Okay. So the take-home is no free parking right now. I will keep asking. Wear KN95 or something like that if you're on public transportation, if you possibly can. And with that, I'm going to... Thank you, Tim. I'm going to hand it off to Anne.

Anne:

Good. We'll run maybe one minute long today, just so I can get some questions into Santiago. To echo what John and Tim have said though, COVID is all over the place. And so exposure is pretty much inevitable by getting it isn't so trying to figure out how we can best mitigate our risk as we move through this time.

Anne:

A lot of folks have asked over the last couple weeks about masks. I'm somebody who tries to reuse resources as much as possible. I think this has been in my office since like early 2021. I'm curious, how often do I have to throw out my mask? How long do they last?

Santiago Neme:

Yeah. It depends on the mask and it depends on the use. I think the most key aspect is really the integrity of the mask. If I'm wearing the mask for nine hours because I'm on the plane, I'm probably not going to reuse that mask. But if I take short trips to the grocery store or do things, then I would probably keep using that mask.

Santiago Neme:

Early on, there's been some data that you can actually place a mask in a paper bag on a clean surface and you can reuse that mask anywhere between, it depends on the papers, two and five days.

Anne:

Okay.

Santiago Neme:

And that's an easy thing to do and doesn't require any technology or any expense.

Anne:

Good. So I can push my KN95 a little further if I try to let it rest so to speak every time.

Santiago Neme:

Right. And careful with the integrity. Just make sure that it's not soiled or just altered.

Anne:

Awesome. Where do you get the good stuff? How do I find a good KN95?

Santiago Neme:

There's multiple websites. I can post them on the chat. It's just that we're running late. So I don't know if we want to do it or send it over.

Anne:

I can put it in the email that we send out if you send that to me.

Santiago Neme:

Perfect. I have like 10 different websites there.

Anne:

Will do. Good. Santiago, taking calculated risks right now, what are you doing as risks you might take just to support your own wellbeing. Are you still swimming? What are you doing?

Santiago Neme:

I'm not swimming. And it's just a matter of time more than anything. I have started jogging a little bit because I find it to be easier and I can do it around my home. But I would say, unfortunately, I haven't really met with any friends or any anybody really. The last get-together was early November.

Anne:

Yeah.

Santiago Neme:

So it's been just me and my husband.

Anne:

I'm curious. Are you still taking the bus?

Santiago Neme:

I have taken the bus. I take the foot ferry, not infrequently. And as Tim said, I wear a KN95 or a KF94, which are pretty much identical. They're just different shapes.

Anne:

Good. Okay. I'm going to hit you with a couple rapid-fire. If you had a teen, would you let them play basketball in a team that didn't require masking?

Santiago Neme:

No.

Anne:

Would you host a super bowl party next month?

Santiago Neme:

No. Oh, next month I would have to see, but I would say unlikely.

Anne:

Unlikely. Would you picnic outdoors with pals right now?

Santiago Neme:

I would freeze probably. I could see a potential get-together with two people outside, but even that, makes me uneasy.

Anne:

Okay. Would you go retail shopping with a KN95 on right now?

Santiago Neme:

I have.

Anne:

Okay. Would you get a massage?

Santiago Neme:

As much as I love massages, not the right time. I don't want to be in the room for an hour with somebody else that I don't know.

Anne:

Would you allow somebody to come and clean your house?

Santiago Neme:

I actually do. And I haven't stopped that. I'm typically not at the house when this is happening.

Anne:

Fair. If you were a single person, would you continue to go out on dates with new people right now?

Santiago Neme:

Wow, no way.

Anne:

I'm sorry, single people.

Trish Kritek:

Wow.

Santiago Neme:

Sorry about the emphasis.

Anne:

Okay. No new dates, person to person. Last one, crystal ball, would you cancel a trip in April to New York or would you wait and see?

Santiago Neme:

Actually, it might be magical thinking, but I'm hoping April is much better than now. So I would wait and see.

Anne:

Awesome. I'm going to take that as a thumbs up on the wait and see, and hopefully, we'll be in a better place. Thank you, Santiago. Trish.

Trish Kritek:

Thank you, Santiago. For me as well, you were very focused today. I loved it. We had a lot to ask. I didn't get to a lot of questions, I'm sorry. I will keep trying to get to as many as possible. The N95project.org has been putting the chat multiple times for people and I would recommend it as well. I want to say huge thank you to this very large panel for answering all kinds of questions. A special thank you to Shaquita because she's a guest star. So she gets a special thank you.

Trish Kritek:

And I thank you to everybody who sent their questions. I also want to thank the person who suggested close captioning. We tried it today. I don't know how it worked for people. I'm happy to hear your feedback about it, but from now on, we'll try it and we're going to learn from it and see if it's working for people. Feel free to give us your input. We're trying to be as accessible to as many people as possible because we think it's really important information.

Trish Kritek:

And with that, I will say, we'll be back next week to answer your questions, please keep sending them. They brought us to do things. They open up new ideas. They make me read papers that I hadn't heard about and they change what we do. So thank you and thank you for taking care of our patients and their families even if they're not in the hospital right now. And really, keep taking care of each other. Thank you very much. And we'll see you in a week. Bye-bye.