

Trish Kritek:

Welcome back to UW Medicine Town Hall. I'm Trish Kritek, Associate Dean for Faculty Affairs in the School of Medicine. With us today, we have Keri Nasenbeny, Chief Nursing Officer at UWMC Northwest. Santiago Neme, Medical Director UWMC Northwest, Tim Dellit, Chief Medical Officer for UW Medicine Anne Browning, Assistant Dean for Well-Being, Jerome Dayao, Chief Nursing Officer Harborview, Cindy Sayre, Chief Nursing Officer at UWMC and Seth thank you for coming back Cohen, who is the Head of Infection Prevention at UWMC.

Trish Kritek:

And I really appreciate you coming in John, is on childcare duty and I appreciate you being here in his stead today. Rick and Tom are both away, and so Santiago is our sole medical director as well.

Trish Kritek:

All right, honestly, last week we thought we'd not have a wellbeing message and weave it into the questions. And the reality is I missed a wellbeing message. So we're going to go back to the way we should have done it last week, and I'm going to turn it over to Anne for a wellbeing message.

Anne:

Sure. Thanks Trish. I was walking around yesterday and I was like, "January 21st, like what?" I felt like it was an important day I was supposed to remember, no birthdays, anniversaries. And then Trish sent a message that it was two years since our first positive case in Washington state.

Anne:

I was like, "Right. That's why that date stands out to me." I was reflecting that it was also a year ago today that my mom got her first vaccination shot and the eggshells, I felt like we were walking on in that first year. And really what has felt like the second year of having some really great highs and some really tough lows over our time, depending on the waves and how things have been going. And then suddenly we're here and looking at what January 21st looks like in 2022.

Anne:

And there's kind of this blessing and a curse to not knowing what's coming, to not knowing if and when there's a new variant, to not knowing when we're going to hit another wave. And in some ways the blessing of it is, I think, if we had to know a year ago what our case counts would look like and what our system would feel like right now, it would be hard to get our minds around it. And yet, as these things happen, we still managed to kind of find our way through it.

Anne:

It's been, again, a tough couple of weeks, and I know we've had a number folks across our community who have been very impacted by people and their families and around them who've gotten sick. Many of our own folks have been getting sick as well. I just want to kind of reiterate that there's just so much pain spread right now, and the virus is just super pervasive. It's almost impossible to not come into exposure. So if you are getting sick, just take the best care of yourself that you can to get healthy again as soon as you can. And it's not your fault, if that's coming up for you.

Anne:

I would say that the strain in our system right now is pretty incredible. I wanted folks to know that we've got teams of kind of our wellbeing practitioners from across our system, who are gathering and brainstorming and trying to figure out what we can do to help folks out. There's nothing that we can do to make this all better, but we're going to do what we can to try and help support folks as we go through the next weeks and months, knowing that this has been a long, long term strain on our system and on each other, but we're here and we're going to back you up.

Anne:

I'm also going to add in the chat today a couple of links to our wellbeing resources, mainly I'm going to put in our links to peer support and our mental health support system. This has been a long drain on folks. If you are finding yourself struggling, please reach out, ask for help, connect with folks and do everything you can to take care of yourself, physically, mentally, emotionally, over the next couple weeks and really over the long term. And we'll continue to just be here for each other as much as we can. Thank you.

Trish Kritek:

Thank you, and thanks for those words because I think it's important to acknowledge that this is a time that's tough for a lot, a lot of people. Tim, I'm going to start off with you. Speaking of it being a tough time, last week we talked about being in contingency in a variety of different ways. And I wondered if you could give us an overall big picture of where we stand and where we are with contingency right now.

Tim Dellit:

Yeah. Thank you, Trish, and welcome everyone again here this afternoon. So we still are in contingency state when you look at our staffing and where we're caring for patients. When you look at our overall numbers, I know others will go through this, but we feel like that the rate of increase has stabilized. We're still at 188 patients across our system today. We were up right around that same level last week. And so we've kind of hit what we hope is a plateau, and when you look at King County overall into incidence is gradually coming down, now the hospitalizations are going to lag, and we're still seeing increases in Eastern Washington.

Tim Dellit:

But it feels a little more stable this week compared to last week when we were still on that increasing incline. With that said, again, we still are in contingency status and we still have a large number of employees who are out either in isolation or quarantine, probably around 600, but that also has stabilized. It hasn't continued to go up. And so I think we definitely have areas that are more stressed than others within our health system. Northwest campus was really under stress earlier this week with a large number of borders. As an example, Harborview always has a large number of orders. But overall, it feels like a little bit more stability right now this week compared to last.

Trish Kritek:

Okay, so a little more stable plateauing in terms of admissions, and patients, and house, and staff who are infected. Relevant to that, one of the questions we got the most was wanting to understand the decision making behind the change in our isolation policy for healthcare workers. And maybe you can say what the policy is and explain the reasoning behind it.

Tim Dellit:

Yeah. No, a great question. And I would definitely say that this is a difficult decision. Certainly one that we did not take lightly, and we had a lot of conversation, not only with leadership across our system, but with many of our clinicians, many of our staff and other healthcare systems, to really get a better understanding of what other healthcare systems are doing, because we're all in this contingency staffing phase.

Tim Dellit:

We also look at what we've learned about Omicron relative to other variants. And so when you look at the rate of infection, in terms of the incubation time, the transmissibility, it seems that the highest risk of transmission with this particular variant is the one to two days before symptom onset, and the two to three days afterwards. And so it seems to be a little bit tighter in terms of that period of illness, particularly for vaccinated individuals.

Tim Dellit:

And we know all of our healthcare workers are vaccinated unless they have an approved exemption. And we know from earlier studies, throughout the pandemic, that those individuals have been vaccinated, also have a faster rate of clearance of the virus. So we looked at the biology of the virus, we looked at what other healthcare systems are doing, and we looked at the CDC guidance. And the CDC guidance, when you're in a contingency stage where you're really trying to mitigate the need to go into crisis staffing, which we want to void. We want to be able to stay in that contingency phase, continue to provide high quality safe care, which does require staffing.

Tim Dellit:

The CDC guidance then is that you can bring healthcare workers back after five days of isolation if they had infection. The way we're doing this and what the current policy is, is for those individuals, if you never had symptoms and you had a positive test, we would then go for five days in isolation, evaluate where you're at on that five days, and if you're still asymptomatic, you could come back on day six.

Tim Dellit:

If you did have symptoms, then we want to see that your symptoms are improving, that you've been without fever or for 24 hours, and checking in, where are you on that day five? Are you meeting those criteria? And how are you feeling? We never would bring back anyone who does not feel well to work. And we want to make sure that they really are having significant improvement in their symptoms. But if those are true, then we can bring those individuals back at day six. But it's an individual evaluation of, where are you within your disease process?

Tim Dellit:

And again, based on that relatively tight frame of high transmissibility, the fact that everyone is vaccinated, and when they come back into the work environment, everyone is wearing a respirator within our clinical environment for additional level of source control because, honestly, since such a high percentage, upwards of 30, 40% if not higher are asymptomatic, with Omicron variant, that we often don't know who may or may have it to begin with. And so that respirator adds additional layer of protection.

Tim Dellit:

So with all of those factors, we felt that this was safe to proceed and necessary to preserve our staffing and to be able to help support one another in the safe care of patients. The last thing I'll just say is that it helped align us not only with the other healthcare systems, but also with university as a whole. The university as a whole has also gone for those in isolation and in recognizing that was in the non-healthcare setting, but they also are doing the five days of isolation and then five days of strict mask wearing. So it keeps it consistent across the university in all of our different learning spaces as well.

Trish Kritek:

Okay. So this is a complex one which is why I took some time to kind of talk it through. And I think there's a lot of people who have emotions about this because we all have different levels of feeling worried right now. And that's been true all over the pandemic. So what I heard you say is we're following the CDC guidelines, we think it's based at least in our understanding of the science, the biology of Omicron, and that we don't think that people are mostly as infectious after those early days, that people are going to need to wear a respirator when they come back to work, that we are doing this because we're in contingency staffing and we need people to take care of patients.

Trish Kritek:

And the most importantly, I wanted to say this specifically, we're not asking people to come back to work when they're sick. And so if you're sick, you're not coming to work. This is really for people who are asymptomatic, who've had dramatic resolution of their mild symptoms. So thank you. And we'll keep talking about it. I think we could spend the whole Town Hall talking about this, because there's a lot of feelings about it and I appreciate that, but I'm going to keep us moving forward. Tim, I'm going to talk about a bunch of things about our system then real quickly. How long are we holding off on scheduling elective surgeries at this point in time?

Tim Dellit:

So originally, we had postponed non-urgent surgeries and procedures through the end of January. The governor's proclamation that came out last week extended that for the state, for hospitals through February 17th. So we are following the proclamation through the 17th. And then I assume that the governor and the department of health will continue to evaluate the situation. But for right now, it's February 17th.

Trish Kritek:

February 17th, based on the state?

Tim Dellit:

Correct.

Trish Kritek:

End date, if you will. Are we at this point considering making boosters mandatory for employees?

Tim Dellit:

Yeah. We've been having discussions around that, and part of it is looking at the emerging evidence. And there were a number of articles that just came out even today and news articles around this. The boosters really do have an impact, not only in decreasing your risk of infection, although we definitely

see breakthrough. But what's striking in this information is the 90% effectiveness in terms of preventing hospitalization. So we really do feel that the boosters are really important. The CDC is absolutely encouraging everyone to get booster, but particularly healthcare workers.

Tim Dellit:

And so we feel that that is important thing that all of us can do to help keep our environment safe for our patients and for our staff. So we are having those discussions of whether we should do that. We haven't acted that one. That hasn't been in place yet, but we are having those discussions as because we really think it's beneficial.

Trish Kritek:

So for right now, strongly recommended but not mandated, conversations are ongoing. I think that's really helpful. In all seriousness, I've gotten lots of questions about parking. I think people feel less safe on public transit with people not consistently wearing masks. So I'm going to ask you again where we stand, and any ongoing conversations about making parking more available to people.

Tim Dellit:

Yeah. Unfortunately we aren't able to offer free parking as we did very early on. Again, parking at the university it's controlled by the university not UW Medical Center. And the big difference is the volume of patients that are currently still here within our campus. It's very different than it was in the spring of 2020. UW Medical Center also has the additional limitation because of the closure of the surgical pavilion parking garage, so we're not able to offer free parking at this point.

Tim Dellit:

I really personally, I do think that public transportation is safe. I definitely would wear a respirator, meaning wear a K95 on there. I think if you do that, you wash your hands after you come off of the public transportation, I think you can do that safely. I totally understand the concern, so I don't want to minimize that, but unfortunately right now we aren't able to offer the free parking.

Trish Kritek:

Okay. So not able to do free parking at this point in time and really, again, respirator on public transportation to be as safe as possible. One more before I pivot to Seth, when do we think ... Right now we have a hold on travel for folks, for faculty, for sure. I think, and maybe broader within UW Medicine for work. When do we think we might lift that as people are thinking about educational conferences, society things in the next several months?

Tim Dellit:

Yeah, no, that's a great question as well. We put that in place, one, for the safety of our workforce, but really to help preserve our workforce in the setting of this surge and the significant staffing challenges that we've had. We will continue to evaluate this. I hope that as we come down off of this plateau that we seem to be on right now, once our staffing improves, then we'll reassess that. I'm optimistic in crossing my fingers that as you look a couple months down the road, just from what we've seen in other places with the kind of rapid increase and hopefully coming down, that in a couple months from now, this won't be an issue.

Tim Dellit:

I totally understand the impact, but right now we had to ensure that we had adequate workforce to respond to our current surge. As that improves, then we'll shift away from the current travel restrictions.

Trish Kritek:

Okay. So driven by our staffing issues which are still challenging. As that improves, we'll re-address it, hopeful for a few months from now. So fingers crossed. Thank you very much. Seth, welcome back again. I wonder if you could start with just the current numbers of UW Medicine. Tim gave us the total, but maybe you could give us the distribution.

Seth:

Sure. I'm happy to. Hi, everyone. So right now we're caring for about 188 people with COVID across the system. That means it's 142 that are in acute care and 46 that are in the ICU. So just broken out, Montlake has 34 patients with COVID, Northwest has 31, Harborview has 65, and Valley has 58. So our COVID census remains really high. As Tim mentioned, the rate of rise seems to be plateauing, and it does seem like there's a lower proportion of ICU level care compared to other surges.

Seth:

Oh, and I will say, Children sent us their numbers, and it sounds like their numbers are only continuing to go up. So they have a total of 29 kids with COVID, 25 of those are in acute care and four of those are in the ICU.

Trish Kritek:

Okay. Thank you for adding the Seattle Children's numbers. And again, it seems like a lot more people in acute care than in the ICU as we've seen over the last several weeks, but still super high numbers. People ask us every week and now I'll ask you instead of John, if we have a sense of the vaccine status of the folks who've been admitted as well as whether or not they might have come in for something else and are incidentally testing positive for COVID.

Seth:

Yeah, it's a really hard question to answer. I can tell you what I found in epic. There is some missing data here, but just among patients that are either hospitalized at UWMC or Harborview, eight of them are ventilated, and all eight of those are ventilated because of COVID, not incidentally found COVID and then ended up on a ventilator.

Seth:

Of those eight that are requiring mechanical ventilation, only one of those is fully up to date with their vaccinations. And I don't know that person's, whether they have an underlying immuno compromising condition. But of our COVID patients, 47 of them are on some type of O2 device, and only 13 of those are boosted. So I would say, it's a lot of people requiring oxygen with COVID. And again, I don't know how many of those are immunocompromised, but it still seems like a lot of people who are unvaccinated getting severe disease.

Trish Kritek:

Okay. And I think the nuances of us sorting it out for every individual patient is beyond now, but we're still seeing people, the sickest people seem to be not fully vaccinated, and we're seeing a fair amount of people who are requiring oxygen having that pneumonia picture. But not nearly as many, I think, in the ICU with the severity of illness. Okay. Can we talk about numbers of staff who are on isolation or quarantine at this point?

Seth:

Yeah, we can. So I think, Tim mentioned we're hovering between 500 to 600 people who are out of office due to either quarantine or isolation across the system. Those numbers were really going up alarmingly. They peaked around the 7th of this month, so it was over 800 people that were out across the system and then really stabilized this week. And I think as of today and early next week, we expect a lot of people to start reentering the workforce as they recover, and also due to changes related to isolation policies that Tim mentioned. But I know that a lot of our offices departments clinics are really continuing to deal with really critical staffing shortages.

Trish Kritek:

Okay. So we're at 800, we're down into the high 500, 600 range, which is better, but obviously that's a lot of people out of our system still. And we're hoping that several of them will be coming back in the near future. Tim talked about the isolation, which someone asked this question. Isolation is what you do when you're infected with COVID, when you test positive for COVID.

Trish Kritek:

The other thing we talked about is quarantine, which is what you do when you've been exposed to COVID. And there are about 63 questions about different nuances of quarantine, which I think probably the infection prevention team answers all the time, but I'm going to try to get kind of a big picture. And that is if you live with somebody, with people who have COVID, and multiple of them have COVID, when does your count start for the days that you're in quarantine? Like your daughter got it one day and then two days later your son tested positive, for example.

Seth:

Yeah. These are tricky situations, and I just want to remind folks that household exposures are still the highest risk exposures that we have, and this is the only time that we are home quarantining people. So almost all other community exposures and workplace exposures. As long as you're fully vaccinated, you can go to work and get surveillance testing. But Trish, the short answer to your question is it seems a little counterintuitive, but the date of first exposure to somebody in your home, who tested positive is usually when we start counting. So the day you're exposed is day zero, then you have five days of home quarantine, and as long as you're feeling okay, no new symptoms, you tested negative, you come back to work on day six.

Trish Kritek:

Okay. So I'm going to say it again. So number one, if you're exposed but you're boosted or vaccinated and boosted, or?

Seth:

Vaccinated. Vaccinated.

Trish Kritek:

Vaccinated. So if you're vaccinated, you can generally come to work if you're asymptomatic. If you live with someone, then you're going to start counting day zero on the first day that you know that person that you're with is positive.

Seth:

Yep.

Trish Kritek:

Five days, test, come back to work if negative.

Seth:

That's right.

Trish Kritek:

Okay. Thank you. And I know there's nuances and I'm going to say, I appreciate everyone's nuances, and I think that those probably have to go to employee health to sort out the specific details.

Seth:

Yeah. Please send us your questions about that.

Trish Kritek:

Okay. The other thing is, what if I just had Omicron and then I get exposed? Do I quarantine again?

Seth:

Probably not. We don't have a lot of data about reinfection with Omicron, but we assume that there is some short-term immunity, and so we would not have you retest for somewhere between 30 to 90 days, unless you develop new symptoms.

Trish Kritek:

Okay. So without symptoms, I'm not going to need to test or probably quarantine. All right. Let's talk about boosters a little bit. And I tried to bring Shireesha in to get you off the hook, Seth, but she's not available today. So can we walk through who should get a booster and the timing of the booster. And maybe you can just walk through a big picture on boosters and I might have a couple follow up questions.

Seth:

Yeah. So there's a really nice infographic at the CDC website. So if anybody has lingering questions, I would say, go there and look at it. It's a great resource. The only thing that differs between Pfizer or Moderna are the age cutoffs. So Pfizer or Moderna, you're eligible for a booster after five months. Moderna, it's 18 and up, Pfizer's 12 and up. J & J is a little bit different. J & J is 18 and up you're eligible, but two months after that first dose, you can get a second booster. And we prefer an mRNA after a first dose of J & J

Trish Kritek:

Keep going.

Seth:

There's one wrinkle there, which is people who are immunocompromised.

Trish Kritek:

Great.

Seth:

With people who are immunocompromised, their primary series, instead of two doses, they actually get a third dose, which is a month after or 28 days after their second dose. And then they're still eligible for the booster in the same way that everybody else is. It's still five months after that last dose, they can get their booster. And those folks are now just becoming eligible. So we're starting to see them in the vaccine clinics.

Trish Kritek:

Okay. So I'm going to try to summarize briefly. For mRNA vaccines, it's five months after second dose, and the cutoff is different ages, 12 and 18 months for Pfizer and Moderna. For J & J, it's two months.

Seth:

Yep.

Trish Kritek:

Hopefully, an mRNA vaccine. And if you're immunocompromised, the standard course is three doses, and then five months later a booster.

Seth:

Exactly.

Trish Kritek:

Okay. Thank you, and I appreciate the reference so that infographic people can consult that for more questions, because it's confusing. It's super confusing. I've asked this before, but I'm going to ask you again. And if I just had Omicron, should I get boosted?

Seth:

Yeah, the answer is yes. You can get boosted as soon as you're out of isolation and feeling better, then you can get your booster. And really, people who have prior infection and then get boosted have super, super high levels of antibodies. And the important thing about the booster is it has really broad-based immunity, so it's not just Omicron. It's going to protect you against other variants that may come up in the future.

Trish Kritek:

Okay. So yes, and it broadens your coverage to get boosted. Do we think we're going to have another booster in five to six months for like me, if I am on a standard pathway?

Seth:

Yeah. I have no idea. I do think this is going to be a three dose primary series where the booster just becomes a third dose for everybody, but it really depends on how quickly our immunity wanes and then how quickly this virus continues to mutate over the next few years.

Trish Kritek:

Okay. One more question on this, Tim was talking about how boosted people are less likely to get really sick, and I think we've said that over and over again. The other question that we get a lot is, are boosted people less likely to be infectious? And maybe you could comment on that.

Seth:

Sure. I would say, one, we don't have as much info about Omicron specifically, but just thinking about other strains. What we know about Delta is vaccines decrease transmission by a number of mechanisms. One is you just don't get sick in the first place and then you can't spread anything. Two, respiratory symptoms are probably milder. Not probably, they are milder to people who are vaccinated, so you're not coughing COVID everywhere.

Seth:

And then three, there's some really nice papers, including one in Singapore that really shows that your viral load drops faster in people who are vaccinated, and so you're less infectious sooner. And I would say, I know there's a lot of talk about this, and even though decrease in transmission is not the primary benefit of people who are triple vaccinated, it's really hard to imagine that there's no transmission benefit from these vaccines.

Trish Kritek:

Okay. So extrapolating from Delta, we think you're probably less likely to transmit the virus if you get infected through multiple mechanisms, including you don't cough and sneeze as much out, you clear your virus more quickly, and you get infected less often, hopefully.

Seth:

Yep. Exactly.

Trish Kritek:

Okay. That's great. I'm going to ask you a couple questions about testing and then give you a break.

Seth:

Sure.

Trish Kritek:

Because I know you have done a lot with the testing. How are we doing now with capacity for folks to get tested, because that's been a really tight thing for the last several weeks?

Seth:

Yeah. We're in a much, much better place with testing than we were. A few weeks ago, we were sort of a perfect storm between surge, snow, a number of test sites being shut down. So I would say, testing is really stabilized. We can generally almost always accommodate employees now for same day testing. They just need to request an appointment at least two hours before the site closes. I do want to give people a heads up, we're switching to a new scheduling platform next week, that I think is going to allow for people to schedule more same day appointments, especially in the afternoon.

Seth:

So the scheduling part is going to look a little bit different, but the main landing page and everything is going to look the same. And then the other thing that people may know is actually the national guard is going to be helping support some testing operations at Harborview. So you may see some new faces there, but also the community sites have a little bit more capacity as well, and there are even a few sites where you can show your healthcare worker badge and you can do walk up testing. You just need to wait in line.

Trish Kritek:

Okay. So improved from before, new platform coming on, national guard helping, should be able to get it, for the most part, on the same day.

Seth:

Yep.

Trish Kritek:

Is that right?

Seth:

Yep.

Trish Kritek:

Okay. Are those tests PCR or are they the rapid tests when you go get those done?

Seth:

They're all PCR tests and through employee health they're prioritized, we get the faster turnaround times than community sites.

Trish Kritek:

So PCR, but turned around more quickly than the average PCR. Okay. I'm going to give you a break for a little bit, but I'm going to come back to you in a little bit too because I have a bunch of other questions that I keep putting on the back burner, that I need to move to the front burner this week. I'm going to turn to Cindy and Jerome and Keri, and I'm going to start off by asking, we've been talking about contingency staffing. We've also talked about patients being in places that aren't the usual places where patients are cared for. So I'm going to ask each of you about that. So Keri, at Northwest, are we taking care of patients in areas that we've expanded into because of our numbers?

Keri Nasenbeny:

Yeah, actually we've dedicated two spaces to the boarding areas the first is our endoscopy area, and we have eight beds in that area. One's a private room and the rest are open bays. And then in our cardiac procedure units as well, and we have nine private rooms there since the boarding.

Trish Kritek:

Okay.

Keri Nasenbeny:

And then we've also opened up all of our double rooms. So basically two of our units have doubled their capacity and that's all full.

Trish Kritek:

So doubling rooms, endoscopy and cardiac procedure. Jerome, how about at Harborview?

Jerome Dayao:

Well, at the Harborview, I mean, we have been consistently full, I mean, today for instance, 114%, but we are always been at 120. So that's a lot of beds over our capacity for 113. So when this occurs, we have our traditional boarding spaces. These are areas that we have opened and staff additionally to house these patients that have admission orders, but don't have an actual bed yet.

Jerome Dayao:

And during the height of the volume that we were experiencing here at Harborview, we actually opened hallways. And we were able to identify about 60 spots where additional patients can go. Of course, we don't want to get in there. But that is part of our surge planning, of being able to open additional spaces where in clinical care can be rendered, and that included some conference rooms that we've identified.

Trish Kritek:

So those are the places you identified. Are you using those places right now?

Jerome Dayao:

Right now we're not. Right now our volume has gone down in the 500s its now 467, still higher than our normal beds, but much better than where we were two weeks ago.

Trish Kritek:

Okay. That's reassuring, and that you have a backup plan to find other spaces for patients. How about at Montlake, Cindy?

Cindy Sayre:

Yeah. So our research unit on seven south was gracious and opened up some beds for us. And we do have routine inpatient care going on there now. And in our short stay unit for south, we transferred some infusion from that area so that we could open up a boarding space there. And we've also doubled rooms just as Keri.

Trish Kritek:

So doubled rooms and opened up some spaces as well. Okay.

Cindy Sayre:

Correct.

Trish Kritek:

But maybe it sounds like numbers have come down in some spaces like at Harborview, which is reassuring.

Cindy Sayre:

Yeah.

Trish Kritek:

How are we staffing these spaces? And I guess maybe the bigger question is, have we had any success in increasing our staffing? We just heard about it being contingency still and what are we doing? So Keri, you are unmuted. Do you want to go first?

Keri Nasenbeny:

Yeah. Well, I think we've done a couple things here at Northwest, one is that we redeployed our labor pool. So as we've closed down our ... Not closed on our OR but really reduced the volume in our OR based on the governor's mandate. We're running seven rooms as opposed to 16 rooms with an urgent emergent room. We've taken those staff and redeployed them.

Keri Nasenbeny:

Some of those staff recently transferred into the OR PACU, and so we've returned those nurses or those CNAs back to their admission unit and actually added them back in a schedule. Some of them are working as what we call team nurses. So it's really based on what their skillset is and how they're able to best help. Some of them are functioning staff officers, but they're really helping supplement when we do have those gaps and we do have those goals. They've been immensely helpful.

Keri Nasenbeny:

And then in addition to that, I think we're doing whatever else is doing, which is hiring travelers. We're offering all the financial incentives we can for staff to pick up extra shifts and really making sure that we're deploying staff evenly so we don't have one unit sitting very nicely and then another unit super short.

Trish Kritek:

Okay. So redeploying folks, load leveling, the same things we talked about over time and travelers. And so I'm going to guess that's true for you, Jerome and Cindy as well. I guess the one question that came up is like, are we doing things that are going to augment our staffing longer-term right now or are there other things we're doing? So Cindy, do you want to add to that?

Cindy Sayre:

What I would say is that UW Medicine, as a goal, we are looking at recruitment and retention, and I'm attending UW Medicine meetings every other week on one of those subjects. And we're really trying to look at best practices from healthcare and from outside of healthcare for retention types of programs. And then the recruitment teams are working as hard as ever. And I will say, for our Montlake campus, our staffing has looked much better this week than it did last week. For the most part, we're able to meet the needs.

Trish Kritek:

Okay. So staffing is better at Montlake, which is great. And then a lot of focus on recruitment and retention. Jerome, you can add to that. But my other question that I had in this space is, specifically, I got a bunch of questions about PCTs and if we're doing things to hire more PCTs. Can you comment on that?

Jerome Dayao:

Oh yeah. That was actually part of the answer that I wanted to give.

Trish Kritek:

Oh, perfect.

Jerome Dayao:

With regard to overall staffing, we're doing what Cindy and Keri had been saying. Our priority is to hire registered nurses where registered nurses are needed. That's the top priority for all of the sites. But in addition with that, we also want to make sure that we are able to reduce nursing workload burden. And we can do that by having the ancillary support staff, PCTs being one.

Jerome Dayao:

Here at Harborview, we had been able to convert majority of our HA roles to PCT, not only ... And the reason why we did that is because then we can offer them a higher salary so that we can keep and recruit these individuals, and also hire them so that they can perform additional tasks that they didn't do before. Like technical stuff like phlebotomy and all of those, get trained and reduce the workload of the nurses. So that's part of the strategy.

Trish Kritek:

That's super helpful. So you are hiring a bunch more PCTs to try to have the nurses perform to the highest level that they can do in their role. Yeah. And it looks like Cindy and Keri are nodding to the same thing. Okay. That's really helpful. Couple more questions for you. Break spaces comes up a lot, so Cindy, do you want to comment on, have you been able to increase break spaces?

Trish Kritek:

And I'll add the second question, which is very specific. Are we considering adding more microwaves? Because people feel like the limiting factor for being able to eat their lunch is if they can't get to a microwave.

Cindy Sayre:

Yes. I think this has actually been one of the most challenging aspects of our response, I'll just say, because it's one that we haven't conquered yet in terms of identifying enough spaces for every team member. It's ongoing. We continue to look for areas. One of the things we've thought about too is if there do happen to be empty patient rooms in your unit, which isn't always common, but might happen. We can use those areas and then just wipe them down after meals.

Cindy Sayre:

So we're looking at every possibility. And I think the microwaves is a little trickier of a question that it may seem, but those can be a fire risk when people use them inappropriately. It happens not infrequently. And so I think we want to be cautious about placing microwaves, just randomly in the building.

Trish Kritek:

So I think what you're alluding to is it's a complex thing, still continuing to try to find more spaces. And the challenges are real about not having a microwave, but it's not easy to just put a microwave here or there. Keri or Jerome, do you want to add to that? Okay, Cindy, I'm going to ask you one last question, and I haven't talked about this at all, but for folks who might not know this, we had a pretty catastrophic flooding event in the surgical pavilion at UWMC that has caused it to be completely shut down. And we got a handful of questions about the timeframe for the return of the surgical pavilion.

Cindy Sayre:

Yeah. I want to just thank all the team members that have been impacted by the surgical pavilion closure. I was rounding in some of the outpatient areas today and people are just adapting very well. And so very appreciated. So I reached out to our facilities folks and here is what they're saying that our goal is to achieve a February 18th, go live back into the pavilion. However, and this is in all caps. **HOWEVER, THIS IS A GOAL, AND WE'RE WORKING TOWARD THAT AS THE TIMELINE, BUT THERE ARE MANY FACTORS THAT ARE NOT IN OUR CONTROL.** So that's what we're working towards right now. Hoping to get back as soon as we can.

Trish Kritek:

The goal is February 18th, but obviously there's already been bumps in the road. So we know there may be future bumps in the road as well. Okay. Thank you. I'm going to pivot now to Santiago for a little bit, and then head back to Seth. Santiago, I'm going to ask kind of a, it's really a more of a philosophical question, but I think it's worth asking because I got it a bunch of times. And people are saying like, all this emphasis I'm masking, if I'm boosted, am I just wearing that mask to protect people who are unvaccinated? Like why not just get everyone vaccinated and then I don't have to wear a mask?

Santiago Neme:

Yeah. So thank you, Trish. So not all masks are created equal. There are some masks that protect the source, that is it's you if you were infected from infecting others, and there are some masks that just protect you from the environment. They switch to respirators or N95s, has to do with that specifically is that it prevents an individual who's infected from giving it to other folks more readily.

Santiago Neme:

But I would say, in general, masking also is twofold because it's really about protecting yourself, but the community around you. And when we talk about, it's not just the unvaccinated, we need to remember

that our vulnerable populations extend even further where we have immunocompromised folks who have a limited response to the vaccines. And therefore, they need an additional dose throughout their primary series as Seth mentioned, and also a booster, and also monoclonals if they get COVID. So the vulnerable population are those who are unvaccinated, but also immunocompromised with unstable housing as well, where you see more transmission and worse outcomes.

Trish Kritek:

So wearing a mask doesn't just protect people who haven't been vaccinated, but also the people who are at higher risk, like the people who are immunocompromised, small kids who can't be vaccinated right now. And so there's lots of people around us who have other reasons that we might want to be looking out for them. So thank you for saying that.

Santiago Neme:

And I would like to add that it's really important to level up your masking, not only at work, which we've done with updating the policy, but also when you're outside, when you go to the grocery store, when you do other things, try to find a KN95 or a KF94. We've shared some of the links. We can do it again. But I think it's really, really important. And obviously, prevent any non-essential social gathering as much as possible.

Trish Kritek:

Okay. You said when you go outside, I'm going to actually ask for a clarification on that. Are you suggesting you need to wear a mask when you're outdoor?

Santiago Neme:

No, no. Sorry. That was a Spanish translation in my head. I mean, when you go out. When you go out and you go into a grocery store.

Trish Kritek:

I knew what you meant. I just wanted to make sure we're clear on it.

Santiago Neme:

No, I caught myself too, so thank you.

Trish Kritek:

I appreciate that. Okay. I'm going to ask some more questions about testing, I asked Seth some, but I'm going to ask you some more. One of the things that has come up with questions over and over again is we used to say, and actually Seth just said it again today that we don't want you to test again for 90 days. Remember we'd test a patient and we'd say, "Don't test again for 90 days because you're going to be positive." And then we started saying, "We'll test you five days after you were infected to see if you are still infected." So what changed there?

Santiago Neme:

Well, I think what you've seen is that there's a lot of emphasis on rapid antigen testing and these tests have been really, really helpful, that because they're less sensitive, one potential use was to say, "Okay, can you get the standard, gold standard, which is our PCR, initially, and then if you're positive, then you

retest with a lower sensitivity test?" And maybe that would be an indication that you may be less contagious and therefore clear for things for activities. But it's not practical to do that, and it's also, some people would still test positive, there's collection issues. But what I would say is that it's really about the test that you use, and it's also the frequency that matters.

Trish Kritek:

I'm going to probably ask some follow-up on that. But I think what I heard you say is the reason that it might be okay to do it is because it's less sensitive tests. So it's less likely to pick it up. And we think there was some correlation with how contagious you are, though, we're kind of moving away from that right now.

Santiago Neme:

Right.

Trish Kritek:

So people have said like, "I tested and I tested negative, and then I tested again and I tested positive with these rapid antigen test." So I'm wondering if we're recommending people repeatedly use them if they're ... Yeah, so maybe you could give background on that.

Santiago Neme:

So yeah. So what's happening is that people, after an exposure, they fill out the red cap and they have immediate availability to testing because the access as Seth was saying is much more open now. So then you go and you tend to test pretty early. So then that first test is likely to be negative, because it's not time yet.

Santiago Neme:

And then you recommend to retest at a shorter interval again. And this was really nicely illustrated on a science paper that was just published, that Dr. Andrew Brian shared with me, where it's really important to look at frequency because the initial test is that snapshot in time, like right then, but then we have an infection takes some time to really show positivity. And there's also an incubation period. So that's why you may test negative initially, and then a few days later, you take another snapshot and that is positive. That's the reason.

Trish Kritek:

So would you recommend people do that? That if they are still symptomatic, they test again?

Santiago Neme:

Yeah. So again, we're recommending things for the healthcare worker, and it's different in the community, I would say, because it just depends on your circumstance. But for us, we've always really prioritized safety, and we felt that if you've had an exposure, like a household exposure, that high risk exposure, we don't want just one test in time. We want to be able to test you before you come back to work on day seven or ... Seth can go over this, but basically we want to retest you.

Trish Kritek:

So yes, because they're less sensitive, we would want you to test again. Okay, if you're still symptomatic. Okay. I'm going to just hit a couple more quick ones so I can get back to Seth and save some time for Anne. Have we transitioned to doing nose and throat? You had talked about that last time. Are we doing both now?

Santiago Neme:

So no, not yet. We're actually validating the two anatomic sites, and we're actually doing this at UWMC through the ERs. And we're in the process of validation, but it may take a few days because we're basically comparing the different sites and we're trying to figure out about the swabs, are we going to use one? Are we going to use two? What is the supply chain, et cetera? But it's exciting that we're doing this to try to really increase the sensitivity even more.

Trish Kritek:

Okay. So we're testing it more to come once we've seen what the results of this test are. So I'll probably ask you again. I'm going to ask you one last question. It's about therapeutics and it's not about outpatient therapeutics. It's about, are we still giving patients in the hospital Remdesivir and do we have access to it?

Santiago Neme:

We are. So there's two clear indications for Remdesivir now that are different. One is the three day protocol, and the other one is the five day protocol. The three day protocol is an option if you got to admitted with COVID but you do not have severe COVID at the moment. So you don't need steroids. And that was actually from the Pine Street study, a study from UW actually, that was really nicely done. And it basically showed efficacy. So when you go to COVID treatment, the smart set, you'll see the different regimens that are clearly outlined. And if you have any questions, you can always call ID and then we'll walk you through that.

Trish Kritek:

I think this is probably someone in the community who's just curious if we're giving it. So I appreciate the details, but the answer is yes, we are still using it. And I think that's great. And yes, we use different levels depending on how sick you are and where you are in the hospital.

Santiago Neme:

Can I clarify something? I think I mixed up a couple things around the testing question. One was, if you're positive, do you need to test again? The answer is no.

Trish Kritek:

I didn't ask that question.

Santiago Neme:

Perfect. But if you're exposed in a household, then you get tested before you return to work. Seth, can you confirm that? Just to keep me honest. Okay, perfect.

Trish Kritek:

Yeah. So if you're positive, you're positive. And I'll ask you this question, Seth, I'll take Santiago off the hot seat. If someone in our community who's ... And this is a hard one for you, but who's not a healthcare worker, test positive. What should they do with that information? Should they tell anyone that?

Seth:

It's a really good question. So right now our counts of cases in the community are significant underestimates because all sorts of people are taking at-home rapid tests. So no, they don't have to necessarily tell anybody, but they just need to make sure that they're adhering to CDC isolation guidance. I would just say, the one nuance there is we do see false positives with rapid antigen tests, and so if somebody has symptoms and they test positive, that's a done deal. You've got a diagnosis. But if somebody doesn't have any symptoms and they get tested just to check, and it's positive, you probably want to confirm that with a PCR or another test.

Trish Kritek:

Okay. So if I'm symptomatic and I test positive and I'm not a healthcare worker, I should follow the guidance about isolation, but I don't need to tell anyone. If I test but I was asymptomatic, I probably should follow up and confirm that that's actually positive.

Seth:

Yep.

Trish Kritek:

If I'm a healthcare worker and I test positive with a rapid antigen, I should tell employee health.

Seth:

Then we want to know right away. Yep.

Trish Kritek:

Got it. Okay.

Seth:

And we want you to isolate and then we can give you additional instructions about whether you need to retest or whether we just say, "Okay, you're on the isolation policy."

Trish Kritek:

Okay. So I'll call employee health if I get that positive. All right. I want to spend a little bit of time on masks, because I said I was going to do that last week and I failed. So lots of questions about the use of N95s, and this is people both in the hospital, but also in the clinic. And I'm going to ask you to be really specific about what's okay in terms of taking it off and putting it back on, or wearing the same one all day and putting a surgical mask over it. So could you walk through that for me?

Seth:

Yeah, definitely. And I just want to make sure we all understand the rationale for wearing N95s, which is, yes, we want to protect healthcare workers from patients and other staff, but we're also trying to protect patients from healthcare workers because we have seen transmission from our staff to patients.

Seth:

And so the term for that is source control. And that's really why we've moved, we're using these as a universal mask at Harborview and UWMC. So you can use the same respirator to see multiple patients, as long as they're not suspected or known to have COVID. So that's called extended use. And when you wear respirators for source control outside of patient care, you can basically continue to wear it until it's wet or soiled, or until you want to take it off because you face needs a break and you're away from people, or you need to take a snack break or something like that. So that's called extended use, and we want people to do that with their universal N95s.

Trish Kritek:

Okay. But let's say I take it off to have a snack. Do I need to put a different one on after my snack?

Seth:

Yeah. It's a really good question. Yes, we want you to put a different one on, and that's really a regulatory issue. There is some concern that if you put the same one on, you might contaminate yourself. I would say, that's different if you're in the community. If you're in the community and you want to take it off, it's okay to put that mask back on as long as it's not soiled or dirty. Those masks will keep their filtration ability for a long time. The straps will probably break before the filter degrades.

Trish Kritek:

So that's super helpful. So if you have an N95 or a KN95, and you're using it to ride on the bus, because I think a lot of people are worried about that. You could keep wearing it until it kind of breaks, basically. Is that right?

Seth:

Yeah. I mean, it's hard to know. It depends how much you use it and how frequently you use it. But I think most people would say, if you use it consistently for maybe a week or so, that might be a reasonable amount of time, as long as it stays clean during that time and still fits your face well.

Trish Kritek:

Okay. All right. But at work, if you take a break, you're supposed to put a new mask on. If you're in a clinic, what if you're wearing a surgical mask over your N95? You're supposed to put a new surgical mask over at each patient you go into?

Seth:

Right. So there are a couple times where you might want to put on a surgical mask over it. We have a couple industrial models of N95s, and the only difference between those industrial models is they're not fluid resistant. So if you're in a setting where you're expecting to potentially get splashed or sprayed, and you would need to wear one of these industrial models, which are very comfortable by the way, especially the 92 or fives, you can just put a mask over it. And then you can continue to change that out.

Seth:

There are some other settings like in the emergency department, where again, if you feel like there might be splashes or sprays, you can just change out that surgical mask on top of it when you're going room to room. Otherwise, we would strongly prefer if you're going to change your mask because you think it's contaminated. Just take it off and get a new N95 rather than playing around with surgical mask.

Trish Kritek:

Okay. So mostly, just get a new N95, unless you're wearing the non-fluid resistant one, or you're going in and out, in and out of rooms like in the ED. Okay. I'm sure there's more nuance questions because there are a bunch of questions about but that's a start and I appreciate that. I'm going to ask one last question because, again, I've not gotten to it too often. Is there any evidence of long COVID with Omicron so far? Have you heard anything about that?

Seth:

Yeah. No, but I don't see why there wouldn't be. We see severe disease from Omicron and people who are unvaccinated and I don't know why it wouldn't cause long COVID in the same population. Long COVID is super common. It probably affects between 10 to 30% of people who recover from COVID. So I am sure it's happening.

Trish Kritek:

Okay. So that is actually a follow-up question. So we see it in about 10 to 30% of folks. We think it's probably happening with Omicron but we don't have a lot of data on it because it's still pretty new. Okay. I lied, I am going to ask you one more question, Seth. And I asked John this question, I hadn't put in the chat, which was bad decision making on my part. If you get an alert on your phone that you've been near somebody with COVID, what are you supposed to do?

Seth:

Yeah. I find those alerts incredibly unhelpful because they don't tell you-

Trish Kritek:

So do many other members of our community.

Seth:

Yeah. I would say, we don't find those actionable. If those alerts were accurate, my phone would be going off all the time, but I'm in PPE and I'm protected, and I'm not getting COVID. So there's really no follow-up needed unless you really know that there is a high risk exposure, in which case employee health definitely wants to know about it.

Trish Kritek:

Okay. But it would be like, you already know there's a high risk exposure. You're not really acting upon what comes through on your phone.

Seth:

Yep.

Trish Kritek:

Okay. I appreciate that. Thank you very much. With that, I'm going to hand it off to Anne to do a little bit of ask an ID doc with Tim.

Anne:

Before I jump into ask an ID doc, I've noticed that there's a lot of commentary in the Q & A, around notifications. If you do an antigen test and test positive, around notifying the department of health so that they can track. Anybody know differently and want to comment on that from this group? I just saw some stuff coming up around how to do the washing notifications.

Seth:

Yeah. Thank you. I mean, you're right. We do want to notify public health or department of health. I just think most people are not able to do that in a timely manner, and so it just leads to significant undercounting.

Anne:

Good. So if you do test positive, do try and follow up so that we can track it through department of health. And thank you to the folks who are posting that. And thank you, Seth, for the clarification. All right. Ask an ID doc. I have Tim on the hot seat today. A bunch of you were putting questions in the Q & A, so I'll try and add some in. Some of these are repeats, but we're going to jump into it. We've talked about not deferring care, but if you had a dentist appointment coming up, how would you feel about going to the dentist right now?

Tim Dellit:

I would be okay. Many of the dental offices have patients completely separated and the dentist and hygienists are also wearing respirators. They've been wearing higher-level throughout the pandemic. So I actually feel pretty safe.

Anne:

Good. Thank you. If you had to take an emergency flight somewhere right now, would you wear goggles?

Tim Dellit:

No, I would wear a respirator. I probably wouldn't wear goggles. It's not a bad thing to do, but I think the biggest risk is the respiratory route. And so that's where I'd be most concerned about wearing a good respirator unfit.

Anne:

Thank you. Would you stay in a hotel right now?

Tim Dellit:

Yes.

Anne:

Lots of questions around eating of all kinds. Would you eat indoors at a restaurant?

Tim Dellit:

No.

Anne:

Would you eat outside on the patio?

Tim Dellit:

I think if it's well-spaced. I don't want to be in a patio where I'm right next to someone else. So I look at the spacing and the surroundings and how many people are there.

Anne:

How about doing takeouts?

Tim Dellit:

Takeout? I do. Yeah. I have no concerns with that. I go in with my respirator, I pick it up and I go home.

Anne:

Perfect. The cracking of one two games in a row. How would you feel about going to a cracking game right now?

Tim Dellit:

Not now.

Anne:

Would you go cross-country skiing with a pal assuming you know how to ski and you're not at risk of personal injury?

Tim Dellit:

I grew up in Iowa, that's all we had, was cross-country skiing. There are no hills or mountains. But yeah, I would feel comfortable outside. Again, you want to know who you're with, what are their patterns? In terms are they vaccinated, et cetera? But you're outdoors, and so I think you can do that safely.

Anne:

Here's a fun one. Cirque du Soleil happens under a giant tent, but tons of people inside, outside, would you go if you had Cirque du Soleil tickets from the end of the month?

Tim Dellit:

No, I avoid large crowds.

Anne:

Fair.

Tim Dellit:

Period.

Anne:

You kind answered this, but just to clarify, you would do a bus, but you would wear a respirator and a respirator means N95 for folks who are-

Tim Dellit:

Yeah, KN95, N95, KF94. I mean, if I were in New York, I'd ride the subway, but I would do it with that level of protection.

Anne:

Would you go visit an elder family member in a long term care facility right now?

Tim Dellit:

I would, as long as I'm following their policies, but again, I would be wearing that higher level respirator and making sure I didn't have symptoms. I know that I'd been boosted and I would feel comfortable in doing that.

Anne:

A lot of folks have been getting COVID and thankfully recovering, would you hang out with a couple that had had COVID and recovered? Would you consider them like extra safe right now?

Tim Dellit:

Yeah. Well, what do you mean by hang out? I mean, I think I would see them not in my house right now, just because of the high rates of transmission. I think sitting outdoors in a spaced area. I don't have concerns with that. I wouldn't view them as somehow protected completely. We're still learning about, could you get reinfected? So I think, certainly their risk may be lower because they've been vaccinated and now infected, but I still would be cautious.

Anne:

I think that's the heart of the question. Like, suddenly if you recover from a Omicron, are you somehow a little more invincible? Do you take fewer precautions?

Tim Dellit:

I worry about that mindset of invincibility. I think we all still have an obligation, particularly from a population standpoint to continue to follow the guidance. Even if we had COVID 19 recently I would still wear the mask. I would still follow all of those recommendations. I think it's really important that we collectively do that to decrease transmission overall.

Anne:

Okay. One or two more, the crystal ball question, folks want to know, can they plan travel for March or April? How are you feeling about the future?

Tim Dellit:

Yeah, so my own experience, we actually had plans for a trip this week to be gone, of course we're not. And so I postponed it until the end of March and we'll see. So I'm cautiously optimistic. I hope given what we've seen elsewhere, that in a couple of months we'll be in a better space, but I have to play it by ear. We've been kind of keep rescheduling things throughout the last two years, which I totally understand is incredibly and frustrating. In fact, I think, yeah, my wife keeps arguing, 'is it better to reschedule or is just like give up.' But I think you just have to see where it is. And I try to be optimistic that at some point we will get through the other side and it'll be safer to travel again.

Anne:

Good. If somebody who hit some excellent peak travel in the middle of last summer, don't give up, keep trying to put it stuff on the calendar. With that I'll hand it to Trish.

Trish Kritek:

Thanks Anne. Thanks Tim, as always for answering the questions, I want to just reflect for a second. I have been reflecting on the fact that it's two years, and I said that at the beginning, two years. And I thought about that in my run this morning. And I said, that's why I'm so tired. That's why we're so tired. We're tired. And I was thinking about it a lot and I'm on service right now in the ICU at the surgical ICU, and it's crazy in the hospital still. The endoscopy suite from the surgical pavilion is in our ICU, kudos to the endoscopy team. They're still making it work. And people in our service are people who have life threatening surgeries. They need to get done. And we're negotiating how to do those and keep taking care of all the patients in the hospital.

Trish Kritek:

And we're wearing these things all day every day. And I honestly, it's a good thing and it's really hard. It's hard to wear this for 12 hours. I find it hard to wear it and I can come to my office and take it off. And yet I feel energized at the end of this week. And that is because this week I got to sit and talk to patients. I got to collaborate with so many different surgeons, and interns, and residents, and fellows, and nurse practitioners, and bedside nurses, and RTs, and PTs, and OTs, and social workers, and pharmacists, and speech pathologists, and all the people I'm forgetting to say and helping patients navigate really challenging times. And I got to stand at a whiteboard and teach about ventilators and I love to teach about ventilators. And I even closed the team room door a few times and laughed at the silly moments that happen during the course of the day in the ICU.

Trish Kritek:

And honestly, those moments have helped me come back to have that energy, bring me back to the purpose. I'm so grateful for everybody in the surgical ICU for helping take care of me this week and really helping me come back to why I do this. I so love being a doctor and a teacher, and it's been inspiring to have that happen. So I'm going to end by saying a really big thank you to everybody in the surgical ICU to Robb Glenny who's covering me right now, to all members of my team for taking care of our patients and their families. Even if it's by zoom right now, but really taking care of me. And I really appreciate that. So to all of you, let's keep doing that. Keep taking care of each other. It's going to be what makes a difference. Thank you everyone. I'll see you back next week without scrubs and I look forward to it. Bye-bye.