

Trish Kritek:

So, welcome back to UW Medicine Town Hall. I'm Trish Kritek, Associate Dean for Faculty Affairs. And with us today, are John Lynch, Head of Infection Prevention Employee Health at Harborview Medical Center, Tim Dellit, CMO for UW Medicine, Keri Nasenbeny, Chief Nursing Officer UWMC Northwest, Anne Browning, Assistant Dean for Wellbeing, Tom Staiger, Medical Director for UWMC, Jerome Dayao, Chief Nursing Officer Harborview and Rick Goss, Medical Director Harborview.

Trish Kritek:

And I'm going to begin by saying thank you to everybody who's on the screen and everybody who sent in questions. This was obviously an add-on town hall. I said at the last town hall, that was going to be our last one of 2021 and I was wrong. We came together somewhat more urgently, because there's a lot going on and we thought it was important to come and talk with everybody. And we got over 100 questions in the few days that we had the portal open, so clearly I think it's a good thing. So, this is our first and ever Wednesday town hall. I'm glad for everybody to be here and with no further ado, I'm going to kick it over to Anne for a wellbeing message.

Anne Browning:

Thanks, Trish. I wish that we weren't saying happy new year this way, but here we are and Omicron feels different. I'm planning to listen to what everybody shares today, because I kind of want to figure out what's going on too. I think there's quite a bit of uncertainty right now, as we're trying to figure out how to navigate this new landscape. I've already had extended family test positive, so this is landing closer to home. This feels different. I know early on with COVID it felt like there was kind of a stigma around getting COVID and some of that stigma, I think, has still kind of persisted, but I'm recognizing that you could do your best and take really good calculated risks and still get it right now. And I just want to emphasize that I hope people can be really kind to themselves and kind to others who are testing positive right now. This is a really, really hard moment. We're seeing a lot of community transmission and we just want to make sure we're taking care of ourselves and each other in this.

Anne Browning:

One question that came in, in the town hall questions this week, was around how are we taking care of ourselves during Omicron? And it had me thinking back to a conversation during the ask and ID doc with John Lynch, where we both discussed how we're taking calculated risk to make sure that we're balancing our own wellbeing. John goes rock climbing, I've been rowing boats, but those risks are kind of moving targets depending on the context and our environment. And there's kind of these ebbs and flows to the waves of COVID. And as we're riding up a wave, it feels like our movements and the calculated risks we can take, they constrict. And then after we crest and we come down the backside, our worlds can expand again.

Anne Browning:

And we've been here before and this phase of kind of constriction sucks, but this wave will pass. And so, there will be more disruptions. There are disruptions happening right now, more travel plans getting blown up. My wife actually asked me the other day, "Should we even bother planning trips anymore?" I said, "Yes." Sometimes our timing, we get it right and other times our timing is terrible, but our goal is to kind of stay flexible in these ebbs and flows of the waves of COVID. And I found myself as I was on my run this morning, kind of thinking about Bruce Lee and just kind of the phrase of, be like water. We kind

of have to flow with this. We've been here before and this too will pass. So, happy new year's to folks, do your best to stay flexible and this too will pass. Trish.

Trish Kritek:

Anne, thank you very much for those thoughts, which very much resonate with me. And I will note, that might be the first Bruce Lee reference at town hall, so thank you for bringing that as well. But in all seriousness, I do think it's feeling different right now. It's closer to home for me as well with family members testing positive and I think it feels different, so I appreciate you acknowledging that. John, I'm going to jump to you and we'll start with current numbers of patients in our system and you can kind of give a flavor of what that looks like right now.

John Lynch:

Yeah, sure thing. So, we are definitely increasing in our inpatient volume and I want to point out a couple details as we go through this. So, our total patients as of early this morning was 51 across our four hospitals. And I'm going to actually run the numbers really quickly here, Trish. So Harborview's got 10 folks in acute care, eight in the ICU, so 18 overall. I think actually above 20, as of later this afternoon. Montlake's nine acute care, three in the ICU. Northwest is at two acute care, one in the ICU and Valley is up to 16 in acute care and two in the ICU.

John Lynch:

And what I really want to point out, one, is we got a big increase in cases since the last time we had a town hall, so we're definitely starting to see an impact to that wave of Omicron. The second thing is, if you actually break that down, we have historically, especially at Montlake and Harborview, had way more patients in the ICU. That's probably your own experience too, Trish. But what we're seeing across UW Medicine is actually almost most of the patients, two thirds, three quarters, are actually in acute care, which is a different sort of pattern than we've seen in the past and I think we'll come back to in some of your questions.

Trish Kritek:

Yeah, I appreciate that. So, definitely way up from when we last came together and that's part of what we are responding to, but maybe not as sick. And so, I want to ask some questions digging into that a little bit. So, the first question is, do we know what percentage of these folks have Omicron versus Delta? Do you have a sense of that?

John Lynch:

Yeah, so we don't have a breakdown per patient, right? So, just to give people just a quick understanding here is that you get a test, that tests for COVID, the PCR test, doesn't say Omicron or Delta or whatever, it just says yes or no. And then the lab takes those tests and puts them on a different platform and does sort of a first pass, a rough and dirty test to see whether it could be Omicron or not, looking for what's called an S-gene target failure, and then they can sequence it.

John Lynch:

What I'll tell you right now, and the dashboards in public aren't totally updated, is that when the last time our clinical lab, Dr. Roychoudhury, posted information, we were well above 80% of all of the positive tests are Omicron. And so, I think that if you've been infected in the last couple weeks, it is very likely that it's Omicron and probably as of this week, it's essentially all Omicron.

Trish Kritek:

Okay, so what we're seeing is the vast majority of folks are Omicron. We don't know exactly what percentage of those 50 some people are Omicron, but the vast majority of people who are testing positive right now are Omicron in our space.

John Lynch:

Correct.

Trish Kritek:

I'm going to follow up with Omicron just a little bit more before I go back to another question about those patients. So, relevant to that, and the fact that we're not seeing as many people in the ICUs, there's been a lot of talk about whether or not Omicron might not be as severe a disease, so I'm wondering where we stand in terms of data about, is Omicron not going to make people as sick or be less lethal or however you want to describe it?

John Lynch:

Yeah, so first thing is, still very early, right? We've only been dealing with Omicron globally for a month or so and locally for a couple of weeks. So, still early. And to be clear, we are seeing more people in the hospital, so Omicron is clearly having an impact. When you look across King County, we've had an over 200% increase in cases, so an astronomical number and people have used nationally the word tsunami. This is happening across our entire country. We have seen over the last seven days a 98% increase in hospitalizations across King County, but the death rate still is going down. Still, early days, still a couple weeks in now, I'm not seeing a budge there and actually seeing a continued decrease, is actually a little bit reassuring.

John Lynch:

But to answer your question more fully, I have to look at, what are the data from other countries that are further down the path than us? South Africa and the UK. And I'll say one thing that's coming out of the incredibly good surveillance that's being done in South Africa, is that it looks like their big surge in cases is coming down. And at no point during their surge, did they see a huge increase in hospitalizations, so that's one. Two is, if you actually look at data coming out of the UK, which also has really good surveillance across the whole country, is that they have seen a 40% increase in the last seven days in cases, but their death rate has gone down, still, 30% of decrease in death rate and their hospitalization rate despite a 40, nearly 50% increase in cases, has actually gone up only about 13%.

John Lynch:

So, we are seeing signals at the national level and big population level, a disconnect between how big that wave of cases is in the cases of hospitalizations. So again, clear, people are still getting sick and end up in the hospital, but not as many as we would anticipate. And so, you look across that and looking at other science out there, it does appear that Omicron is causing less severe disease in the population as a whole, while still causing very serious disease in some people at higher risk.

Trish Kritek:

Okay, so some people can get very sick. People can die from Omicron, but local data, as well as national data in other countries who are further along in this than us, suggests that lots of people positive, but

not nearly as many people hospitalized and hopefully many fewer people dying. We'll learn more as we go.

Trish Kritek:

I will add, I also heard you say numbers are already coming down in South Africa, so I think that's the other thing that maybe this is a quick up and quicker down, is a suggestion that you're saying. Okay, thank you. I think that's something that people have been hearing and thinking a lot about and are hopeful, as I am, that it's less severe. Do we know about the folks who are in our hospital right now about their vaccination status? Are we seeing more unvaccinated people, are we seeing now more people who are vaccinated now there's more Omicron, do you have a sense of that?

John Lynch:

So, I was trying to get that data for you today, Trish, I don't have it all at my fingertips, but we are still seeing, and we know across King County in the last 30 days, that if you are unvaccinated, you're still six times greater chance of getting infected, 33 times greater chance of ending up in the hospital and a 45 times greater chance of dying. And that is reflected in our inpatient numbers.

John Lynch:

So, being unvaccinated is still the greatest risk in our population. We are seeing breakthroughs and hopefully we'll get a chance to talk a little bit about employees here shortly and their infection rates, but we are seeing breakthroughs, but the rate of breakthrough infections among vaccinated people and even in the hospital still remains remarkably low.

Trish Kritek:

Okay, I think I'm going to stick with that last message, which is, we're seeing breakthrough infections, but those are not the majority of folks who are ending up in the hospital. We don't have exact numbers right now. We can work towards those for next town hall. I actually think that you're leading into exactly what I wanted to ask about next, which is, we have a lot more healthcare workers who are testing positive, so I actually want to start off with, what are our current numbers of healthcare workers who have tested positive in our system?

John Lynch:

Yeah, so as of right now, it looks like across neighbor clinics, Airlift, Valley, Northwest, Montlake and Harborview, we have approaching 200 healthcare workers who are in isolation due to infection.

Trish Kritek:

Okay, and how does that compare to where we were before?

John Lynch:

That is much, much higher. This has been an overwhelming number of infections. Our employee health teams and exposure teams are working pretty much nonstop with this for the last week, week and a half. It really started right after the holiday. And it's been just, again, a tsunami of cases coming in. And I just want to emphasize what Anne said around this. This is really, it feels different than anything we've experienced before and the transmission rate of Omicron is really exploiting a lot of things that we're doing in our daily lives.

Trish Kritek:

So, I have a couple different follow up questions and let me start with health care workers and testing and then we're going to talk about quarantine, because with the CDC guidance, there have been lots and lots of questions that came in about that. So, right now, if you're a healthcare worker who is symptomatic, what are you supposed to do?

John Lynch:

Get tested. So, the most important thing is to get tested. And I just want to be clear about this, PCRs are what we have out there, that's the UW Clinical Virology Lab, that's the lab at Northwest and Montlake and all the drive up testing, those are PCR tests. They're the most sensitive tests. We want you to get tested. If you happen to have one of those at home point of care tests and antigen tests or lateral flow tests, they're called lots of different names, if you have them at home and that test is positive and you have symptoms, you're done, in either a PCR positive or an antigen test positive and you have symptoms. You don't need to confirm that antigen test, you got COVID, let employee health know so we can help you with determining how long you need to be in isolation.

Trish Kritek:

Okay.

John Lynch:

Does that answer your question, Trish?

Trish Kritek:

Yeah, it does, so I think get the PCR test and we have increased, I think, availability for testing, I saw a bunch of emails about that, or do a home antigen test, if either is positive, you're positive, let employee health know. And then, how long do you need to isolate? And obviously, that's relevant to the CDC guidance that came out yesterday or two days ago.

John Lynch:

Right, so cut me off here if I go a little too long. So first, testing, we recognize there's been constraints on access to testing and I see that coming from the Q and A. We are working very hard on improving that access, so we're really trying to improve access for healthcare workers and health worker families. And so, don't give up, it's still there, it's going to get better in a matter of days. And so, just been a lot going on with the holidays. So, just in terms of the CDC thing, if people haven't seen it yet, the CDC released new recommendations around both isolation and quarantine. So isolation's what happens when you're infected and quarantine is what happens when you're exposed. These came out last week and then the CDC follow up with general recommendations in isolation and quarantine of the general public, I think, on Monday.

John Lynch:

So, we are still working through this. So, the first thing I'll say is the employee health infection prevention teams are still working through this. Where we see the first step is around health workers who are exposed, and so, what it says right now, if you look at the CDC recs, they separate out exposed people, whether they're boosted or they're not boosted, right? So, if you're vaccinated or unvaccinated, that's one bucket. And then if you're boosted, they put you into a different bucket. And that's because

we've seen such good data in the lab with improvement in antibodies responses in folks who have been boosted versus those who have not. So, in the boosted population, the CDC says, "All things being equal, no work restrictions, if you can get a test on days two and five or seven, that would be great." If you are unvaccinated or you don't have a booster, then they want you to work restrict for a week or so.

John Lynch:

And then they move through different strategies depending on how tight your staffing is, so contingency or crisis. And so, what we've done in UW Medicine, we've actually been developing these actually at the same time and a huge number of people have contributed to these. I wanted to give a shout to Dr. Chloe Bryson-Cahn, who has really spent a lot of time working in this, but everyone in the employee health teams across our system have been working on it. We have a bit of a more nuanced approach in that we look at what the exposure was. So, the CDC guidance is only exposure. They just say, "You've been around someone with COVID for more than 15 minutes and six feet." What we do is we separate it out into whether it's a community exposure, a community prolonged exposure, you're there around someone else there for a long period of time, or whether you live with someone and whether that person you're living with, you can't isolate from.

John Lynch:

So for instance, you're a vaccinated health worker who lives with a child, who's got COVID. You can't isolate away from that person, you're a caregiver. And we treat those cases differently, but in all of them, we either allow people to work and test, or we keep them at home based on their vaccination status. So, that's why it's so important to contact employee health. We have a slightly more conservative approach based on our own data and also some of the emerging signs around Omicron specifically and what's called the secondary attack rate. What I mean is how many people get infected in a household and Omicron does seem to be more infectious in households compared to Delta. And so, we're trying to make sure we're covering those folks a little bit differently.

Trish Kritek:

Okay, I don't think I can summarize all of that. I think the take home here is you need to talk to employee health.

John Lynch:

Yeah.

Trish Kritek:

That testing and isolation, I mean, testing and isolation are going to... Or quarantine we're talking about right now. Good Lord, sorry.

John Lynch:

Yes, exactly. That's why it's complicated.

Trish Kritek:

Yep. Testing and quarantine are going to be determined by booster or no booster and type of exposure.

John Lynch:

Right.

Trish Kritek:

And so, I think there's a nuance between whether or not you can come back to work or you're going to have to quarantine, so you're going to need to talk to employee health.

John Lynch:

Right.

Trish Kritek:

I think that's the take home there and that may still evolve as we kind of continue to digest what's happening with Omicron and CDC guidance.

John Lynch:

Well, I have to toss in one more part, because it's really...

Trish Kritek:

Yeah.

John Lynch:

And that's around isolation. So, the other part of the new guidance from CDC is around whether we can shorten the time that a health worker needs to be away from work. And so, right now, we're looking at that. Now, the key part to that is a recommendation potentially for testing. That testing is an antigen test, right? So, if we test someone after they've been tested positive PCR within a week or two, or actually out for many days, that test will very likely be positive. The PCR will still be positive, even if the person's not infectious, they can't give someone else COVID. What early data says is that the antigen test may be a reasonable proxy after five to seven days of someone's infectiousness.

John Lynch:

And so, what we're looking at is using the antigen test to potentially look at people with either no symptoms at all, they never had symptoms, they were detected on some travel or something like that or an exposure, or extremely mild symptoms that are improving, whether an antigen test, a negative antigen test at that point, five, six, seven days out, would allow them to come back to work sooner. And so, that's the part we're trying to figure out right now. One caveat is we have very limited number of antigen tests. They've been short across, as everyone in this call knows, short across the country and we're working very hard on trying to find more of those. So, once we have those antigen tests, we can look at operationalizing, maybe getting some asymptomatic or extremely mildly symptomatic improving health workers back to work a little bit sooner.

Trish Kritek:

Okay, so right now we haven't changed anything.

John Lynch:

Right.

Trish Kritek:

Our quarantine right now is 10 days, is that correct?

John Lynch:

Isolation is 10 days.

Trish Kritek:

Well, isolation. God, I'm losing my mind today.

John Lynch:

Welcome to my world, Trish. Every morning I have to get my head back on straight. Trust me, I know right where you are.

Trish Kritek:

Thank you, I appreciate your empathy. So, isolation for 10 days is still where we are. However, if we obtain more antigen tests, which we don't have a lot of right now, and we continue to see the emerging data, there is ongoing conversation about changing to a shorter term, five or seven days, with a negative antigen test for people who are mildly or asymptomatic. So, more to come is what I would say, but right now it's still 10 days.

John Lynch:

Right.

Trish Kritek:

Yeah? Okay, thank you. I mean, I think it's super confusing to people and so it's hard to understand all of this in a way that kind of makes sense, and so, I appreciate it.

John Lynch:

Please call employee health. Please, please, even if you get tested someplace else, let them know. Please call them, because we can really help you walk through this and help you understand and maybe make it better for your circumstances.

Trish Kritek:

Yeah, so talk to employee health, which I also think is overwhelming our employee health folks, so we'll continue to thank them for all that they're doing.

John Lynch:

Yeah.

Trish Kritek:

Okay, many more questions, I'm going to come back to you for a whole masking series of questions in a little bit, but I'm going to give you a break for a second. I'm going to turn to Tim, and Tim, John was just saying that boosters seem to make a difference with Omicron and we've been encouraging boosters and



one of the questions that came in a bunch is are we going to start to require boosters as part of being kind of fully vaccinated for UW Medicine like we have the earlier vaccination requirement?

Tim Dellit:

Well, currently boosters are not required. I would say that we've had discussions with our infection prevention and employee health leadership, both within UW Medicine, as well as with other health systems and have had ongoing discussions with Public Health and Department of Health, so I wouldn't be surprised if things gradually move in that direction, but right now, they're still in the discussions. We're also trying to get a better sense of where we are. We think, looking at our data, about 75% of our employees have been boosted, but we still need to capture if they got boosted outside of our system, do we have all that information within our employee health records?

Tim Dellit:

And some of our employees may not yet be eligible based on timing, so if they got one of the mRNA vaccines and it hasn't been six months, are they eligible yet? So, as we clean up that data, we want to see really what is the number of individuals that have yet to be boosted. We're still actively trying to, one, strongly recommend, but two, proactively outreach to those individuals to get them boosted. But I would say there's a lot of conversation within the state around potential requirements. People may have seen what California has done. California has required boosting for healthcare workers and historically through the pandemic, the West Coast States have stayed in alignment, so I wouldn't be surprised if that comes out in the future, but currently no.

Trish Kritek:

Okay, so potentially on the horizon, not yet. And I'll just highlight the 75% at least, and maybe more of our employees are already boosted, which I think is great. The other thing that came up in a bunch of questions, two other big things, one was what therapeutics do we have available for people right now and what's available in our system that treats Omicron?

Tim Dellit:

Yeah, and I want to thank Santiago Neme who was not able to be here today, he's in clinic, as well as Shireesha Dhanireddy and our outstanding pharmacist Rupali as well. So, we do have the newer monoclonal antibody, Sotrovimab, that is now active against Omicron. It's still in limited supply, and so we're using the REDCap survey to identify, for instance, if people have been vaccinated. It's really, are you immunocompromised or pregnant in terms of eligibility. If you haven't been fully vaccinated, then we look at comorbidities. Each of those REDCap requests is then reviewed by Santiago or Shireesha to determine if that individual is eligible. So again, really appreciate your patience given the limited supply right now and we're trying to ensure that we have equitable distribution for those eligible patients as well, so each request is being individually looked at to see if they are eligible for that monoclonal antibody.

Trish Kritek:

Great, so limited supply, is effective against Omicron and there's individual review of each request, because immunocompromised or pregnant vaccinated folks or unvaccinated folks with other risk factors, are going to be prioritized as we try to do it equitably.

Tim Dellit:

Correct.

Trish Kritek:

Thank you for that. The other thing, John touched on this a little bit already, but I want to talk a little bit more because we got a ton of questions about antigen testing. And I heard John say we don't have very many yet, but as we get more, are we considering distributing them to clinics or to local sites or other places throughout UW Medicine? Do we have other strategies for using antigen testing as we move forward?

Tim Dellit:

Yeah, I think the antigen testing, as John mentioned, short supply right now. Even internally, we only probably have a few hundred of these tests available. We pulled them back from the gift shops as an example, to try to think about how could we best utilize these potentially with our employees? But the supply is really not there to sustain. We're actively working with our supply chain folks, who've done a terrific job throughout the pandemic. We've also been having conversations with Public Health. Public Health had anticipated receiving several 100,000 antigen tests and thus far have not received any. And so, that is a challenge and people, if you've looked in your local drug store, they're also not available, so there's just a real paucity of supply right now. If we have adequate supply, then we are starting to think about, "Well, how can we make those accessible for our employees to be able to use?" Especially in those situations, for instance, if they've been isolated and if we change our policy to incorporate antigen testing, how do we get it to individuals to see if they're negative on, say, day seven, right?

Tim Dellit:

And so, those discussions are happening now with our logistics team. I do also want to go back from the treatment side. I'll be remiss if I didn't comment on the oral therapies that were approved through emergency use authorization by the FDA, one from Pfizer that looks quite effective, roughly 80% effective in decreasing hospitalization and death, and then there was a Merck drug that also received emergency use authorization, probably about 30% effective and contraindicated for pregnancy, because of risk of mutagenesis. So, the Pfizer drug looks in some ways more promising. We're still waiting to see when those will be actually available in our area. Once those are available, hopefully in the next week or two, we'll set up a similar REDCap survey, because they will be limited supply and we really need to identify who will best benefit from those medications. So, a lot of work behind the scenes in preparation for when those do become available. And again, particularly the Pfizer drug sounds encouraging right now and at least early studies suggest that it's going to be effective against Omicron.

Trish Kritek:

Okay, so I'm going to go back to summarize what you just talked about. So, I didn't push you on the oral ones, because I knew we didn't have them yet, but they're on the horizon, when we have them, we'll be using a similar system and the Pfizer one particularly seems promising, even against Omicron, so that's great news. More to come when we have availability. We'll kind of figure out how to get it out to folks in that same kind of thoughtful way.

Trish Kritek:

Going back to antigen testing, making plans for when we get some with, it sounds like, a prioritization of using it for employees to potentially test to come to work if that becomes our algorithm. I think everyone's looking everywhere. I've walked by Bartell's and it says, "We have no antigen tests." And I

think it's true across the country. Last bucket I'll ask you before I give you a break is the other implications of so much folks testing positive, so I'm going to start with you, I'm going to go to Rick and Tom next, but my first question is, are we going to transition to having people work from home again like our administrative folks? Are we going to start doing classes remotely again? Are we changing those things in response to this rapid rise in Omicron?

Tim Dellit:

Yeah, so I think here too, we want to stay in alignment with the overall university. And so, there was a message from President Cauce and the provost about a week or two ago where they did transition the first week of classes to remote. Now, that would not affect, for instance, our medical students who are on clinical rotation, would still be in person, or those educational activities that need to really be hands on, but they did transition for that first week to get a better sense.

Tim Dellit:

And keep in mind, since we had the return to onsite work in September, each unit has had the discretion to evaluate how they manage the overall capacity within that space in terms of, is this someone, based on what they do, is this appropriate for remote work, for a hybrid mix of in person and remote, or do they need to be in person, because of their position and what they do? And so, that hasn't changed. We'll see, I would anticipate the university will update their messaging here, I would either expect later this week or beginning of next week, just in terms of what they anticipate as we go into winter quarter and we'll want to stay in alignment there, but we are watching this very closely and coordinating with upper campus.

Trish Kritek:

Okay, so right now, first week is remote, we'll wait for more announcements.

Tim Dellit:

For students.

Trish Kritek:

For students, yeah. And then for telework in other spaces, it's the same kind of individual unit guidance can make decisions about that. I appreciate that. Relevant to teleclass, I want to ask you, Tom and Rick, about telemedicine. So, Tom, one of the questions that came in was, are we going back to mostly telehealth visits with the rising numbers of Omicron? So, how have we pivoted or have we pivoted in terms of telemedicine visits?

Tom Staiger:

So, I'm not aware of a general pronouncement to pivot to telemedicine visits. That said, individual clinics, I know, have been messaging this, so my general internal medicine clinic sent out a couple of days ago saying that patients calling for appointments are being offered telemedicine appointments for infection control reasons, as well as this week's weather reasons.

Trish Kritek:

Right.

Tom Staiger:

And then, all of the providers were asked to review our schedules and if there are patients for whom it's appropriate to offer them telemedicine instead of in person visits, to make a note of that on our schedule so that our front desk folks can contact them and offer them telemedicine visits.

Trish Kritek:

Okay, so it sounds like we're not doing it everywhere and every place, but individual clinics and spaces are potentially encouraging looking at more telemedicine right now. Rick, did you want to add to that?

Rick Goss:

Yes, similarly in speaking with our ambulatory leadership, this week we very actively pivoted toward telehealth visits, because of the weather, but with the backdrop of our staffing challenges and the rise of Omicron, our leadership is poised to kind of get together quickly and start really make making that available even proactively with our patient visits.

Trish Kritek:

Okay.

Rick Goss:

I think we also realize the need for patients to be seen in person, so we'll sort of really work out the balance that we think is most appropriate.

Trish Kritek:

Okay, so it sounds like we're attending to potentially more telemedicine visits, while also maintaining the ability to see patients in person when that's needed, and have the ability to ramp that up if we need to. I appreciate that. I think the other thing that I'm going to ask the two of you to start with is, our censuses are incredibly high in staffing because, as you both have alluded to, the weather plus Omicron plus ongoing challenges with workforce that we've been talking about for months have really tested our hospital. So, I had planned to ask you, are we considering pausing elective surgeries again? I saw an email earlier today about that, but maybe, Rick, you can comment on what the plans are around elective surgeries?

Rick Goss:

Sure, and until today's message, we had the dates set at the seventh and were considering extending that by another week, so here at Harborview, we really have placed limits on inpatient to same day admissions and even same day outpatient surgeries as well as procedures, so that will be in effect through the 14th and obviously reconsidering as we move along.

Trish Kritek:

Yeah okay, so assessing now through the 14th for those elective procedures. Tom, is there anything you wanted to add to that?

Tom Staiger:

Just similarly for us, non-urgent procedures that require an overnight hospital stay or longer, we're rescheduling out past at least until January 14th.

Trish Kritek:

Okay, so if you're going to need to stay in the hospital overnight and it's elective procedure, and I heard Rick say, and some same day procedures even, we're putting on hold until the 14th, if it's safer to do so for the patient. I will ask the last question right now for the two of you. How are we managing outside hospital transfers with our census so high? That was another question that came in from a few different folks. How are you approaching that, Rick, in terms of outside hospital?

Rick Goss:

Great question. Well, I think as the medical directors, we're very active with the transfer center and we have some pretty well worked out strategies around that, so we're all really delivering a similar message. We're working very closely with the WMCC and the WMCC is helping to coordinate such that when UW Medicine is sort of in the rotation, we will do whatever it takes to place one of those patients within our four hospital system. There will be out of state requests and to the full extent possible, for example, Oregon, we're really trying to coordinate with their essentially WMCC equivalent, which has gotten more and more advanced over the last number of weeks. There will also be those case by case, which we also handle just like we always have, which is really based on the clinical necessity.

Trish Kritek:

Okay.

Rick Goss:

Tom, any other...

Tom Staiger:

Yeah, similarly for UWMC at Montlake, we've asked our medical staff to accept patients, only those who have Montlake specific needs, capacity of being available, we can sometimes accept more patients at the Northwest campus, but we're also using that to help out Harborview, Montlake and Valley. And then out of state transfer requests, unless their mission specific patients, have to go through the medical director or on call medical director for screening to determine if we, at that point, have capacity and we're in an appropriate place to take the patient.

Trish Kritek:

Okay, so I think what I heard is, a lot of collaboration across our sites, as well as across the state and even now interstate and a fair amount of scrutiny about trying to get the people that we could uniquely help into our spaces in a timely fashion. I appreciate that and I think the series of questions about it, I think, reflect the tension and the exhaustion that people are feeling, so I appreciate that. And sounds like the two of you are involved in a lot of the review of those patients as well, so thank you for that.

Trish Kritek:

I'm going to go back to John and do a series of questions about masks. That was good, you saw my warning, because I know you're answering questions in the Q and A like crazy, so thank you for doing that. Last week, I think there was a change in our masking guidance and I want to walk through that, but before I do that, I think, the question that came up the most related to it is, do we think Omicron is transmitted in a different way or that masks are less protective against Omicron, because I think that was the downstream question people had when they saw the change at masking requirements.

John Lynch:

So, no, I don't think Omicron's transmitted in a different way. I think it's transmitted just like all the other variants of SARS-CoV-2, but it is more transmissible, right? So, why it's more transmissible has to do with probably intrinsic properties of this variant, which we're still learning about. And also, its immune evasion, right? We know that it infects people who have been vaccinated at a rate higher than Delta did. Not 100%, but definitely more. And so, given that increased risk to a highly vaccinated workforce, dealing with people in many of our places, sort of in an unknown situation, right? Ambulatory care clinics, emergency departments, patients coming through our doors for lots and lots of reasons, many of which may not be associated with they have COVID. And so, the other part of this is that our colleagues may have COVID. They may have asymptomatic COVID or very, very my mild symptoms.

John Lynch:

And I want to be careful here, I'm not blaming anyone. We want to work, it's part of our lives, we have lots of reasons that we show up to work with even mild, mild, mild symptoms and whatever. And so, the idea here is, how do we improve, I don't know if resiliency is the right term, sort of our respiratory resiliency across the population? How do we keep people a little bit safer, every little incremental opportunity to make people safer? There's also, I want to recognize that there are people who feel unsafe. Maybe you aren't unsafe, but if you feel unsafe, I don't want you to feel unsafe. I want you to feel safe while you're at work. So, if we look at the biological issues of Omicron and the stress of working in a healthcare in Omicron era, our goal here was to let you, and ask you, to level up. That was our term here.

John Lynch:

And coincidentally, Public Health put out a message using a slightly different term, I forgot what their term was, almost the exact same day. And our ask here was, hey, if you feel comfortable wearing a respirator, an N95, taking care of patients and that's comfortable with you all day, go for it. We want to support you in that. And if you feel like you have a KN95 or KL or a KF94, that really fits your face extremely well and you're comfortable with that, go for it. Wear that, put one of our procedure masks over the top. If the knot and tuck is the best thing for you and that's the thing that you can tolerate throughout your entire shift, as you clean rooms on acute care or you're doing facilities and management work, then go for that. If it's double masking, go for it.

John Lynch:

Our goal here was to empower healthcare workers to find, either using our materials or their own materials in terms of respirators and masks, the thing that works the best for them. Comfort, tolerability and protection. And that was the idea here. I think there's a lot of challenges with asking everybody to wear a respirator. They are very uncomfortable for a lot of people. They bite into your skin, they cause skin breakdown. I'm also concerned about people taking them off more frequently and congregating around other people without masks on, right?

John Lynch:

I've also done surveys of healthcare facilities, just like all of our sites across the United States, big urban centers, community hospitals, and really everyone is sticking with the surgical masks, the procedure masks that we have been using for the last two years. And again, we're definitely actually being a little bit more open to opportunities here in different approaches to respirators and masks and again,

allowing health workers who really do want to take that extra step to do so. So, that was a long answer, but it was a lot of conversations that went into it and our goal here is to allow people to feel as safe as they want to be, while also creating a more resilient environment.

Trish Kritek:

Okay, I'm not sure about respiratory resiliency as a term, but I'm going to think about that one for a little bit, but here's what I heard, and I think it is hard, because sometimes we want things to be a little bit more black and white, but this isn't super black and white, but I think I heard you say we want to allow people to feel, if they would feel more safe with a respirator on, whether that's ours or theirs, we want to allow that.

John Lynch:

Yes.

Trish Kritek:

And we want to potentially give a higher level of protection to everybody, but we don't think that Omicron is being transmitted in any new way than was the case before, but we do think that people are being infected more often and so, we're trying to be extra safe.

John Lynch:

Yes. And I'll just be clear, we're not seeing transmissions from patients to healthcare workers and that's been the same thing for the last two years. We are seeing health workers infect other healthcare workers, so it appears in our environment, it's not what mask you're wearing or what respirator you're wearing, it's what you're doing when you're not wearing a mask or respirator.

Trish Kritek:

Right, and I think relevant to that, I think the other thing I heard you say is, sometimes it's hard for people to wear an N95 all day, so for people who don't feel like they can wear an N95 all day, that wearing a surgical mask and maybe wearing two of them is one of the things, I think, you said you could also do, are options. If you wear an N95, how often are you supposed to change that N95?

John Lynch:

Yeah, I'm talking about when you're not taking care of patients with known or suspected COVID, this is your day to day operations, treat it just like you did your surgical mask, so what we call our source control mask, right? So, if you wear it from breakfast to lunch and then you toss it out, then do so. If you get a fresh one then after lunch, go ahead and do so. If you take it off for a break, you can put it back on, so think about it the same way you think about the mask that we wear for source control in our day to day work.

Trish Kritek:

Okay, so just like the other masks, you can wear it most of the day. If you go to lunch and come back, get a new mask. But if you take it off for a little break, you can put it back on.

John Lynch:

Just like we've been doing.

Trish Kritek:

Your surgical mask.

John Lynch:

Yep.

Trish Kritek:

Okay, last question about masks. The other thing that people asked about is that they saw people wearing masks outdoors again now, and I've actually seen that too. I couldn't decide if people were doing that because it was freezing out, but there are people wearing more masks outdoors. Do we think there's a risk of getting Omicron outdoors that's different than there was with Delta and previous variants?

John Lynch:

I don't think we have good data on this. What we know is being outdoors is probably the safest place possible. I don't wear a mask outdoors, but I also don't go to large crowded, outdoor congregate areas, like for instance a professional sports game. In those settings, I would wear a mask. Omicron is showing us that it's way more transmissible and if I'm going to be around a lot of people, particularly if they're unmasked, I'm going to wear a mask in those settings. But as far as walking down the street, even in an urban setting, I don't feel compelled to do so.

Trish Kritek:

Okay, so no evidence that it's different in terms of outdoor spread. It's the safest place, but if you're in a place where you're around a lot of people then would recommend wear a mask. Just walking around your neighborhood, no.

John Lynch:

Yep.

Trish Kritek:

Okay, that's super helpful. Okay, thank you. I'll let you go back to the Q and A. Keri and Jerome, John kind of alluded to this, I think we had a ton of questions about, what about transmission from visitors and are we going to change our visitor policies? And then I saw an email that came out today, so I think I'll actually just ask you, Jerome first, and then Keri, to walk through what the current status of the visitation policies are for each hospital.

Jerome Mendoza Dayao:

Right, that is true. The visitation policy is always constantly under review. Right now at Harborview, we implemented the reduction of the visitation hours from 2:00 to 6:00 PM, effective today. So, I was out in the cold earlier, checking if lines are forming or anything like that. We're not seeing that. I also asked our security personal over there if they're seeing any issues now that we have recently changed our visitation hours from 2:00 to 6:00 PM and they're reporting not really. So, we're looking to see how that turns out to be for this week. Next week, there would be additional changes and one of the things being considered as part of that change is reducing the number of visitors from having two back to having one



visitor and visitation hours being subjected to each of the entities, policies or procedures as to how they manage that.

Trish Kritek:

Okay, so right now, Harborview is 2:00 to 6:00, still 2:00, and then, Keri, do you want to talk about what is going to happen at the UWMC hospitals?

Keri Nasenbeny:

Yeah, so at both campuses for UWMC, on Monday we will be implementing a new visitor policy that limits visitation to one designated, we're going to really encourage designated visitors for each patient. That's hard to enforce, so I'm just going to say that's not going to be perfect, but that's really what we're doing. Messaging is one designated visitor per patient, and that they can visit for an hour each day. And there are visitor hours, so they can come any time between 11:00 AM and 8:00 PM, so a little bit of a wider span there just for some operational reasons related to how we screen at our campuses, but really trying to limit the amount of time that they're in the hospital and potentially exposing staff. They still have to mask and they still have to show proof of vaccination or a negative testing.

Keri Nasenbeny:

And we're still going to have the same exceptions around caregivers, end of life, the CBC, our childbirth centers and L&D areas are going to have a little bit of a different policy, but that's in general going to be our approach. I'm not aware of any changes to our ambulatory, because they already are just one and really a caregiver, so I think they'll probably stay the course there though. There are some conversations going on around ambulatory, so.

Trish Kritek:

Okay.

Keri Nasenbeny:

That'll be our first step. And then I think as Jerome alluded to, we meet weekly about the visitation policy. And so, I think there's a distinct possibility it could change again.

Trish Kritek:

Okay, this is an evolving space. It's literally evolving today, so on Monday at UWMC, it'll be 11:00 to 8:00, I think you said, one visitor preferably the same visitor coming back, a designated visitor, for one hour a day. And sounds like, Jerome, some evolution towards that might be what happens at Harborview. This is going to be something that we're going to... I would just say people keep paying attention to what's coming out, because it's going to continue to evolve as we test these out. And I'll just emphasize, Keri said no changes to ambulatory accompaniment yet, but that may evolve as well.

Trish Kritek:

The other big questions were about staff. The first one is about what are we doing for creating safe places for staff to eat? So, John was talking about this and I would argue that seems to be one of the biggest challenges for people, is finding a place that feels safe to eat? Keri, you're unmuted, so strategies on that one?

Keri Nasenbeny:

I think they continue to be the same strategies that we've had, I think we really just need to reinforce them. So at the Montlake and Northwest campus, as we've closed a variety of spaces including conference rooms, all of our waiting rooms, other type spaces like that, we've opened up some additional areas for people to eat in. And so, I think we really just need to be very purposeful and intentional in encouraging people to use these alternative spaces, to be six feet apart, to wear masks when you're not eating, et cetera.

Keri Nasenbeny:

So, even if you are in one of those spaces and you're just taking a break, you should have your mask on if you're not eating. And so, that's really the approach that we've been taking. And also, those occupancy signs that we had up initially around how many people can safely be in that space, so I think we have sufficient spaces. It's really just a matter of that we really need to be intentional again, over on our messaging around using those.

Trish Kritek:

Okay, so we have the spaces, and Jerome, is that true at Harborview as well?

Jerome Mendoza Dayao:

That is correct. It's very similar our approach here. And I think that is further augmented that is the reason why we wanted to limit the number of foot traffic within the institution so that we can have those designated places for our employees to be able to take their breaks.

Trish Kritek:

Yeah, so we're going to use conference rooms and some of the waiting rooms like we have been before, and it's kind of reinforcing the message of, if you're not really eating, keep your mask on and keeping those distances and not overpopulating the spaces beyond what we're recommending.

Trish Kritek:

It's hard. I mean, it's way easier when you have an office like me to come to and eat as opposed to trying to find the space, so I just want to acknowledge that and I appreciate that we're finding places. One more question before I go back to John for a little whirlwind of potpourri questions. What are we doing about staffing with so many healthcare workers testing positive? We heard earlier more than 200 healthcare workers, so Jerome, what are your strategies on this? And then, Keri, I'll ask you.

Jerome Mendoza Dayao:

Well, I would admit that this is one of the challenges that truly keep us awake at night, trying to figure out the day after the day and you add the snow situation, that even becomes more challenging. So, we've been very fortunate that a lot of our staff had been very kind to pick up extra shifts, even though it's the holidays. And then we're seeing a lot of these call offs and people being out, because of quarantine or isolation, so that's one of the strategies that we've been using and relying on, are these extra shifts that staff are picking up. Incentivizing them continuing to do the double time for this critical positions that are needed in the hospital. We're also asking help from our travelers that are here, and moving their assignments so that they can work on the shifts that have more holes, so that we can safely staff the units.

Trish Kritek:

Okay, so incentivizing having people pick up extra shifts and then using travelers to kind of fill in holes where they exist. Anything else that you want to add to that, Keri?

Keri Nasenbeny:

I guess the other thing I would just add is that I think in recognition of what we saw coming a couple weeks ago, we added some additional travelers in anticipation of sick calls. And then finally, I think part of the reason why we're pulling back on surgeries is in fact because of our concerns around staffing. And so, not only creating capacity for patients, but also really thinking about what we can safely care for, given the constraints around staffing.

Trish Kritek:

Yeah, so the pulling back on surgeries allows us some flexibility with staff and not to be so stretched in the OR so I appreciate that as well. I think I also want to acknowledge what I heard Jerome say, which is that this is the thing that keeps you awake at night. And I know this has been something that people have been working in pretty much continuously through this holiday season and the storm didn't help at all, so thank you.

Trish Kritek:

John, I have about 25 potpourri questions of which I will definitely not be able to ask you all of them, but I'm going to hit some of them with you. I'm going to do my best. And you can tell Santiago that you missed it, because you didn't get to do some of these today. One of the things people are really worried about, this kind of risk of transmission and how it's different with Omicron, so the first question is, do we think that asymptomatic people are actually contagious?

John Lynch:

Yes.

Trish Kritek:

Okay.

John Lynch:

That's been true throughout and probably more so with Omicron.

Trish Kritek:

Probably more so with Omicron. I appreciate that. What about the risk of transmission from somebody who is boosted who gets infected? What do we think the risk of them infecting other people is?

John Lynch:

Probably less. If you want to point out, being boosted means that fewer of those people get infected in the first place, so that's a really important part that correlate, so if you're boosted, you're less likely to get infected, which means you're going to be less likely to transmit as a population, so think about the individual and the population.

Trish Kritek:

So, asymptomatic can transmit, boosted can transmit, but less so for sure and you're less likely to get infected, so I think the take home there was get boosted. That was a secret take home.

John Lynch:

Yes.

Trish Kritek:

Okay, two other questions that came up a lot that I want to make sure I get to is, do we think that people are getting symptoms faster with Omicron, that they have onset of symptoms sooner than with Delta and other variants?

John Lynch:

Yes, so there are some early data, again, we're early days in this wave of Omicron, but there's some really good data coming out of the UK and including a study that came out of Denmark, I made sure I got a lot of notes here, from an outbreak that they had there. And so, when we think about Alpha, remember that was the old strain last winter, looked like onset of symptoms from exposure to symptoms, about five days. Delta, maybe four days. With Omicron, it may be around two to three days.

Trish Kritek:

Okay.

John Lynch:

So, what we're looking at is, from that exposure, maybe two or three days till that symptom onset, which is going to make things a little bit tricky with testing access and turnaround time.

Trish Kritek:

Yeah, because everything happened so fast, so quicker onset-

John Lynch:

Not Denmark, Oslo. It was Oslo, excuse me.

Trish Kritek:

Okay, thank you for your European geography. How about, are there different symptoms, are people having different symptoms with Omicron?

John Lynch:

So, I'll say that one really important thing is with Omicron, there appears to be less loss of taste and less loss of smell, so when we look at, again, from the UK, there's a couple epidemiologists who have a kind of an app for the whole country. What they're seeing, most reports, most common things they're seeing are runny nose, headache, fatigue that's either mild or severe, sneezing and sore throats, so it does not mean that losing taste or smell means you have Delta, it just means it's much, much less common.

Trish Kritek:

Okay.

John Lynch:

So, it looks a lot like the cold and some of the early data coming out of the UK, somewhere between half and 75% of people who have cold symptoms, actually have COVID.

Trish Kritek:

I think that's super helpful, so this looks a lot like a cold, runny nose, sore throat, feeling achy, and it's going to come on faster, so I think many people might think they just have a cold, but it could be COVID and so you should get tested. Last question, and then I'm going to hand it over to Anne, and it's probably a little hard, but is it true there's some data that multiple people refer to in questions about waning effectiveness of the booster after 10 weeks, so are we worried that people's defenses from getting boosted are going to wane in the next three months after they get boosted?

John Lynch:

It is extremely hard to know what that timeline is and give it like an eight week, a 10 week... We know that neutralizing antibodies decrease over time, that is normal, that it happens with all vaccines. But what we're learning and some data just came out around Omicron, is that the next line of defense, your T-cells, these are like a long lasting type of immune response that we don't typically measure, only in a laboratory, those appear to be really good after boosted. So you not only have your antibodies, which may wane over time, just like any other vaccine, we have this other line of defense, the T-cells, that are ready to rev up and protect us against Omicron, Delta and other variants. So, I still feel very, very confident in the persisting protection of getting boosted, particularly.

Trish Kritek:

I love that. So boosting, antibodies may wane, they always wane, but the T-cell immunity, we've talked about that before with Santiago, persists and we think is good protection. I want to end with that and say thank you for answering a bazillion questions for me. Anne, hit it.

Anne Browning:

Awesome. I'm going to put Tim on the hot seat today, we've got a lot of questions, Omicron's crazy, new world order. Tim, would you go to a grocery store right now?

Tim Dellit:

Yes.

Anne Browning:

Would you go to the movies?

Tim Dellit:

No.

Anne Browning:

Would you go to a restaurant?

Tim Dellit:

Not indoors, no.

Anne Browning:

Is there any way to do a potluck in a safe way?

Tim Dellit:

Never a good idea for a potluck, if it's not COVID 19, it's norovirus.

Anne Browning:

It's like no cruise ships, no potlucks, people. Would you keep school aged vaccinated kids home right now?

Tim Dellit:

No, I think being in school is also really important for their overall health and wellbeing. And so, I think you have to balance that and we have to see how things evolve here, but I am still hopeful that we can keep kids in school. I think it's really important.

Anne Browning:

How about navigating kids under five who can't be vaccinated yet, would you try and keep them home? What are you feeling?

Tim Dellit:

Yeah, think of them almost as immunocompromised there, right? So, how do you try to bubble them so to speak? I would get everyone around them, so all the other family members who can be vaccinated, get them vaccinated, get them boosted. I would probably limit contact for those younger children with either other families that are part of your pod or very limited interactions right now, just because they don't have that same protection, so try to build a wall around them and limit exposure.

Anne Browning:

Thank you. Would you fly domestically right now?

Tim Dellit:

I would. I still think the airlines gives me a little bit of pause. I'm more worried about depending on what you're going to do once you get to the other side, as opposed to the actual exposure during the plane.

Anne Browning:

Good. What do you think about international travel right now?

Tim Dellit:

Personally, I wouldn't do it and I've canceled a trip, in part, because things are changing so quickly, it's very hard to know what the other local jurisdiction or government is going to do. And if I needed to have access to medical care or testing, it's just not as easy in that context. But the big thing is, you just don't know what's going to happen in terms of requirements around traveling and getting home. And we have seen people where, if they do become infected, then all of a sudden they have to isolate there and you

have to have a negative test before you can get back to the States, so it's a little more challenging right now, I think, for international travel.

Anne Browning:

Thank you. Would you go to a gym right now?

Tim Dellit:

No, but I wouldn't go anyway.

Anne Browning:

If you worked out, would you wear a KN95, which whoever is working out in gyms in a KN95, I'm not sure that's a good idea to start with, regardless of COVID.

Tim Dellit:

No, I wouldn't.

Anne Browning:

How about for new year's? Would you get together with a couple families if everybody did like antigen testing beforehand, like the rapid testing?

Tim Dellit:

No, we live in an environment where everyone around us has been boosted and there were some anticipation of maybe a dozen people getting together and we've canceled that. I think, unfortunately right now we really got to go back to that pod concept and really limit exposures, just given the transmissibility, even if everyone's been boosted, it's a very different environment right now.

Anne Browning:

Good. Tim, thank you, that was a crazy amount of rapid fire very fast. And with that, I'll hand it back to Trish.

Trish Kritek:

And I'm going to say a huge thank you. First, a thank you to everyone on the panel for rallying to do town hall, our first Wednesday town hall ever, I really appreciate it. Thank you to the lots of you who send in questions, very much appreciate it. A huge thanks to our healthcare teams who have weathered a real storm and a tsunami of Omicron and all the challenges that have been happening in the midst of the holidays. This has been really hard and I'm so appreciative of everybody who's been doing such hard work. I want to call out specifically the infection prevention teams who have been working literally 24/7 trying to respond to all of our healthcare workers who have needed testing and guidance and support as we weather this storm.

Trish Kritek:

So, I'm incredibly grateful for all of you. I will end as I always do and this time for real, that this is our last town hall for 2021. I am incredibly grateful for all of you for all of the support you've given to each other, so I know that we will get through this next challenge and it will be a challenge, but we will get through it like Anne talked about, together. So, thank you for continuing to take care of our patients,

their families, and really right now, continuing to take care of each other. We'll do this together. We'll see you, for real this time, in 2022. Bye-bye.

Anne Browning:

Happy new year, you all.

Trish Kritek:

Happy new year.