Trish Kritek:

Welcome back to UW Medicine Town Hall. I can't even say welcome today. I'm Trish Kritek, the associate dean for faculty affairs. And with us today are Dr. Santiago Neme, medical director at UWMC Northwest and actually on service as a hospitalist right now. So thank you for taking time out, Santiago to join us. Tim Dellit, chief medical officer for UW Medicine, Anne Browning, assistant dean for well-being, Keri Nasenbeny, chief nursing officer at UWMC Northwest, Tom Staiger, medical director at UWMC, Cindy Sayre, chief nursing officer at UWMC, John Lynch, head of infection prevention and employee health at Harborview Medical Center, and Jerome Dayao, our chief nursing officer at Harborview as well. Rick is away today.

Trish Kritek:

Welcome back. Holy cow. This is quite a start to 2022. We had over 250 questions come in since our last town hall. I know that doesn't even start to cover the amount of questions people really have. So we have a lot to try to cover today. I'm going to be moving us through it, but it's important to start as always with a wellbeing message from Anne. Anne.

Anne Browning:

Hey, y'all. It has been a tough week in and out of our hospitals. After a winter break, we've had kids going back to schools. I've already been hearing about folks who have had positive exposures to classrooms and are needing to quarantine. So just recognizing that that is a continued and ongoing challenge for many folks in our community. The snow that seemed festive for a little bit is now shutting down our passes and the current deluge melt situation is nuts in terms of our rivers. I feel like we're about to float away on a raft made out of positive Omicron tests.

Anne Browning:

It's a bit intense right now, all across the board. And in talking with folks across our system this week, we know that staff are just working flat out and really it's becoming hard to even get our basic needs met for folks to have the time and space to eat and drink and take care of their own wellbeing while doing everything they can to take care of the folks in our community who are passing through our doors.

Anne Browning:

So thank you all so much for what you're doing and just recognizing that it's really, really, we're in a tough spot right now. I think in terms of wellbeing, just recognizing this will pass, we will get through this, we will get over this peak and we're in this and just working to try and get over this wave right now. So hang in there, but we recognize and feel that folks are really, really strained right now.

Trish Kritek:

Yeah. Anne, thank you. That's definitely what I've been feeling too. I appreciate your sentiment that we will get through this and we'll get through this together as we have through other surges before, but it feels hard right now. Tim, I'm going to turn to you actually first today and maybe give us a sense of where we are as a system and how that fits into what's going on in the state to start with.

Tim Dellit:

Thank you everyone for joining us here again. I think both Anne and Trish highlighted two keywords. This is really hard right now. This is really tough. I think people are just at their wits end, quite frankly.

Two years into this to think that we are now on the sixth surge. Now, this surge, I do think it's important to spend a little bit of time talking about how this is very different and everyone feels that, right? The intensity this week is much more. In fact, it reminds me of March and April of 2020 in many ways, given the intensity.

Tim Dellit:

So I think everyone is feeling that. With the emergence of Omicron, we have seen literally an exponential rise in cases in our community that is still going up. We're now at over 1,000 cases per 100,000 over the last seven days. We had 5,000 new cases in King County just yesterday. So we are seeing this dramatic increase in cases well beyond what we've ever seen with any of the surges. And we're now seeing increased hospitalizations rapidly increase. We're up to 144 patients, which is the highest that we have been as a system throughout the pandemic.

Tim Dellit:

Our previous highs were 124 back in April of 2020 and December of 2020. Right? Again, it's hard to imagine that we are back here. What's unique here is the impact on our staff. We have over 700 employees who are out either in isolation for infection or in quarantine because of exposure to a known case. We never saw that much impact on our staff before. And that is causing real challenges when you combine really incredible capacity challenges with a lot of patients in our hospitals, as well as staffing challenges. We have staffing challenges even before this last surge nationally in healthcare, and it's just been exacerbated at this level.

Tim Dellit:

Now, the good thing is that overall, most of these cases do seem more mild than perhaps what we've seen before, but the sheer volume of cases has led to increased hospitalization. Now, the parameters are different. Historically, we often talked about maybe half the patients were in the ICU and half on acute care. Now, it's about 80% of people in acute care. And even there, it's a mix of individuals who are admitted for COVID-19 symptoms themselves, and some people who are admitted for other medical or surgical indications and happen to be infected with COVID-19. But that shift to acute care is different.

Tim Dellit:

Now, we are still seeing some critically ill patients. So I don't want to minimize that, but the majority do have more mild symptoms. Fortunately for our staff, our employees, almost everyone, 99% of you are vaccinated. The vast majority of you, probably 80% have been boosted as well. And so again, we're seeing mild disease, fortunately in our employees as well. But just being out of the work environment has really caused significant impact.

Tim Dellit:

People are feeling this., And I just want to acknowledge that what you are feeling at work is very different. We're taking care of patients in places that we typically would not take care of them. We have had to shift staff in ways that we typically would not need to do that or change staffing ratios. We've had to postpone non-urgent surgeries, both because of capacity, but also quite frankly, because of staffing and sometimes the need to shift staff from the OR to other areas to be able to continue to provide essential services.

Tim Dellit:

So when we look at all of that, we are in contingency. So if you think of our surge planning, what are we doing around our staff, our space, our stuff, we're in contingency both in terms of our space that we're using in terms of our staffing and how we're approaching that. So that is very different and it feels very different for people. And you're absolutely right.

Tim Dellit:

I do want to touch on one more thing is that people are really feeling that they're in crisis right now. I totally understand that we are in the midst of a public health emergency. It feels like a crisis, but I want to differentiate that from a very specific term crisis standards of care. We are not in crisis standards of care. In this contingency phase where we have adjusted our staffing, adjusted our spaces, we are functionally providing the same standard of care.

Tim Dellit:

Crisis standards of care means that you have such a shortage of a given resource that now that's when you start to have triage teams basically deciding who can use that scarce resource. The best example is a ventilator. We are not making decisions on who gets a vent or who doesn't.

Tim Dellit:

We are still caring for each individual patient based on their medical needs and their desire. Crisis standards of care, you shift to managing a population. It's a very different approach and we are not there. So I just want to keep that distinction clear as we think about where we are. Acknowledge the difference that we're doing, but also that we're not in crisis standards.

Trish Kritek:

Yeah.

Tim Dellit:

Now...

Trish Kritek:

Oh, sorry. Go ahead. Go ahead.

Tim Dellit:

The one thing that I just wanted to ask everyone, and just as you're talking with friends and family in the community, one of the things that we have not seen as much right now as we did very early in the pandemic, we've got to push out efforts to prevent the transmission of COVID-19 in our community to help decrease the impact that it is currently having on our healthcare systems.

Tim Dellit:

And it's not just UW Medicine, it's all healthcare systems in our state are really suffering right now, overwhelmed with patients staffing challenges. And we've got to refocus on those preventive aspects within the community to decrease that transmission, to try to decrease the pace that's coming at us right now.

Tim Dellit:

I just want to highlight that because sometimes we get so focused on responding to the patients, responding to the pandemic that we've got to step back and think about what can we do to try to prevent this onslaught of patients that we are currently experiencing?

Trish Kritek:

All right. You said a lot and I'm going to highlight a couple things. The first is an exponential increase in infections and a really dramatic increase in hospitalizations. Not as much in critical care, which it feels different to me, but it is exhausting lots of people in our hospitals right now. The second is you said we're a contingency status, and I think people are feeling that. We want to acknowledge that we are a contingency in terms of staffing and space right now, but we're not in crisis standards of care, which is a very different phase.

Trish Kritek:

Then we're going to keep coming back to what we can do to keep decreasing the burden that is making everything so tenuous in our healthcare systems across the city, the state, and truthfully the whole country right now. A bunch of follow up questions, Tim, before I go to John to dig into those numbers a little bit more. Lots of questions about, are we recommending now doing more remote work again?

Tim Dellit:

Yeah, and people may have seen the message from Ana Mari. So we are absolutely encouraging at the individual unit level use discretion to identify those activities that can be done remotely. And if you can do that safely while continuing operations, now is the time to do so, particularly through the rest of this month. So we are encouraging that clinically an example of how we're doing that, we're shifting actively towards telemedicine again. So we are contacting patients. We're seeing if they are able and willing to do telemedicine, then we are shifting those visits.

Tim Dellit:

So we are really trying to focus on decreasing the overall density. Now, it's hard in the clinical environment, but are in our nonclinical spaces, we really want to decrease that density whenever possible to minimize that risk of exposure.

Trish Kritek:

Okay. So encouraging remote work, wherever possible, encouraging telemedicine wherever possible, and then I think you alluded to, but Ana Mari said, you can teach remotely through the end of January, at least, and then we'll see where we are. So really trying to keep people hunkered down a little bit more than we had recently. What are we doing to ramp up testing? Because a lot of questions came in about, "I can't get tested. I don't know where to be tested." I'm going to ask you, John, a lot of questions about when to test, but are we doing to things to ramp up the testing capabilities?

Tim Dellit:

Yeah. Our testing sites are really overwhelmed right now. And the testing sites, particularly UW Medical Center Northwest and Harborview, we're really trying to preserve the ability to have access to testing for our employees. We want to be able to test their household members as well. And then we're still doing pre-procedure testing. We have been working with the services to try to decrease... In some situations we may be doing pre-procedure testing for procedures that don't need testing.

Tim Dellit:

So in those situations, we want to try to minimize or eliminate that so that we can continue to offer testing for our employees and their household and family members. When you look at the broader from a lab standpoint, there's an article in Seattle Times with Jeff Barrett, who's the chair of laboratory medicine and pathology, because the positivity rate is so high, they can no longer pull samples.

Tim Dellit:

What that means is previously when the positivity rate was less than 10%, they could take six samples, take a little bit from each one, mix it all together, test it. If it's negative once, it's negative for all six. If it were positive, then they go back and test each one individually.

Tim Dellit:

Now, they have to test each sample individually. So their capacity is about eight to a 10,000 per day compared to 15 to 20,000 before. But the real challenge we're having internally is at our testing sites. We've got to preserve that ability to offer for our employees and their household members.

Trish Kritek:

Okay. So Harborview and Northwest are prioritized for healthcare workers. We're not able to run as many because we can't pull because so many are positive now, which we're seeing across the community and trying to facilitate getting few... Like only testing before procedures where you really need to test before procedures. So I appreciate all of that.

Trish Kritek:

One last question, and if I have time, I might come back, but I know you have to leave early today. People are worried about masks. I'm going to ask, I'll ask John more about masks in a minute, but have we discussed making N95 or KN95s available for our folks to purchase or give them to for free for outside of work? Because I think people are worried about community exposures.

Tim Dellit:

Yeah. There's the definitely a lot of emphasis as John's messages have said. Within the clinical environment where we are providing those, whether they be KN95s, KF94s encouraging the use of even non-fit tested N95s outside of aerosol generating procedures or airborne isolation areas. Those respirators are clearly important in patient side, both as source control because up to 30% of people with Omicron may not have symptoms, maybe even higher, but also to help protect our employees and our patients. So we have leveled up our masking and we recommend that.

Tim Dellit:

Right now, I'm not aware of our ability to provide that or outside of the work environment. It's a very good question. I just don't right now know if we're able to do that for people, but I understand the question, but we are really focusing within the healthcare system to ensure when you come in to work that they're available.

Trish Kritek:

Okay. So the priority is making sure we have them for the folks within the healthcare system. We'll put it on the list of things that are sometimes good suggestions that come in through town hall, which is quite

common. Thank you for all of that. That's a lot of information. I think it captures a lot of how people are feeling right now, which is how different it is.

Trish Kritek:

John, I'm going to come to you. Tim already told us that there's 144 patients across the system today. I wondered if you could give the breakdown, and he alluded to the difference between acute care and IC, but maybe you could give the specifics.

John Lynch:

Yeah, sure thing, Trish. And Tim, thank you. That was an amazing summary. That was just-

Trish Kritek:

It was. Thank you for acknowledging that.

John Lynch:

Yeah. So across the system, we have 144 patients. I would like to make just one little outside comment there. If we go back to December 26th, which is what two-ish weeks ago, we had about 30 patients.

Trish Kritek:

Wow.

John Lynch:

So going from 30 to 144 in the short amount of time is astounding. When we look at the breakdown across the facilities, Valley, and this is of 6:00 this morning as always, 53 patients at Valley. Northwest is at 17. Remember they were at zero two weeks ago or so, two and a half weeks ago. Montlake at 30-ish, Harborview at 44. As Tim mentioned, the vast majority of the patients are in acute care. So at Valley, it's 44 out 53, 15 out of 17 at Northwest. 21 out of 30 at Montlake and Harborview 34 out of 44.

John Lynch:

That is remarkable because especially at Harborview and Montlake, it's been the complete opposite for almost the entire pandemic. So lots and lots of people in our acute care facilities and that number just ramped up so, so fast.

Trish Kritek:

I appreciate that-

John Lynch:

Can I just mention the Seattle Children's numbers?

Trish Kritek:

Yes. Oh, please. I was going to ask you them, but yes, please.

John Lynch:

Okay. I should have waited for you.

Trish Kritek:

No, no. Go my friend, go.

John Lynch:

I think this is another one that's actually really important. Seattle Children's is up to 21 patients, which I think, Trish between the last three days went up double basically. 19 acute care, two in the ICU. So a lot of kids getting COVID. I just want to clarify kids get COVID too and some of those kids are in the hospital.

Trish Kritek:

The reference numbers were really helpful for giving a number to that exponential increase. I think also, again, highlighting the not nearly as many of these people are in the ICU. I will just say in my world, it feels very different. Whereas in Santiago's world, it also feels really different because there's so many more in our hospital, acute care and wards right now in other spaces. The most common question, and you and I have talked about this already is how many of these people have incidental? And I'm going to say, that's not a perfect word, but we've learned that they have COVID or they test positive for COVID when they're coming in the hospital versus they had things related to COVID that brought them into the hospital. I wonder if you could just talk to that a little bit.

John Lynch:

Yeah. And please cut me off here if I go too long. So the first thing I want to do is caution people. So I definitely... Clearly, Omicron is a less lethal, less dangerous disease compared to the prior variants. So I just want to make that clear. We see that in the acute care versus ICU numbers. But it is definitely a way more transmissible and probably has a lot of asymptomatic carriage like Tim mentioned.

John Lynch:

So when we look at our cases, and so our infection preventionist who work and review these cases at all of our campus, they go through all of them looking at whether they need to be isolated or cohorted or so forth. They are observing that a lot of these patients on our acute care teams, especially are not coming in with pneumonia, they're not coming in with a cough. They're not coming in with those respiratory symptoms.

John Lynch:

The reason I say caution is that COVID causes a lot of things. It can cause pneumonia. It can cause a sore throat. It can cause a runny nose, these upper respiratory tract things. It can also make someone's diabetes worse. It can cause something like diabetic ketoacidosis, a complication of maybe diabetes is pretty fragile. We know it causes clots in some people, things like pulmonary embolism. Maybe even make stroke risk worse.

John Lynch:

So parsing that apart can be really hard. So what we're doing, we're engaging a project right now. And I just want to give a shout-out to at least one of our infection preventionists here at Harborview who is named Buddy Decker, who's going to go through every single one of our 50 patients. She's going to figure out whether they're completely asymptomatic, mildly symptomatic or symptomatic from COVID. And that is going to give us some insight into what's actually happening, but it takes that level of investigation to actually do that work.

John Lynch:

Dr. Tara Bernstein, our chief medical information officer actually pulled some numbers earlier this week as well, and I think it also helped us with this. If you do just look at the assigned primary diagnosis, if you look over the course of December and then this last week or so, the number of people who come in with no COVID diagnosis, with a positive test was pretty low and it stayed low compared to the people with a COVID diagnosis and a positive test.

John Lynch:

Then all of a sudden in the last week of December and those first week of January, they became almost the same. So the number of people with a COVID diagnosis or without a COVID diagnosis had about the same number of PCR positive tests, which is sort of indicative signal that we're seeing a lot more people who aren't coming in for COVID, but are coming in with COVID. But among that with COVID population, I'm always cautious that maybe some part of their disease process is being exacerbated by their infection.

Trish Kritek:

Yeah. Okay. That's really helpful. So it sounds like about 50% of folks are coming in, as you just said with COVID. Another way I like to think about it is they're not coming in with the classic respiratory failure and hypoxemia, or low oxygen levels that we saw before, but maybe some of the other stuff that's bringing them in the hospital is really due to COVID too and that's what's hard to tease out, but clearly, it looks different as it comes in, but it sounds like around 50% is where you're coming roughly.

John Lynch:

Roughly, and we're going to learn more. Actually in the next 24 hours, we'll have even better information thanks to Bonnie's work. The other thing that I'm a little uncomfortable about is if you look at King County numbers, the death rate due to COVID is actually climbing pretty fast.

Trish Kritek:

Okay.

John Lynch:

Generally, that's a lagging thing, two to four weeks out and it's not matching up with the hospitalization numbers in the same way. We're two weeks into this, maybe three weeks into this. So I want to be cautious. I think everything I just said is true, but how this plays out over the next four to six, eight weeks is still up in the air.

Trish Kritek:

Okay. More to come on this, and I appreciate it. People are very curious. It doesn't change how stretch our hospitals are regardless of which of those buckets people fall in. The other thing people ask about is vaccination status. Do you have data on vaccination status of folks who have been admitted?

John Lynch:

Yeah. I didn't get the data concretely right now. I will get that for our next one. But what I can tell you is that this is another area where interpreting that data has to very cautious. In King County, we have very high vaccination rates and where we're seeing a lot of asymptomatic infection or maybe people

admitted with COVID as opposed to for COVID, a lot of those people are vaccinated because we live in a highly vaccinated place.

John Lynch:

So it looks like a lot of people in our hospital have COVID and are vaccinated, but that is because we're a highly vaccinated population. If we went to another part of the country where vaccination rates would be lower, we'd be seeing a lot more people who are unvaccinated with COVID, probably more people with severe disease as a result. It is clear that vaccination continues to keep people very safe.

John Lynch:

The one place where I would say that there's a signal is that the boosted population are very rare. We're not seeing people with COVID in the hospital either for, or with who are boosted. So that does seem to be a pretty standout signal right now. So again, a really strong indication that getting fully vaccinated now is three shots for those mRNAs. It's getting that booster.

Trish Kritek:

Okay. So I think we're going to keep working on these data because lots of people are asking about them, not just at town hall in general. So we're going to come back to you with more data on this. However, what I heard John say is there are people who are vaccinated or in the hospital with COVID, maybe some for COVID. We'll find out those numbers. But boosting very rare to be in the hospital right now in either bucket. So thank you for that. I appreciate it. What percentage of case is are Omicron in our community in general right now?

John Lynch:

Yeah. Thanks to the amazing work of our UW clinical virology lab and data shared by Dr. Pavitra Roychoudhury. We're over 88, 90% of all COVID right now is Omicron here. That means there's still a signal of Delta out there, which again, this feels very different than prior surges. Delta was clearly a much more dangerous variant, much more lethal for a lot of people and it's still out there. We're still, I would say in a transition phase, whether we get to 99% like we did with Delta, I think we're not quite sure yet. But right now probably 88 to 90%.

Trish Kritek:

88 to 90% Omicron. One question that a lot of people ask is can you get Omicron and Delta at the same time?

John Lynch:

Yeah. So I did send out an email to those experts just a little bit ago. It might have been a little too late. Sorry, friends.

Trish Kritek:

No problem.

John Lynch:

But I did search around for this and I found a couple of media of reports of dual infection with Omicron and Delta, but I want to be very, very cautious. Media reports, very, very rare. And one thing we do want

from the scientific side is that it appears unlike having Delta before, Delta infection does not protect you against Omicron but appears that Omicron protects you against Delta.

Trish Kritek:

Oh, okay.

John Lynch:

So unless you're in a place with a lot of exposure where there's lots of Delta and lots of Omicron and you'll probably have these case reports, probably people who have comorbidities and maybe some measure of immuno deficiency where they both jump in at the same time, getting Omicron seems to be helpful against pushing off the Delta.

Trish Kritek:

Okay. So if you had Omicron, it seems likely that you'll get Delta and we'll come back to it if we need to, but I think we have other things to worry about in the moment. So thank you for trying on that one.

John Lynch:

Not a big worry right now.

Trish Kritek:

I will also come back... I have to talk to you about masks, but I actually want to talk about isolation and quarantine first. So what is our current policy around return to work after infection? Or another way to say that is how long do people need to isolate after they have COVID right now for healthcare workers first?

John Lynch:

Yeah. So we talked about this a little bit last week, but we've continued to evolve in this and I'd say that's one of the things that I'm so appreciative of everyone on this audience right now is their ability to be flexible as we continue to respond and modify our approaches. It can be overwhelming at times. So the first thing is our basic take home here is from the time of symptom onset or your first test, positive test, if you have no symptoms.

John Lynch:

Generally, our isolation approach is 10 days. Now, the CDC came out with guidance that for people who have had who have been recovered, basically, you could potentially get them back to work depending upon the same sort of thing that Tim was talking about, contingency crisis or conventional status. In UW Medicine, we are taking a slightly more conservative approach given our contingency status here, and we have basically three options.

John Lynch:

Either people continue to have symptoms, they stay home for 10 days or more. We want people to get better, right? So if you're sick, stay home, get better, take care of yourself. That's important. Your colleagues support you in that and we support you. If you have symptoms and you're better, and you have no fever and just generally feeling ready to work, we can test you on day seven.

John Lynch:

We're mailing out as of this week antigen tests to those folks. Mostly we're going to start with folks in the patient care footprint, so the clinical footprint first. We're mailing them antigen tests. And if their test is negative on day seven, they can come back to work. We're working that after evaluation and conversation with employee health teams. So we're reviewing those negative tests, making sure you're feeling asymptomatic and ready to return to work. Sorry.

Trish Kritek:

I know.

John Lynch:

Yeah. And then the last one is if you had never. Say you had an exposure or you were traveling, when you could get tests for travel and your test was positive, but you're fine otherwise, we're allowing those people to get an antigen test. Again, we're mailing them out to people. If those tests are negative in day five, you can come back to work and ready to go. So that's our big modification around infected, isolated health workers.

Trish Kritek:

Okay. I'm going to say it back. If you are infected and you are isolating, if you never had symptoms. You're asymptomatic, five days, isolation, antigen test, test it. If it's negative, you can come back to work. If you have symptoms, you need to have your symptoms go away. If they go away quickly you can-

John Lynch:

Improved. Yes.

Trish Kritek:

Oh, improved.

John Lynch:

Yeah, it's not go away.

Trish Kritek:

Significantly improved. You can test it seven days. If you have persisting symptoms, you're going to be out 10 days, at least, and longer. If you're still symptomatic, we want you to get better before you come back to work. Okay. That's an evolution. So thank you. And we'll keep talking about that. How about for non-healthcare workers? Because again, there's that question about what's UW 's guidance, particularly in the school of medicine versus the CDC?

John Lynch:

So the University of Washington, I think across our entire spectrum supports the CDC recommendations for general public. What that basically means, and it was updated since we last talked as we intubated last week. So right now the CDC guidance for general public, which we support is that if you have COVID-19, after five days, if you are feeling better, no fever and your symptoms are improved, you can go back out to your general, whatever activities while wearing a mask for the next five days.

John Lynch:

I mean really rigorous around that. Now, the updates since last week is that they did say if you choose to... You can choose to get an antigen test. If that antigen test is positive, you should stay isolated for five more additional days. So retreating back for the prior 10-day isolation period. But if the antigen test is negative, really robust masking for those next five days.

John Lynch:

I think that was a result of a lot of feedback they got over that week, that the guidance came out. So as providers, as community members, we should be supporting those public health recommendations right now.

Trish Kritek:

Okay. So it's five days and then masking for five days. Five days, if you do an antigen test and it's positive, then it's 10 days.

John Lynch:

Yeah. I know you made this point about school of medicine. There are other guidance for educational institutions. So I'm just saying this applies to the clinical oriented UW medicine folks. I understand there's people who have a footprint in the upper campus and so forth and you should really be checking the EH&S, Environmental Health and Safety website.

Trish Kritek:

Okay. That's actually what I was asking you. So you are not able to clarify the EH&S guidelines.

John Lynch:

I don't know them off the top of my head. I will look them up while we're sitting here. I would just hesitate because there's K through 12 guidance, and I think the university was still working on where they're... I think right now they want to do stick with it 10 days because they have students who can stay home and do hybrid learning. Not stay home, but stay in their domiciles and so forth. But I think that that is still a discussion.

Trish Kritek:

Okay. I think we want to clarify that. If we can't clarify today, we will clarify it moving forward, but if we can clarify it, that's great. I'm going to give you a break for a little bit, because you just answered a ton of questions and I'm going to pivot to Santiago for a few. Thank you, John for all of that. That was a lot. Lots of people have gotten infected.

Trish Kritek:

I think a lot of those people are asking the question, when should I get a booster with respect to having just been infected if they're not boosted yet?

Dr. Santiago Neme:

A recommendation is to get it as soon as you've recovered if you've had your second dose six months ago. Right?

Trish Kritek:

Okay.

Dr. Santiago Neme:

So you have to be eligible and then as soon as you've recovered.

Trish Kritek:

So if you're eligible mean you're months after the last dose and you're feeling better, get your booster.

Dr. Santiago Neme:

Yeah.

Trish Kritek:

What is our recommendation for 12 to 15 year olds around boosters now?

Dr. Santiago Neme:

The boosters have been approved for that population. So then you get a third dose after the six months.

Trish Kritek:

Same kind of thing that we've been doing for older folks. And we're that?

Dr. Santiago Neme:

Yeah.

Trish Kritek:

Okay. What are the therapeutics we're offering now? Because I think Tim tried to do it for you last week and he did a great job, but I'm glad to have you here today.

Dr. Santiago Neme:

So we currently have an assortment of options. We have the monoclonals. We have Sotrovimab which is effective against Omicron for that monoclonal. We follow the tier 1 NIH criteria. I'm going to put the website of our therapeutics team online on the chat for folks to see, because there's excellent links that Shireesha Dhanireddy and Rupali have put together for folks to just directly have access to what's current because it's been really dynamic and changing.

Dr. Santiago Neme:

So there's that monoclonal for folks. And again, it's more of a selective criteria now. It's more limited because of low supply. So these are for severely immunocompromised patients.

Trish Kritek:

High risk folks.

Dr. Santiago Neme:

Right. Or folks who are over the age of 75 and unvaccinated or over the age of 65 unvaccinated plus comorbidities. So very restricted criteria. We also have the oral medication, Paxlovid which is the Pfizer drug, very effective drug that we've already been giving. We utilized the same criteria. These are for the same NIH tier 1 folks. We also are about to launch Evusheld treatment for those who need pre-exposure prophylaxis. Again, a very select subset of patients. And the information again will be on the website.

Dr. Santiago Neme:

Because the case counts have risen so high, the number of referrals and the number of cases, I will review within the system is very, very high. So special thanks to Shireesha, Rupali, Jean Chang and multiple folks who are helping review. And obviously, doctors, Lu and and Pergam from SSCA. We have a really good team and we're all helping and try to slot the patients in as much as possible. And the ER's also who have been actively helping with this since the get go.

Trish Kritek:

Okay. So we have the monoclonal antibody that's active against Omicron and we have the oral Pfizer drug now, and we're starting to also use this prophylactic medicine for folks who are immunocompromised. And for all of these, it's people who are super high risk and there's a lot more demand than there is supply. You answered one of my questions, which is, do we have a centralized place for outpatient providers to access this information? And it sounds like you're putting the website in now, so that people can-

Dr. Santiago Neme:

It's right there. And please look at the links. They're hard to see because they're faint, but you can see all of the NIH guidelines, everything. It's a very equitable process. We follow this to the T. There's no flexibility. It's very solid and rigid.

Trish Kritek:

I appreciate the emphasis on equity as always. I'm going to ask you two more questions. Ages ago, I think you and I talked a lot about fomites. So one of the questions that people have asked a lot is, is there evidence that there's transmission by fomites for Omicron? In other words, stuff that you might touch and pick up on your hands off the surfaces?

Dr. Santiago Neme:

I would say from the get go, we've known that COVID can be transmitted through fomites, but it's not the primary mode of transmission. Unfortunately, the primary mode of transmission is airborne transmission. That is, this virus is suspended and those small droplets that stay suspended, and this is why folks get infected without even touching anything. It's just about the environment. It's the ventilation. It's the barrier that you have with your mask. And this is why there's so much emphasis in leveling up your mask, because you want to have that protection.

Dr. Santiago Neme:

That being said, you always want to be in a clean environment, but I would say number one is not really the gloves, it's your mask. As John has been saying is that three or more layers. If you're in the hospital, it's respirators, right? If you're outside also level up your mask. It's about reducing that viral load that you encounter as well.

Trish Kritek:

Yeah. So maybe a little bit, but that is still not the predominant way of transmitting. It doesn't mean you shouldn't wash your hands folks. But at the same time, it's really the masking and the droplets that we've been talking about for quite a while.

Dr. Santiago Neme:

Exactly.

Trish Kritek:

I will talk to John about masks in a little bit, so I appreciate that. I'll let you off the hook and I'll pivot to our chief nursing officers for a little bit. Cindy, I'll start with you, and then Jerome. Are we evolving our visitor policy with this exponential growth in cases? And if so, how so?

Cindy Sayre:

Yes. Well, as of January 3rd, we have changed the visitor policy to be more restrictive. And that is at all of our sites. It's carried out a little bit differently, I think at Harborview than it is at Montlake and Northwest, but for Montlake and Northwest, the visiting hours are 11:00 to 8:00, I believe. One visitor for one hour. Designated visitor, trying to have the same person each day come in. And then we have all of the same exceptions that we've had throughout the pandemic.

Trish Kritek:

Okay. So it's the same as when we last met, which is one visitor for one hour. Hopefully the same visitor in those hours. And then Jerome, I think you have the same policy, but slightly different hours. Is that right?

Jerome Dayao:

Yeah. Very similar. The only difference is at Harborview, our visitation starts from two to 6:00 PM.

Trish Kritek:

Okay. Thank you. Are we considering going back to no visitors? That was an exceedingly common question.

Cindy Sayre:

I think what the visitor task force works with our med tech team very closely and it's all based on the community transmission rates. I would look to my other colleagues to hear more about those discussions. It wouldn't surprise me, I think is what I mean.

Trish Kritek:

It would surprise you if we would-

Cindy Sayre:

Would not surprise me.

Trish Kritek:

Would not surprise you.

Jerome Dayao:

Right. Well, as what Cindy is saying, it's not out of the picture. I mean, we consistently still meet. There is a visitation committee that discuss this. We get insights from our infection control partners. They make recommendations. But the important part here is two things is reducing foot traffic within the organization, so that there's less risk for that exposure. And the other part there is really enforcing the masking and this basic precaution.

Jerome Dayao:

I mean, we also have moved into making sure that our staff are wearing the best masks that they can fit. So that's also part of that prevention so that we can continue to have visitation and because they're also impacting our patients and equity in general. So it is a delicate balance that we have to consider.

Trish Kritek:

So efforts to maintain some presence of family is important for our patient care and for our patients. And we continue to assess it based on what's going on in the greater community. John, you had unmuted so I didn't know if you wanted to say something. I saw that.

John Lynch:

Yeah, I was going to take a pass, but Cindy did ask, she put it out there. I would say from the medical technical perspective, the idea of the possibility of turning off visitation is definitely on the table. As Jerome mentioned, decreasing density foot traffic is really important. Giving our healthcare workers space to eat and to drink is really a big part of that as well. So they can take those respirators and those masks off safely and have a breather. And that's certainly part of it.

Trish Kritek:

Okay. So I hear that.I think it's the same tension we've had and it's a little different because the masks that people are wearing are harder and the need to distance is a little different. So this is going to be an ongoing discussion. I'm going to keep asking it every week, and I think we may see that evolve is what I heard. Keri, John brought up something that actually was also a pretty common question, something Anne and I have heard a lot, which is people worried about safe places to eat and drink and take off their mask for a little bit. So can you talk about what we're doing to create more of those spaces or prioritize those spaces?

Keri Nasenbeny:

Yeah, I think across all three entities, we're doing sort of a similar thing, which is repurposing common areas like waiting rooms or conference rooms as eating spaces. I think the other thing we're trying to do is really encourage our teams to stagger their breaks so that as they move into these spaces, there's not many of them. It's a challenge and I think as a challenge that our teams are working through every day.

Keri Nasenbeny:

I think the other thing that we've done in all of our organizations is create more designated like we have a couple other spaces that are designated break spaces as well, in addition to those waiting areas or team rooms. It's not perfect and some of them are a few minutes walk. And what I've told people is if

you need to extend your break by few more minutes so that you can get to that space, please do. I would rather you take a 20-minute break instead of a 15-minute break so that you can eat safely.

Keri Nasenbeny:

But I do think it's important that as much as possible, and this is not easy is people are trying to plan and stagger their breaks so that not everybody is going to lunch at the same time or breaks at the same time and then really using those alternative spaces. So it's definitely still a work in progress and something I think is on top all of our agendas.

Trish Kritek:

Okay. So we're working on it. We're adding some spaces versus staggering breaks and allowing longer breaks to get to the spaces if they're far away and we're going to keep working on finding those locations. Jerome, the other thing that was super common and it's not something new is what are we doing about to try to maintain staffing right now?

Jerome Dayao:

Well, we're still utilizing our strategies of having travelers, asking people to work double time, getting all of those, including utilization of care and nurse extenders from our clinical spaces into the inpatient spaces. In fact, in the last weekend we were able to fill about 40 shifts into having these individuals come and help us.

Trish Kritek:

Okay.

Jerome Dayao:

So those are the strategies that we've been utilizing in there to achieve that.

Trish Kritek:

Yeah. So similar to what we've been doing all along and more use of these care extenders, nurse extenders. Cindy, did you want to add to that on staffing?

Cindy Sayre:

Same strategies at Montlake for sure. I think one thing I would say is that as we move into this contingency phase, and we've been in and out of it over the last probably two years, but really I foresee us being more in it for the next few weeks. Really important for all of us to think about the fact that every patient in our building is our patient. So we're going to use the staff that are able to make it into work, to take care of the patients that we have.

Cindy Sayre:

And that was touched on a little bit by Tim earlier, I think just really appreciating people's flexibility and their ability to adapt to the circumstance.

Jerome Dayao:

Yeah, and if may add...

Cindy Sayre:

So grateful. So grateful for everyone in all they're doing.

Trish Kritek:

Yeah. Go ahead, Jerome.

Jerome Dayao:

I just wanted to also add that we have created a new policy and that actually policies in effect right now at Harborview about contingency state documentation. So this is to help reduce some of the documentation burden amongst the inpatient areas. This is not crisis standards, but rather documentation contingency that gets covered. So we're looking at every avenue that we can not only increasing workforce, but also decreasing workload. So those are important.

Trish Kritek:

Oh, I appreciate that. So we're taking down the kind of requirements in terms of documentation in this contingency state so that people can do the other stuff that they need to do to decrease that burden. And then Cindy is saying, we're flexing people into other spaces, and I'll echo her gratitude for people being flexible and gracious in doing that. Keri, you're unmuted. I was going to ask you a question, but did you want to add to that before I move on?

Keri Nasenbeny:

I was just going to say at Northwest, we've actually taken a step of activating our labor pool. So have re deployed many of our OR procedural staff nurses, surg techs into that labor pool to help in our inpatient units in a variety of places. So really just appreciate the work that they're doing. That will primarily go into full effect on Monday, but I already have had some of those folks out in our units. So have an active labor pool and are redeploying staff at this time.

Trish Kritek:

So a labor pool that's redeploying people from their usual place at work to alternate places at work. So again, gratitude for people for pivoting in those ways. The last thing I'll ask, and Keri, I'll ask it of you is people are worried about losing their sick time when they have to isolate or quarantine. And I know we're trying to shorten that time a period, but particularly I got a bunch of questions about people who are new, because we have a lot of new people who might not have accrued sick time. So what are we doing in that situation?

Keri Nasenbeny:

Yeah. So HR was able to share a couple resources with us and I'll just pull that up in front of me so that I have it. So new staff who've had a community exposure may be eligible for the paid family medical leave if they've worked in Washington state for at least a year. And they also may be eligible for shared leave.

Trish Kritek:

So maybe FMLA and maybe shared leave?

Keri Nasenbeny:

The PFML.

Trish Kritek:

Oh, PFML thank you.

Keri Nasenbeny:

Yeah, if they've worked. And they can also apply for a grant. There's an COVID-19 emergency fund that they could also apply for.

Trish Kritek:

Okay.

Keri Nasenbeny:

And then for resources for work, if it was in workplace exposure, there's workman's comp that they can apply for. And I think L&I has some new, or maybe not new, but they... Because many of these folks hadn't seen a doctor. A COVID test will suffice for that. So L&I is also a possibility.

Trish Kritek:

Okay. So lowering the threshold a little bit to show that you have COVID. So that's a little bit more flexible. Okay. Maybe we can share-

Cindy Sayre:

I'll also add something. We heard from Jennifer Petritz today, their team trying to reach out to every single employee individually that's positive to give them these resources. Which is incredible. It's going to probably take a little time. Right?

Trish Kritek:

Right.

Cindy Sayre:

Because we have so many people to talk to. But those calls should be coming to employees that are affected.

Trish Kritek:

I think that's super helpful because it's still confusing to me. So I think the fact to say that someone's going to reach out to you and help you weigh through the different options, I think that's huge. So thank you to the HR team for doing that, and thank you for clarifying that Cindy. Tom, I'm going to pivot to you. I just asked what we're doing to support our nursing and other allied health. How about the staff? What are we doing to support staffing of our physicians and APPs. As Tim said, there's lots of folks who are getting sick.

Tom Staiger:

So we have reinvigorated our efforts to identify moonlighting, backup individuals, working with our graduate medical education leaders to identify resident and fellows who will be able to moonlight across

a variety of services and as well with our clinical department chairs and service chiefs have all been asked to assess staffing to start work on contingency staffing plans for when staff are out for faculty and number departments including... I know the department of medicine has sent out calls for people to sign up to be in risk pools so that we can have as many people available to step up when people are needing to stay at home because they need to isolate or quarantine.

Trish Kritek:

Okay. So we're going back to that extra moonlighting risk pools, jeopardy so that we have backups and backups for folks who can't be at work. I know it's happening because it's the first time really in the pandemic that I have colleagues who are out sick and it definitely feels different in those spaces. The other things that people are asked about was what's our plan with elective surgeries? How far out have we postponed them for now?

Tom Staiger:

So this is true at UWMC, and I think the same is at Harborview. We are deferring all non-urgent emergent surgeries that require overnight stays through January 31st. And in some selected instances, even surgeries that don't require overnight stays because of staffing, we've had to push out, but that's the approach at UWMC and I think the same is at Harborview.

Trish Kritek:

Okay. So elective surgeries where you have to stay overnight in the hospital are pushed out to the 31st of January. And some of the ones where you don't have to stay over are also being postponed because of our staffing issues. And then transfers, are we accepting transfers and how are we doing that?

Tom Staiger:

We are accepting transfers. We are screening through a medical director screening process that just got ramped up to little bit higher levels today. Out-of-state transfer requests to assess whether we have the capacity one, which increasingly we don't have the capacity to safely take a patient. And two, if we do have the capacity, if it's somebody that requires our unique services.

Trish Kritek:

Okay. So higher level of medical director scrutiny of any transfers particularly those out state. So thank you for the medical directors for doing that. I think all the inputs are what people are feeling, particularly when it's so hard to discharge folks from the hospital. John, I said, I would come back to you. We had a bunch of questions about our masking rules right now. So maybe you could just walk through what our policy is in terms of masks right now.

John Lynch:

Yeah. Sure thing, Trish. I appreciate that. Quickly though, I have some updates from the clinical virology lab. They've had maybe a couple of co-infections at Delta-Omicron in the lab. Just a couple that they think are consistent. And Dr. Gottlieb from upper campus, the reason I was confused is because they're still officially 10 days, but they hope to move to five, like the CDC next week, but they move the dorms to seven. They're evolving as time goes and so the goal is to get to the public health recs. That's why I didn't remember it perfectly.

Trish Kritek:

Okay. So before you answer my other question, I just want to say it out loud. So we're still at 10 days except for people in dorms, which is seven days, but the plan is to evolve to five days.

John Lynch:

Yeah. And one of the challenges is that public health communicates with people on upper campus, especially the students and the university communicates with them. And they're telling some people separate things. So some of the students are hearing five, some are hearing 10. They're working very hard on unifying that message and getting to five.

Trish Kritek:

Okay. Thank you. And thank you whoever fed information to John. That was awesome.

John Lynch:

Dr. Gottlieb. And Alex Greninger gave me the virology data. Thanks.

Trish Kritek:

Thank you both. I deeply appreciate it. Okay, masks.

John Lynch:

Masks. So you remember, I don't even... Time right now in those last couple weeks is a little even crazier than recent. But at some point in the near recent past, we asked everyone to level up their masking. Wear the best respiratory protection that you could feel comfortable with. This week on Monday, Harborview asks... Or we are asking all people who work with patients directly to wear a respirator. And it's the respirator that best fits you. If it's a fit tested one, great. We're asking people to use the fluid resistant ones.

John Lynch:

These are like the 1860s, 1860 smalls. Only if you are directly impacted working with patients, because those have fluid resistance. So keep blood and other body fluids out. So we've asked all patient facing folks to wear respirators all the time. Now, if you go into an aerosol or airborne contact room like Tim mentioned, this is someone with COVID or someone with tuberculosis, you must wear a respirator that is fit tested for you.

John Lynch:

And we are working very hard on increasing access to more fit testing. We did that big push last year. We're going to try to build up something like that again. In addition, we probably need to move some people from the 1860s and 1860 smalls, because 3M is not really supplying those the way that we thought they were and we need to move them over to different respirators that are appropriate for it. So at UWMC, because they're different institutions in terms of congregate spaces and shared spaces and other architectural issues.

John Lynch:

They are asking all patient facing folks... And Santiago, Cindy, I'm pretty sure I got this right, everyone there to be doing the same thing, wear respirators or KN95s or KF94s in that setting. And then across the whole system, we're asking people to level up. Again, wear the thing that works best.

John Lynch:

And I would say that in this last week, I'm seeing it. I'm seeing a lot of respirators out there. I think people are finding the right respirator that works for them. I just want to say, thank you. I know wearing respirators is hard, especially if you're working many hours at the bedside, it's hard. But we appreciate it. We're trying to keep you safe. We want to keep the patient safe. Our message here is that we hope we can get back to surgical masks and maybe even someday the mask won't be there. At least during the summer. But for now, just hold tight. Let's stick with it and it'll keep everyone safer.

Trish Kritek:

Okay. I'm going to try to do a teach back here. It's going to be a little dicey. So let me try it. At Harborview, in all people who are patient facing, we're asking they wear a respirator, which by that you mean an N95?

John Lynch:

Yes.

Trish Kritek:

Okay.

Dr. Santiago Neme:

Or a PAPR.

Trish Kritek:

I just want to say that out loud. Or what?

Dr. Santiago Neme:

Or PAPR if you're taking care of COVID.

Trish Kritek:

Or a PAPR. But an N95 if we're talking about a mask.

John Lynch:

Wait, wait, wait. Stop. So when you're in routine care, an N95. If you're in a-

Trish Kritek:

Wait, wait, wait. I haven't said it yet. Let me keep teaching.

John Lynch:

Okay. But you just said routine care. Are you talking about COVID?

Trish Kritek:

Yup. I'm not talking COVID yet.

John Lynch:

So just routine care, not PAPRs. N95s.

Trish Kritek:

That was Santiago. Santiago messed me up.

John Lynch:

Yep. Cancel him off. No, I'm just joking. I'm just joking

Trish Kritek:

Hold on. Let me take it from the top.

John Lynch:

Yes.

Trish Kritek:

If you're at Harborview and you're engaging in routine care, you should wear an N95. It doesn't have to be fit tested.

John Lynch:

Right.

Trish Kritek:

If you are taking care of a patient with COVID or other aerosol rooms, you need to wear a fit tested N95 or a PAPR.

Dr. Santiago Neme:

Exactly.

John Lynch:

Perfect.

Trish Kritek:

If you're at UWMC, the difference that I heard is that we're saying that a KN95 or some other tighter fitting mask is okay as well.

John Lynch:

Correct.

Trish Kritek:

Is that correct?

Dr. Santiago Neme:

But essentially, Trish, it's working. No one is doing that. Everyone is wearing either an 1870 plus with fluid resistance. And if you're not wearing a fluid resistance mask, you need to put on the extra surgical mask to provide that protection.

Trish Kritek:

So you would add a surgical mask over the KN95.

Dr. Santiago Neme:

If your mask is not fluid resistant, so instead of the 1870 plus that's red, this is just blue. It has the blue bands.

Trish Kritek:

Okay. We might do more mask 101 next week, because I think this is an ongoing area of confusion. And it's challenging for everybody because it's evolving. And I just want to highlight the last thing that John said is this isn't forever. There are a lot of people who are having a really hard time that got a ton of questions about how hard it is to wear the mask. And so I'm just going to reiterate this isn't forever.

Trish Kritek:

Okay. I have so many more questions. I can't even tell you how many more questions are. So we're going to be back next week. Don't worry. I know that you had a lot of questions about kids and I've invited Dr. Shaquita Bell back for next week. So I'm going to save all the questions about kids for then, and you can send in more and because I feel like everyone's exhausted. I agreed in some moment of insanity to be asking ICU doc today for Anne. And luckily, I've only given us like three minutes to do this. So it's going to be fast because I know I am fast and efficient. So Anne, you have me as your ask an ICU doc. Hit it.

Anne Browning:

Gotcha. Okay. We keep rescaling the graphs because we have so much community spread right now. I'm curious about how you're shifting your behaviors based on the spread. When you go for runs, are you wearing a mask for a buff at this point?

Trish Kritek:

No. When I run, I feel fine outside. I just wear my clothes.

Anne Browning:

What kind of mask do you wear at a grocery store?

Trish Kritek:

I now wear a KN95 in the grocery store.

Anne Browning:

Do you ever double mask?

Trish Kritek:

I don't. I wear a KN95. I guess if I was in that situation Santiago said where I had to wear a surgical mask over something I would, but otherwise I don't double mask.

Anne Browning:

Have you shifted from cloth masks to the KN95?

Trish Kritek:

I shifted from a surgical mask to a KN95, but I wasn't really wearing cloth masks before.

Anne Browning:

Would you fly right now?

Trish Kritek:

If I had to get somewhere to see my family because someone was sick or something like that, I would. I wouldn't take my mask off when I was on the plane, but I wouldn't fly someplace just for the fun of it right now.

Anne Browning:

If you had a trip to Hawaii at the end of the month, would you cancel or postpone it?

Trish Kritek:

I would postpone it right now.

Anne Browning:

Would you ride in an Uber right now?

Trish Kritek:

If I had to get somewhere, but I like to walk places, so I might try to figure out how to walk there.

Anne Browning:

Would you eat either indoors or outdoors at a restaurant?

Trish Kritek:

No, I wouldn't. I mean, I think you could eat outdoors at a restaurant, but it's really not very nice out and I don't feel the need to do that. I like to take out though and support my local restaurants.

Anne Browning:

Agreed. When it's a little icy the outside it loses its charm a bit here. Would you let repair folks into your house to do work right now?

Trish Kritek:

Yeah, I probably would stay away from them and I'd make sure they're masked.

Anne Browning:

Would you check if they're vaccinated before you let them in?

Trish Kritek:

I probably wouldn't.

Anne Browning:

Would you hang out with a couple couples for dinner at this point?

Trish Kritek:

So I live in a couple where I am the less averse of us, and I would say even I now would say no. Andy would've said no for a long, long time, but right now we're locking it down and it's just the two of us, which is sometimes dicey.

Anne Browning:

I'm guessing no out of town visitors staying over in that case as well?

Trish Kritek:

No, not right now.

Anne Browning:

This is question that came in. Would you advise against sending your mom to water aerobics right now?

Trish Kritek:

My mom would not do water aerobics. I'm pretty sure she's watching right now. She can affirm that. I wouldn't because I think that you don't wear a mask when you're doing water aerobics. So I wouldn't want her without having a mask on. So I'd say nix on the water aerobics for now, even though I think it's a great form of exercise.

Anne Browning:

3:59. I'll hand it back to you. Thank you for being on the hot seat. It was super fast this time.

Trish Kritek:

I thoroughly enjoyed that experience and I want everyone to see that as a model of how you give a very brief answer at ask the ID doc. But it all seriousness, thank you, Anne. And I appreciated being on the hot seat. I have new empathy for Santiago, Tim, and John, as well as Tom and Keri who've done it in the past. And with that, I'm going to end by saying, "Wow, this is a really hard time. I think we've highlighted that a lot of different times. I just want to say it again. It feels different. It's going to keep feeling different and we're going to keep coming to you. Please keep sending us your questions. You plant seeds for us to do things, to make things better for you. So we want you to send them in.

Trish Kritek:

A huge thank you to our EDs, our acute care settings, the folks who are doing our therapeutics, our vaccines, and all of that testing. So important right now. I always want to thank the critical care folks, but it's really the acute care teams right now that are really ratcheting it up. So thank you.

Trish Kritek:

To all the leaders who are taking care of people, let's keep taking care of folks. It's so important. I'll plea for people to donate blood, because we're really short on blood. So I'm going to say please donate blood. And again, I'm going to promise you that we're going to come back to you weekly. We're going to try to figure out how we keep communicating more and more, because we need to do that more and more right now.

Trish Kritek:

So a deep thank you from me and everybody on the screen to every member of our community as we work together, because we'll get through this together by taking care of our patients, their families and please let's just keep taking care of each other. We'll see you in a week. Bye-bye.