Trish Kritek:

All right. Welcome back to UW Medicine, town hall. I'm Trish Kritek, associate Dean for faculty affairs. It's my pleasure to welcome back Tim Dellit, our chief medical officer, Santiago Neme our medical director at UWMC Northwest, Anne Browning, our assistant Dean for well-being, Keri Nasenbeny, our chief nursing officer at UWMC Northwest, John Lynch, head of infection, prevention, and employee health at Harborview Medical Center, Tom Staiger, medical director at UWMC, Cindy Sayre, chief nursing officer at UWMC, Jerome Dayao, chief nursing officer at Harborview, and Rick Goss, our medical director at Harborview. Thanks everybody for being here. As is our usual routine, I'm going to kick it to Anne for a well-being message.

Anne Browning:

I feel like I've been in both literal and figurative thought pretty much all week, but the sun is out and I feel a bit better, a little lighter, numbers are coming down. I'm seeing a lot more smiles on the screen than I did a week ago or two weeks ago, so I am excited that we have a little bit more levity and a little bit more brightness around us right now. For the well-being message, I just wanted to highlight one resource we have for folks knowing that folks are still going through times where daycares are being closed, schools are being canceled.

Anne Browning:

It's our employee emergency fund. I'll throw that link in the chat. But I just wanted to clarify for folks, if you are in a place where you're having to pay for some extra care for your kiddo because they're out of school or out of daycare, or if you yourself have exhausted your leave and have some loss of income, you can apply into the employee emergency fund. It's really there to support folks who are under the most financial strain right now. So I'll share that link, but if that applies to you or to some of your colleagues, then please share that resource widely. We have funds that we desperately want to get out to folks who need the most right now. With that, I hope we all get a little bit of more sunshine in this afternoon and have a good weekend ahead.

Trish Kritek:

Thank you, Anne and thank you for highlighting that fund because I think it's an important thing that we still have opportunity for people to use it. So thank you. Tim, I'm going to turn to you. Anne already said it, feels a little bit better, but maybe you could give us a big picture of where we stand across UW Medicine right now in the Omicron surge.

Tim Dellit:

Yeah. Welcome everyone. Thanks again for joining us. It does feel a little bit better, I have to stay, this week and people are able to take a bit of a breath. We definitely are still in the surge, but we seem to be coming down the backside of it. We certainly, if you look at King County, appear to be past the peak in cases. We went as high as 2,000 per 100,000 over seven days. I think today, we're around 1,000 when I looked this morning per 100,000. So still extremely high levels of transmission. I want to emphasize that, but it definitely is coming down, and so that is positive. Hospitals tend to lag. When you look at our numbers, we had been around 190 for about 10 days including a high of 204 this past Sunday. But today, we're down to 156. So the number of patients with COVID-19 in our hospitals also seems to be coming down.

Tim Dellit:

The other really good news is that when you look at the number of employees that have been out, either in isolation or quarantine, those numbers also are coming down. We had been around 600. Now, I think today or yesterday evening when I looked at it, it was about 260. We're seeing fewer positive new employees on a daily basis as well. So all of that is encouraging. When you look at the lab positivity through our UW virology lab, they did over 12,000 tests yesterday. That positivity rate is still very high. It was 30%. So again, I just want to emphasize, there's still a lot of ongoing transmission, but it does seem that we've, at least here in King County, seem to be trending in a favorable direction.

Tim Dellit:

The other really positive news, we've talked before about Eastern Washington lagging Western Washington, but even information out of the WMCC this week shows that Eastern Washington seems to have flattened outside of Spokane, which still was increasing. But that's also positive news because we weren't sure how that impact from Eastern Washington rise was going to impact our entire state healthcare system as well. So a lot of positive signs. We're still definitely in it. It's interesting that we now look at 156 as positive news when our previous high was 124, but definitely better than the 190-200 range. Things seem to be headed in the right direction, at least right now from this surge, which is very reassuring and I think does feel like people are able to breathe a little bit better this week.

Trish Kritek:

Okay. Thank you. I think we're all feeling it to some degree that it feels a little lighter. So lower numbers, although still really high across UW Medicine, lower numbers of positivity rates, lower numbers in King County, on the decline, and the whole state seems more stable than we thought it might feel right now. There were actually a bunch of questions about workforce because we were concerned about the workforce. I appreciate that you said we have much fewer employees who are out right now in quarantine or isolation, but I'm going to ask you a series of questions about that. One was, have we considered rehiring unvaccinated employees in this setting because of needs and with our staff?

Tim Dellit:

No, we haven't. That's still a condition of employment. If you aren't vaccinated, it's something being checked even before someone can be hired within our system. So, no.

Trish Kritek:

Okay. So vaccination remains a condition in employment. Where do we stand with adding boosters to that?

Tim Dellit:

Yeah, that's a great question. We feel very strongly, all of our healthcare team members and quite frankly, everyone in our community that's eligible should receive a booster. Data came out last week, as we mentioned, that showed that boosters decrease hospitalization rates by 90%. So boosters are really important in terms of our response. As we've been discussing with this, I do think that we're going to be moving forward with requiring boosters similar to what we do for influenza vaccination, where we require everyone to participate. We really want everyone and expect everyone within our healthcare system to be vaccinated, but there will be a declination process, including an educational process for those individuals. If people had an approved exemption as part of the vaccine mandate, that exemption would still be in place for the boosters as well. So we are going to move forward. It's going to be different than the previous mandate that was tied to employment, but we still very much want

everyone to be receiving that booster both for their own protection and the protection of our workforce and our patients.

Trish Kritek:

So strongly encouraging everyone to get boosters. We'll have a process of either saying that you're attesting to the fact that you've been boosted or sharing that you've been boosted or going through a process of declining it, not to the same strict rule of it has to happen, but still strongly encouraged to do so. Is that right?

Tim Dellit:

Yes. John, feel free to chime in, but when we've done this with influenza, we've been able to achieve over 95% vaccination rates.

Trish Kritek:

Okay.

Tim Dellit:

So it's more than strongly encouraged. We expect you to be boosted, but in those situations where someone does not, there's a process that they will need to go through to be compliant with the program. We absolutely will require 100% participation in that booster program.

Trish Kritek:

Okay. Thank you for clarifying the strength. I weakened it from what it should be, that you need to be boosted and there's a process to go through if you're declining to do so. How about redeploying administrative staff? There was an ask across the school of medicine about administrative staff who might be redeployed.

Tim Dellit:

Yeah. We reached out across our shared services and within central services to really identify professional staff who potentially could be redeployed. I don't believe we've actually done that, but we were getting those pools ready in case we needed to do so. I really appreciate everyone who was willing to participate as part of that process. Again, that was an important step just to be prepared. We didn't know when we started that where things would be headed, and so I think it's important that we have that list of potential individuals available and ready should we have to pivot in that direction. But there are no plans, at least that I'm aware of right now, of having to do so given the staffing situation. But again, I look to Cindy or Keri to correct me around that.

Trish Kritek:

They're seeming to affirm you, and that is, we have it as a plan so that we have the back up and the readiness, but we are not currently deploying anyone and we're not planning to deploy anyone right now, that appreciate the people who are willing to be deployed. One more question before I ask a big picture one which is, I've had a handful of questions about what is our guidance for clinical research at this point in time and what people can do in terms of clinical research and our clinical spaces. I wonder if you could comment on that.

Tim Dellit:

Early in the beginning part of the pandemic, we did limit some of the clinical research in part to decrease the density of individuals within our hospitals and clinics. After we moved through those initial stages, I don't believe we've done that same thing in subsequent. Right now, I don't believe there are restrictions around that. We still all need to be mindful around just the overall number of people and our interactions, but we haven't made that sort of a restriction as we did at the beginning of the pandemic.

Trish Kritek:

Okay. So the restrictions that we had earlier about who could or couldn't be in clinical spaces, we have them about visitors for patients, but not for clinical research staff at this point-

Tim Dellit:

Correct.

Trish Kritek:

... in time. Okay. Last question. I know this is hard, but I'm going to ask you anyway. What do you think the next few weeks will look like and how do you see that evolving over the subsequent weeks?

Tim Dellit:

Yeah. I think that we will continue in this general downward trend, but there could also be a period where we hit another plateau and we hang out at a given level. We've seen this in other surges. There is this new Omicron subvariant being-

Trish Kritek:

Oh, I'm going to ask John about it.

Tim Dellit:

... and John can tell you all about it. There's some places where that has emerged and it seems to be as transmissible, if not a touch more that you could see a little bit of an increase in cases. So my prediction, which again, you're making me do, would be that in general, we'll see a gradual decline, but we could level out at periods during that. We still have 150 patients. We still have a number of staff out. I still think we're still in the midst of this over these next couple of weeks. So while we're positive and optimistic, it's not that we've completely finished this and we still have to continue to prepare. There could be other variants in the future that emerge, and we fully anticipate that as well. I hope there's not the same degree of surges just because of the number of individuals who have been infected and if we continue to get our vaccination rates and boosters to the point where they need to be. So there's a balance, right?

Trish Kritek:

Yeah.

Tim Dellit:

Continuing down, but not over.

Trish Kritek:

In the ICU, we call that cautious optimism, that things are going to continue to improve, but there will be bumps in the road. Maybe there won't be as big a surge as we've had, but that there's chances that things will go up and down or plateau as we continue to hopefully resolve. Thank you. I like that you think that I can make you do that, but I'm going to hold that to my heart for a second. John, Tim already gave us some big picture numbers, but maybe you could give us the little bit more granular numbers, and then I have a bunch of other questions for you.

John Lynch:

Sure thing. I'll go through it quickly. I think Tim covered really nicely.

Trish Kritek:

Yeah.

John Lynch:

When we last met was last Friday. Actually, Dr. Seth Cohen, thank you for covering last week. He already did a great job.

John Lynch:

When Seth spoke last week, he mentioned probably mid 190s. Sunday, we've got 204, but as of this morning, we're at 156 patients in UW Medicine facilities. 110 are acute care, 46 in the ICU. Valley's at 51, Northwest, 18, Montlake at 35, Harborview at 52. As you said, most of those patients are in acute care. Just some special populations, Montlake has three people on the OB service who have COVID right now and that's been pretty consistent over the last week or so. In Harborview, we've been between three and four people on ECMO or ECLS, all linked to COVID this last week, which is more than we had even earlier in January.

Trish Kritek:

Okay.

John Lynch:

Want me to just jump into the county or do you want me to keep going?

Trish Kritek:

Before you do that, Seattle Children's, do you have those numbers?

John Lynch:

You know what? You sent me those and I haven't looked at it yet.

Trish Kritek:

Okay.

John Lynch:

Have it off the top of your head??

Trish Kritek:

Do I know it off the top of my head? Not a chance, but I can look them up.

John Lynch:

Okay. Well, maybe why you're taking a peek of that, Trish, I'll just give you an update in the county.

Trish Kritek:

Yeah, please do.

John Lynch:

The county is actually, again, good data over the last week or so. We have seen a decrease in new cases, as Tim mentioned, of a 36% decrease in new cases, which is just tremendous. That's really great, although maybe just a little bit leveling off of the past couple days. As Tim mentioned, we went from about 2,000 cases per 100,000 a week ago to 1,000 per 100K. Hospitalizations in King County come down about 26%. Sorry, from the prior 7 days, it was 514 down to 381. Interestingly, as I mentioned before, the death rate is still fairly high. It went up over January and continues to be there. I know we've lost a few patients here at Harborview due to COVID-19 in this last week and a half. So still having a big impact.

John Lynch:

The state level data, this is a really important data from WMCC Steve Mitchell and Mark Taylor, leaders of that group. We have seen a decrease in hospitalizations across the state down to just over 2,000 patients with COVID-19 across the state. With the DOH data, it's about a week old, about a third of all beds in the state at one point were COVID patients, so huge impact. One thing I will point out though, although the ICU numbers, as I've mentioned a couple times over January, haven't ramped up like we saw with Delta, they did go up. If you look across the state, they actually went up last fall and that just stayed very high due to COVID since then. Then ICU census just keeps there. It just stays there. We still see a small group of people that require critical care across the state continuously through Delta and right into Omicron.

Trish Kritek:

Okay. So big picture things that I heard were 154 across the system, which is down a lot from last week, but still very high. Then numbers coming down in King County, numbers actually coming down across the state, which is encouraging. Then what you said was, and yet we still see a bunch of people in the intensive care units. I think we often see people stay longer when they're in the intensive care unit. If you get sick enough to be in the ICU, you often stay in the hospital longer. So that doesn't entirely surprise me, but I think it's important to say we still see that. We still see people on ECMO or the heart lung bypass machine. The other thing, I'll just pull up. I think Seattle Children's census of patients who tested positive for COVID is 26 down from 34 last week. 21 of them are in acute care, five in the ICU. I'd asked them that most are unvaccinated. They're across all ages. I don't have more demographics than that, but I also want to share that and thanks to Richard Shugerman, who shares them with me on a weekly basis.

Trish Kritek:

Thank you. I think it is generally feels good and I think it's also good for us to keep saying there's still a lot of patients with COVID in our system and our hospitals are still pretty stretched. How many staff do we currently have? Tim gave an idea of it, but maybe you have a more specific number.

John Lynch:

Yeah. Let me pull up those data right now. As of again this morning, we have 157 health coworkers across our whole system who are in isolation, people who have active COVID-19. We have 105 people who are in quarantine and those quarantine folks are folks with really high risk exposures. They're living with people with COVID-19. When we look at our positivity rate, as Tim mentioned, that's definitely come down quite a bit. In the last day or so, we had about 15 across our entire system tested with the UW Medicine are positive out of about 90. So it's about 17% of those who got tested. Over the last week, 139 positive health coworkers out of about 1,000. So it's about 15%. Just to throw back to pre-Delta, we're in the 3% range, through between 3% and 4%, so still pretty high.

Trish Kritek:

So still high. Down a lot from where we were, numbers down a lot from where we were, but when we compare it to previous surges, still a very different feel in terms of the number of staff, medical staff and staff who have been impacted.

John Lynch:

Yeah.

Trish Kritek:

Okay. Thank you. Now I have a bunch of other types of questions for you. I alluded to this. The thing that I got the most questions about was the BA2 subvariant of Omicron. I'm going to ask two questions together. First of all, can you explain the difference between a variant and a subvariant? Then can you tell us about what you know about BA2?

John Lynch:

Yes. These terms are evolving. We weren't really necessarily built for these types of technical terms to be used out in the world. The way I would think about it is that Omicron, like all the other lineages or variants we've heard out there, Delta and other, they're not one single virus with one single genetic code that's equal to Omicron. What we're looking at is each of those Greek letters refers to a small cluster, a genetically related group of viruses that relatedness is determined by scientists and fantastic researchers like Dr. Trevor Bedford and Dr. Pavitra Choudhury in our system who do this amazing work. The way to think about BA2 is that it is a sibling of BA1, which is what we've been calling Omicron. Both of those come from a parent lineage, the B11529 that we talked about. When we first heard about Omicron, we used this longer term before it was given the Omicron name.

John Lynch:

To think about it, that's the parent. That's the one that came out. Then BA1, for reasons that we still don't understand, maybe got out of the gate a little bit earlier, maybe even from the same person, maybe from the same community, the same source, get out in front, got to the right person and the next community a little bit faster than other variants. Just to be clear, Omicron is actually BA1, BA1.1, BA2, BA3. What we're seeing now is the emergence of BA2. Maybe that one just was a little delayed in getting access to other people.

John Lynch:

We're still early days. The things I want people to take home is that we're going to be learning more about the impact of BA2, as Tim mentioned. There's some evidence that maybe even a little bit more transmissible than BA1, but it's still Omicron, so the immunity associated with Omicron immunity, with BA1, appears to be the same. There's no evidence of increased pathogenicity. There's no evidence of immune evasion in a way that's dramatically different than BA1. But again, early days, going to be learning about it. It's not a new variant. I'm not even sure the term subvariant is right. It's one of the Omicrons.

Trish Kritek:

Okay.

John Lynch:

Again, we'll be hearing more about it in the coming days and weeks.

Trish Kritek:

I'm going to go with it's one of the Omicrons, a sibling of the first one. So still same bucket of Omicron and maybe a little bit more transmissible, but we think the immunity is the same.

John Lynch:

Yeah.

Trish Kritek:

It sounds like the severity disease associated with it is the same as far as we know so far.

John Lynch:

Exactly. We don't have any data to point in another direction.

Trish Kritek:

Then the last question about that that came up the most is, if you were infected with BA1, do we think you can get infected with BA2, i.e., reinfected?

John Lynch:

The data we have, which is limited, looks like the vaccine efficacy, how good the vaccines we currently use is the same for BA1 as it is for BA2, and that if you have immunity to BA1, you have immunity to BA2. That's our current understanding right now.

Trish Kritek:

Okay.

John Lynch:

So vaccination and boosters continue to be the most important tool we can have against all the BA siblings.

Trish Kritek:

So vaccines are good, but what about if I got infected with BA1? Does the immunity of that infection cover me for BA2?

John Lynch:

As far as we know, in the short term, yes.

Trish Kritek:

Okay. All right. It seems like the things that previous infection, we're not saying you're going to get reinfected with Omicron as far as we know right now, and I heard you loud and clear, vaccination and boosters are the thing that we think is most protective in the situation.

John Lynch:

Yeah. Just remember, we've only been having the conversation around BA2. Most of us, I think some of the virologists has been talking about this in December and maybe even earlier. We've only been really talking about this for about a week and a half. So a little more time will definitely tell us more.

Trish Kritek:

There's nothing about town hall that is more emblematic than me reasking questions over and over again, so I'm sure I will ask again. Thank you for clarifying. We don't have that long knowledge yet, so fair enough. Do you recommend that folks get the free antigen test that are being offered by the federal government and the state right now? I'm going to have a follow-up question to that, but let me just start with, should you get them?

John Lynch:

Yes.

Trish Kritek:

Okay.

John Lynch:

I've ordered mine from the federal government and from the state.

Trish Kritek:

Then what should you do with them?

John Lynch:

Yeah. I have a couple of really great possible uses. I think the most important one is if you wake up or someone in your household wakes up and has symptoms of COVID, sore throat, headache, fatigue, all the things that we know that are caused by Omicron, that's a great time to think about using an antigen test. Now, some experts out there say, "Well, if you develop those symptoms, stay home. If you're healthy otherwise, you can stay home. Don't need medical care. Maybe give it 12 to 24 hours and then do an antigen test." If that antigen test is positive, you're done. You can think that you have COVID. You don't need to go out of your house and get a PCR, and you're all set to go in terms of your diagnosis.

Now, if it's negative and you have those symptoms, then getting a PCR probably makes sense because we know the antigen tests aren't as good.

John Lynch:

The other place where they could potentially be used, and this is where we might be challenged with the number of antigen tests that are coming out from the state and the feds, is that we know that for healthy, vaccinated, people who may want to get together with other pods, maybe someone in their pod, maybe expand a little bit, maybe be with someone in their family or their household, maybe as a higher risk or more vulnerable patient population that getting vaccinated, making sure you don't have any symptoms going to that gathering if it's going to be no mask or variable masking, doing a few antigen tests going to that gathering may be a really nice way to do that too. So doing two or three tests, day zero, negative one, negative two on the way to that gathering maybe another way to do it.

Trish Kritek:

Okay.

John Lynch:

But those are a little more complicated, but I think the most important thing is develop symptoms, get a test, and that saves you for ever having to leave the house.

Trish Kritek:

Okay. So maybe serial testing before you're going to go into a group where you're going to be amassed, multiple ones, but for sure, the reason to maybe have them is you wake up with symptoms and you can use it then. If it's positive, we're going to say you're positive. Maybe you do it in that morning or maybe you wait 12 hours later, but you use it at home and you don't have to go have another test. I think that seems like the thing that might be a reason. I also ordered mine. I messed this up last week, so I'm going to give myself an opportunity to correct it. Now, I swab myself and it's positive. Who do I need to let know? Let's start with healthcare workers within UW Medicine.

John Lynch:

Yeah. We really, really want everyone who has an exposure or has a positive test anywhere to let employee health know. The employee health teams at all of our campuses are amazing people. They have been through every possible scenario out there. They know the recommendations around quarantine and isolation, and they are here to help you, and sometimes connect you to testing or connect you to other care. What I really strongly recommend is to contact them. It also allows us to know what's going on in our health coworker community and for me to tell you, everyone on this call, how many people are positive, how many people are in isolation, so they know what's going on and we can make the best decisions for UW Medicine and our work. Let employee health know.

John Lynch:

Someone asked, how do we contact employee health? Everybody is assigned to an employee health group. If you're at Northwest, there's an employee health group. Montlake, there's an employee health group, Harborview. I would say, if you don't know who to contact, talk to your supervisor manager because everybody in UW Medicine is connected to one of those employee health teams and we're here to help you.

Trish Kritek:

Everyone in the clinical spaces who is-

John Lynch:

In the clinical spaces.

Trish Kritek:

... a healthcare worker in UW Medicine is connected to one of those spaces. You almost made me do it twice, but I'm not going to let it happen because there's lots of members of UW Medicine who are not part of our healthcare team, who are part of the school of medicine and administrative staff, shared services. So Tim, you are-

Tim Dellit:

Yes. For the nonclinical members of our school of medicine, please contact environmental health and safety. If you go to their website, they have instructions on how to report positive test. They want to know about the positive test there. EH and S, environmental health and safety, provides the employee health services for the nonclinical parts of our school, and so please contact them.

Trish Kritek:

Okay. If you're a healthcare employee, use employee health. Talk to your supervisor if you can't figure it out. It's also on a lot of our websites, point you in the right direction. If you're a member of the school of medicine use, EH and S, and then Santiago put into the chat also the way to report to the department of health in the state of Washington. So thank you all for that incredibly comprehensive answer of who to tell if you test positive. I very much appreciate it. Okay, two more quick questions, John, before I move on. Maybe just one. Let's do one. Have you heard any updates on the vaccine for zero to four-year-olds? Because I heard that someone in the question says Fauci was talking about it.

John Lynch:

I think there's optimism, cautious optimism that it'll be available sometime this spring-ish. As I think Dr. Bell mentioned, that the early data for the under fives was that two-dose regimen wasn't quite immune, isn't as energetic as we wanted, and so there's looking at three-dose version. I think we just have to wait for those data to come out. Hopefully, you're going to have Dr. Bell back in the next few weeks or so since, but I'm hoping maybe later this spring.

Trish Kritek:

I always love to have Dr. Bell here.

John Lynch:

Yes.

Trish Kritek:

I think hopeful for the spring. Need to prove that we are having the immune response that we want from the vaccine, and so we're waiting for the results of that additional dose trial or trial of the additional dose. So thank you. Okay, you're off the hook for a little bit. I'm going to turn to Tom and Rick. We heard a little bit about how things were calming down potentially in the state. Folks were

wondering about transfers in. Tom, I'll start with you. Are we seeing more transfers from Eastern Washington? Then I'll add to that, how about Idaho? Because people heard that Idaho was in crisis standards of healthcare. Where do we stand with transfers?

Tom Staiger:

Consistent with what Tim said about the WMCC and what John said, we are not, at least at UWMC, seeing a surge in transfer request from Eastern Washington. Likewise, the out of state transfer request, some of which are coming through our on-call medical director review system seem to be decreasing a bit.

Trish Kritek:

Okay. So not a lot from Eastern Washington and not as many from out of state. Rick, how about at Harborview? How is it looking?

Rick Goss:

Yeah, I think similar as we're both really working across with WMCC and the out of state partners on these referrals. I would say one other item of real good progress has been our work with Oregon where we've set up some pretty good relationships with the medical leadership of their network, essentially the Oregon medical coordination center, OHSU, and Emmanuel, and with Tom, Santiago, myself, Steve Mitchell, Mark Taylor, we're all kind of working together. Typically, those referrals are really just sick patients more so than just COVID per se. I think the only other thing about Eastern Washington is that we're keeping that cautious optimism that perhaps there is a little bit of a delay and we're just keeping ourselves in preparedness in case we see some increased numbers.

Trish Kritek:

Okay. So still waiting and being cautious, but right now, it doesn't feel like we've had as many requests for transfer or transfers. I appreciate you adding the improved partnership with Oregon, which is great.

Rick Goss:

Mm-hmm (affirmative). Mm-hmm (affirmative).

Trish Kritek:

While you're talking, Rick, the other thing that we've talked a lot about is the degree that we're having patients board. So I'm wondering how the boarding situation is at Harborview.

Rick Goss:

Yeah. That's a great question. We're really in a good place right now with that. Just over a week ago where Harborview had that high total census of around 500, which is a really big number here at Harborview, and we really try to avoid that. That was a day where we had 70 patients with COVID and had that 30 plus, 35 boarders. So that's really pushing the limits. That was at the peak of where we are now. A week later, we're now down to essentially 458,-

Trish Kritek:

Wow.

Rick Goss:

... down to about 50 patients. We have no ICU boarders and only eight acute care boarders. So this is a really pretty steady state place for Harborview to be. The staffing ratios are better. That's our optimism as part of the cautious optimism.

Trish Kritek:

Yeah. I appreciate that. For people's context, boarding at Harborview is pretty common all the time, it just that that degree of boarding was so huge. Now we're back to, I don't want to say normal boarding, but feeling more like normal. That's great. Tom, is that true at UWMC and...

Tom Staiger:

Things are a little better over the last couple weeks at UWMC, though this morning, we were boarding 13 patients at Montlake and I think 12 at Northwest in the ED. Part of that is exacerbated by some of the facilities issues that we've had here that have taken some of our boarding beds out of commission that we expect and hope by later February to have resolved and reclaim those boarding areas. Over the last two weeks, there's less pressure, but we're still frequently boarding at levels that are higher than we would prefer to be.

Trish Kritek:

Okay. So more improvement at Harborview than maybe at Montlake and Northwest. We're still boarding across all of our hospitals, but in general, it feels like better, still not normal. I appreciate all of that. I'll turn to Cindy, Keri, and Jerome to follow-up on that. Relevant to the numbers, I'm going to start with the question that I do ask all the time, which is where do we stand with visitors and do we have plans about changing that? Cindy, I'll start with you.

Cindy Sayre:

Yeah. Thank you. Well, we were in conversations today about the visitor policy and what might be next. There's so many complexities to the issue that we need more conversation.

Trish Kritek:

Okay.

Cindy Sayre:

So we're talking about it, but we need a little bit more time.

Trish Kritek:

Okay. So right now, no changes, but ongoing discussions, which we've said before and things will evolve, so we'll keep coming back to that. There are a bunch of questions about how we're responding to the challenges of staffing. One specific question that came up is, have we had any further discussions about hazard pay for nurses? Keri, do you want to respond to that?

Keri Nasenbeny:

We have not, actually. That topic has not come up and instead, I think we've taken a different tactic, which is at least I know at both UWMC campuses, we're offering either what we're calling incentive or a

lump sum payment for staff working extra shifts. That's really the path that we've gone down in, but in all our labor conversations, actually the conversation around hazard pay has not come up recently, no.

Trish Kritek:

Okay. So the focus hasn't been on hazard pay, though you're giving extra money for people who are working extra time. Jerome, did you want to add to that?

Jerome Dayao:

Yeah. We have done something similar with all of the sites, including now the incentive for hiring has been expanded to all of the nursing positions, whereas before, it was just the different classifications. So we've expanded on that. We continue on the double time. We continue to meet with our labor partners to make sure that we can identify other opportunities. Then we also have now, two system-wide committees that discuss recruitment and retention because these are very important things as we try and solve this workforce issue.

Trish Kritek:

Okay. So broaden the recruitment fund indications, continuing discussions, talking with the unions about this. The discussion, it sounds like not focused on hazard pay, but on these other ways to support people. Thank you. Jerome, I'll ask you a second question. We've talked about bringing in travelers to support nurses, but are we bringing in temporary support for other folks in the clinical team? I think we talked about PCTs before, but maybe the whole spectrum. How are we supporting maybe not the doctors and nurses, but the other members of our clinical team?

Jerome Dayao:

Right. We're you utilizing at Harborview travelers in other disciplines as well. We have travelers in respiratory therapy beyond nursing and PCS, patient care services, but truly, our goal here, Trish, is not to be overly reliant on the travelers, but rather make sure that we're able to hire our own and recruit and retain them. That's why I know that at the system level, this is an active effort that's being done currently for recruitment and retention. So that's what we're focusing on, but to your question, we are utilizing traveler beyond nursing currently.

Trish Kritek:

Okay. So we're using travelers in other spaces like respiratory therapy, but really working on trying to recruit people to become a permanent part of our workforce across the spectrum of roles. Cindy, I'm going to ask you the next question, but do you have anything you want to add to that one before I move on?

Cindy Sayre:

I'm thinking about categories like surgical technicians. We do have other clinical roles that are being filled by agency travelers, yeah.

Trish Kritek:

Okay. Like surgical techs, okay. I appreciate that. Last question I'll ask is when we're tight on staff, we've had people who are staffing our vaccine clinics and people who are asking, are we going to start ramping down our vaccine clinics and potentially deploying those folks in other spaces?

Cindy Sayre:

Yeah. I do think that that work is underway. We have cut some of the hours at the vaccine clinic, I think at both Northwest and Montlake just because the demand for vaccines has decreased. There are many areas where we could use their help. It's been really great to have them, for example, working as we call them dofficers here at Montlake where they're observing teams donning and docking their PPE, and there's other functions that they're helping us with. So yeah, we are finding work for them.

Trish Kritek:

Yeah. We've already narrowed the hours because the demand is down and folks are doing other jobs. We keep assessing the need for our standing vaccine clinics as the push for vaccines is waning, I'm hoping because everybody's vaccinated, which would be what I'm cautiously optimistic about. Okay. Thank you all so much. Santiago, I know you've been working hard on the Q&A, but now, I'll have you turn on your mic. I've asked you this before, but I'm going to ask again. For the people who don't yet have a booster, how do you schedule a booster? Do you go online? Do you call? What is the way to do that right now?

Santiago Neme:

Yeah. Let's distinguish staff from patients. Staff have two options. They either walk-in or they go online and schedule their shot. For patients, they either call or walk-in as well. So we are taking walk-ins. There are days when maybe the staffing was not really great and there were no walk-ins for patients, but now, as Cindy mentioned and Keri, we have more access. I'm also going to put this info on the chat because there's a phone number as well.

Trish Kritek:

Okay. So for staff, it's walk-in or go online. If you're a patient, it's call or walk-in. You can walk-in and we said maybe hours are changing, so pay attention to those things as we move forward. The other question that comes out a lot about boosters is, if you didn't get it in the five or six months right after your last dose, is it going to be less effective to get your booster now? Like it's been eight months, should I still get my booster?

Santiago Neme:

Oh, you should still get your booster, for sure, as soon as possible. We've seen the effect, as Tim mentioned, of reduced mortality, reduced hospitalizations and severe disease. Clinically, we're also seeing that in our hospitals. The patients who don't do well are those who are not fully vaccinated or sometimes, they're immunocompromised, they weren't boosted. So there is definitely an effect of that booster that we really need to take advantage of. We have the luxury of having great access to it.

Trish Kritek:

Even if it's been like eight months, it's still going to be effective to get that booster?

Santiago Neme:

Oh, absolutely.

Trish Kritek:

Okay, great. I'm going to ask a couple mask questions of you. People are wearing a lot more N95s and one of the questions that came up a bunch is, is it bad for our health to wear N95 so much of the time?

Santiago Neme:

Yeah. I'm not aware that it's bad for your health. I do think that it causes some issues around your skin when you're wearing them for a long time. I personally feel that after wearing it for eight hours in a clinic, if I haven't taken a break or anything, it starts to wear on you. You start to feel that it's irritating. Sometimes, the foam can be a little irritating. Sometimes it's the metal that is applying too much pressure. I'm not aware of any biologic issue around wearing these masks and we have been wearing them for a long time now other than the local issues around the skin.

Trish Kritek:

Okay. So we know of no long term health consequences of wearing N95s as much as people are wearing them. It's as if you read my mind, people did ask about, what do I do about my skin because it's starting to affect my skin to be wearing the mask? It's hard to wear a tight-fitting mask. I do know people are having issues.

Santiago Neme:

It is. I can share a website where I read some recs about this. Basically, the key here is that you want your skin to be clean and you want to use a gentle cleanser. You want to avoid any makeup, anything that could be an irritant, any acne products or anything that you leave in after just your routine facial care. But I think it's really important to take a break from your mask. Wearing your mask for eight to 10 hours is pretty hard, so at least try to find 10 to 15 minutes every four to six hours to take that off and be able to readjust. The other thing that I find helpful is that sometimes, we might not notice, but the metal is applying too much pressure, more pressure than needed. You want it to be tight, but you don't want it to be really cinching your nose or really digging into your cheeks. I think that you can make those adjustments and you'll find that you still have great protection as long as you have no gaps.

Trish Kritek:

I so appreciate that because I actually had that. I would crank down on it when I left my office and then by the time I got halfway down the hall, I was like, "This is too tight." I'd loosen it a little bit and it made it so much more comfortable. So I agree with you completely. I appreciate you thinking through. It does affect your skin, so thinking through those things, I appreciate very much. Are we offering N95 to patients who have COVID so they can wear them when we come in the room now or not?

Santiago Neme:

We're not yet, but John, Seth, and the Med Tech team are looking into this and we're working with supply chain. There are specific areas where we would have a COVID-infected patient who needs to access ambulatory care settings for their treatment, let's say monoclonals. We've been piloting fitting those patients into a KN95, which has worked out well. But we are looking into more widespread fitting of KN95 for patients and also visitors, hopefully. I don't know, John, if you want to add anything to that.

Trish Kritek:

Nope. He says you're good. So we're looking into it. We're not there yet, but we might move in that direction. Okay. One question about therapeutics. What have been our results so far with Paxlovid? Do you have a sense of that?

Santiago Neme:

Yeah. Paxlovid is one of the treatments that we have to offer along with the sotrovimab, which is the monoclonal, and then the Evusheld, the prevention agent. Paxlovid is a highly efficacious medication. This is the Pfizer product. The issue with Paxlovid is that many folks are taking already drugs that interact with this medication, because the medication has a component that potentiates the effect of other drugs and drugs like the drugs that you take when you had a transplant and you want to suppress your immune system. So there's a subset of patients for whom this medication is not really a good option and therefore, we would go to a monoclonal. We use it a lot. Our pharmacy team has been amazing in really designing a system through which you either can pick up the medication at the Montlake outpatient pharmacy through curbside, or you can have that delivered to your home and you don't pay for this.

Santiago Neme:

So we have a mechanism to make sure that we do this through an equitable lens. For instance, two weekends ago, we had a patient at Harborview at the PES psychiatric ER. The patient was being discharged. We basically sent Paxlovid to Harborview from the Montlake pharmacy and got that patient the treatment so he could be discharged with the treatment as opposed to the curbside or riding a taxi or whatever or home delivery. The patient really didn't have a clear home. We really try to do this-

Trish Kritek:

Okay.

Santiago Neme:

... through an equitable lens.

Trish Kritek:

It sounds like we're having good results with it. There's a significant subset of people who have other medications that they can't take it. So those people are excluded. We use the monoclonal setting. We're doing a lot of things to make it easy for people to take it and equitable. I appreciate it and I appreciate you being our resident dermatologist today. I definitely push you outside your usual comfort zone and you rolled with it beautifully, so thank you for doing that.

Santiago Neme:

You're welcome.

Trish Kritek:

John is appreciative. I am going to ask John a few more questions before I hand it over to Anne for ask an ID doc. I'm not sure how many of these will get through. We have a bunch, but I'm going to try a few. The first one is, and people asked this a couple weeks ago. I didn't get to it, what's the difference between endemic and pandemic?

John Lynch:

Yeah. These are epidemiological terms that have a lot of history behind them. We are right now in the midst of a pandemic. It is a pathogen that is moving at higher than expected levels across the planet, across international boundaries. That's what defines a pandemic versus an epidemic, which tends to be

something that's occurring at very high levels within a specific area, within a boundary. You can already start to see some of the historical context here around boundaries, locales, many of which don't really exist anymore and actually, have some rooting in a colonialist perspective on the world. I just say there's some caution here. Underneath that is this term, which I think you're going to get to, Trish, is endemic.

Trish Kritek:

Mm-hmm (affirmative).

John Lynch:

You're hearing this a lot in the media. When are we going to get from pandemic to endemic?

Trish Kritek:

Mm-hmm (affirmative).

John Lynch:

A lot of the times when we think about endemic, we are thinking about, "Oh, this is going to be okay. It's benign. It's controllable." I'll just point out for a long time, hundreds if not thousands of years and up to this point, diseases like tuberculosis, malaria, polio were endemic. They occur in many parts of the world at either stable or fluctuating levels. Endemic doesn't mean harmless or benign. We also have to recognize that endemic was often used by particularly Western scientists as over there. TB happens over there. Cholera happens over there. This is not going to be an over there thing unless we continue on the root of the vaccine equity issues that we're dealing with right now.

John Lynch:

So COVID is here to stay in some way, shape, or form for a long time. If the level's going to come down at some way, shape, and form, when that's going to happen at a level that we find we can roll back respirators and roll back masking or roll back the level of testing that's needed, I'm not sure. I do not know. I do believe we'll get there at some point, whether it's weeks, months, or years, unknown. That's when we get to that point, when we come to a point in our lives where society says, "This is where we are moving into our new normal, an accepted number of infections, an accepted number of deaths associated with COVID-19," that to some extent is going to define what endemicity is, where things are fluctuating at some stable-ish level, some predictable level that we are not at right now. Just to be clear, it's completely unpredictable right now. That's why when you ask Tim to predict, or me or Dr. Bell or anyone else in this call to predict, we can't because it is not endemic.

Trish Kritek:

Okay. I think the big take homes of that were at first, I appreciate the cultural and the racism are biased background of some of this that you just alluded to. I appreciate you highlighting it. Pandemic means really high levels and we're still in a pandemic because there's really high levels all over the world right now. Endemic means there's just an ongoing level of infection, which can go up and down, but it's not super, super high, make it higher and lower. I think the distinction that you made that I thought was really important, sometimes people are saying endemic, it means it's not a big deal anymore. It doesn't mean necessarily that people don't get sick from it anymore, it's just the volume of infection is significantly different. And I know because we've all been surprised multiple times.

Trish Kritek:

I keep asking because I think navigating the uncertainty of this time is hard for everybody and the people on this call have more information and more experience to give their opinions. I want to be really clear. Sometimes people give their opinions, then we're not going to hold anyone accountable. I'm not going to hold anyone accountable to those opinions. It's just helping people deal with the uncertainty that's present for them day to day. Okay, I'm off my soapbox. I'm going to ask you one last question and then I'm going to hand it over to Anne, and that is, we've talked about fit testing of N95s and then we say, you don't have to wear a fit tested one. When is it that I need a fit tested N95? I think that's the best question to ask.

John Lynch:

Okay. Where I want you to be wearing a fit tested N95 is when you're in, taking care of a patient who's in precautions. They require an N95. So that means someone who has known or suspected COVID-19, we need you to be wearing a fit tested N95. You have someone who has tuberculosis or suspected known tuberculosis, we want you to be wearing a fit tested N95. We also really want our health workers who are doing aerosol generating procedures, intubation, extubation, nebulizers, things like that to be wearing a fit tested N95. The reason is that we really want maximal protection in the highest risk scenarios. Now, the challenge is that all these terms are on respirators and fit testing are actually way out of date. They do not apply to Omicron to large extent because we have to recognize that respirators, they have both directions. They protect the wearer, but really, really importantly, in a way that we've never really had to struggle with before, they also protect everyone around the person who's wearing the respirator.

John Lynch:

The reason we move to respirators and the leveling up over the past few weeks is because we wanted to protect everyone, including our patients from us, from the ones who are wearing the respirators, as well as protect the people who are wearing the respirators from patients who may or may not have COVID. That part is not at all in the paradigm of how we use respirators historically. They don't fit into the regulatory framework or the fit testing part. So we're navigating that. We're trying to figure out the way it works, but we know that putting a respirator on, even if it doesn't fit by the regulatory perspective, does provide a higher level of protection for the wearer and also protects those around them. So the take home, as you mentioned, your short answer here, Trish, which you never get from me is if you're the precautions patients and aerosol generating procedures. We are ramping up our fit testing access, so please look out for that. Please do get fit tested when your time is due. We're doing our very best to make it easy for you.

Trish Kritek:

I actually appreciate the nuance of that answer, so it's all good. You need a fit tested when we're in patients with COVID or other reasons where you need to have the N95 like TB or aerosol generating procedures. I think that really important thing, and just to say it out loud again, is we are having you wear them both to protect you, but really because people could be infected and not realize it, to protect everyone around you. That's different right now because there's so much Omicron around still. There's still a lot around, that's why it might evolve over time. Okay. Thank you. With that, I'm going to hand it off to Anne for ask an ID doc.

Anne Browning:

Excellent. So I get to have John on the hot seat today. Also, I wanted to say thank you to everybody who is putting in the Q&A questions around how they could support the COVID-19 employee emergency funds. Very nice to see that kind of outpouring of support for folks as well. John, as Tim mentioned at the top of the hour, for a minute there, we were at 2,000 cases per 100,000 per week, which was nuts. Now we've dropped down to about 1,000, which is still three times higher than we'd ever seen before. But folks are starting to get a little stir crazy, and it is starting to feel, maybe we've turned a corner. I want to start with just a broad question for you. We've got a lot of questions that came in, but when will you feel like we've descended the wave enough that you feel like you can go about some of your more routine within COVID behaviors?

John Lynch:

Well, my routine has actually been conservative throughout. I've actually not changed much with the Omicron surge aside, actually, maybe just a higher level of caution. I'll just give you two concrete examples. One, as I've talked about before, I like to climb. It's one of my mental health things. I've never stopped climbing throughout the Omicron surge. I know where I go. I've talked to the people who do it. I know the ventilation's awesome. I'm spaced out. I wear a respirator and everyone in that space is tested or vaccinated. So I feel like that's worked out really, really well for us and I've continued that. On the flip side, maybe in December, at the beginning of December, I would've let one of my daughters have a sleepover, a birthday party sleepover, which she was just asked to go to this week. With the Omicron surge, my answer right now, my wife and I have decided that's probably not a good thing right now. Those are two examples of how I'm dealing with this right now.

Anne Browning:

What do you think you would want to see happen to ease some of that, for instance, for your kiddo to suddenly be able to have a sleepover again?

John Lynch:

What would I want to see? I'd like to see these numbers continue on a trajectory. I think I have a threshold sort of approach to this. I'd like to see that trajectory, but I'd like us to get down to that moderate level, back to the 50 to 100, maybe 150 per 100K level. As someone who looks at these numbers all the time, I have a good sense of them. That's probably what's going to drive me. If I see that coming in the next week, knowing that all these numbers are delayed, I'd start thinking about easing up. But again, I've approached this whole thing for two years from a pretty conservative standpoint. As your question's going to indicate, I'm still with the same pods and the same activities throughout.

Anne Browning:

Good. Thank you. Somebody had asked if you were still rock climbing. So yes to that for that question. Would you let your 14-year-old kiddo, your daughters go to the gyms as well?

John Lynch:

Yeah, both my kids have actually climbed. They're both climbers too and they are on a team. That's, for me, is an essential part of their mental health. Again, I know the environment and they're vaccinated, fortunately, because of their ages and they don't have medical comorbidities. So we've kept up with that. They're still doing it.

Anne Browning:

Would you go swimming right now?

John Lynch:

If there was not too many people, I think you can be in a swimming aquarium, not aquarium, a human aquarium, a swimming pool. Sorry, it's the long week, a pool. I think a few people in there in a big pool is probably pretty safe. Mask on as soon as you get out.

Anne Browning:

Cool.

John Lynch:

Probably shower someplace else.

Anne Browning:

Would you get a haircut right now?

John Lynch:

I get my haircut in the back porch with a pair of dog clippers, but if I needed to go to the barber, then I think that can be done very well.

Anne Browning:

Would you get a pedicure right now?

John Lynch:

I've never had one, so I can't speak to it clearly. I might need one. I don't know, but I think it's okay. I think if you have a mask, person who you're working with and you're masked and you're vaccinated and especially boosted, I think it's pretty safe environment. I'm allergic to super crowded environment, so if it's stuffy and crowded, I'd probably turn around.

Anne Browning:

Would you go to the aquarium or the Seattle Art Museum right now? I'll say, I've been to the Seattle Art Museum. How would you feel about going to those places?

John Lynch:

Oh, when you sent me this question, it actually makes me want to go. I would go. Again, if it's crowded, if it's stuffy, I would turn around and leave, but if I feel like the air's moving and I have a mask on, I would feel pretty good about that.

Anne Browning:

Same questions come in every week and folks just want to know where you're at. Would you eat indoors in a restaurant?

John Lynch:

No.

Anne Browning:

Would you eat outdoors at a restaurant right now?

John Lynch:

I would if it only is completely outdoors. I don't even do the little kiosks. I like outdoors, picnic table, no covers.

Anne Browning:

Yeah. So not the unventilated tarp situations. Yes.

John Lynch:

Right.

Anne Browning:

Would you ride in the car with the windows up with somebody who is not in your pod?

John Lynch:

Not masked or masked? Not masked, no.

Anne Browning:

Not masked. No. Would you go grocery shopping right now?

John Lynch:

100%

Anne Browning:

If you had had Omicron, would you be living it up right now?

John Lynch:

No.

Anne Browning:

That echoes what Tim shared last week as well. Crystal ball, because everybody wants to know, would you get on a plane in February?

John Lynch:

Given the trajectory we're on, if I had to put the crystal ball on, I'd say probably yes, late February.

Anne Browning:

How about international travel for March or April?

John Lynch:

Yeah, I would, if I, again, crystal ball, taking Trish's words to heart here, I'd say probably. Recognize it's going to be tricky. You got to get these tests within a day. It's not straightforward and what's happening in other countries and other parts of the world, you're going to have to keep an eye on it. Japan, New Zealand, thumbs up, but other parts of the world may be having a tougher time.

Anne Browning:

Awesome. John, as always, thank you very much with that. I'll hand it back to Trish.

Trish Kritek:

Thank you, Anne. Thank you, John. Thank you everybody. I want to pause for a second because I have a special thank you today. As many, but maybe probably not everyone knows, this is Jerome's last town hall. Jerome is moving on to a new chapter of his career. I want to pause to say a special thank you to Jerome. This has been a rough two years and it has been hard, hard work. I know that you have been doing it 24/7. I'm deeply grateful for all that you have done for everyone at Harborview. Personally, I'm super appreciative of your willingness to buy into this crazy idea of doing town hall and letting me tumble you with questions every week.

Trish Kritek:

I'm really appreciative. I'm appreciative of your grace in answering them, of acknowledging the times when we don't have answers. I think for the people who don't know it, going behind the scenes to try to come up with answers and implement things based on the ideas that people give us here at town hall. I speak for me, but I really think I speak for everybody on the screen that we're deeply grateful for all that you've done. I want to wish you so much luck in this next chapter of your life, that I will miss you and I will notice a space that's not on the screen when you're not here at next town hall. Thank you.

Jerome Dayao:

Thank you, Trish and thank you to everyone. I'm extremely grateful to be a part of UW Medicine family.

Trish Kritek:

Yeah. So it's with sadness that I say goodbye, and again, say thank you to Jerome. I say thank you to all of you for tuning in. We're going to take next week off. I think we all need a little bit of a breather and we'll be back the following week. Please continue to submit your questions. We'll be looking at them in between, and we'll see you back in February. Thank you. Keep taking care of our patients, their families, and right now, with our fingers crosses, looking a little better, keep taking care of each other. See you soon. Bye-bye.