Trish Kritek:

Welcome back to UW Medicine town hall. I'm Trish Kritek, and with us today are Tim Dellit, our chief medical officer; Santiago Neme, medical director at UW MC Northwest; Tom Staiger, medical director UWMC; Cindy Sayre, chief nursing officer, UWMC; Rick Goss, medical director Harborview; and Jay Sandel, interim nurse manager ... CNO, sorry ... at Harborview. Jay, I was already basking in the glory of getting all the titles right, and then I messed it up. Sorry about that.

Trish Kritek:

As folks can see, there are fewer people than usual here. It's school vacation week and folks are away, which is great. John's away, Keri's away, and sadly, Anne is away, and when Anne is away it makes me sad for many reasons. I see her most every day because her office is right next door to mine, and on Fridays at 3:00 she delivers a wellbeing message, and when she's not here, that responsibility falls to me, which stresses me out.

Trish Kritek:

So, with that in mind, I spent my morning run thinking about, "What am I going to say for a wellbeing message?" And I started with, "Boy, it feels a lot lighter the last week or two. There's fewer numbers of patients. It feels better. I've been feeling pretty good." I checked in with Keri and got pictures of the beach in Hawaii, and checked in with Anne and got pictures of beautiful snowy mountains. My mom is even on vacation. She sent pictures of wine tasting. And I was like, "Maybe that's it."

Trish Kritek:

And then I kind of acknowledged to myself that, for the last 48 hours, I've felt a weight because of everything that's happening in the Ukraine. It's crazy. I've been trying to get my head around it. It's been super distressing to me, really. And as I thought about it, I thought of my former fellow ... I used to be a fellowship director ... who's Ukrainian. When I got back from my run, I emailed him and I said, "Alex, I'm just thinking about you. Hope you're okay. Hope your family's okay. Just wanted to check in."

Trish Kritek:

And that's when I thought of what my message is, and that is that over the last two years, I've checked in on a lot of people, and I think I used to do that, but I do it a lot more now. And sometimes I check in because something great has happened, and sometimes I check in because something hard is happening, and sometimes I just check in to check in. And other people do it for me. Molly Jackson checks in just to say, "How are you doing?" And folks on the screen do it for me, to check in.

Trish Kritek:

So, one of the things I was thinking about is, Anne and I talk about what are the things from this pandemic we want to hold on to. For me, that check-in is going to be a thing I'm going to hold on to. So, I want to bring it to all of you. I think that little email, or the message in the chat, or a quick text just to check in on each other is something that we've done as we've dealt with physical distancing and staying at home and not being able to travel, and it's a good thing to keep doing as we move forward. And it helped me today, as I kind of thought about the challenges related to Ukraine and beyond, and it helped me kind of know about the joys that people are experiencing as well as they're on vacation.

Trish Kritek:

So, that's my wellbeing message for today. Anne will grade it later, and she'll tell me if I passed or failed. With that, Tim, I'm going to turn to you, and I'm going to start with the questions that were kind of in the same spirit of this tension of feeling good, and also not sure where to go. There was a theme of questions that were about, "Are you worried about us lifting the mask mandate? And what do we think the implications are going to be of lifting the mask mandate in the state?"

Trish Kritek:

So, I'm going to start with that and kind of ask you what a lot of people ask, which is, is it too soon? And what do you think the implications are going to be?

Tim Dellit:

Yeah. Thanks, Trish, and again, welcome, everyone. I think your wellbeing message passed. It was excellent, so that's my vote.

Tim Dellit:

You know, we've talked a little bit in our last town halls where we anticipate that March is going to be a month of transitions. What we have seen now are some announcements, starting at the governor level, from the state standpoint, both around outdoor masking earlier at large events, and now removal of the indoor masking requirement as of March 21st.

Tim Dellit:

Keep in mind that excludes healthcare, long-term care, correction facilities. So, again, within the healthcare environment, I fully anticipate that we will continue to be wearing masks, and we'll talk a little bit more about that later.

Tim Dellit:

I think, again, we're in this transition phase where if you look at the numbers in King County, we were at, this morning, 126 per 100,000 over the last seven days in terms of cases. That is still in the high transmission level. Now, it is markedly down from the 2,000 per 100,000 that we were at, it seems like just a few weeks ago, so definitely going down in the right direction.

Tim Dellit:

It got a little more confusing today because the CDC has just come out with some new modeling in terms of how they describe what's happening with respect to COVID-19 at a county level, and if you look at the CDC site now, it says 'low'. The reason is is that they just literally this afternoon introduced not only looking at the number of new cases, but the number of new hospitalizations, and the percent of beds that are occupied by patients with COVID-19. And if those are less than 10 and 10%, then you fell into that low category. So, that just raises a little more confusion, but if you look at those transmission numbers of 126 per 100,000, that's in line with where we were in previous surges. So, it's still going down, but it's not gone, and I think that gives people pause around the masking lift.

Tim Dellit:

Now, again, March 21st is still three weeks away. I anticipate that these numbers hopefully will continue to go down. I also think, again, even if the mandate goes away at the state level, we still don't know what King County is going to do. Jeff Duchin has not made any statement yet in terms of whether King

County will follow that March 21st date, or whether they will extend it, so again, we have to follow our local public health jurisdiction.

Tim Dellit:

That's also why the university as a whole has not made any announcement on what they're going to do in terms of indoor masking. Again, outside of the healthcare environment, because that's separate, but the university is waiting to see what King County is going to decide before they make any determination. And I also suspect even if the mandate goes away, many people may continue to wear masks when they go into grocery stores or other environments. I personally probably will continue to do that. So, I think people ...

Tim Dellit:

I said before, early in the pandemic, it's easier to ramp up many of these mitigation steps. It's much harder to come down and start to pull them back, and people are going to have a range of comfort level, ranging from, "I want to get rid of those masks now," to, some are like, "Oh my god. We can't get rid of those masks." And I think that's all okay. That whole spectrum is okay. The good thing is, overall, things are improving, but there is going to be a little uncertainty over these next couple of weeks as we move towards the 21st.

Trish Kritek:

That's really helpful, because I think I felt that spectrum of reactions in the questions that we got for this week. So, the big things I think I heard you say are, one, it's March 21st and things could still evolve over that time, and hopefully numbers continue to come down. Two, we have these two different metrics of, are we high or low in terms of risk right now. The number of infections, still high, but the numbers in the hospitals, much lower, so, got to figure that out. And then, the last one was ... And at the end of the day, it's the King County rules that are going to matter the most for us, and the university will kind of follow the lead of the county, so more to come on that. Thank you for that thoughtful and nuanced answer.

Trish Kritek:

The other side of this questions were, "Are we at the point where we can start having in-person meetings and conferences again?"

Tim Dellit:

Yeah, and I think I just reached out ... Both John and Seth are out this week.

Trish Kritek:

I know.

Tim Dellit:

But I do think we're at a point where we start to have to think about, how can we start to do that safely? And again, I think March is that transition month. We'll still be wearing masks, particularly within the hospital and clinic environment, but I do think we have to start to think about, when can we start to gather for, particularly educational activities, and maybe it's initially, what is that size? Some of it depends on the room space, the ventilation within that room, all of those things that we've continued to

focus on throughout the pandemic, but I do think those questions are very natural, and I think we're going to slowly start to move in that direction.

Trish Kritek:

Okay. So, more to come on starting to gather more and figuring out strategies on how to do that. What about with your working in a non-clinical shared office space? Do you still have to wear a mask in those spaces?

Tim Dellit:

Currently, you do. Again, we're under both the university and the King County ... and state, for that matter ... until March 21st. And again, we have to see what the university and the county do; if they stick with that date, or if they extend. But, for right now, yes, if you're in a shared space indoors, you have to continue to wear a mask. Yep.

Trish Kritek:

Thanks. So, yes. The answer is yes. Shift gears and ask a couple questions about boosters. People who were asking about folks who are potentially in clinical spaces, but have non-clinical jobs, like clinical research staff, or non-clinical employees of UW Medicine, what is the requirement around boosters?

Tim Dellit:

The requirement for boosters is really within our hospitals and our clinics, within that clinical environment, those individuals who use our employee health services that are based in the hospital, so our shared services that use our hospital-based employee health are following that requirement. That is separate from individuals within the non-clinical parts of our school, such as in the research environment. They are not included in that.

Tim Dellit:

Now, if they happen to work in the research environment, but part of their research is going into the hospital, then they should be boosted. So, people who are coming into that hospital or clinic environment do need to be boosted.

Trish Kritek:

Are we keeping track of those people in some way, if they're coming into the clinic spaces?

Tim Dellit:

Well, I, again, would defer to our employee health folks who are not here. We have good denominators for those people who they track as part of their normal service there. It gets a little more complicated for those individuals who normally use EH&S, but I think some of this is ... We also have to rely on the individuals to understand that, if they are coming into that clinical space, we really expect them to be boosted for their protection and protection of the rest of our employees, and particularly our patients.

Trish Kritek:

Okay, so the recommendation still is to get boosted. For sure, if you go to employee health as your place, as opposed to EHS ... EH&S?

Tim Dellit:

EH&S, yep.

Trish Kritek:

EH&S, then you are part of that umbrella of it's required to be boosted. If you're a research person coming into the clinical spaces, you should be boosted, and how we track that is still a little bit gray, so, more to come on that.

Trish Kritek:

Last question for you. There were a bunch of questions about vaccines for under-five-year-olds, and I know we don't have them yet, and I'm going to bring back Dr. Bell when we have that on the horizon, but, are we going to have a clinic at UW Medicine for small children?

Tim Dellit:

The strategy for vaccinating that younger group will be a little bit different, in part because public health recognizes and has concerns about using mass vaccination sites as the vehicle to really vaccinate those under five, so we will be doing a combination of vaccinating through our pediatric clinics; so, our pediatric clinics at Harborview, UW Medical Center, in the neighborhood clinics, and I believe the Harborview mass vaccination site will also offer for that age group. We'll probably do some pop-up clinics, vaccination clinics, through the UW Medical Center, so it's going to be a little bit different recognizing that we have to navigate that age range just a little bit different, rely more on the pediatric clinics, while supplementing with some of our other vaccination sites.

Trish Kritek:

Okay. So, the UWMC clinic, sounds like that's a no, but maybe at Harborview, the clinic, and then mostly in our pediatric clinics in our local sites, based on public health feeling like it's a little bit different for smaller children. Is that right?

Tim Dellit:

That's my understanding.

Trish Kritek:

Okay. All right. Santiago, you have to return to the days of being an infection preventionist today. Thank you for filling in for John and Seth and everybody else who's away this week. Let's start with numbers. Can you give us the numbers for the system?

Santiago Neme:

Yeah, some really good news. We have a total of 22 patients across UW Medicine today. With Harborview, Harborview has a total of five patients. Unbelievable.

Trish Kritek:

That is unbelievable.

Santiago Neme:

Two in acute care, three in ICU; still proportionally more in the ICU, which is common at Harborview. At Montlake, we have nine patients; eight in acute care, and one in the ICU. Unusual for Montlake, but again, decreasing. Northwest, three, all in acute care. And then Valley, five total; three in acute care, two in the ICU. I don't know if it's the weather or what, but things are just looking really good.

Trish Kritek:

Yeah. It fits with the sunshine. Those are great numbers. Tim alluded to the fact that numbers are better in King County as well. Do you want to give a sense of King County?

Santiago Neme:

Yeah. King County, when you look at only cases per 100,000 residents over the past seven days, that number is 122 cases per 100,000 residents over the last seven days. That puts us at the high transmission rate, still considerable amount number of cases in the community. That is in contrast to the guidance that CDC just published, where they're basically putting a lot of emphasis on the admissions for COVID, so it is the hospitalizations rather than ... So, it's the burden on the hospital that's now part of that equation. Where certain counties in Washington are kind of on the low or green mark, including King County currently, per that CDC guidance.

Trish Kritek:

Yeah, like ... Sorry. Please, continue.

Santiago Neme:

No, but like Tim said, we don't really live in a vacuum. For us, it's really paid off to have a very strong relationship with public health, King County, Dr. Duchin and his team. John and Seth have been in constant communication with that group. Also, what the government, what Inslee does in terms of guidance as well.

Santiago Neme:

And also, I just wanted to point out that, for us in a hospital setting, things are a bit different in that the guidance that you're hearing is really about the community and not necessarily the healthcare areas.

Trish Kritek:

Yeah. So, I think the big take-homes I heard are numbers are way better ... And there's still a high number of cases, but way, way, way lower numbers of cases in the community than we had. And we're still trying to sort out how we're going to gauge whether we call this low or high, and I think that's going to evolve over the next few weeks, several weeks.

Trish Kritek:

Okay. There are two big topics of great interest. The first one is, have we been seeing BA.2 in folks infected here in Seattle?

Santiago Neme:

The answer is yes. I was fortunate to be able to talk to Dr. Alex Greninger, who leads a key lab, who has been amazing throughout the pandemic. I'm sure all of you know him. But, basically what he said is that our rate's at about 3% to 5%. That is kind of matching what we're seeing in other parts of the country.

CDC now has a new revised website dashboard where you can actually see all the variants of concern, and has B.2 at between 3% and 5%, which is the same data we have locally.

Trish Kritek:

Okay, so 3% to 5% here, and pretty much everywhere, it sounds like, in our country. Have we learned more about what it means to be infected with BA.2?

Santiago Neme:

Yeah. BA.2 is associated, at least preliminary data, with higher transmissibility. It's still too early to know about the severity of disease. One would say that it's probably akin, or maybe less severe than Omicron, but that would be an extrapolation that I don't think I should make. So, I would say we don't know in terms of severity. It's likely that it's more contagious.

Trish Kritek:

More contagious. Don't know about severity yet. And how about the last question about BA.2? Can you get infected with BA.2 if you've been infected with BA.1?

Santiago Neme:

For several weeks, a lot of scientists were saying that it's unlikely. Now there's a paper from Denmark, and Denmark has seen a lot of B.2, and they have had a handful of cases ... I would say 45 cases, and they're serious ... where they saw reinfection, but not right after getting Omicron. So, I would say still the reinfections that soon after being infected are pretty, pretty low, infrequent. So, is it possible? Yes, according to the study. Is it likely? I would say it's unlikely still.

Trish Kritek:

Okay. That's really helpful. Possible, yes, but unlikely. Okay. Second most popular question for you ... Actually, number one. Talked to Tim about stopping masking in the community. I think, as these numbers have come down, a lot of folks in the hospitals want to know where we stand with stepping down from wearing respirators all the time. So, where do we stand with the question of, can we go back to surgical masks in the hospital?

Santiago Neme:

Yeah. Our med tech team has been very, very thoughtful and focused on the safety of our workforce, but also our patients. We've always taken kind of a deeper look at the data and the regulations and the guidance, and put everything together again working with public health. We can see a future where we don't have mandatory masking, for instance, or we downgrade to a procedural mask as opposed to a respirator for regular care. I would say the respirator for the AGB's are probably going to be still on, because we've identified that as being a really high risk area. But again, it all depends on where this goes. Also, we need to see ... Although I'm optimistic, we need to see what happens with B.2.

Trish Kritek:

So, right now it sounds like we're not changing. It sounds like you're thinking about it. Do you have any threshold for when we might transition to surgical masks as opposed to respirators?

Santiago Neme:

We have been discussing that threshold, and there's different parts of this metric, including what's going on in the hospitals, what's going on in the community, and the levels of vaccination, and everything else. I would say it's an active discussion, and apparently this week, because our leaders in infection control are away right now, we're working through this, and also we're listening to what CDC is saying now. Again, it's a guidance, but we're evaluating it.

Trish Kritek:

Okay. So, I think the take-home is, ongoing discussion, more to come, keep asking. I personally am supportive of the questions, because I also would like to go back to surgical masks.

Santiago Neme:

And one addition. I want to say, we have been traditionally very conservative, and I think that has been a good thing.

Trish Kritek:

I know.

Santiago Neme:

Because we've been very safe, and our approach will continue to be safety first. In terms of just associated with this, a lot of people ask me what to do in your regular life. I haven't changed what I'm doing in my regular life, and I think that will remain for a while until I'm sure, and until we assess the situation.

Trish Kritek:

So, what I think you're saying is you're still leveling up your mask when you're out and about, and wearing a KN95 or an N95 as opposed to just a standard surgical mask.

Santiago Neme:

I am.

Trish Kritek:

Okay. That's helpful. Thanks for that perspective. Couple more questions before I give you a break. Are we still doing pre-surgery PCR tests for patients? With so many people having tested positive in the community, I think people are wondering what our process is there.

Santiago Neme:

We are. The transmission rate, again, looking at cases, still high, so we are pursuing that. Fortunately, our access to testing is amazing right now. And that we reopened the non-urgent electives just based on ... I mean, we didn't, the government did, and it's a key tool, because it's different to know that you have a confirmed patient whose surgery might be delayed further, if clinically indicated, so it's been a really good tool for us.

Trish Kritek:

Okay. So, we're going to continue doing PCR testing pre-operatively. Better access to testing. The one caveat I'm going to ask about that is, what if the patient just had COVID within the last 30 days, or something like that?

Santiago Neme:

Based on what we've learned, and looking at a lot of cases and studies, we actually today just switched from ... Remember in times of early on, we had a 90-day block, basically, where you could not reorder a COVID test?

Trish Kritek:

Mm-hmm (affirmative).

Santiago Neme:

Now that we re-instituted that, because that's going to give patients more access, and we realized that it was too close, so now we're reopening to that 90-day limit. So, if you just had COVID, you don't get retested for 90 days.

Trish Kritek:

Okay. I think that's an important one. So, no re-testing for 90 days. When you're an inpatient, or if you just had COVID and you're going to have a surgery, you don't get re-tested? Is that right? Okay. Thanks.

Trish Kritek:

Last one, Santiago. Came in earlier today. How does getting Omicron compare to getting the flu?

Santiago Neme:

That's a tough one.

Trish Kritek:

What he's showing you is I didn't give him a heads up that I was going to ask him that.

Santiago Neme:

In what way, you think?

Trish Kritek:

Like how sick people get, I think is what they were trying to understand.

Santiago Neme:

To be honest, I mean, Tim is here, and Tom, and Rick, who see patients ... A lot of people initially said that Omicron is kind of piece of cake, but I personally know people who got Omicron and they were feeling quite ill and yucky for several days. So, I would say it's a spectrum. I would probably guess that it's similar. Honestly, I haven't had the flu in years, so I don't quite remember that. But, Tim, what do you think?

Tim Dellit:

I was just going to add, the other confounder is that most of the people that we've seen within our workforce that have had Omicron have also been vaccinated, and most of them boosted, too, so we're seeing it in the setting of individuals who are boosted versus if we saw this in a population of unvaccinated individuals. And we continue to see, across the state, we have seen people ... especially unvaccinated ... who have been admitted with more severe disease as well. Now, you can see severe influenzas also ending up in the ICU, so I don't want to minimize them, because we get lulled into a lot of mild disease, but that's in the context of a pretty high vaccination and boosted rate.

Santiago Neme:

And unfortunately, I've met patients at the Montlake ICU who died from Omicron, who were immunocompromised or unvaccinated, and they still did very poorly, despite everything.

Trish Kritek:

So, I think the take-home is, it's a spectrum of disease, kind of like the flu is a spectrum of disease, because definitely I've taken care of patients in the ICU who got very, very sick from the flu, and most people don't. And we're seeing it more often in people who are vaccinated and boosted, which is kind of ... hopefully, I think we know, tempering how sick people get. So, that's a tough one. I thought it was an interesting one though, so that's why I added that one.

Santiago Neme:

No, it was. Just one quick thing, if I may. I would say we still need to remember that, although all these mandates and things are coming down, we still care for patients who are immunocompromised, and it's the key difference between being a healthcare worker and not, is that when I personally compute what I might be doing in my social life, I also take into account when I'm going to be on service, when I'm going to be in clinic, because I don't want to disrupt that, and I think that that will continue for a long time for me personally, because again, we see those patients that we treat, normally in clinic, I would not feel good if I gave them COVID.

Trish Kritek:

Oh. I appreciate that very much, Santiago, and I appreciate your emphasis on the fact that we have lots and lots of patients how are immunocompromised. And folks have family members who are immunocompromised. That plays into their calculus as well, so thank you.

Trish Kritek:

All right. Cindy and Jay, I'm going to pivot to the two of you. I'm going to start off by kind of asking as we're talking about numbers coming down. How are we doing with staffing in our hospitals? I'll start with you, Cindy, and then go to Jay.

Cindy Sayre:

Yeah. Well, my answer's going to be the same as it's been the last few times, which is that it's still variable. I will say in general, we're doing okay at the Montlake campus, but we still have shifts where we're very short, and that's true at Northwest and Montlake as well, so it's still variable.

Trish Kritek:

Variable, and still times when it's tight. Okay. Thanks. Jay, how about at Harborview?

Jay Sandel:

Yeah, I would say the same as Cindy. We've seen some improvements on many of our shifts, but that seems to change depending on what's going on in our hospital, but I would say that we are doing everything we can to continue to improve staffing here.

Trish Kritek:

Okay. So, better, but still tenuous at times, and still tight at times across our system. I appreciate that, and I think people still feel that, so I think it's good to acknowledge it.

Trish Kritek:

Got some questions ... have gotten them before ... about what we're doing to retain ancillary staff. I'm wondering ... I think we often talk about nurses, and so, what efforts are we doing to retain our staff that are the rest of the team that takes care of our patients? Cindy, I'll start with you again.

Cindy Sayre:

Yeah. Well, I will just say that retention and recruitment are the number one priority right now for UW Medicine leadership and all of us at the medical centers, and I am in lots of meetings about the subject, so we're really trying to take a broad view of retention, and look across all of the disciplines and all of the employees that we have, looking for ways that we can increase flexibility for people's schedule to the degree that we can and still operate our clinical areas. I think another thing that we are thinking about at Montlake and Northwest is about meaningful recognition, and realizing that nurses have built in nurses week, Daisy Awards and things like that, so we're instituting something called the Rose Award here, which will be people that are non-nursing are eligible for that, could be nominated, and they'll get a small gift of appreciation, and a certificate, and we'll celebrate them. So, we're looking for ways that we can recognize team members for all of their incredible work.

Cindy Sayre:

And one final comment I would make is, I think now more than ever we just need to have a lot of grace and mercy for each other, and a lot of patience. And also, when we see ... Sometimes I see a colleague doing something great, and we have to make that choice, "Do I want to say something in real time," I'm always going to say something. If I have a positive thought about what somebody's doing or what I'm seeing, I'm going to say it, because I think that's another way to build our team.

Trish Kritek:

I appreciate that. So, increasing flexibility, some novel ways to recognize folks that are other members of our healthcare team, and then, I think, grace and appreciation are both great things for us to all remember. Jay, how about at Harborview?

Jay Sandel:

Cindy said it so well I don't know what I could follow that with, but same kind of tactics here at Harborview, trying to look at flexibility of our workforce and offer those out to individuals if we can. One thing special that we have done here at Harborview is that we took all of our HA's and we are in the process of switching them over to PCT's so that we could be a little bit ... put those folks in a better position that increases the amount of work that they can do for the current license that they take, which is really important for them as they are part of an integral part of our care team, and it also increases

the pay that we're able to give them. So, that was a really big step for us here at Harborview that really, we were focused on them to help retain those folks.

Trish Kritek:

So, elevating HA's to PCT's. Thank you. That's great. Sounds like that has meaningful change for folks when that change is made.

Jay Sandel:

Mm-hmm (affirmative).

Trish Kritek:

Jay, while you're unmuted, we almost always ask about visitation, and I think we've all done our visitations, so there's visitors at all hospitals now. The question that people asked is, when will we go back to "normal" visitation?

Jay Sandel:

Yeah. I think we're having those conversations at Harborview still. We opened up our visitation for short intervals throughout every day, and I think we were going to test that for the rest of February, and then start looking in March to see if we need to expand that even more. So, having those conversations, we're just not quite there yet.

Trish Kritek:

Not quite there, but looking to March to maybe start stretching the times. Okay.

Jay Sandel:

Correct.

Trish Kritek:

Cindy, how about ... Anything different at Montlake and Northwest?

Cindy Sayre:

No. Just in conversations about it, but nothing new at this point.

Trish Kritek:

Okay.

Cindy Sayre:

Yeah.

Trish Kritek:

Well, the good thing is we have visitors coming into all of our hospitals again, and I think that was one thing that people were asking about. One last question about that, specific to Harborview, Jay. I wondered if you could just walk through what the current policy is for end-of-life visitation, because we had some questions about that.

Jay Sandel:

Yeah, I would say end-of-life visitation has been something that has been very stressful here at Harborview at times, I would say, and I would say nothing has changed in our policy for end-of-life. We allow end-of-life visitation beyond what our normal visitation hours are, and beyond the number of people that we allow to come visit. Really, it is a collaborative approach that we do here between the RN's at the bedside, the family members, the providers, myself if I need to get involved, and we do a pretty good way of assessing all those variables to decide how we're going to allow people to come in when we're looking at end-of-life situations.

Jay Sandel:

Every situation is a little bit different, I would say. It doesn't all fit into one box, so it changes at times, so really, the best approach that I have seen here is that we collaboratively come up with a plan, and then we institute it. So, I would say it's hard to answer that question specifically because each situation is different.

Trish Kritek:

Okay. So, there's flexibility. As throughout the pandemic, we've prioritized that families can come in. We expand the boundaries of that, and the numbers of people. And that it sounds like, for each case, there's kind of a discussion of the team to figure out how best to do that in a way that's hopefully feels fair and equitable from patient to patient.

Jay Sandel:

Absolutely.

Trish Kritek:

Okay. Cindy, I saw you nodding. Is there something you wanted to add?

Cindy Sayre:

Yeah, it's the same, and I just ... I will say that I know the teams are working diligently to be as compassionate as possible in these situations, and each situation is unique, but, agree with Jay; it's a collaborative approach.

Trish Kritek:

Yeah. Okay. Thank you both. I'm going to pivot to Tom and Rick. I'll start with you, Tom. Bunch of questions about how the return to elective surgeries has gone, and what are we doing to kind of keep our hospitals not from exploding as we start doing more of these elective surgeries, and a staff that's still tight, as Cindy and Jay just said.

Tom Staiger:

We are glad to be in a ramping up phase to re-introduce non-urgent surgeries as of the end of last week. Prior to the 18th of February, for the prior four to six weeks, our surgeries at UWMC were down about 40% from our baseline. Since Tuesday, we're down about 20%. So, we're up about 20% from where we were, but we're not back to where we had been, so we're ramping up.

Tom Staiger:

We are, my understanding is, to some degree, targeting patients who have ambulatory surgeries and short stays, because we know that beds are tight, so that's one way of getting patients who need to come in, but without overwhelming our bed capacity. And then, we are fortunate that, as of a week ago, we started being able to use the surgery pavilion again, and have gradually opened up over this last week, and that we've gotten to move into our medical specialties clinic as well as of earlier this week. So, from the surgery pavilion standpoint, we have more boarding capacity than we did prior to a week ago. That gives us a little bit more breathing room.

Tom Staiger:

So, we're expanding into that, we're gearing up, but we haven't opened the doors to non-urgent surgeries because we still have some constraints.

Trish Kritek:

Okay. So, about 20% less than we were, but we were 40% down, so, progress, but ramping up, not opened up fully. And the great thing of having the surgical pavilion and those clinics opened, which I know has eased the burden on a lot of folks, so that's great news. Rick, how about at Harborview? How has it gone with surgeries?

Rick Goss:

Yeah, sure, Trisha. Thanks. At Harborview, over the last six weeks or so, we definitely reduced the OR volume around the non-urgent, but there's still quite a bit of that urgent work that has happened. However, as a result of the last week and into this week, we're seeing those numbers really jump right back up to, I was told, even almost busy summer days. So, we know that the backlog that was created, that there really is a need for people to be seen and to get their cases done.

Rick Goss:

And, as you had suggested, just the fact that as the COVID numbers have subsided some, and there is that sense of relief, the hospital continues to be very full, censuses is high, the challenges with the discharge, a lot of referrals. A lot of that unmet need is, I think, really still evident, and we know how hard people have been working for so long, so I just think the impact on all of us as providers, as staff, as physicians and residents and nurses, everybody involved, we're still really in this for the long run. And whether it's COVID or just other stressors on the system, I think we just need to do what you've talked about so often, and that's continue to just really look out for each other, and realize these are some pretty stressful times.

Rick Goss:

But it's good news. I think most of what we're talking about today feels good. It's just busy, and it's hard work.

Trish Kritek:

Yeah. All true. And it sounds like at Harborview, ramping up and ... because so much of your surgery is trauma and urgent stuff, that's been the case, and sounds quite busy. I'll ask a followup to both of you, or either of you. Have we seen better ability to discharge patients to skilled nursing facilities or other destinations? That has been a sticking point, so, is that any better, Rick?

Rick Goss:

Well, that remains, I would say, one of our biggest challenges, really at a system, and I'll say even societal level. We've had people, our CEO and others, who've been working so hard with some of the legislative opportunities, and others, just to create more opportunities there. It's probably our biggest barrier to truly moving patients through our hospital to the full extent possible.

Trish Kritek:

So, still an issue, it sounds like. And I hear you saying it's acutely an issue right now for us, but it's really a bigger picture societal issue in terms of skilled nursing facilities and post acute care.

Rick Goss:

Definitely.

Trish Kritek:

Tom, I'll have you put on your primary care doctor hat for a second. The other thing that folks asked about is, as we've kind of ... turning to normal-ish, maybe, or moving in that direction, have we ramped down telemedicine, or are we still doing a lot of telemedicine?

Tom Staiger:

I think we're still doing quite a bit of telemedicine, though I'm sure that, for a number of reasons, we're doing fewer than we were a month ago. Part of the reason is that many of our clinics are asking patients if they would like to be seen in a telemedicine visit or not, and as community transmission rates to down, patients tend to be more comfortable coming in. Some of our medical staff members go through and review their schedules to see if there are patients that ought to be contacted to ask them to change to a telemedicine visit, but again, as community transmission rates are going down, I think there's a greater comfort level in having patients come in.

Tom Staiger:

And then finally, at UWMC, since we were able to open up our medical specialty clinic and our surgery pavilion this last week, where we had been doing a tremendous number of telemedicine visits, by virtue of having those clinic spaces back, we got people that now have the option of coming in when, before, we were preferentially scheduling many visits as telemedicine.

Trish Kritek:

So, it sounds like yes, we're still doing it and offering it, and maybe more selectively, but we have space to do in-person visits again, and we have a lot lower transmission rate, so we're doing more in-person visits.

Tom Staiger:

Yep.

Trish Kritek:

That's great. I think that's good. I'm going to kind of pivot now back to you, Santiago, which I usually think of as the potpourri of questions that I ask John later in the session, so prepare yourself.

Trish Kritek:

The first one is, we haven't talked about the fact that we may not need to show vaccination, but for the short-term, people were asking, is there a way for folks who are vaccinated in another country to get a card to use to show people here that they're vaccinated so they can go to dinner or go to an event and things like that? Do you know anything about that?

Santiago Neme:

Yeah. The first time I heard about this is when I was talking to Adam Parcher, because we had some employees who got vaccinated overseas, and then how do we enter that in the system? And there is a guideline where you basically can enter ... For an employee, you code it as 'other', and you can enter those vaccines, provided that they are approved by the WHO. If it's AstraZeneca, that's one of the approved vaccines, yes, you can find that. For people outside of our environment ... patients, the people in the community ... there is a way. I would say the most straightforward way is to go to your doctor and show the vaccines that you've gotten, and the dates, and provided that they are WHO, we can go under historical administration and enter them. And then, on their My Chart, it shows as a complete vaccination, and it can issue a certificate. It is not a CDC card. It is a legitimate record that UW Medicine gives patients.

Santiago Neme:

The other thing, let's say I don't have a doctor. You can go on DOH, there's a link under DOH where you can actually request this. But, I would say contacting a doctor, it takes a minute. I'm happy to help anyone in this regard. It's really easy.

Trish Kritek:

That's very generous of you.

Santiago Neme:

If they don't have a doctor. Yeah.

Trish Kritek:

Okay. So, talk to your doctor, they can fill this out and give you a certificate, or there's a way to do it through the department of health, and so you could go to their website to do it that way. Okay.

Santiago Neme:

Yeah. Just don't expect that you're going to get a card, because that's issued in the US.

Trish Kritek:

Okay. So, you can't get a CDC card. They're going to come up with something else that hopefully the vendor will say, "That looks legit." Okay.

Trish Kritek:

There was some popular press this week about cardiovascular risks of folks who've had COVID, and so I wondered if you could talk a little bit about the risks of, let's start with just cardiovascular disease post-COVID.

Santiago Neme:

Yeah. I think you're referring to a very large study, Nature Medicine, that looked at over 150,000 patients, veterans who have had COVID, and they looked at them after day 30. They found a pretty significant increased risk for many things cardiovascular, brain, including dysrhythmia, arrhythmias, including some increased incidents of myocardial infarction, or heart attacks, and also nonischemic ... that is non-infarction ... processes affecting the heart and the cardiovasculature.

Santiago Neme:

That is one of the most well documented pieces of evidence we have. We have anecdotally, I think, in our patients, have commonly heard and seen that patients are struggling with arrhythmias. That's a pretty common complaint. I would say I'm less familiar with other systems because I feel like they've been less studied, but in conversations with Janna Friedly and folks at the rehab clinic who actually lead the post-COVID clinic for UW Medicine, there's a lot of sleep disturbances and a lot of other issues. Also, international societies for anesthesia have had caution in proceeding with a non-urgent surgery in a patient for several weeks after that. We're actually reevaluating this because there's a new trial, as we discussed, that's coming out that's going to shed more information. But, as we said, this is one of the areas where COVID is very different from having the flu.

Trish Kritek:

Yeah. So, it sounds like ... I think you're right. People are referring to this very large VA database study, and that showed an increase in a broad range, a very inclusive definition of cardiovascular events post-COVID, so there is some signal there. Is there anything that we can do about that, or is it just something that we are aware of?

Santiago Neme:

Honestly, what I recommend typically ... well, first of all, is trying to prevent COVID, right? With all the measures. And second is really, try to see your doctor. You might need to see a specialist, but, to my knowledge, vaccines have been shown to prevent things like long COVID, for instance. It decreases your rate by 50%. So, again, avoiding that, taking care of yourself so you don't give it to your patients, again, these are the things I would want to do, and you might need to see a cardiologist, or you might need to see that excellent post-COVID clinic that we have here that has a huge array of specialists who can help you.

Trish Kritek:

Okay. So, there is some increased risk. I guess we'll learn more about this over time. You also mentioned some sleep disorders, and that our clinic, our post-COVID clinic would be a place that potentially people could go and get kind of a full assessment about implications after COVID, including long COVID, which we've talked about before.

Trish Kritek:

Last maybe one or two questions, depending. If you've had COVID ... Because we've talked about it; a lot of folks have had COVID now ... and then you get symptoms within the 30 days of having had COVID, should they retest? What should they do at that point in time?

Santiago Neme:

No, we don't really recommend a test for cure with COVID. Most infections, we don't recommend that.

Trish Kritek:

But they have new symptoms. They have new symptoms.

Santiago Neme:

Oh, they have new symptoms.

Trish Kritek:

So, like, I had COVID, I got better, and now it's three weeks later and I'm having symptoms that I think could be COVID. What should I do?

Santiago Neme:

It is a challenging situation, because a lot of people have symptoms, they get better and they get worse, and if I get a PCR, it might remain positive. So, we don't recommend retesting within 90 days. I would probably evaluate the patient and see whether there's any complication associated with this. But if you talk to many people who have had COVID, they tend to have a protracted kind of slow, where they feel better, and then a bit worse, and then ... so, it's fluctuating in a way. But I would not retest. Unless you think that you're going to have ... I don't know, I can think how I could retest a patient who is immunocompromised, who might be one of those reinfections early that was shown in Denmark, but still, we're talking about very infrequent cases. I don't know if Tim or Tom or Rick or anybody have any additions to that, but we do not recommend retesting.

Trish Kritek:

So, I think the take-home is don't retest. You said don't retest for 90 days. But even if you have repeat symptoms, you're suggesting not to retest right now.

Santiago Neme:

I suggest not to retest, because it is possible that the PCR is positive still.

Trish Kritek:

But does that person need ... Okay. I guess the question I think I would ask ... I'll just ask the question I have, which is, how do I know that I'm not infectious again at that point in time? Do I then isolate?

Santiago Neme:

I would say no. I would say typically we don't get retested because of the positivity rate now, the PCR remaining positive. But, if you have new symptoms after fully recovered, I think I would consider retesting you, especially if you're in healthcare. But I would probably look at the cycle times, I would look at other things associated with the testing. Because if your cycle time is 38, your symptoms have nothing to do with COVID.

Trish Kritek:

Okay. So, big picture, we generally don't retest. If you're a healthcare provider and you develop new symptoms, this might be a good time to talk to employee health, because like Santiago's saying, he would have a nuanced approach towards retesting in that situation. Is that fair?

Santiago Neme:

Yes.

Trish Kritek:

Okay.

Tim Dellit:

And the other thing that I would just add, again, depending on where we are in the year and so forth, but your other respiratory viruses, you want to just make sure that you're not missing something else. You could have the flu. Maybe you had COVID, unfortunately, three weeks ago and now you have influenza or RSV or one of the other respiratory viruses.

Trish Kritek:

Thank you.

Tim Dellit:

We haven't seen a lot of that, but periodically we will see some cases.

Trish Kritek:

That's helpful.

Santiago Neme:

Especially when mask comes off, right? I haven't been sick in two years, but now, if masks are lifted ...

Trish Kritek:

Yeah. There are other viruses that could give you some of the things that we're particularly seeing with Omicron, which are upper respiratory tract stuff. Okay.

Santiago Neme:

Just one thing. Let me rephrase what I said. Normally, we don't retest. If I retest for COVID, I really need to look at additional data and all that if that test is positive, because it's likely to be previously positive, still the same. That's the most likely scenario.

Trish Kritek:

Okay. I think that's helpful. Generally, we don't retest. If we do retest because of whatever circumstances, we're going to have to take the whole constellation in interpreting that test, because the odds are it could still be positive from your original infection.

Santiago Neme:

Right.

Trish Kritek:

Super. Thank you. All right. You're off the hook. Tim, you're on the hook. I'm also wearing the hat of Ask An ID Doc today. I'm wearing many hats. And you are the ID doc, so, there were lots of questions. We'll see how many of these we can get through.

Trish Kritek:

First, we'll do some quick ones. Would you go to a Kraken game right now?

Tim Dellit:

You know, crowds still make me personally nervous, but I think we're getting close, where, again, if you're masked ... My worry with some of the indoor athletic events is that people don't always keep their masks on, so I'm probably not quite there yet, but I think, over the next few weeks, I could be.

Trish Kritek:

Okay. And I'll just tell everyone, I went to the Kraken game with the most conservative significant other in the world, and he even went to the Kraken game, so ... Fair enough. You're on the cusp, but not quite there, so I won't ask you if you would eat at the game. So, I'll ask you this. Would you have dinner with friends indoors now?

Tim Dellit:

At our house?

Trish Kritek:

Yeah, at your house.

Tim Dellit:

Yeah, I think probably at some point in March. We had a very small, within our bubble, individuals who we would periodically eat with. We stopped that over the last couple of months, and I've always said, "Well, we'll reevaluate in March," so I think I'm getting to the point where, for people who are boosted, we know their practices, I think we can start to resume those activities.

Trish Kritek:

Okay, so, boosted bubble friends can come over for dinner. I like it. If you had younger children than you do, let's say ... much younger ... would you let them play indoor sports at this point in time?

Tim Dellit:

I would. I would probably still like to have them masked, and I think those are still the school requirements, but again, I think we have to be able to reengage in these activities, and I think participating in those athletic events is important for their development and their socialization.

Trish Kritek:

Yeah. I appreciate that. The other group that people are worried about are their unvaccinated less-than-five-year-olds, particularly as the mask mandate may be lifted. Very specific question that came up actually multiple times is, would you send your unvaccinated small child to childcare after the mask mandate is gone?

Tim Dellit:

That is a really tough question, and if I think back to when I had children of that age, honestly, I didn't have a lot of other options. So, I probably would, because I wouldn't really have another way to do that.

I also, again, do trust that public health, as they evaluate when it is safe to do that, I think at some point we have to make that transition. I know it's going to be uncomfortable for many, but I think we're going to need to do that. I also wouldn't be surprised if some places, even when the mandate lifts again, they may still ... People who work there may still wear masks, or maybe the place itself will say that we want to continue to wear masks, but I think it is going to be a period of uncomfortableness for many people, but I totally also appreciate that you don't have any other choice. So, I probably would in that context, and also recognizing we have to move in that direction as a society.

Trish Kritek:

Yeah. I appreciate that. I'm reigning in my tendency to want to summarize you so that I stay in the Ask An ID Doc, so I'm going to stay with questions. People are talking about traveling now. Would you go to Disney World right now?

Tim Dellit:

I don't like Disney World on a good day, so I probably would not, and I know I'm going to hear about that. I apologize.

Trish Kritek:

Probably you are.

Tim Dellit:

But, on the flip side, it's outdoors, so I would wear a mask, but I would feel comfortable being outdoors and in that environment.

Trish Kritek:

Okay.

Tim Dellit:

I probably wouldn't go into the indoor restaurants and things like that, but I think that's a largely outdoor activity that you could start to reengage in.

Trish Kritek:

Okay. And then, how about, would you feel comfortable going to the UK right now, where they've kind of lifted COVID precautions already?

Tim Dellit:

Yeah. I would still wear my mask, and interestingly again, I'm anticipating going to London in May for a meeting, and I'm hoping to be able to do that, so I probably would. Again, I'd still use my own precautions around mask wearing and so forth.

Trish Kritek:

Okay. And then the last two are also with a vision towards people worrying about mask mandates going away. How would you feel about flying if there was no more mask mandate for being on a plane?

Tim Dellit:

I'm still wearing my mask.

Trish Kritek:

But you'd still fly with your mask on if other people weren't?

Tim Dellit:

If I controlled the airlines, I'd say that they check for vaccination status too, but that probably won't happen. But, I probably, in all seriousness, I probably will continue to wear a mask on the planes here for a little bit, even if they relax that requirement. Again, I have a lot of confidence in the air flow and the ventilation within the airplanes, and so I think that's actually pretty good, but I probably still would wear a mask for that prolonged period of time.

Trish Kritek:

Okay. So, you would go, but you would be wearing your mask. And last one, would you go to a gym when there's no more mask mandate?

Tim Dellit:

Again, I think, for individuals that you have to keep spaced, if I were doing that, I probably still would wear a mask. Right now you can see my leaning. I am not going to be throwing them out as of March 21st. Same thing when I go to the grocery store. I'll continue to wear my mask here for a little bit. And some of that may just be a security blanket, and it's also the habit of the last two year, so it's going to be, I think, a tough transition, at least for me personally, and I think for many of us to feel comfortable in those environments.

Trish Kritek:

I very much appreciate that. Thank you for answering all my questions for Ask An ID Doc. I very much appreciate it.

Tim Dellit:

Can I make one more thing? I forgot to do this earlier.

Trish Kritek:

I know.

Tim Dellit:

I want to, again, really thank all of our residents and fellows. Today is Thank A Resident Day. We have over 1500 residents and fellows who we are fortunate enough to work with, and they are critical members of our healthcare teams, caring for our patients, and so I just want to acknowledge and really thank all of you for all of the work that you have done every day, and especially over the last few years. So, thank you so much.

Trish Kritek:

And that's a perfect transition into the ending thank-yous. As always, I'd like to say thank you to everyone who's here on the panel, particularly since you're the only ones left standing when everyone's on spring break, so thank you all for being here. A special thank you to our residents and fellows from

me as well. You are the lifeblood of our institution in so many ways, so thank you. It's a joy to work with all of you. Thank you to the UW men's basketball team and UW Medicine for sponsoring the Healthcare Workers Appreciation men's basketball game on March 3rd against Oregon. There's tickets available, I'm told, so thank you for supporting our healthcare workers. We appreciate that.

Trish Kritek:

And thanks to all of you. We are kind of on the downswing, which feels good. It's still ... I think Rick said it really nicely. It's still hard work, and we're still really busy, and we're still feeling it, so I just want to acknowledge that that's how it still feels. There are those tensions of feeling better and seeing the sun and days getting longer, and still some challenges, so thank you all for all that you do, and continuing to take care of our patients, their families, and, as Cindy talked about, continue to take care of each other.

Trish Kritek:

We're going to take a little break. We'll be back in March, and we're going to adjust our tempo as hopefully we continue to see an adjustment in the tempo of disease in our community. We'll see you soon, and take care. Bye-bye.