

Trish Kritek:

Welcome back to UW Medicine Town Hall. I'm Trish Kritek, associate dean... Actually, I think I'm vice dean now. Vice dean for faculty affairs before Tim corrects me. And with us today is a lean focused team. Anne Browning, our assistant dean for well-being, Tim Dellit, our chief medical officer for UW Medicine, Santiago Neme, our medical director for UWMC-Northwest, Keri Nasenbeny chief nursing officer UWMC-Northwest, Cindy Sayre, chief nursing officer UWMC, and John Lynch, head of infection prevention and employee health at Harborview Medical Center. Rick and Tom are gone. Jay is away. So you got what we got. With no further ado, I'm going to turn to Anne for her message of well-being.

Anne Browning:

Thanks, Trish. We've had a hard two years. We've seen a lot; we've experienced a lot. And as we talk to folks across our institution and we listen to what's coming up in peer support encounters or those got burnout sessions, or in rounding, we hear about the exposure to stress, to trauma, and to crisis that builds up and has taken kind of a cumulative toll on us both individually and as a broader organization. And to give ourselves a collective understanding of what a trauma exposure response looks like and how it can manifest sometimes even as like anger or cynicism or numbness, we've heard that folks are experiencing. We're partnering with the Trauma Stewardship Institute and having the founder, Laura van Dernoot Lipsky, whose work actually developed out of her time working at Harborview, she's going to come and lead two sessions for us for folks at cross UW Medicine and the School of Medicine Community.

Anne Browning:

And our first will actually be next Wednesday, March 23rd, from 1:00 to 3:00 PM. And we'll have a second session on June 21st, I'll put those links into the registration, into the chat in just a minute. But whether you're a bedside nurse or you're running a lab or you're working from a home office, the themes that Laura's going to discuss and the impacts of that accumulative toll of exposure over the last two years, it's going to be useful to you. And importantly, these workshops will focus on really concrete strategies for how you can sustain yourself individually, but also how we can sustain collectively within our larger organization. So again, I'll put some details into the chat, but please join us as part of kind of how we can support each other and take on caring for each other within our broader institution. If you have any issues registering, try and use a browser other than Internet Explorer. We heard that some folks were having a little bit of trickiness there. But we really hope to see you. Laura is going to have this as a pretty interactive workshop. So be there, have your video on, be ready to kind of interact with other folks. And we'll really hope to see you next Wednesday. Thanks.

Trish Kritek:

Thanks, Anne. That might be the first well-being message that included a reference to Internet Explorer. But I think the concept of how can we come together to heal and how we can come together to build some skills, I think it probably resonates with lots of folks in our community. So thanks for all the work you did to bring that forward. I really appreciate it. Okay. It's been a while since we've had town hall. Things have changed a lot since we last had town hall. I'm actually going to start with John so he can tell us kind of where we stand as a system and maybe as a county in terms of numbers. And then we'll talk a lot more about what's happening around us.

John Lynch:

Sure. Thanks, Trish. Hi everyone. Welcome. I'm excited to be back on town hall. Some it's kind of I think generally good news for us right now. When we looked at COVID cases, hospitalizations and deaths due to COVID-19 across our county, things are all headed in the right direction. As of this morning, public health is just reporting out a 25% decrease in cases, 53% decrease in hospitalizations, and a 48% decrease in deaths. And to put some numbers on that, that means in the last seven days, we had about 1,200 cases reported. Probably a little bit of an undercount because of the antigen testing and similar versus 1,600 cases in the week before that. Similarly, around hospitalizations, 19 in the last week versus 40 the week before that. And in terms of deaths, 43 in the last 14 days.

John Lynch:

So two weeks, versus 82 in the 14 days before that. So county-wise all headed very much in the positive direction. When we look within UW Medicine facilities, we've seen a slightly different picture in terms of our hospitalizations. As of this morning, we're at 24 patients. Northwest has three people, one in the ICU. Harborview has four people, two in the ICU, Montlake has seven with three in the ICU. And Valley has 10 people, which is actually an upward tick for them. Fortunately, no one in the ICU. We don't have any ECMO patients right now. No one in OB. And so those are both good markers. But we've been actually right around 20 for really since the Omicron surge really dropped dramatically without really ever going below it. And in the past few days, we've actually crept up a little bit. And particularly, at Montlake and Northwest, they've really maintained higher levels of patients for the last several weeks compared to Harborview and Northwest. And that Valley number of 10 is sort of a bump up. So hospitalizations with UW Medicine, stable, kind of plateauing, maybe up a little bit. And across the county, numbers all heading in the right direction. And I'd say that's also true across the state.

Trish Kritek:

Okay. So state, county numbers all really looking good. UW Medicine numbers looking good, but having a stable level of business, maybe a little uptick. And so I think people are feeling that generally it feels better and I think there's some worry. So I have some follow-up questions. The first one is around the number of cases reported per 100,000 in King County and how originally we were kind of striving to get down to like 10 per 100,000. And it seems stuck significantly above that.

John Lynch:

Yeah. So as of this week, so public health are reporting those data out once a week now on Thursdays. And as of yesterday, we're at 53 cases per 100,000 over the prior seven days, which was definitely an improvement from a week ago and the week before that. So definitely heading in the right direction. And remember, I think 50 is where we transitioned from substantial to moderate, which is great because we were in that high category for a long time with the Omicron surge. And you're right, Trish is that with this recent transition from sort of the prior CDC tiering where we had at high, substantial, moderate, low, right, we're now in this new sort of classification of community transmission risk and King County is in low, which is great. Right. The issue is that it's different, it's a different measurement that we used before.

John Lynch:

And the threshold for a large part of this, it depends upon hospitalization rates and numbers, but it also depends upon that number. And that number threshold is 200. And it is a difference in the way we think about COVID transmission rates. And I think it reflects a lot about what we learned with Omicron, where we saw really high rates. And although we saw lots of people in the hospital, there was a bigger

disconnect between positive rates and hospitalizations. It was very different than we saw with Delta and everything before that, where they were really pretty tight. And so I think that this new perception, this new way of sort of this new matrix that we're in now reflects some of that, what we've learned from Omicron. And so what was a 50 back in even the fall of last year is different than 50 per 100,000 now.

Trish Kritek:

Yeah. So coming down regularly. Not as low as we were before. And that fact that's a little bit higher, we're saying that's okay. I mean, not entirely, but okay because don't see as many people get super sick when there's that degree of infection, which is reassuring. So I appreciate that. The folks who are admitted to the hospital, do you have a sense of if they're mostly unvaccinated or they have other risk factors since we're seeing so many fewer people in the hospital? What's the characteristics there.

John Lynch:

Yeah. It's still of the folks are either not vaccinated or under-vaccinated. And again, I think larger populations tell us a better and more robust story. So when we look across the county, for every one person who's boosted who ends up in the hospital with COVID for whatever reason, we have 14 people who are not fully vaccinated who end up in the hospital. For every one person who is fully vaccinated, they have two mRNA shots or one, so they're unboosted or one J&J, we have four people who haven't had their full vaccine course or are unvaccinated that end up in the hospital. So it's definitely folks who are not fully vaccinated and they've been the hospital. And the same numbers and they're actually even bigger, larger ratios when you get to serious outcomes like getting on a ventilator, ECMO, or dying from COVID.

Trish Kritek:

Okay. So I think that the big take-home is, it's kind of the same pattern we've seen and that is if you're not fully vaccinated or boosted, the odds are much higher to be in the hospital. And that's what we're seeing, which I appreciate. Actually, the single biggest theme... No, there's two themes. But one of the biggest themes or the questions that we got was, are you concerned about rising numbers in China, Europe, and the UK. And if so, kind of what do we think it means for us?

John Lynch:

Yeah. So cut me off here if I go too long because I'm trying to be very clear on this. So we have three different sort of areas. Right. So let's just take care of sort of what's had happening in China. And I'd say really importantly, what's happening in Hong Kong right now. So Hong Kong is seeing astronomically high number of cases, and they are seeing an astronomically high number of people end up in the hospital and dying due to COVID-19. In part, this is probably linked to the fact that there's sort of zero COVID approach. Right. But the other part of this that's really, really important is tied to your prior question, in their most vulnerable particularly folks in their seventies, eighties, and above, the vaccination rate is actually very low. I know this from data that's been presented, but also from personal communication with families in Hong Kong. Older adults in Hong Kong, the vaccination rate is really low.

John Lynch:

And we know the bad outcome of COVID infection in that population and what we're seeing, devastating impacts of COVID-19 in that population. In a population where younger people who probably wouldn't get very sick, there's not that vaccination rate and combined with sort of the infection-mediated immunity that we've experienced here in the United States. So I'd say that what's

happening in Hong Kong is different than what we're facing here. So that's one, devastating, awful. And I hope that they're able to get it under control. What we're looking at in Europe, we have a couple of things going on. We have a mix of a bunch of different countries, most of whom actually have higher vaccination booster rates than we have in the United States, but obviously, demographics that are different. So you can't just put one to one across these countries.

John Lynch:

What they are seeing, and this may come to a question you're going to ask me later is that they are seeing a transition in the epidemiology of what they're seeing in terms of the type of Omicron they're seeing. We can talk about this more later if you want, but there's BA.1, and we talked about this last time at town hall. That's the strain of Omicron that we've seen here in the United States. And we're seeing this other one, BA.2 In Europe start to really ascend. And in some places become the majority strain. What we know about BA.2 right now is it appears to be much more transmissible. And for those populations, especially those who aren't fully vaccinated out there, they're still getting infected and they're transmitting to other people. And we're starting to see increases in cases. In a couple of countries, we're starting to see increases in hospitalizations. But it's not the exact same pattern in each country. So it's really hard to know exactly what's driving this in terms of demographics, vulnerable populations, vaccination, and similar. But it does make me very concerned about what we could be seeing here. And so tell me when you're ready to talk about BA.2 because I think that's the part that we do need to talk about when we start talking about what things are going to look like here.

Trish Kritek:

Okay. Well, I'm going to ask you that in one second, but I'm going to make sure that I fully understood what you said. So we have two different pictures, Hong Kong, the picture there is really they have gone for this kind of zero COVID. Lots of people are not vaccinated, and we're seeing not dissimilar from earlier in the pandemic, the most vulnerable folks getting very sick and dying in that setting. Different picture. Europe, more similar picture, lots of folks vaccinated, more than us even, and they're seeing more infections related to this new variant of Omicron, BA.2.

John Lynch:

And being a little ahead of us on rolling back mandates.

Trish Kritek:

Okay. And being a little earlier and taking mask mandates away, being in spaces with each other more often. And what I heard so far about BA.2 is it's more transmissible. And that we're starting to see that signal in different patterns in different countries. So yes, the next question, and this was what I was saying that people are worried about is what do we know about BA.2, and are we concerned about a next wave of infection here?

John Lynch:

Yeah. So first I want to thank Dr. Trevor Bedford, fantastic scientist at Fred Hutchinson Cancer Research Center and University of Washington for a fantastic talk he gave on Tuesday. Hopefully, maybe we can even put the link up from the Brotman Baty Institute discussion, but as well as his publications, many other scientists, what we have learned is that BA.2 appears to be more transmissible than BA.1. Just a reminder for everyone, BA.1 and BA.2 are sort of siblings in the Omicron umbrella. For reasons of sort of historical science, they're grouped together in Omicron, but in many ways, they're actually very different

inside the virus. Outside the virus, the sort of spike protein, the thing that our immune responses are to, are very similar, though not perfectly the same. So what we're seeing is that just like with Omicron displaced Delta-like we saw in December and January in the United States, it appears when you look at what's happening at the state level and at the country level, that BA.2 is on target to displace BA.1 Because of its increased transmissibility.

John Lynch:

And the issue is when you have something that's easier to transmit, it exploits that population of people who are under-vaccinated. And we know that time since vaccination also makes you a little bit more vulnerable. So in some ways, and I think we mentioned this before, the world population right now is actually maybe more susceptible than we were a year ago when we were closer to our vaccination and boosting. And as long as we've had people who are under-vaccinated now, which is still a large part of the world's population, BA.2, this more transmissible variant, is infecting them. And some of them are getting sick. Some of them are asymptomatic, but they are transmitting to other people. And as I said, the thing that I'm looking at probably most closely now around these are two things, one is the UK numbers are up, but importantly, the hospitalization rates are starting to go up and that's really important, right, because we know this disconnect with Omicron.

John Lynch:

The second thing is when we look at our own data, clinical virology, and work that they're doing with larger databases is that we are now starting to see the United States and here in Washington, a big increase in BA.2. So for a couple of weeks, it was less than 1% and then for about two to three weeks, it was about 3% to 4%. And now it bumped up to about 20% in the last seven days. So that's a big increase in a more transmissible variant that definitely is going to target folks who are under-vaccinated. It makes me a little concerned.

Trish Kritek:

Okay. So what I heard you say is, again, I reinforce, it's more transmissible. We're seeing more and more of it. We think it will displace the original Omicron as time continues and we're starting to see that happen. There's hospitalizations in the UK, which is a little bit of a signal that's concerning. I'm going to ask a very specific question. Do we know if it causes the same severity disease, less severe disease, more severe disease than the Omicron that we just lived through?

John Lynch:

Yeah. So there's very good data that demonstrate that Omicron as a whole leads to fewer hospitalizations per group of infections. So that's good data. There is no data whatsoever that differentiates BA.1 versus BA.2 in terms of clinical illness. So it looks like it's very similar if not the same in clinical outcomes as BA.1

Trish Kritek:

Okay. I think that's reassuring because we know that was milder. It doesn't mean we shouldn't take it seriously, but that was definitely milder than Delta. Okay, last question for you, John, before I pivot is the second most common question which is, are we going to get a new booster now? There's been a lot of talk about Moderna and Pfizer putting in requests for a next booster for either 65 or older or everybody. So where do we stand with boosters?

John Lynch:

Yeah, so everyone will probably know there's been a couple of things in the media. One is one of the pharmacy executives that we should be doing fourth shots. Right. Boosters for non-immunocompromised people. That company has put in a request to the FDA to be able to market a fourth. I would point out that I think that the data aren't there yet. That's my read of the data right now. It's from a very small group, about 1,000 health workers in Israel. And so there may be other data that just aren't publicly available yet that maybe the FDA are seeing. But I think that the FDA and the Advisory Council on Immunization Practice, part of the CDC, the two groups that review these data, have been great throughout this pandemic. They recently thought that the under-five vaccination application didn't have sufficient data.

John Lynch:

And I strongly suspect they're going to have the same response to this application for a fourth dose. So yeah, until we get more data, I don't see a booster in the very near future. But we have to be very careful and remember that boosters aren't just about the level of immunity over time, they're also about what we're seeing in terms of the evolution of the virus. So if we see a new variant or an evolution of Omicron BA.2 into something different, additional vaccines may be absolutely needed and absolutely appropriate. So we're kind of dealing with both things at once that the intrinsic function of the vaccine as well as the environment in which it's acting, the virus that's out there. So right now I don't see any boosters in the near future, but only time will tell.

Trish Kritek:

Okay, no boosters right now. Data will be looked at and we might need one if we get a new variant that we have to have a different response to. Okay. I appreciate that. I think we may come back to more boosters in a little bit. I want to tell people that I got the numbers for Seattle Children's because there were evidently lots of questions about that. There are currently four children in acute care or regular part of the hospital and one in the intensive care unit, which is less than the last time that we had town hall. I call out of thanks to Richard Sugarman who responded to my emergent plea for the numbers for Seattle Children's. So thank you for asking and thank you Richard for providing it. Thanks, John. I appreciate all of that. And I think overall it's good.

Trish Kritek:

And I think people also are feeling this little bit of I don't know what's coming, which has been how we felt through this pandemic quite often. Tim, I'm going to pivot over to you and talk about something else that we've kind of had as a major focus, which is our census. And so John has told us that the numbers with COVID have come down and kind of held stable. I think the other thing people are feeling is that our census numbers have stayed up and have been really high. So the kind of theme of the question was what are our long-term plans to mitigate kind of this really ongoing crisis with the census?

Tim Dellit:

Yeah, no, thank you, Trish. I also just want to take a moment just take knowledge the real devastation that all of us are unfortunately witnessing in Ukraine right now and the impact that it's having on really our entire community, but in particular, those who may have family or friends over there. And so again, I really appreciate what Anne and the wellbeing steering community are doing and bringing in the trauma stewardship program that is really timely, not only because of the two years of the pandemic but now yet another stressor for our entire community. So thank you. Yeah, we talked about this before about

this disconnect where even though we would start to see fewer patients with COVID-19 in the hospitals, we're still going to be with challenges. So we still have challenges around overall high census and limited bed capacity. We had previously had challenges around OR capacity.

Tim Dellit:

Those still remain. They're a little bit better now that the surgical pavilion is open. So at least we have that, but we still have OR capacity challenges. We have this influx or backlog I should say of postponed or delayed care because of the prior surges as well as the governor's proclamation. And we still have staffing challenges. And so all of those remain and I really want to emphasize when you talk up to colleagues around the country, every healthcare system that I have communicated with, they're all facing the exact same challenges. And so when you look at this is going to have to take a multi-pronged approach and there are no easy, quick solutions. Some of this work, long term is going to be physical structures. Right. So when you think long term, there are plans in terms of expanding the number of ORs, both on the Northwest Campus, on the Montlake Campus, looking at possibilities, looking at the behavioral health teaching facility down the road, the bond was passed and the new Harborview building. But that's several years down the road. And in the interim, a transition to try to create more single beds at Harborview.

Tim Dellit:

So there are physical issues. There's also network expansion. So prior to the pandemic, with our strategic planning, we had really looked at the eastside network expansion, both around primary care, multi-specialty care, ambulatory surgical clinic center. And we need to get back into that activity and get those expanded as well from a capacity standpoint. The staffing is again, a challenge. A lot of work, and I'll let Keri and Cindy address that as well, just in terms of how do we stabilize our staffing and really continue with our recruitment, our retention efforts, and try to really help support our employees and maintain our staffing. And then that backlog is again, working with particularly the perioperative area, how do we navigate that, and prioritize and gradually get through that backlog? The other big piece here is when you look at our length of stay and our length of stay at some of our facilities has gone up by over 60%, even in the last few months.

Tim Dellit:

And so that is creating a significant bottleneck and that also is a multifactorial component. Right. We have patients who really are medically ready for that next level of care, but there just is not availability in the community, whether it be in long-term care facilities, adult family homes, or they are facing even worse staffing challenges than we are. Right. And so at Harborview, I believe the number is around 18% of the individuals hospitalized at Harborview really medically would be ready for that next level of care if it existed. That's going to take coordination with the state and other partners. Right. And so when I think about this, there's kind of what can we do and control ourselves and what are those things that we need to partner with? I also think when you think of the length of stay, it really is not just about what we do at discharge, even though that gets a lot of focus.

Tim Dellit:

It's really we've got to rethink the entire care progression of our patients. And that involves both the continuum of care in terms of our ambulatory care when patients need to be in the hospital, how do we really focus that care to take care of that acute need and then allow them to return effectively to that ambulatory environment? It's looking at how do we progress care for each day that a patient is in the

hospital? How do we move the patients towards that medical readiness for discharge? Sometimes our processes are not as consistent as we would like and there are maybe opportunities there. It's not because people are trying to hold on to patients. I'm not saying that at all, but I think because sometimes we have inconsistencies in our approach, we've got to really rethink about how do we navigate and manage these patients. We provide outstanding care. So we want to absolutely maintain that high quality of care, but the efficiency of our care, sometimes as we all know, there are opportunities there. And we've got to look at that because that creates a bottleneck when such a significant portion of your beds are occupied by patients who otherwise would be better served being outside of the hospital.

Trish Kritek:

Okay. That was a lot. What I heard was long-term plans of increasing space. So that's ORs, that's inpatient beds, that's also building our network of clinics that goes beyond this area to increase capacity. I heard staffing, which I'm going to pivot to Keri and Cindy next. I heard improving our processes inside of the hospital to be efficient as we progress care. And then I heard partnering with the state and other institutions because we have lots of people in the hospital who don't actually need to be in acute care any longer, which are lots of things that are going on. And I asked you about long term, I think the feel of it is short term. So trying to figure out how we get through those short-term challenges, Keri and Cindy, Cindy, maybe I'll go to you first. There is obviously lots of stress on staffing and I think there was some public reporting about lots of surgeries happening at UWMC and I think people are worried about feeling that impact in terms of staffing. So maybe you could comment on what we're doing around that.

Cindy Sayre:

Yeah, thank you, Trish. I want to acknowledge at the Montlake Campus, we have had a challenging week of staffing. Some of that is due to even the travel contracts that we have and there was a gap between when they left and when they're coming. So for sure, we have felt very constrained this week. So our approach right now, we need to take care of these patients. I think as Tim said, this backlog of patients really needs our care. And even in the past, when we've reviewed the list and we look for like can we reschedule any of these, the cases that are being done at Montlake are very serious, the ones that are being admitted. So with that being said, we are using the areas that we have in the hospital to take care of patients, which is beyond our regular footprint.

Cindy Sayre:

So boarding patients. And the opportunity that we have is to fully staff those areas. Like let's just acknowledge, we will be using those areas for the foreseeable future, we need to bring on the staff that we need to make sure that's all covered and that we can provide staff to the inpatient nurses. The last thing I'll say is, and we've talked about this before, from a national lens because the workforce has just been so disrupted by COVID and it's multifactorial, but what we are starting to see at the national level, yesterday I received a report, there's been a 56% decrease in the posted traveler jobs over the last 13 weeks. That is across every specialty. And so I do feel like that's an early signal that people will be returning to more classified positions as that demand cools down. And that's that long term-strategy. So short term, trying to do everything we can to bring people in the building, trying to retain them and then hoping that these national signals we're seen are going to bear out.

Trish Kritek:

Okay. So maybe there's an evolution in the national trend. And then things I heard was, sounds like a particular strain because of a gap in traveler staffing this week. But in general, focusing on actually staffing all the places where we're regularly taking care of patients, even if they're expansion spaces to take care of those patients. And then the strategies that we've talked about in terms of getting people to be hired and keeping the ones that we have in an ongoing way. Keri, did you want to add to that if you can unmute? Looks like you can't

Keri Nasenben:

Yeah. Sorry. I don't know, I'm having technical problems here today. Yeah. I mean, I think that's exactly right. At Northwest, we've done exactly what Cindy's talking about. So we've had those travelers in those areas. We've grown probably by about 30 plus patients on the Northwest Campus, which is a lot for us here in the last year. And so we finally have reached that point where we are staffing for those patients every day. And so as I rounded this week in the nursing units, it's been music to my ear to hear that we're doing okay for staffing. And as we project forward, it looks much better. And now we're in the place we are also actively working really to bring in staff permanently so that we can, as Cindy said, move those travelers through our system.

Keri Nasenben:

We really want those permanent staff. We want our staff to stay. And so a lot of work in that area. And we want to bring in permanent staff. And so having some success there. We have definitely not arrived for sure, we still have a lot of travelers in this building. And it's going to take us the better part of a couple of years I think, to get there. And then I guess the last thing I would say is it's not just nursing, right, it's also social work, it is also our care managers. It is also our therapists, right? It's our dietary aids. It's soup to nuts. And so I think we have a lot of work to do in those spaces to really make sure all of those areas are appropriately staffed because we're a team. And if EDS is short, it impacts our throughput dreadfully. So I think a lot of focus has been on nursing, but I just want to really reiterate that it's not just nursing. It's all of our folks are really important in this process.

Trish Kritek:

I think that's excellent. And I think it's important to amplify what you said, which is like all the members of the care team and that we felt shortages in staffing in lots of those spaces. So really working on that kind of increasing the permanent long term-staffing in all of those roles is a priority. So thank you for that. I'll come back to the two of you in a little bit. I want to go back to Tim. Tim, I want to shift gears and kind of think about other parts of UW Medicine. So one of the questions that came up a bunch is what will be the masking requirements for employees in health sciences and nonclinical spaces as of March 28th, which was the date that Ana Mari Cauce said for the rest of campus is when masking is optional?

Tim Dellit:

Yeah. So those areas such as the health sciences outside of the physical footprint of the hospitals and clinics will follow the overall UW guidance. And so as you mentioned, the university will stop requiring the wearing of masks as of March 28th with the new quarter. I think there's a balance here, right, because people are going to have a wide range of comfort as that date approaches. And we have to acknowledge and support everyone. And by that, I mean that even though masks may not be required, we also have to encourage those that if they feel more comfortable wearing a mask, by all means, wear a mask. And so we have to be accepting here and recognize that this transition could be challenging for

many in our community as well. And people will have different viewpoints, but ultimately it won't be required. We'll follow the university guidance again, outside of the clinical environments, which John can speak to more directly. But for the health sciences, we'll follow the university.

Trish Kritek:

Okay. And I'm going to come to John and ask questions about masking a little bit, but health sciences after the 28th, same rules as the rest of the university, masking optional. And let's give folks grace because we're going to all feel different about what level of masking feels okay right now. So thank you. Relevant to that, I'll just ask you this as a systems thing, do you see a time when we'll be unmasked in the hospitals and clinics and what would it take for us to get there?

Tim Dellit:

I think that still is a better question for John. I think that's going to be quite a while in my own sense, in part because of all the factors that said. We are optimistic and we're very happy that our numbers are low, but we also are watching what's happening in different parts of the world. And I think we all have to be braced for the fact that we may again see some increase in cases. Now, hopefully, the severity won't be there in terms of hospitalization and deaths, but we have to anticipate that we are going to be flexing kind of up and down here during this period of time. So I suspect masks are going to stay within the healthcare environment for a while until we get further along. But that's just my opinion. And so I look to John who actually makes those decisions.

Trish Kritek:

Okay. He's not unmuting, and I think that might be because he is answering questions in the Q and A. But John, do you want to...

John Lynch:

I wasn't sure whether you wanted me to talk yet.

Trish Kritek:

Yeah, go ahead. I feel like it's relevant to this question. You're right that I am very regimented about when people can talk, but in this case, please chime in.

John Lynch:

I follow the rules. Yeah. So just to update people on the UW Medicine approach, we'll be sending out a communication next week just to clarify where we are on all this. Basically, the employee health and infection prevention teams working all together made a concerted to we're going to hold in place with our masking. So that's in our clinical footprints, right, so at all of our hospitals, we're going to continue to require masking in both patient care areas and non-patient care areas in those clinical footprints. As part of that communication, we'll put our list out, for those of you who were around last summer you may recall, we about a week-long period last year where we rolled back the required masking in some of those non-patient care spaces. We obviously reversed that, but one of the things we did that was really helpful was to delineate those spaces.

John Lynch:

And so we'll be publishing that again. We recognize that people may move between those spaces and we support people who are moving from a UW space to a UW Medicine space to follow the policies that are there. And if they want to wear masks in both spaces, we fully support that as well. But until we know more about some of this uptick we're seeing, even the little bit UW Medicine, what we're seeing in some of these other countries, the increase in BA.2, we're going to hold tight, just please pump the brakes and see how things go over the coming month. And then we're going to continuously reassess. Our goal is to have a formal reassessment at the end of April. So quick take home, to try to marry you, Trish, masks are still required inpatient care spaces. Masks are still required in non-patient care spaces within UW Medicine,

Trish Kritek:

Within the clinical footprint of UW Medicine and the hospitals and clinics.

John Lynch:

Correct.

Trish Kritek:

Because the School of Medicine is part of UW Medicine, I feel like I need to say that out loud. Yes.

John Lynch:

Tim, Tim continuously corrects me on all that, but yes, that's what I meant.

Trish Kritek:

Okay. And I want to also highlight what you said, which is, and we'll be readdressed later in April as we see what, how things evolve. So thank you. And I appreciate the kind of regular check-ins about that.

John Lynch:

I'll say we're going to be putting down all the data that all the sources of data that we use to help make these decisions so that everyone on the call all can go to the same exact places and look at the same data that are informing our decisions.

Trish Kritek:

I appreciate that. And I appreciate the kind of making transparent how you're coming to the decisions, which I think people also appreciate. Okay, Tim.

Tim Dellit:

Trish. One other comment. We focus a lot on the clinical spaces within UW Medicine, but the university has other clinical spaces as well such as Hall Health. Those other clinical spaces will still also require masks similar to what we're doing within the hospitals and clinics. And so it's really those clinical spaces. When we're talking about the rest of like the school, we're really talking about the non-clinical areas of the school, but there are other clinical spots within the university as well.

Trish Kritek:

I appreciate that. So clinical spaces, we're staying masked. That is definitely true. Tim, I did have one more question for you. Are we at the point where in-person meetings make sense because we're kind of

evolving and the mask mandate is gone and yet we're saying we're still being a little cautious? So where do we stand on in-person meetings? And I'm going to ask you the follow-up right now. And what about eating at those meetings?

Tim Dellit:

Yeah, I think that we can gradually reenter into those in-person meetings. We want people to still I think use judgment and this may flex over time. And then also, I think we really want to make sure that the people who are involved in those are comfortable in that setting. Again, recognizing that people are in different spaces here. But I do think that we have to be able to move into that environment, especially outside of the clinical footprint. And again, I'll let John speak to the hospitals and clinics, but the rest of the university, we are having in-person classes as an example. Right. They've been masked to date. Come March 28th, masks will not be required. But we're still going to be in-person. And so I think we have to look at that. It's not going to be all or none. I think there's going to be this gradual transition during this period of time based on the comfort level of those who are involved within those meetings.

Trish Kritek:

Yeah. I hear you. We've definitely been teaching in-person for quite a while now and we're talking, yeah, let's start moving into the space of having meetings in-person. What did you say about food, I lost that part?

Tim Dellit:

So my understanding, there will be a formal announcement around this as well, but I believe that current food and drink guidance will end as well. So there basically won't be a separate guidance on how to manage food and drink. And if you think about it, if we no longer require masks, that was the main reason to have that guidance. Again, I'm talking about especially the university outside of the hospitals and clinics. Right. But in those settings, the main concern with eating and drinking was having to remove your mask. And so if we are now in an environment where we no longer require masks, then it probably doesn't make as much sense to have such specific details around the food and drink. With that said, my understanding is that EH&S still will be available kind of to help consult as people have questions because I'm sure there'll be groups that will want... Well, how can we mitigate some of that risk? Or, okay, we don't require masks, but we still want to do this in a thoughtful way, and what would be kind of best practices in terms of how to do this? But the actual food and drink required guidance will end for the university overall.

Trish Kritek:

Okay. So there's more latitude. Let me just summarize that part before I go to John. For the nonclinical footprint, we're saying when the mask mandate goes away, there's flexibility around food. We still want to be thoughtful. And if you need guidance on how to make it a safe a place as possible, you can talk to EH&S about how do we mitigate risk as best we can. That's different than in the clinical footprint. So, John, do you want to comment on food in the clinical footprint?

John Lynch:

Well, I think Tim actually captured really nicely, food isn't the driver in the situation, it's unmasking that was associated with eating. So in the clinical footprint, we're going to continue masking, which means you can be in meetings, right, we want to keep the physical distancing in place, keep the density down, but that also means we're going to continue with not eating and drinking in those spaces because it

ultimately leads to people being unmasked in those spaces. And so we're going to stay the course with our current policies.

Trish Kritek:

Okay. So slightly different approaches in different spaces based on kind of who's in those spaces, what the risk is to folks, patients, and whatnot. So thank you for those clarifications. All right. I'm going to take you off the hook, Tim, and switch to Cindy and Keri. Keri, I'm going to ask you a question. I don't entirely understand it, but I always ask the questions. Can you discuss the email that went out about job satisfaction and flexibility at UW Medicine and kind of what the meaning of that email was? I think it went out to most staff, if not all staff.

Keri Nasenben:

Yeah, thanks, Trish. I can and Cindy can also speak to this. So a group of UW Medicine leaders came together tasked with creating recommendations in a very sort of urgent way around retention and thinking about what we're hearing from staff, how we can address that and what that future should look like. And so that group was focused from across all of our entities that came together. And there was a bunch of recommendations that we put forward to Lisa and Tim, I think, around what we think that work should look like and be. And so really what we wanted to do was to make sure that staff understood that we're hearing them, first of all. So I think this email really details a lot of the concerns that we're hearing from people. Scheduling and flexibility is one of the number one things I think we're really hearing from folks.

Keri Nasenben:

And so we want them to know that we're thinking about this, we're actively working on it and we're trying to come up with solutions. I think what we all appreciate is that we have to think and act differently. COVID has changed everything and we can't return back to what we were, whatever that was. We have to think and act differently if we're going to retain our staff. And so right now we're actively rounding on staff and leaders from across organization, hear from them about what are those things we need to fix? If they're looking for another job, why and what we can do to keep them, or do we keep them at least within UW Medicine? And we're also going to be doing focus groups as one of our tactics.

Keri Nasenben:

So bringing together, especially some of our higher-risk employee groups that we've seen really high turnover rates to hear from them. And then making sure that work plan is moving forward. So that's really what that email was about was I think wanting to be as transparent as we can that we hear your voice, we're working on this. It's not perfect. And we want to continue to hear your voice and we're going to make changes to try to keep people here in the building and take care of our patients. I mean, I think we can't have everybody working Monday through Friday, 10-hour shifts. We have to take care of our patients. And so it's always going to be a balancing act. And I think there's ways that we can think differently, be creative and try new things. So I think that's really the intention of it. I'm not sure I answered your question either and I would welcome Cindy.

Trish Kritek:

Well, go ahead, Cindy, do you want to add to that?

Cindy Sayre:

I think you said it really well, Keri. One question I saw come up in the Q and A is if we're only talking about professional staff versus classified staff, and I'll say it's all staff, to the greatest degree possible, we want to increase our flexibility and still with the imperative that we have to meet the clinical needs of the patients. But we're really thinking across job classes.

Trish Kritek:

So what I heard was across staff, trying to hear voices about what are the things that would make it be the employer of choice, be the place where people want to work because we want to keep people here. And that includes greater flexibility and listening to what other things would help them want to stay here. Okay. I very much appreciate that. I'm going to ask people to engage in those efforts because I think that is a very sincere desire to hear what would make it a better place for you? And I appreciate that we're reaching out and asking those questions. So thank you. One last question, Cindy, before I go to Santiago, are we planning to loosen our visitation rules at some point in time? Where do we stand with that?

Cindy Sayre:

So right now at Montlake and Northwest, we are at the one to two visitors. We did take away the visiting hours and we added a little bit of flexibility in terms of one to two visitors at a time as opposed to in 24 hours per day. I don't see that change, especially with everything else we've talked about until we have more information about what might be coming.

Trish Kritek:

Okay. So some loosening a little bit more flexibility, a little bit more latitude for who might come. Hours are broadened significantly. But also in this kind of holding pattern to say, we're not sure where we're going. Appreciate that. Okay, Santiago, I'm going to pivot to you. You're kind of wearing half ID hat, half medical director hat. My first one is where do we stand with the Evusheld supplies, the prophylactic medication because it sounds like that's been pretty limited.

Santiago Neme:

Yeah, no, the supply right now is actually quite good. I checked with UW Medicine pharmacy earlier today. And it's good actually for Washington State currently. So that's really good news.

Trish Kritek:

Okay. So there's more available than there has been. So people, if they are wanting it, I guess maybe it's time to check back in with their provider.

Santiago Neme:

Yeah, we do have for UW Medicine patients. We've been working really closely with the specialties that tend to have these patients, which typically are NIH one category. So patients who have had a transplant, for instance, patients who are undergoing cancer care. So we're actually, in addition to the appointments, we're launching a program where we're going to be administering Evusheld in the inpatient setting right before the patients get discharged. So then we don't really miss that opportunity of care to really give them that prophylactic treatment.

Trish Kritek:

That's great. So for folks who are admitted to the hospital, getting a dose before they leave as protection. Great. Next question is what would be your recommendations for immunocompromised folks now that the mask mandate has been lifted in our spaces and kind of does it differ if somebody is on like a low dose of immunosuppression, like a low dose of prednisone versus somebody who has had an organ transplant?

Santiago Neme:

I would say we know that the more immunocompromised you are meaning if you've had a transplant or cancer therapy ongoing, you have a more limited response to the vaccine. So those are the folks who are really more at risk, especially when we're now are seeing unfortunately that there are staff members at pharmacies who are not masked and really helping those patients. So I would say in order of priority, there is that CDC moderate to severely immunocompromised, which is the most worrisome at-risk population. But I would have to say that... I mean, at least for me, I continue to mask when I'm indoors in areas that are shared by others. The best thing that an immunocompromised person can do is not only continue to mask, but be sure to be up to date on vaccines. Remember that the series is a bit different for them. So they need additional doses, but also hang out with people who have been boosted and who are also careful.

Trish Kritek:

Okay. So masks, be up to date on your boosters, which are different for immunocompromised folks, and then hang with the people who are also fully boosted and behaving in a way that seems like they'll mitigate risk. I'll ask you one more. I'm going to try to squeeze in two to John before I hand it off to Anne. How should urgent care providers treat or prescribe meds around COVID? Do we have guidance for our urgent care folks?

Santiago Neme:

We do. We actually have on our coronavirus drive, Rupali Jain has put together a really wonderful diagram and you can find it under screening and testing. It's great. It walks you through how to get Paxlovid. By the way, right now, Paxlovid is available at Safeways, Walgreens, CVS, and also our different pharmacies. One at Harborview called GCT, the one at Montlake, the UWMC outpatient pharmacy, and at Northwest, Northwest prescriptions. I tend to pick those pharmacies because I know our pharmacists do a really good job checking interactions and other things.

Trish Kritek:

Okay. So availability locally in our pharmacies, but also in community pharmacies, and really nice online resource to kind of guide you on how to do it. So thank you for that. John, I'm going to ask you just a couple of quick ones before I hand off to Anne. The first one is any news on vaccines for kids under five.

John Lynch:

No.

Trish Kritek:

Okay. I don't want to belabor it because I think that's the answer. And I'm going to keep asking because I know that all the folks who have kids under five are really feeling like they're in this like donut hole of

everybody else is protected. So I'm going to keep asking. And then last one, are we going to continue... I asked you a bunch of mask questions, which you've already answered them in the flow, but the other one that came up a bunch is respirators in the OR, or are we thinking about changing that?

John Lynch:

No. And for two reasons. One, we do a lot of aerosol generative procedures in procedural areas like that like in the OR. Lots of different things go on in there. And so we are going to continue doing that to keep people in those environments safe. I'd say behind that, we also have a regulatory requirement that is very, very clear around the requirement for all health workers to be using respirators not only when the patient's in the room, but for even highly ventilated places like the OR for 15 minutes later. And so that's a regulatory requirement. So I think for both a good biological and occupational health perspective, but also a regulatory perspective, we're staying the course.

Trish Kritek:

The rule says we have to do it and we think it's the right thing to do. So thank you. And with that, I'm going to hand it off to Anne to do ask an ID doc.

John Lynch:

Ready, Anne?

Anne Browning:

Yes, it just took me a moment to unmute. I think Tim had a really good lead in the sense that we're lifting mask mandates, but people are going to be all over the map. Again, some folks were ready to like burn them down last June and others really feel much more comfortable with them on. A lot of the ask an ID doc questions were around masking. So I'll start with kind of a broad one. What are your thoughts on the mask mandate removal and will you continue to mask?

John Lynch:

Yeah. So I'm continuing to mask in almost all public indoor spaces. I've been to grocery stores. I still haven't gone to restaurants, although my wife and I are still talking about a little bit. Maybe some future date here soon. In the climbing gym, as you all know, I go to a climbing gym pretty regularly and I wear a mask there. Although I will be completely transparent, I was at a small climbing gym in north Seattle on Sunday morning, 10:00 in the morning. There was almost no one there except for some of my friends and their kids. The garage door was open. I know the vaccination status of almost everyone, lot of distancing, and I took my mask off. And I climbed and I was very happy for those two hours. So it is possible. The real challenge in all of this, I'd say, and this is a longer answer than you wanted, Anne, but I think the gap in all this is I feel very comfortable making risk assessments. I understand ventilation and distancing and vaccination status. And I'm fine asking my friends and colleagues about what those things are. And so I felt very empowered to do that, but I'm not so sure we've given those tools to everybody to be able to make those same assessments. In crowded settings, indoors in the gyms, I'm still wearing my mask.

Anne Browning:

Thank you. And honestly, I think empowering folks is just giving folks a chance to hear what is more risk calculation and it's different for everyone and it changes over time. I think even kind of starting to understand that is helpful. So still no restaurants and therefore I'm going to extrapolate no bars.

John Lynch:
I'm getting closer.

Anne Browning:
Closer. Okay.

John Lynch:
But my wife and I have... It's a conversation. Both of us have to feel comfortable going there. We also think about what, like what could COVID impact us? Going to your risk calculation. I'm fortunate, I'm really lucky. I'm vaccinated and boosted. Both my kids are. Four of us are all vaccinated and boosted. We're really lucky that we don't have comorbidities or immunocompromised situations. But even with that, I mean, I don't want to minimize anything, but if we got COVID, the disruption to school and work and sports and all these other things, I think about all of those things every time that mask comes off. And I think everyone does, and it's almost like a unique decision for each person on this continuum. And so I think your point is really important, Anne, we've got to keep telling people what the tools are to help you make those assessments and recognizing it's not always fair. I just want to be clear about that. It feels unfair a lot of times, and it is.

Anne Browning:
It makes sense. A bit of mitigation, a little more conservative because you don't want the potential impacts, and kind of weighing that can be helpful. Would you sing in a choir yet?

John Lynch:
I don't think so. Not unless it was really ventilated. You could also if your choir is smaller, vaccinated and boosted, and good ventilation. I think it could be done pretty safely. But I would want all those things. Outdoor choirs, even better.

Anne Browning:
Conferences are starting up again, would you go to a gathering, like 200-plus people indoors, mask or no mask?

John Lynch:
Yeah, one of my daughters had a musical concert on Wednesday night and there were 203 students playing instruments. And I went and we were all masked. There was a vaccination check at the front door and I thought it was fantastic. I will point out that we got a notification next day that there was someone who had COVID there. So it does happen. And I'm so glad everyone was vaccinated and masked because you get that many people, you will have someone with COVID in that population.

Anne Browning:
Thinking about kids, a lot of folks have questions around mask mandates are getting lifted for kiddos, what do you think about sending your K-12 kid to school without a mask or would you recommend still masking?

John Lynch:

Yeah, this is a tough one. So I think talking to both my kids, again transparently, they've chosen to wear masks at school. Now, they take off their masks when they have lunch, they take off masks when they're outdoors. But I would say in practice, their school practice or their sports practice, which is indoors and at school and their classes, they've chosen to continue to wear masks. I think some of it has to do with, again, that continuum, what's the impact of COVID for that child, for their family, their sort of local community. So for us, that's just the decision we've made right now. Would I think it's safe in most of these environments, probably so? But you can just imagine you get one of these less poorly ventilated place with lots of kids in there, it becomes a little bit higher risk. So it depends upon all the same things around the decision-making I make in indoor spaces myself. I'd also point out that kids also follow their peers. When I talk to them, that's what I hear over and over from parents. So they're like, well, I'm going to see what my friends do. And I understand that's important too.

Anne Browning:

I'll ask you one last question. If you had tickets to Billie Eilish in the Climate Pledge Arena next week, would you go?

John Lynch:

Oh my goodness. It all depended upon all those things I just told you. If I didn't have like something coming up, my kids' sports event, all that sort of stuff, I would probably consider going. I feel pretty safe in terms of my vaccination boosting status if I really highly valued that music. I think Billie Eilish is an amazing artist. I would be pretty cool to go and see. Keri's clearly going. So I think it would be okay to do. It's a big space. I am hoping great ventilation. I feel okay.

Anne Browning:

Awesome. So thumbs up to the person who put in the Billie Eilish question. Best of luck. Hope you have a great time at the concert. With that, Trish...

John Lynch:

We all know who it was

Trish Kritek:

I'm kind of wondering if it was Keri who put that question in, but anyway, I want to say thank you to everybody for answering their questions. I also want to just pause for a moment and say this is a momentous day in several ways. One, today's match day for medical students across this country. And for those of you who don't know a match day, it is the day that graduating medical students open an envelope and find out where they're going to be living for the next three to seven-plus years. It's crazy. It is a day of great excitement. It's a day sometimes that's bittersweet because it might not be exactly what you thought was going to be in that envelope. It's a day where you might lose a community as you gain a new community. And sometimes it's a time of anxiety because it's a time of big change, but it's also a big day of celebration for lots of medical students across this country.

Trish Kritek:

I want to pause to say thank you to all the people that help them get there. All the teachers, all the staff, all the faculty and all the family, the spouses, the parents, all the folks around them that help them get to this point. Thank you. It's so important. And to all the medical students, good luck on this next chapter. It will have its highs and lows, but overall, I know it will be a wonderful experience for you. And

as we think about chapters, the other chapter that I reflected on is I saw the EOC email, the Emergency Operation Center email asking for feedback about how we've done in this last chapter. And as we've had these conversations about what's our next chapter, sometimes I'm like is this the last chapter? I know we all think that. And we're like, oh, not quite yet. This is a momentous day because it has marked two years and five days since the first town hall. I can't believe that. I went back and looked at it. We looked younger.

Trish Kritek:

I had different glasses. John was in a closet. I'm not sure why, but John was in a closet. And Tim was still wearing the exact same blue shirt. Some things don't change over two years, but a lot has changed. And as we move forward, I do think this is a next chapter. I think there will be more chapters. We'll keep coming and meeting with you as it makes sense. And so for now, we're going to stretch out how often we have town hall. We'll be back next month. We'll respond to what's happening in our environment and judge kind of how often we need to come back and talk more and answer all your questions. So please keep sending your questions. Please feel free to give us your input on what we should do with town hall as we move forward.

Trish Kritek:

These are the next chapters and we keep trying to think about what to do next. So share your feedback with the emergency operation center, share your feedback with us. We would welcome it. And keep moving forward into this next chapter. We will get through it together. Thank you to all the panelists as always. Thanks for all the outstanding questions that you send in and thank you for continuing to take care of our patients, their families, and as Anne highlighted at the start today, so important to keep taking care of each other. We'll see you next month. Bye-bye.