Trish Kritek:

All right. Well, I think we'll get started and I'm sure that more people will keep joining as we get going, but we have a bunch of stuff to talk about. So welcome back to UW Medicine Town Hall. I'm Trish Kritek, Vice Dean for Faculty Affairs in the School of Medicine. And as you can see, we have a special panel today, partly because it seems like this is a really popular day to vacation. So we're excited that lots of folks are on vacation today. Who we do have with us today from our usual crew is Keri Nasenbeny, Chief Nursing Officer at UWMC Northwest, Anne Browning, our Assistant Dean for Well-being and Tim Dellit, Chief Medical Officer of UW Medicine, and two great guests joining us. Dr. Shireesha Dhanireddy is back. She is a professor of medicine in the division of infectious diseases. And is it, no, I'm messing it up, allergy and infectious diseases. Is that right?

Shireesha Dhanireddy:

That's right. But I'm not an allergist, so it's okay.

Trish Kritek:

I know. So I can't even remember it in your title. And the head of our vaccine efforts for COVID. So welcome back Shireesha. We're glad to have you back. And then for her first visit with us on Town Hall is Dr. Janna Friedly, she is a professor of Rehabilitation Medicine. She's a vice chair of clinical affairs in the department. And really importantly, she is the executive director of the post COVID rehab and recovery clinic. And so she's come to join us today to answer a lot of the questions people have sent in about the syndrome of long COVID and the symptoms folks have after COVID. So thank you so much for joining us today, Janna. As usual, we'll start off with a wellbeing message from Anne.

Anne Browning:

Thanks, Trish. And hello everybody. Things are changing rapidly. Yes. We see mass mandates are dropping, there's conversations about us being out of this pandemic phase of the pandemic and more into an pandemic phase and more of life as we used to live feels like it's coming back now, but I found myself sitting more and more with the impact of the last two years and change. I had some conversations with colleagues this past week around really this challenge of shifting out of this crisis response mode into this mode of like getting our heads up and looking around and thinking about long term planning.

Anne Browning:

And some folks mentioned that they've been so fueled by the adrenaline and that they've needed to respond to whatever phase of the pandemic we've been in that it's almost hard right now to find ourselves motivated and able to do things without that adrenaline surge rushing around. And honestly, it can almost feel like hard for us to move projects forward and get work done. Even if it's stuff we really like doing, because we're just so depleted and that can just be really unnerving. So what can we do, I would say first, try to be really kind to yourself patient with yourself. If you find that challenge resonates with you.

Anne Browning:

Second, we need to recover. And we've talked about in these waves of COVID when we're at these lower points, really trying to take advantage of those dips and doing things, getting out, finding ways to recover that can be really powerful. We need breaks. I know I managed to take a break a couple weeks ago and I managed to go an entire week without sending an email. And that felt a little bit crazy, but it was actually really, really nice. And part of being able to do that was setting up a really strong handoff in advance and leaving a wonderful group of my team around me, ready to carry the work forward in my absence. And then when I get back, I turn around and take handoffs from everyone else.

Anne Browning:

So we can cycle through and get folks really disconnected for a little bit of time and really have that chance to recover. So part of your work right now might be to actually set up some of those structures in place so that you can take the breaks you need so that you can recover so that we can come back and start lifting up our heads and getting excited about thinking years out in the future and thinking about our work in really positive ways again. So again, be kind to yourself, be patient for yourself as we're navigating this phase of pandemic recovery, so that we can be excited and really shifting to being proactive rather than just reactive and give our nervous systems really a chance to recover as well. Thanks, Trish.

Trish Kritek:

Anne, thank you. And it resonates with me. I definitely know what you're talking about and I also just had a vacation. I strongly recommend the van life because then you're fully disconnected. There's no way to connect. So I spent the last 10 days in Southern Utah in a van and thanks to Anne for covering while I was away. That's why we have a panel at Town Hall today. So I really appreciate your words. Tim, I'm going to start with you today. And we have lots of questions about COVID and want to go over the numbers and things like that.

Trish Kritek:

But before we jump into that, I want to pause since last Town Hall, we had a major announcement for UW Medicine, and that was that Dr. Paul Ramsey was stepping down at the end of June as the CEO of UW Medicine and the Dean of the School of Medicine roles that he's held for 25 years. So that's a moment of great change for our organization in many ways. And so I wanted to pause and ask for your thoughts about this transition time and how we move forward.

Tim Dellit:

Yeah, no. Thank you, Trish. And again, thank you everyone for joining us here again today. You're absolutely right. This is a huge change for our organization. Dr. Ramsey's been in this position as Dean and CEO of UW Medicine for 25 years, an incredibly long time. And I feel myself very fortunate to really have a window in working very closely with Dr. Ramsey, especially over the last several years. And what strikes me as I think about this, it's really his character, his integrity and his values

that have allowed us as UW Medicine to really strive towards what he always reminds us is our single mission to improve the health of the public.

Tim Dellit:

And that has really resonated with me, especially over the last couple of years during this pandemic and Solo's values that he has instilled upon us. And I say us as a community of people here within UW Medicine. And again, whenever you have a change like this there's opportunity as well, but it's going to take all of us. It's going to take all of us collectively to navigate this transition, but I'm also very confident in us because of our people. We have wonderful people from our leadership to our frontline, whether you're in a clinical space, you're in a research lab, you're teaching. We have absolutely wonderful, dedicated people here at UW Medicine and University of Washington.

Tim Dellit:

And we collectively, we will navigate this and we will move forward, but it is definitely a big transition and I think very much worth now. And so personally, all I have is nothing but gratitude and thanks for Paul and his leadership, but I think it's important for all of us to take a moment and pause and really reflect on what is going to be a big change.

Trish Kritek:

Yeah. I appreciate that. And I think more to come on that topic is things evolve over the next many weeks and months. Thank you. And thank you for, I'll say it now. I'll probably say it again later. Thank you for stepping into the leadership role that you're stepping into, which is somewhat daunting, I think and I am very appreciative of having you in that role. Okay. Now put your ID hat on because now we're going to have you remember the days when you were an infection preventionist and where-

Tim Dellit:

We've John and Santiago when you need them.

Trish Kritek:

I know exactly as if you didn't have enough hats, but you have this one in the back of your closet. So pull it out. Let's start off with current numbers of patients with COVID across UW Medicine right now.

Tim Dellit:

Great. So today we had that 22 patients hospitalised across our system. Importantly, 20 we're in acute care and only two in the ICU. So still relatively low numbers, even though we are seeing increases in the number of cases, when you look at the King County dashboard, I'm happy to talk about that in a little bit more detail.

Trish Kritek:

Yeah. I do want to follow up on that. The other question before where we leave UW Medicine is people asked about, are we seeing people who are vaccinated, who are getting admitted? Are they all folks who are unvaccinated? What do you know about that status?

Tim Dellit:

We are seeing some individuals who have been vaccinated and boosted hospitalized. I believe about a third of the current people who are hospitalized were vaccinated and boosted. Again, if you look at the King County information, what's interesting there between those who are vaccinated and boosted versus those who are not the rate of infection isn't that different when you look at that dashboard, but there still is a significant benefit when you look at the severity of disease and risk of death from COVID 19.

Tim Dellit:

And so, as we see these more transmissible variants, we definitely are seeing people who have even been boosted and getting infected, but the vast majority are having mild disease. And so I really think that the vaccines are holding up well in that respect.

Trish Kritek:

So boosted and still getting infected. And that's why we see those numbers of looking the same between unvaccinated and boosted folks testing positive, but the emission rates and the severe disease much lower, I am also encouraged that there's only two people in the ICU across our system is really great news. Following up on that King County, I guess, on the dashboards, it says that King County reflects us as being an medium level of infection, whereas the CDC criteria categorized as low. And I wondered if you could reflect on that conflicting image or status if you will.

Tim Dellit:

Yeah. I looked at the CDC site earlier today and may have King County and medium as well. And so I think there may have just been a data lag. And so it's gotten a little bit more complicated with the new CDC methodology, but in essence earlier this week, we crossed over that threshold of 200 cases per 100,000 population over the last seven days. And in fact, we're at 246 today, that threshold is important for the CDC categories, because once you go above 200, you automatically move into the medium activity. Then they look at two other parameters, the hospitalizations per 1,000 over the last seven days with COVID 19 and the percent of hospitalized patients.

Tim Dellit:

And if either of those are over 10, then we would potentially move into that high category. Those numbers are still low. And I think what's striking here is that even though we're seeing 800 cases a day, if you look at the King County dashboard, the overall level of hospitalization, although it's gone up a little bit for the county, we're not seeing that within our system, we continue to hover in that 20 to 25 range. So there's a little bit more of a disconnect, even with more cases in the community,

we're not seeing as much impact in terms of the number of people requiring hospitalization.

Trish Kritek:

Okay. So it actually CDC and King County are in sync at this point time. And that's driven by the fact that we're having more than 200 cases people test positive. And then the part about the hospitalizations is reassuring and why we're not going up to high right now, which is good. Do you know how much of that is BA.2 or what percentage of the disease that we're seeing is this new variant?

Tim Dellit:

Yeah. So I need to look at my notes here. So yeah, our virology lab, which is fantastic continues to do sequencing on samples of positive tests and they do about 1,000 a week in terms of sequencing earlier in April BA.2 was about 93%. So widespread. Now, if you look at some of the state data, probably mid April, we're starting to see another variant called BA.2.12.1. So it's another sub variant. And so these are continuing to evolve.

Tim Dellit:

It also is highly transmissible and it was at about five or 6% when I looked at state data. So I suspect we'll start to see that increasing year over time as well. So he went from Delta last Fall, we had the original Omicron, and then now we're starting to continue to see these subvariants of BA.2 And another subvariant of BA.2.

Trish Kritek:

Okay. So lots, almost all BA.2 or some subvariant of BA.2 At this point in time. And you answered another question that came in and which was how many of the swabs get sequenced? And it sounds like in general, there's about 1,000 per week that we sequence in our lab.

Tim Dellit:

Yeah. And I followed up with the lab. They said, when they looked at the state data, like in March, about 20% of all the positive samples from the state were sequenced. It varies a little bit depending of volumes, but somewhere in that 10 to 20% range.

Trish Kritek:

Okay. And I guess they're just picking random ones to sequence or are they doing each-

Tim Dellit:

Yeah. That I don't know in terms of how they do that.

Trish Kritek:

Okay. I know Anne's going to ask this more and ask an ID doc, but I'm going to just because it is a super popular question and I think she'll ask it in a slightly different

way. There are a bunch of people who ask, are we at the point where this is like the flu yet?

Tim Dellit:

Not yet. We don't typically see 800 cases of flu a day. So we're seeing very high transmission. I think what you're really raising is a great point that as we start to see this change where we can see high numbers of transmission or higher numbers of transmission and yet not have the same degree of impact in terms of severity of illness or hospitalization, it starts to feel very different than in some of the other waves.

Tim Dellit:

So I don't think we're quite there, but it gives me some optimism that we're moving in that direction. I also saw an estimate earlier this week. I think it was estimated about 60% of individuals in this country have been infected-

Trish Kritek:

I read the same thing.

Tim Dellit:

And then you throw on all the vaccinations. So you're starting to get to a point where the vast majority of individuals have had some exposure, be it infection and, or vaccination. And I think, again, that's helping. We still have to remember in our immunocompromised population can still be very impactful. So again, I hesitated, I don't want people to minimize this, but it does feel very different with this surge and where we're at now compared to where we were certainly a year ago.

Trish Kritek:

Yeah. So I think numbers wise, it's nothing like the flu, but that situation where lots of people are getting affected, but so many fewer people are getting really sick, makes it feel different. It is different. And so this is an evolving picture and I think it's important to acknowledge that, because it definitely feels it to, I think a lot of folks.

Trish Kritek:

With that in mind and I realize that this is not your wheelhouse, but I'm going to ask you anyway, because it was the single most popular question in some variation was can you clarify our current mask policy specifically around clinical spaces and the distinction between if you're delivering patient care versus you're in an office and clinical spaces.

Tim Dellit:

Yeah. And I think there was a little bit of subtle differences in some of the messaging the went out. But I did confirm with John yesterday, before he disappeared today that within the physical footprints of the hospitals and clinics, the expectation right

now is to use a respirator. So even in non-clinical spaces, but if you're in that footprint of the hospitals and in clinics.

Tim Dellit:

If you're in the health sciences, then that's a different environment. And the university did come out with messaging from Jeff Gottlieb earlier this week, strongly recommending masking indoors in those settings, but it's a little different than within the direct hospitals and clinics.

Trish Kritek:

Okay. So if you in the footprint of our clinics or hospitals, it's a respirator, which is an N95 or is it also a K-

Tim Dellit:

It could, yeah, it could be a KF94 as well, particularly in the nonclinical areas where it's not indicated by the patient disease. And it's also important just to remind all of us why infection prevention moved us back into the respirators. It was because we started to see increased number of employees, our healthcare workers in particular that were out either with infection. So in isolation or quarantine because of exposure. Again, the vast majority of these were acquired within the community, just because we see more cases within the community and people are more active than perhaps they were previously. And so we went to respirators both to help protect our staff from any exposure, but also protect patients.

Tim Dellit:

And so again, they act as source control in addition to protecting the individual who's wearing them. And I think that's important to mention in terms of the number of people out, we went up to around 250. So not nearly as high as we had gone up as high as 800 in that earlier Omicron search, which really staffing challenges, but even this 250 and Keri can certainly talk about this more has caused us to go back into contingency staffing in certain units and areas within our hospital. So it's definitely had an impact. So even though we may only have 22 patients hospitalized, we've had again, some significant impact on our staffing with this latest increase in number of cases.

Trish Kritek:

Okay. So respirators in the clinical footprints of our clinics and hospitals could be a KF94 and 95, if that's required for the patients that you're caring for. And that's really to protect our patients, but also really to protect each other as there's more people out with infection like we just talked about. Okay, that's super ho helpful. Last question, before I pivot to Shireesha, do you have a sense of a threshold when we would come back down to surgical masks instead of respirators?

Tim Dellit:

Yeah. I thought that was really nice when the infection prevention folks sent out the message. They looked at a few of parameters. One, we want to make sure that none

of our units within the hospital are in contingency staffing. We want to see that community transmission ideally go below 150 per 100,000. And again, that's where we're at 246 today.

Tim Dellit:

And we'd also like to see less than 100 of our employees out in isolation or quarantine. So those are the parameters that we're all tracking. We're above each of those right now, but those are the parameters at which point, then we would transition back to wearing surgical or procedure masks.

Trish Kritek:

I think that's super helpful because people, I think having something tangible is useful for folks as there it's more challenging to wear a respirator. I personally think. So, no contingency staffing less than 150 per 100,000 in the community and less than 100 employees out with COVID. Okay. That's very helpful. Thank you. I'll give you a break.

Trish Kritek:

Shireesha, I'm going to pivot to you. The second, most popular thing to ask questions about was boosters. Lots of questions about boosters, second boosters, particularly. So I'm going to ask for your guidance on who should get a second booster and then I have some nuanced follow-up questions about that. So let me start with that.

Shireesha Dhanireddy:

So just to backtrack a little bit, we're talking about second boosters and first boosters are definitely recommended. And actually there was a recent change in the definition of being fully vaccinated to include that first booster for individuals 12 and over. So for second boosters, really the recommendation is for anyone 50 and over, sorry, there's some background noise. For 50 and over, but anyone who's 12 and over who's moderately to severely immunocompromised. And then anyone who got a J and J as their first two doses, like the first J and J and then the booster for J and J for the first dose should get a second booster with an RNA vaccine.

Shireesha Dhanireddy:

In the language by CDC in terms of that nuance that you're referring to, they do mention if you've had COVID within the last three months, maybe you can wait to get that second booster. And also if you feel like getting a booster is going to deter you from getting another vaccine later, when it may be more important, then maybe you should hold off on that second booster. And that's because right now, even though we've got a lot of transmission going on in terms of where we are in overall surges compared to where we were before, we're in a lull. I understand that there's a lot of ongoing transmission that we're probably missing, because people are doing rapid tests at home, but in terms of the severity of disease, it's definitely as by those hospital numbers fairly low.

Shireesha Dhanireddy:

And so if we're anticipating another surge later on with a different variant that we want to make sure that people have had vaccine nation closer to that time point. And that's because in studies in other countries that have looked at when that immunity wanes, it looks like... And there were two countries that looked at this Qatar and UK and their data. And they found that if it's been greater than six months, that you've been vaccinated, the protection really goes down to about 20% or less in terms of preventing symptomatic infection. I'm not talking about hospitalizations, but symptomatic infection. And so I think that nuanced language is to really allow for people if they're hesitant to get more vaccine, maybe they would be more encouraged to get vaccine as we're closer to another surge potentially.

Trish Kritek:

Okay. So let me try to distill some of that. That was a lot that you shared, which was great. So over 50 is the recommendation for the second booster or folks who are immunocompromised 12 and up. And then I think what I heard you say is if you had, so the first one was people I just had COVID what should I do? Sounds like waiting three months after COVID makes sense for most people. And then the other one is, I'm not sure I want to keep getting boosters and if that's the case, getting a booster closer to, if there is a future surge, which we think that probably there will be again, at some point in time, getting it closer would be a better time because right now people aren't getting that sick. And the last thing I think I heard you say is that six month time period. So if you've gone six months without a booster, you're probably starting to wane in terms of your protection against getting symptomatic, not necessarily sick, but symptomatic. Is that about right?

Shireesha Dhanireddy:

That's exactly right.

Trish Kritek:

Okay. That's super helpful. I think you answered like every, or at least most of the nuanced questions that people had. One other thing is does the second booster protect against BA.2? Does that seem like that's the case?

Shireesha Dhanireddy:

Yeah. There isn't any evidence that it doesn't, but I will say that similar to BA.2, the efficacy is lower than it had been with the initial variants of COVID. So it looks like it works to prevent severe disease still, but in terms of its efficacy from mild to moderate disease is definitely lower on the order of about 30 to 60% rather than what we were seeing originally, which you know, was in the studies when they were originally authorized was in the '90s.

Trish Kritek:

'90s. Yeah. So less effective but still protective against getting really sick, which I think is what we keep focusing on. Couple more questions about boosters. Should you mix and match. What's your advice on that one?

Shireesha Dhanireddy:

Yeah. I think as I pointed out before, if you got J and J I would really recommend it an mRNA vaccine, but I think either one is fine in terms of whatever is available is better to get than nothing. So, Pfizer or Moderna.

Trish Kritek:

So if you have the J and J get an mRNA vaccine, otherwise it's dealer's choice. I mixed a match just for a disclosure. How about if you're pregnant? Can you get a second booster when pregnant?

Shireesha Dhanireddy:

Yeah. I mean, there's a lot of data about the benefits of vaccination in pregnancy. And I think the society of maternal fetal medicine really doesn't want us to withhold things for people that are pregnant because they've been studied in other populations and found to be beneficial. There is some nuance language about whether pregnancy itself counts as a condition to warrant that second booster. But there is language in the CDC saying that we should not withhold vaccine for people who self attest to needing that booster.

Shireesha Dhanireddy:

And so that's the language that we've been saying to people if we don't want to put up barriers to getting vaccination, but in terms of if you're pregnant and fully vaccinated, meaning vaccine and boost times one, I don't necessarily think that there's a compelling reason to say that your immunocompromised to get that second booster.

Trish Kritek:

Okay. So maybe not pressing people to push to get that second booster, not withholding it from folks who are pregnant, but not really pushing it for that. Are there any safety concerns about a second boost that have come out and study so far?

Shireesha Dhanireddy:

Not that we're not that I'm aware of. I think there have been some increasing reports and that's one of the questions I think you had for me about tinnitus. And so I can talk about that because-

Trish Kritek:

Sure. Go ahead.

Shireesha Dhanireddy:

There's been some increasing reports and concerns and about particularly with Pfizer and tinnitus. And I will say that to give some context, billions of doses of vaccine have been given and the reports are in just about 200 or so cases have been reported and I recognize that there's likely under reporting. But when we think about the sheer volume of how many COVID vaccines have been given worldwide, it's pretty

astounding. And to have complication rates that low is still pretty darn good. I think they're still looking for why that would be in terms of a causal association. So not a whole lot of information, but there does seem to be some reports, particularly after Pfizer of tinnitus.

Trish Kritek:

Okay. So 200 reports of tinnitus and lots and lots and lots of people who've been given the vaccine. So it's a very small percentage of people, but there is an association between Pfizer and this tenants are ringing in the ears that people have had. And we do have some people, I think, in our community who have had that, because they ask about it and I think it's super troubling for the individuals. And I don't know if there's any data about whether or not it resolves. Have you seen anything about that, Shireesha?

Shireesha Dhanireddy:

I haven't seen anything about it, but I also want... I know that Janna is here and to, I think when we think about the long-term symptoms of COVID itself versus the complications of vaccine, I think it's important to compare that because she is our expert about long COVID and I'm sure there are many things that I don't understand about long COVID, but many symptoms that are associated long COVID in a higher percent of people than you would after a vaccination.

Trish Kritek:

Okay. So Janna, I'm going to come to you in a little bit, so we can come back to this because I think it's a really good point. And I also want to acknowledge that for the individuals who have it as a complication, it can be quite distressing. Okay. I'm going to ask you a couple more questions about vaccines and then give you a break, but I'm going to warn you. I'm going to come back to you. I think the other big bucket of questions about vaccines that came up is vaccines for children under five. So updates on vaccines for kids under five.

Shireesha Dhanireddy:

Yeah. Your timing is always so great because I got a question about before and it was delayed. And today actually they just made an announcement that they're meeting in early June to talk about the younger than five vaccine for younger than five for both Pfizer and Moderna. And just looking at the data in children in general, I'm not sure if they're going to move forward with a decision at that or that meeting, but there will be a discussion by the FDA that was just posted on their schedule. And so hopefully we'll have some information by mid to late June that about these pediatric less than five vaccines.

Trish Kritek:

Okay. So on the schedule to talk about both Pfizer and Moderna, I had read about Moderna, but that's great. And that will probably be mid to late June before we know more. So we'll keep asking about that. How about boosters for five to 11 year olds? Is that on the horizon?

Shireesha Dhanireddy:

I think that's going to be, he discussed as part of that discussion, but I haven't seen any recent recommendations about it.

Trish Kritek:

Okay. So nothing right now about that. Super helpful. Thank you. I'm going to give you a little rest. Keri, I'm going to jump to you before I go to Janna, because Tim alluded to this already, and that is boy, we've talked about staffing at so many different points of time. And then all of a sudden we have not the same staffing crisis, but staffing issues again. So maybe you could talk about how we're doing in terms of staffing. That was basically the question.

Keri Nasenbeny:

Yeah. I can speak to the two UWMC campus. I can't speak to Harborview, so-

Trish Kritek:

That's fine.

Keri Nasenbeny:

Yeah. I will speak to what I know. Northwest is actually we've been doing okay. I mean, we've had a couple shifts here and there where we've been short, a nurse or two or a CNA or two, but despite really high boarding numbers today we had close to 30 borders here at Northwest, which is unheard of for us. We've been actually doing okay on the stopping front. We've also had lower numbers. I think we've only had below 20 out with COVID around quarantine. So that's been helpful. Molly it's been a little bit more challenged and I think really the source of that is all the boarding areas. So we're drawing on our float pool slash resource team to staff those boarding areas. And when we have many of them, because we've had to lean into several different alternative spaces, because we might get four beds here or five beds here.

Keri Nasenbeny:

We're not as efficient as we normally would be. And so that really draws on our resources. I know the team at Molly gets actively working to increase those numbers and to staff those boarding areas on a regular cadence as we've been using them consistently to help with that. And they said, I'm not really sure what's going on to have you. I will say that we do get a report every Sunday. And so I can share with you that in the last 20 weeks Northwest has been able to hire over 60 nurses and 25 CNAs. And it looks like Harbor View and more like around 130 nurses each and I don't remember the CNA numbers off the top of my head. So I will say that all of the campuses hiring and retention are some of our top priorities. And I know that everybody is really working in that direction.

Trish Kritek:

So making some progress and hiring and multiple domains on the clinical team, having some impact of the folks who are out, but it sounds like a lot of impact has

been the boarding status at hospitals. And I'm pretty sure Harborview has been boarding too, because I've seen emails about the same. So I think the overall census is a push on staffing as well as these other things. Exciting to hear that we're hiring though. That's great.

Trish Kritek:

The other thing that comes up every time we have town hall is where do we stand with changes in the visitor policy? And I will tell you that I got questions, but going both ways, are we going to make it more restrictive because there's so much infection or are we going to start to let more people in and expand the hours? So maybe you can just tell us where we stand with visitor policy.

Keri Nasenbeny:

Well, I saw an email approval and I think all three campuses and Tim, you may know differently, but I think all three campuses are now at one to two visitors per patient. And I think that's the case at Harborview. I'm not sure if Harborview's ours, UWMC and UWMC Northwest we don't have visiting hours so you have to leave at this time, although we are saying, I think spending the night is on a case by case basis, at least here at Northwest Molly, like might be a little bit different on that. I have not heard any discussions though. I think things could change rapidly and we could think about feeling back a little bit. So right now, holding study with that one to two continuing to acquire masking and making sure that our visitors are masks, our patients are mask as able and that they're following all those protocols.

Keri Nasenbeny:

So, I think we're trying to weigh all of the different needs here. Safety for everybody, the need to have visitors. People having just had a loved one in the ed, we all need visitors. We need that family with us. So I think we're doing the best we can in this space and it will probably continue to change and evolve. So I don't really have anything concrete to say, except that we're staying where we are right now. How's that for a-

Trish Kritek:

No. You're like, that's a really long answer to say no change. No, I think that the part about one to two visitors and the fact that visitors are really important and that we're trying to do it in a safe way with folks masking getting back closer to the spaces where we were in the past, which I think as a clinician, I'll just say, I think family members are so essential to the care of our patients. That it's really important that we figure out ways to do this safely. So I appreciate all the work on it. I'll give you a break. I'm going to pivot to Janna. Janna, thank you so much for being here today.

Trish Kritek:

It was John Lynch who had the first idea to bring you here probably because I kept asking him questions about post COVID symptoms and he had had enough of that. So I actually, I'm going to start with language and I thought about this as I started and

we you've heard us use the phrase long COVID and then I think the clinic is called the post COVID rehab and recovery clinic. So shouldn't we be calling it long COVID or is there a better phrase we should be using? Maybe you could just reflect on that first than I have lots of questions from folks.

Janna Friedly:

Yes, absolutely. So, I think long COVID is the lay term that people are using to describe the longer term symptoms that people experience after COVID. You'll also hear PAs or post-acute sequela of COVID, which is more of a research term, but long COVID is really what is most recognized. We chose the name specifically post COVID rehabilitation and recovery, really to be broad in terms of what we're seeing. And I have a strong preference not to label people with something that sticks with them for a long time. So I tend to shy away from terms like long holler or some of the other terms that, and even long COVID syndrome or things like that can tend to label people.

Trish Kritek:

Okay. So I appreciate that. And I appreciate that language matters. And I appreciate your walking through that. Okay. So my first question, I think actually the most common one for questions about symptoms after COVID was, is there anything we can do to avoid it?

Janna Friedly:

Yes. So we've talked before that probably that the best way to prevent getting long COVID is to prevent getting COVID in the first place. So our masking and vaccinations are important. One of the questions also related to this is does vaccination reduce your risk of getting long COVID? And it looks like at least the initial studies that were done with the prior variants, it show that it does. So people who are fully vaccinated are less likely obviously to get more severe COVID initially, and it prevents hospitalizations and deaths, but it also seems to prevent to some degree long COVID. So the risks go down anywhere. The studies are ranging between 40% to 70% decrease in risk of long COVID. If you're fully vaccinated.

Janna Friedly:

Most of these studies again were done with prior variants, it's still a little bit early of Omicron and the newer variants to see because by definition long COVID is really defined as having symptoms that are ongoing after about three months from your initial infection. So we haven't quite yet hit the period where we'll we'll know for sure what the rates of long COVID are with people who are fully vaccinated and getting these newer variants. And I should also add that the studies have also, most of the studies initially were really in people that had the first two doses and considered that to be fully vaccinated at the time. So I think there's going to be ongoing information coming out about the effect of the boosters as well.

Trish Kritek:

Okay. So lots of really important information. One way to avoid it is to not get COVID if possible. And obviously there's a lot of work to try to avoid that to start with, but then we do think that vaccination is protective 40 to 70% maybe. That's without the data around boosters. And we don't really know about Omicron, or BA.2 yet, because the symptoms are symptoms that present three months after your infection. So I appreciate all that. That's super helpful. What are those symptoms that you're seeing that people are coming in with? What are the symptoms that people are saying that constellation that is part of long COVID?

Janna Friedly:

Yeah. So there are a lot of different symptoms associated with long COVID. So most of the reports are indicating the people can have, or that there's really more than 200 different symptoms that are associated with long COVID. And on average patients are presenting with 14 or more different symptoms. So it's a pretty big range of symptoms that people are experiencing. And there isn't one specific diagnostic test for long COVID. So it's really the clinical diagnosis of having symptoms after COVID that are persistent, that are new symptoms that weren't present before you had COVID.

Janna Friedly:

The most common things that we're seeing in our clinic by far are fatigue. And that's the number one symptom that people are presenting with, but we're also seeing a lot of brain fog or cognitive issues. People having difficulty with short-term memory and finding the right words, being able to concentrate, stay on task and then also limitations and endurance and being able to participate in exercise and higher intensity activities like they used to. But there's a wide range of symptoms that people are experiencing.

Trish Kritek:

Yeah. Over 200 different types of symptoms, but fatigue, brain fog, trouble concentrating and then exercise intolerance are high on the list. Are there things that we can do for these symptoms? Are there treatments for the symptoms associated with this post COVID syndrome?

Janna Friedly:

Yeah. So currently there's not one specific treatment that uniformly works for every patient and for every symptom. So there isn't that one medication that affects all of the symptoms. So really it takes an individualized approach to you to help understand the range of symptoms that people are experiencing the context in which they're experiencing them and developing strategies and treatments for those specific symptoms. I will say that there is a lot of research going on right now about specific treatments. And when you look at clinical trials dot of their, at least 50 to 60 ongoing clinical trials of different treatment strategies for long COVID.

Janna Friedly:

So I think within even six months to a year, we're going to have additional options for treatment for people. Here at UW, there's a great clinical trial called the resolved trial that Dr. James Andrews is leading at our site here at, at UW. It's a national study, looking at medications that are specifically targeting the immune system response that's thought to be part of COVID symptoms, despite not having one single treatment that's effective, I just want to reiterate that there are lots of tools and strategies that we know are effective in managing people's symptoms all already. It just sometimes takes some trial and error and takes really a holistic approach to be able to come to the right treatments strategy for each individual person.

Trish Kritek:

Okay. So not one medicine to make it go away, which is not really surprising to me with 200 different symptoms and lots of trials going on to try to figure out things and taking a holistic approach and trial and error. We can treat a lot of the symptoms that people are having.

Janna Friedly:

Yeah. And I think the other message that I just want to make sure that people are aware of is that there's, people are really searching... This is such a difficult problem for people that they are really looking for answers. And so there's a lot of treatments out there that people are trying. That don't have evidence to back them up and potentially can be harmful or expensive. So I just want to caution people that well, while we are still learning about this and we are trying medications to just be cautious about what treatments that you try and really this safest way to new medications or new treatments is to enroll in a clinical trial and where you're closely monitored and it can contribute to the learning about it.

Trish Kritek:

Yeah. So a little bit of caution about trying something, because you're feeling crappy and you want to try something that there's some risk with that and engaging in a clinical trial is a good strategy in that situation. I understand people wanting to feel better. So people could come to the clinic that you have, which is at Harborview. Is that right?

Janna Friedly:

So it's a complicated clinic because we have now about 15 physicians and growing in the clinic. And we have in multiple different locations, the hub is at Harborview and we have an in-person clinic there as well as telemedicine, but it's a clinic that in includes rehab physicians as well as internal medicine, physicians, family medicine, and neurology, and we are all over the UW system now. And increasing to meet the demand of the patient need.

Trish Kritek:

Okay. So there's shifting physicians distributed hub is in at Harborview. And if people are interested in connecting with people with the clinic, how do they do that?

Janna Friedly:

That's a great question. There is a website, and it has the information on there. So if you just search for the UW post COVID rehab clinic, it'll have the information on there.

Trish Kritek:

Okay. Maybe if someone can put it in our chat, that would be awesome. Last question. Well, actually, two questions. One just came in the chat. Now I'm going to ask, do you know if antivirals treatment with antivirals leads to less likelihood of developing long COVID?

Janna Friedly:

Yeah. That's a great question. I don't know for certain, I think that the general thinking is that the less severe the initial infection, the less likely you are to have complications and sequel. So if treatment early on reduces the incidence of severe COVID, it most likely will reduce the incidence of long COVID, but I don't know that there's been a direct study of that yet.

Trish Kritek:

Okay. I appreciate that. So because maybe you get less sick and so you're less likely to get long COVID, but don't know for sure. Last one was a great question. Someone sent in with was, do you have guidance for other clinicians in the system to support the psychological impact of all of this COVID infection and post COVID symptoms? Because not everybody can come to your clinic. Do you have guidance for our clinicians in the community?

Janna Friedly:

Yeah. Absolutely. And I just want to recognize that our clinic really is scratching the surface in terms of the need out there. When you think about the estimates there are 25 million Americans who are affected by long COVID at this point. We know that we are seeing just a very small subset of patients and we're really trying to rapidly expand the clinic to make sure that we have access to the people who need it. And we also know just as a disclosure, that we know that we are not fully reaching some of the most vulnerable patient populations that need access to this care. So I think it is important to make sure that primary care physicians and physicians in general are well trained on long COVID, because you're going to see this in your clinic and it's really helpful to have this knowledge in terms of the emotional coping.

Janna Friedly:

I think there's a few things that are important. And I think that the first thing is that it's really important to ask patients how they're doing and to assess how patients are doing in terms of their mental health. We're seeing really high rates of depression, anxiety, and PTSD symptoms and people that have had COVID people who have long COVID oftentimes have family members that have long COVID. They often have family members who have been hospitalized or have died from COVID. So it's a lot of trauma and it's important to assess that. I think it's also important for clinicians to reassure

patients that recovery does take a long time and may take longer than they expected with COVID, but that symptoms get better over time. And that even having symptoms several months after COVID doesn't mean that they won't improve or resolve.

Janna Friedly:

So I think the other important message is that many... I think it's important for all of us to be open with patients about what we know and what we don't know, because we're all still learning about this. And there's, there's more that we don't know than what we do know, but we need to partner with patients to help them throughout the entire course of their recovery. So we hear this over and over again that patients have felt like they have been dismissed because there is a, in a single diagnostic test and oftentimes they're having these really distressing symptoms like chest pressure or pain and palpitations or shortness of breath, but they're things they've never experienced before, but their lab tests are normal.

Janna Friedly:

And the tests of their heart and their lung are normal. And they can't really understand it and they feel like they are being dismissed. And that physicians are telling them that everything is normal and just send them on their way, when to them they're not normal. And they're still experiencing these really scary symptoms. So I think that the more that you can do to reassure people that there may not be structural damage to the harder lungs, but it doesn't mean that those symptoms are not really impactful and issues that need to be addressed.

Trish Kritek:

Oh, sorry.

Janna Friedly:

Nope, that's fine. Yes. A long answer.

Trish Kritek:

It's a great answer. And I think what you're talking about is-

Janna Friedly:

Is the topic you talk about for a very long time.

Trish Kritek:

Your passion is clear and I appreciate it. I appreciate all the work that you do for folks, because what I heard you say is one, listen and validate that something's really going on. Two ask about the impact on people's mood and their mental health, because it's clearly affecting people in terms of depression and anxiety. And three reassure them that even though it may take a long time that people do get better. I think those are all really important messages. So I appreciate the time. I often give John a hard time for giving a long answer for you. It's all good.

Trish Kritek:

So thank you for all that thoughtful input and really for all the work you're doing in this space, it is a place where I think there are more and more questions, as you said, and maybe we'll have the opportunity to invite you back and answer more as we learn more. I really appreciate all that work. Okay. I'm going to jump to Shireesha and Tim, each of a couple quick questions, Anne, before I hand it off to you. So Shireesha, I'm going to come back to you. We were just talking about treatments. And one of the questions that came in was, have you heard about recurrent of symptoms after treatment with Paxlovid? Like someone gets treated and then they have symptoms come back. Is that something that we're learning about or not?

Shireesha Dhanireddy:

Yeah. It is something that we're learning about. And a couple people had that question in the Q&A as well. The study that led to its emergency use authorization really looked at decreasing hospitalizations in death among one month out from treatment. And it was highly effective, 88% effective. It did not look at symptom resolution as its outcome. And while these meds are under emergency use authorization, we often learn a lot more about the virus. We learn more about how the medications work and we may have different goals in terms of our treatment.

Shireesha Dhanireddy:

When these meds came out was during Omicron surge, our hospitals were really full. So the goal was to really keep people out of the hospital. We may see as we move on in this pandemic to see, we want to reduce transmission, we want to keep people symptom free and go back to work. So we may see some amendments to this UA that for a longer treatment or for different indications than we do right now.

Trish Kritek:

Okay. So yes, there are symptoms that come back after treatment. Really the focus in improving this drug for emergency use was to keep people out of the hospital. And this will be an evolving space. And probably something I'll ask about again, because I think clinicians are seeing this happen. Now, two last questions for you, Tim, and you may defer Shireesha if you need to. The first one is, what's your personal guidance for faculty gatherings at this point in time, people are sometimes now bringing faculty together at somebody's house. There might be food. We know everyone's vaccinated, but what would be your guidance? Is that okay? Should they test before they come together? What do you think?

Tim Dellit:

One, I don't think there's clear your right answer. I think it really depends on the comfort level of the individuals who are participating. I do think we're in that transition phase where we should expect that people will gather more together. And I think the good thing is that especially among our faculty, that they're essentially all vaccinated and I suspect the large number are hopefully most are boosted as well.

Tim Dellit:

So I think it's certainly something that I would feel comfortable in doing, but people have to base that the re-entry is challenging. It is people are at different levels. And so you just have to be sensitive to where people are in that journey of re-entry. But again, there's certainly no restriction against it. And I think it's really based on the comfort of those attending.

Trish Kritek:

Okay. And in that gray space that we're all trying to navigate right now, which I appreciate acknowledging the grayness of it. Last question, if you're recovering from COVID and you do a rapid antigen test and it's still positive, let's say five days out. Does that mean you're still contagious?

Tim Dellit:

Yeah. I may punt that to Shireesha as well. In general, I would say that early in the pandemic, we would typically say that and the data suggested that after 10 days people were not infectious. I haven't followed this as closely in that five to 10 data. I think the way we managed employees is if they were still positive when we were not in contingency state, if they were still positive, then we would wait until they hit then day 10.

Tim Dellit:

So I think there is that still potential at the same time, again, this is the antigen with the PCR, we know that people can be positive for a long time after, even when they're not infectious or at risk to others. But that five to 10 window still makes me a little bit more nervous. Again, Trisha, may be aware of more current data in that space.

Shireesha Dhanireddy:

I guess what I would say is that I would probably still mask, encourage masking at social gatherings or going out until through day 10. I'm not sure what to make of repeat antigen tests either. We recommend not testing. We notice when we review charts for therapeutics, that a lot of people are retesting unnecessarily to see if they can go out and do something with friends. If when they've had COVID, you know, a week before. So I hope the messaging is to not repeat your test and just wear a mask.

Trish Kritek:

Okay. So mask.

Tim Dellit:

Those are the CDC recommendations too. Isolate for five days, continue to wear a mask through day 10, just because of that little bit of uncertainty.

Trish Kritek:

Okay. So maybe we shouldn't bank on what the antigen test says instead, five days away, next five days with a mask and then move forward. Okay. And well, yeah.

Shireesha Dhanireddy:

The only caveat is for immunocompromised individuals, we want to make sure that they done that longer.

Trish Kritek:

Thank you for that. And good collaboration the two of you. All right, before I give Anne no time and ask an ID doc.

Anne Browning:

Good. And you set me up with a decent segue for Tim here. I'll ask this question as it was submitted and it's a big picture question and it assumes how you'll respond, but I'm curious what you think. The question is if hospitalization rates are low for otherwise healthy folks who are 50 years of age and under why shouldn't folks just return to their normal behaviors now?

Tim Dellit:

For me, it's the other people around us. So it's the immunocompromised who may not be able to respond as well. It's there still be young children who are not eligible for vaccination, because we know even with boosting, you can still get infected. Your symptoms may be mild, but there is that risk then that you can go on to transmit it to someone who may be at greater risk for more severe disease. And so I think that's the biggest rationale. It's what do we do collectively to help protect all of our community?

Anne Browning:

Thank you for that. Later question, would you go to a movie theater and eat popcorn now?

Tim Dellit:

I would not, but I would say that I would be okay. I think you can do that. One, I think the movies are not very packed right now. So I think you can sit aside and I do think if I were to do that, I would probably wear a mask. But if you dip the mask, throw in the popcorn, put the mask, I think you can do it. I'm not doing it, but I think you can, Anne.

Trish Kritek:

It's high level of coordination for Tim.

Anne Browning:

Yes. How are you feeling about going to restaurants now? Have you eaten and out?

Tim Dellit:

My wife and I think are also facing re-entry challenges. I think when we have traveled and we needed to eat out, we have started to do that. We definitely try to sit outside if possible. And there's still a little bit of anxiety when you first go into the inside,

but I have done that a couple of times. Locally, when we're at home, we still just would order out if we're going to do something like that. So we're in transition like a lot of people I think, but it's interesting that feeling of, is this totally right? Is it not? Even sometimes like, do I wear masks? Do I not? When you're in different gatherings too, it's that uncertainty. I think that we're all experiencing as we re-enter.

Anne Browning:

Yeah. I've got a couple on travel for you. I'll say I was on a flight from JFK to Seattle. When on the ground, the mask mandate was lifted for travel. Pilot comes on, makes this grand announcement, says everybody can take off their masks. The stewardists are running up and down the aisles taking off their masks. And I'm just like, this is a really bad idea. And it was creepy. And we had a couple questions coming in around public transport. How do you feel about being on planes, trains, automobiles without mask at this point?

Tim Dellit:

Yeah. I was on a plane just last weekend. I did wear an N95, although the vast majority, probably less than 10% of us were masked. But I still am right now. I do have actually a lot of faith in airflow within the planes, but I still feel more comfortable in wearing a mask right now. So I'm not quite there.

Anne Browning:

I going to squeeze in one more before I hand it back to Trish, would you travel on a plane with a baby at this point?

Tim Dellit:

Usually in my experience, when you're traveling with a baby, it's often to go visit family. And so I think you have to weigh the risk benefits there. And so I probably would in the setting of where I want to go to see parents or relatives, but I wouldn't do it if I were just going on vacation without doing that. But I think again, it's a judgment call. And so I think you can do it. And I think that family connection, at some point we have to be able to move forward. And so I would do it particularly if it were to go visit relatives.

Anne Browning:

Good answer. And thank you, Tim, as always. And you were extra on the hot seat today. Trish, I gave you almost no time back.

Trish Kritek:

That's all good. I want to just say thank you. Thanks to Shireesha for coming back and answering so many questions. Thanks Jennifer, for joining us for the first time and really filling in a gap that we've had. So I'm so appreciative of the work you doing, the knowledge you shared. Thanks to the three other panelists who are still here and standing yay, to have you all here. I want to hearken back to what Tim said at the beginning and say a special, thanks to all the leaders across UW Medicine, who I know will keep our ship going forward in a really great way. There will be bumps in

the road, but I have faith in and all of the folks who are leading us and all of the members of our community who have really come together through so many challenges over the last two and a half years.

Trish Kritek:

I know we will move forward in a good way. I want to say a special thanks to Tim for stepping into some big shoes, both literally and figuratively. It is a challenge and I'm really excited that you are the person who's leading us through that challenging transition. And I'll take this opportunity to personally say thank you to Paul Ramsey for all that he's done for me personally, and for really creating an environment where I'm thrilled to work and really grateful for the spirit of UW Medicine. So special thank you. And thanks to all of you for coming back together for Town Hall. We'll be back in May to answer your questions. Please keep sending us your questions. And most importantly, continue to take care of our learners, our trainees, our patients, their families. And as you just heard people talking about continue to take care of each other. We'll see you back in May. Bye-bye.