Trish Kritek:

Welcome back to UW Medicine Town Hall. I'm Trish Kritek. It's a pleasure to see you again. This week we have a lot of folks back who weren't here last time when Tim had to do a fair amount of the heavy lifting. So with us is Tim Dellit, our chief medical officer for UW Medicine, Santiago Neme, medical director at UWMC Northwest, Anne Browning, our assistant dean for wellbeing, Tom Staiger, medical director, UWMC, John Lynch, head of infection prevention employee health at Harborview, Cindy Sayre, chief nursing officer UWMC, and Jay Sandel, interim chief nursing officer Harborview, and Keri and Rick are away this week, which is great. And I'm happy that people are continuing to have vacations.

Trish Kritek:

It has only been a month and I would just say in that month, it's felt really crazy, and it has felt like the world is a little bit crazy. So I'm grateful to have Anne in my life most days, but I'm actually really grateful to have her as part of our community. So Anne, I'm going to go right to you for a wellbeing commentary.

Anne Browning:

Thanks Trish. It has been a hard week. It's one of those weeks that's made me pause and step away from the news. I've stepped away from social media. I still need to apologize to the parent who at our kiddo pickup wanted to try and engage me in a conversation around gun control and storming the capital. And I was like, "I just can't," and had to step away. I've learned to be a little bit more thoughtful and pause and think about the news that I consume, not because I want to disengage, but because I don't want to become desensitized to what's happening. I feel like it's almost too easy to get overwhelmed for racialized violence, violence in our schools and communities. And with it, it's pretty easy to feel hopeless, "What can I do? What can I do? What can be done about what's happening around us?"

Anne Browning:

One of the things that I think is something I've really learned and taken away over the course of the pandemic is really to learn that when so much feels out of control to really pause and focus on, what it is that I can control? What is it that I can make an impact on? And to almost take this week to really think about, "Okay, my work is to support the wellbeing of folks within this tiny community and recognize that this community actually touches a lot of lives across our community." And really recognizing that when we take care of ourselves and we take care of each other, that's taking action towards us having a healthier community around us. There's a lot that is out of the scope of our control, but focusing on what we can do to positively impact the people that we can touch, that feels like a real big step in the right direction stretch.

Trish Kritek:

Anne, thank you. And I really appreciate that sentiment and I think it's something for all of us to reflect on and I appreciate those thoughts. So thank you for starting us off that way. There's been a lot in the world. There's also been rising numbers of COVID in our community. So I'm going to actually start off with that with you John today, because I can't imagine there's anybody listening right now who doesn't know somebody with COVID right now. It feels like everybody around us is getting COVID. So maybe you can start with current numbers in our system in King County to frame our conversation.

John Lynch:

Yeah, sure thing. Thanks Trish. Thanks for having me back, and thanks to everyone out there. It has been a rough week. And thank you, Anne, that was a really helpful message. UW Medicine, we have 44

patients, these numbers go up and down one or two every once in a while during the day, but around 44 patients total, Harborview has 15, almost all are in acute care, 10 in the acute care four in the ICU, Montlake has nine folks, eight in acute care, one in the ICU, Northwest has six, five in acute care, one in the ICU and Valley is at 14, with 12 people in acute care, two in the ICU.

John Lynch:

I didn't see everyone's numbers perfectly, but like at Montlake, and I think at Northwest nobody on L&D there, but we are seeing patients in many other units like psychiatry units in similar. One question I know always comes up every time we talk about this is how many of them are here for COVID or with COVID? We're still probably running around that 50% range. But when we look at admissions, it's the unvaccinated folks that are really driving the vast majority of admissions with COVID and certainly due to COVID as well. Do you want me to launch into the King County numbers? I just want to pause.

Trish Kritek:

I think I want to add Seattle children's numbers to that.

John Lynch:

Oh, thank you. Yeah. Do you have them? I don't think I got them.

Trish Kritek:

Yeah. I think they have six patients in the hospital right now, most of whom are on acute care. And that's a little higher than they were a couple weeks ago. So six total is what I think. I could double check my numbers, but I just want to add those to the context of the numbers that we're seeing across the rest of UW Medicine.

John Lynch:

Yeah. Thanks Trish, because I think it's really important maybe if people have questions later around pediatric vaccination, thinking about that Seattle children's number is really important.

Trish Kritek:

Yeah. I appreciate that. And I'll just preview everybody that I'm going to make sure that we have a pediatrician with us when we come back together in June, because I think there'll be more to talk about kids. We'll talk about them today though, too, so you're not off the hook completely. So a little higher numbers, mostly acute care. Most of the people who are sick with symptoms of COVID are the ones that are unvaccinated is what I think I heard as the takeoff, which is great. The other thing I think that we're hearing is that there's people all around us who are testing positive, not in the hospital though I think. What's the context of the county?

John Lynch:

You're right. We have a lot of people getting COVID out there. And so when we look at the county as a whole, we're up to just under 9,000 cases over the last seven days, and these are data that just got published today and bring us up to the beginning of the week. Now what I will say since the last time this group met and probably last time I was on town hall, we were up in the going up every week, going above 20, 22, 25%, came down to the mid teens and down in the single digits. And the last couple of

report outs from public health have us around 1% or so. So we may be coming to some sort of either plateau or maybe even a peak.

John Lynch:

The other caveat here... There's actually two caveats I just want to throw out there. One is, we don't know actually what's going on, because the number of antigen tests that are out there that aren't getting reported, some people just aren't testing. And there are some estimates they're missing 60 to 70% of cases. So when we think 9,000 cases in the last seven days surrounded up to 10, maybe 20, 30, 40, 50,000 people, infections out there. And it certainly feels like that when we talk to our colleagues that are actually happening.

John Lynch:

And when we think about that absolute number, the current numbers that we know are reported, that puts us at a higher rate of new cases per week than at any time during the pandemic, except for the January Omicron surge. So it's a lot of cases out there. And this is leading to hospitalizations and unfortunately deaths. We are seeing hospitalizations actually seen, maybe even of plateaued, it's actually come down a little bit this week, which is great news, not nearly what we saw in Omicron, and deaths are also coming down after both going up for week, after week, after week in king County.

John Lynch:

And when we think about these numbers, the impact is broad. It's not only kids and adults and families and healthcare workers who are part of the community, right, in getting infected, we also know there's a lot of outbreaks going on in still nursing facilities, which makes a lot like January... Sorry, not January 2020, but March 2020 and I think I might come back to that later on when we ask some other questions.

Trish Kritek:

Okay. So I think if I can try to summarize that, a lot of cases, as many as we've been having, the only time more was with Omicron surge in January, maybe we're plateauing though on hospitalizations in cases, and we're probably underestimating because people are using rapid antigen tests and not getting the tests that are going to be counted in the same way. And then I heard you say, we're seeing outbreaks in skilled nursing facilities again, which is what we saw at the very beginning of the pandemic. Okay. I'm going to hold that for right now. And you've mentioned healthcare workers and I got a bunch of questions about this is, how many healthcare workers are currently isolated or on quarantine?

John Lynch:

Yeah. Right now, let me see if I can read my writing. Okay. We have... Oh my goodness. I can't read my own writing. We have 154 people in isolation across all the different parts of clinical Utah medicine. And it's about 40 to 50 at Harborview, 40 to 50 at Montlake, about 40 to 50 at Valley Medical Center and then much smaller numbers at Airlift Northwest and similar. And we have about 96 people on quarantine. And again, most of those are at Harborview and Montlake, Valley doesn't have a quarantine policy because of the impact on their staff right now. Oh, they have a quarantine policy, it just doesn't impact folks like the way we do. So they don't have as many people there. So it's about 250 people who are out of office right now. And we've been flogging to 250 and almost 300 for the past maybe two and a half weeks.

Trish Kritek:

Okay. We were way, way higher in the middle of Omicron, but still a lot of people and higher than when we had come down and had many fewer people.

John Lynch:

Yeah. And it's been there for about five weeks now. I just looked at my notes.

Trish Kritek:

Around 250 for about five weeks.

John Lynch:

About 250 to 300. It's been pretty stable.

Trish Kritek:

Okay. And those numbers include trainees residents and...

John Lynch:

Everyone we track through the hospital and clinic exposure teams. Yeah.

Trish Kritek:

Okay. Personally, I have felt it and that lots of people I know are testing positive. So I think we're all feeling that. Numbers are up, maybe plateauing, I want to pivot to talking about vaccines, but if you wanted to say something about the skilled nursing facilities before I move on, I'm happy to have you say that.

John Lynch:

No. I think you're going to have some questions around boosters and-

Trish Kritek:

Oh yes. I'm going to definitely talk boosters.

John Lynch:

Yeah. So let's just come back to it then, because it's a really important topic there. And the only thing I would add to all this is, yes, there's a lot going on. Again, this is going to feel like more of a summary statement, but I can't emphasize enough how our individual actions are connected to everybody else. And the what's happening in the skilled nursing facilities where the workers are taking precautions, where the visitors are taking precautions, where vaccinations are accessible, right? Where there's testing accessible, we're still seeing a lot of outbreaks, a lot. And in these older adults and our elders, these are really dangerous. And every decision we make all of us, every day, gets connected to everybody else. And it gets to these folks in these nurse facilities or folks even are compromised or little kids, so just thinking about that connection was important to me.

Trish Kritek:

I hear you. And I think one of the things we always say is that we want to take care of each other. So I think that's relevant to that. Okay. I am going to ask some questions about boosters. I'm going to

actually start at the other end of the age spectrum. And that is, we recently had approval for five to 11 year olds to get boosted. And I think there were a bunch of questions about that, about when to do it. And as I said, we'll invite somebody else who's a pediatrician next time. But I'm going to ask you to give some thoughts on this. Should folks get their five to 11 year old boosted now or should they wait until the fall when it's closer to school? Because I think people are curious about when that most impact they'll have from the booster.

John Lynch:

Yeah. My thinking has evolved on this topic and what I would say right now is everyone should be following the CDC recommendations. And if you look at those recs right now, it says everybody five years and older should get a booster. So I recommend it. I'd also be very, very clear only about 24, 25% of all kids in this age group are even vaccinated. So I really, really, really strongly support getting vaccinated. If you haven't started that for your kids or family members and for those who are vaccinated fully vaccinated, yes, just it's time to move ahead and get boosted now.

Trish Kritek:

Okay. Vaccinated, if you haven't been vaccinated, if you haven't vaccinated, go ahead and get boosted now. And I'll ask a follow up question. It's a little bit specific. Is the dose the same for five to 11 year olds as it is for older kids? And I think that's because people are trying to figure out if their kid's on the cusp, what to do.

John Lynch:

Yeah. I think I try to dig up the actual micrograms per mil and I was unsuccessful, but I think it is different than the over 11. So if you actually look at the vials, the vials for the five to 11 is different than it is for the older kids. And I'm trying to remember the exact dose and I just couldn't find the exact micrograms to tell you what it's, but it is less.

Trish Kritek:

That's. Okay. I think the answer is it's less and we'll keep coming back to it and we can have people look it up as well and do the follow up. Okay. Then now let's talk about larger people. So people who are 50 and older is recommended that they get a booster, a second booster, if you will. And a couple different questions and I'm going to combine them. One is, do you know when we're going to recommend a booster for everyone or are we going to get a new version that's going to be more relevant to the various variants that we're seeing? And so I think people are trying to decide like, "Should I get boosted right now? Should I wait and see if there's a better vaccine? Are we all going to need to be boosted?" I asked you three questions all in one.

John Lynch:

No, no, no. My brief answer is, I know I never do that, but yes, if you're five to 11 get boosted, if you're over 50-

Trish Kritek:

Oh, I'm talking grownups.

John Lynch:

I'm talking the whole thing. Everybody who's eligible for a booster or second booster should get them. Yeah. We have so much COVID out there and boosting really makes a difference. It infections, hospitalizations and deaths. And when we think about boosters, it isn't some... I don't mean this. To say this slightly, it's not magical. The idea is that immunity wins and boosters just bring that back up. And as we get older, for those of you out there, it's even like in the 30s, 40s range, sorry, that immunity wanes a little bit faster. And so we want it across all age groups. It means more for the older folks, but it is important across all age groups. So should. I would say Melissa just posted for-

Trish Kritek:

Third of the dose.

John Lynch:

Yeah. A third of the adult dose. Yes. Thank you.

Trish Kritek:

Okay. So earlier Tim and I revealed that we are old enough to have it indicated that we should get a second booster and that we both got boosted. You had not gotten boosted. Did you change your mind on that?

John Lynch:

Yep. I'm going to get boosted. My wife is a nurse and we're just trying to figure out, we've gotten all our vaccines together. We want to go get our booster together. So we just want to find a time, hopefully either this weekend or next week, sometime during the week to get our next shots together.

Trish Kritek:

Second booster. A family that boosts together stays together. I like it. Okay. That's great. Do you think we're going to get a booster for those people who are in that space, a second booster for those younger folks?

John Lynch:

I wouldn't be surprised at all. I haven't seen any data on this or hints that it's coming, but I wouldn't be surprised just because these coronavirus vaccines are associated with this waning immunity and these just bump it back up again. I think the other question you asked Trish, was are they going to be new ones? Yeah. There's probably be new ones. Yeah. There's probably going to be new ones. Just like we think about influenza, but probably a little bit closer to what we know is circulating. But that shouldn't preclude how we protect ourselves and our communities right now. It's not going to mean you can't get that one, right? It's just another one.

Trish Kritek:

Right. And so what we're saying is get boosted now and there probably will be a one that comes up later and get that one that comes up. Last couple of questions before I give you a break. As I said, there's many people that we all know who have recently got infected and many of them sent in a question that said like, "How much protection do I have if I've been vaccinated, boosted, and now I've just gotten infected? Do I have a sense of how long that protection might last from just being infected?"

John Lynch:

Well, if you're vaccinated, boosted and infected, yes you do. Getting infected does provide additional immunity and it's not so much like it's way better on top of it, just that probably lasts long, it's like a booster. And I don't advise it. Don't replace a booster with infection. It's not the way to go, but it definitely does lift your immunity for some amount of time. The challenge is that I'm hesitant to give days or numbers, because everybody's unique, age groups, all these types of things, how much you're exposed to and so forth.

John Lynch:

Yes. It gives you additional protection. But the most important message I want to deliver is it does not preclude doing the other things, getting vaccinated, getting your booster. So you got vaccinated boosted and then you got infected three or four months later, if you're over 50 and you still have that second one, you should still get the second one, right? The other thing is, I wouldn't recommend any changes in your behavior either. I'm going to be a little more edgy because I got infected last month, right? I don't think that's a good strategy.

Trish Kritek:

Okay. Does give some protection, doesn't mean you should change the behaviors that you have, and doesn't mean you should stop progressing on the vaccine spectrum as we've talked about. Okay. Last one for you before I give you a break, I'll come back for some more questions a little bit. Do we have any updates on vaccines for kids under five? That is exceedingly common question.

John Lynch:

Yes. I am hopeful. I am very, very hopeful here. I think ACIP, I think we even have a date out mid-June. They may be having a meeting Moderna and Pfizer, both published results of multi dose strategies. I think it's two for Moderna and three for Pfizer or three for both, looking at the six month of five year old age group and looking really good protection. I think Pfizer was 80% and Moderna is probably similar, and so really exciting. And if everything goes as planned and the way we've seen with all of these meetings, the scientists have done a great job, the reviewers have done a great job, the regulatory folks have done a great job. We could be looking, I saw potentially getting vaccines in kids' arms by the third or fourth week of June, six months to five year olds, which is that super exciting.

Trish Kritek:

Yeah, it is. That horizon has seem far, far, far away, and it's suddenly getting a lot closer. So mid to late June we should have some more news and we'll plan to have a Town Hall at the end of June so we can answer those questions with a pediatrician as part of our group.

John Lynch:

Yes, please.

Trish Kritek:

For you and for everyone listening. I do want to ask one follow up that came in through the chat. You said, if you get infected, still get your next shot. I've asked this question before, but I think it's a good one to ask again, is there a time you should wait from resolution of infection to getting the next shot that you're due for?

John Lynch:

Nope. Our recommendation is soon as you feel well, back to baseline, get your next vaccine.

Trish Kritek:

Okay. So if you feel good, keep going on the routine. Thank you. I appreciate it. Okay. You're off the hook for a little bit. Tim, you're on, isn't it nice to have John back?

Tim Dellit:

Yes, it is.

Trish Kritek:

There were some sharing of information about going to conferences recently. And actually we got at least a few questions about whether or not folks should not avoid conferences, but avoid conferences where there's no vaccine mandate. And I thought maybe I just ask you for your guidance about national meetings and I'm just going to be a full disclosure that I went to mine earlier in the month. And it was an interesting and in many ways good and some ways challenging experience. So guidance.

Tim Dellit:

Yeah, I think this is a really good question. I would say we all recognize the value of these conferences, these national society meetings. And we recognize that we've missed those to some degree, certainly the in person meetings over the last couple of years. And so we do support people participating in them, but we think that we can do that carefully. Now, you can never mitigate and eliminate all risk. But what we have seen in some situations is individuals go to conferences, and sometimes in these conferences, people are largely unmasked. There're often social gatherings with eating and drinking. And then we've seen clusters of individuals that come back from the same practice group, since it was a practice group type meeting, coming back with infection or potentially transmitting that to colleagues, which then also impacts an already stressed staffing situation.

Tim Dellit:

And so John and Seth recently put out a message to the community and just really added some additional recommendations. Things that we've talked about before. If you're traveling at a distance and you're going to be on an airplane, wear a mask, preferably a KN95 or an N95, KF94, is better than a surgical mask, wear that on the plane, wear it through the airports, or if you're commuting in a taxi cab in closed spaces. When you're at these conferences again, we would recommend wearing a mask when you're indoor, if you are socializing, can you do that either in outdoor venues? Again, depends on where the conference is, the weather's getting better or in smaller groups.

Tim Dellit:

And so I think there are steps that we all can take to try to decrease that potential risk of exposure. The other piece is have a contingency plan because if a large number of critical care physicians are going to the critical care meeting, we need to make sure that we have coverage in the ICUs when we come back as well. And so thinking about what are those backup plans, if you happen to get infected or exposed and can't come back to those clinical duties when you return. So we support doing the conferences, just use a little bit of guidance around how to minimize that risk when possible.

Trish Kritek:

I appreciate all that. So masks particularly on the plane, in any indoor settings, eat outside if you can, or with smaller groups, and have a backup plan for people getting infected. To be Frank, I went to the American Thoracic Society meeting, and most people did great and some people did get COVID. And I think that having that contingency plan is a really important part of it. And it's really good to see your friends that you haven't seen in a really long time. And I think we have to value that too. It was deeply meaningful for that reason. So how about gathering here? How do you feel about gatherings at work right now with the numbers out as they are and whatnot?

Tim Dellit:

Well, first of all, in the clinical spaces, right? We're requiring masking and we're still requiring now respirators, particularly because we've seen that impact on our staffing, and we have contingency staffing, right? So hospitals and clinics, very clear what we are requiring. In those non-clinical spaces, the university has made it optional, although we strongly recommend and university moved to that strongly recommend for indoor space because of the increased cases that we're seeing here in King County, as well as what we're seeing at Central Campus.

Tim Dellit:

And so when I'm inside, I'm not wearing a mask because I'm in my office, but when I go outside my office, I put a mask on. And so again, we're still recommending that even though it's not required in the university outside of those clinical spaces. But I think just like John said, we're up at 375 per 100,000. And again, this is high level of transition in the community. Yeah. We're just not seeing as many hospitalizations. Even though we are seeing some increase, we're not seeing as many as what we did with Omicron, but there's a lot of COVID in the community.

Trish Kritek:

Yeah. Okay. So mask indoors, that's the take home there. We're talking about a lot now. I think people are already thinking about the fall and some people are worrying about the fall. So maybe you could just take a minute and talk about how we as UW Medicine are preparing for the fall in case there's a larger surge or more people get sick with whatever we might see come the fall.

Tim Dellit:

Yeah. I think one of the reminders is that we've never stopped since February 29th, 2020. We stood up our UW Medicine incident command. We haven't set that down. It has continued to exist this entire time. Now, we've changed frequency of meetings, we've changed some of the things to more behind the scenes, depending on where we are with the ebbs and flows of the pandemic, but that ongoing work, ongoing planning through our EOC continues.

Tim Dellit:

Learning from recent phases, we're working with medical directors around, how do we staff our services? I had a conversation earlier with GME and thinking about how do we prepare for potential moonlighting and what does that look like? And should we modify how we did that from the last time? Again, some of this is just taking lessons learned from the previous searches and incorporating them as we prepare for the future. I think many of this anticipate that we'll see another surge in the fall. I don't know to what degree, I don't know how impactful that will be within the hospitals, but I think many of us anticipate that I just don't know exactly when. So I think I would just try to reassure people that the

team is continuing and hasn't really stopped since the beginning of this two and a half years ago to do ongoing work and incorporate the lessons learned as we go forward.

Trish Kritek:

Yeah. I think that people are still looking at it. People are working on plans and people are in those rules to allow us to respond as it happens. And we'll see what comes and respond when we do learning from multiple surges before that. Okay. Last question for you for right now is around how we as UW Medicine are going to support two things. One is the boosters for the five to 11 year olds that are now being recommended. And then secondly, are we ready to help vaccinate the kids less than five, who we've been waiting for that opportunity for quite a while?

Tim Dellit:

Yeah. We just sent out in the last few days a message, both to our community and to all of our patients with information in terms of how to sign up for boosters in that five to 11 year age group. With the six month to five year olds, it's going to be a little bit of a different strategy. We talked about this briefly when we anticipated we might get to them sooner, but public health recognizes mass vaccination clinics are not the best way to vaccinate six month to five year olds. And I think it's going to shift to much more within the pediatric clinics. So we're anticipating using our pediatric clinics at Harborview, UWMC within our UW Medicine primary care network, the Kent-Des Moines shoreline clinics. There could be popup clinics potentially as well, but it will be a little bit different and shifting much more to the pediatric clinics in terms of the vaccination of those really young children.

Trish Kritek:

Okay. So we're doing the boosters of the five to 11 year olds and we just send out information on how to do that. For the smallest children, we're going to be doing it more in the pediatric clinics. If I'm an employee and I have a kid, but I don't necessarily get my care in one of those clinics, is there an opportunity for my child to get vaccinated somewhere in need of medicine?

Tim Dellit:

I believe there would be. I'll have to confirm exactly in terms of which of those clinics where we would be able to do that. But like I said, we also would be doing popup clinics where we would be able to take all comers. And so yes, we will be there. We'll get more specific information once that time comes.

Trish Kritek:

Awesome. I just think those people have been waiting and waiting and waiting, so there's lots of questions about it and they are like, "Please be ready, because I want my child vaccinated," which is great.

Tim Dellit:

Yeah. And again, our vaccine planning group, they've been anticipating this for several months, and they went back. And again, now that we know this date and just as John said, we're anticipating by the third or fourth week, certainly by the end of June, more likely than not, that will get approved, and so they are rapidly planning for that.

Trish Kritek:

Okay. We're on it. And we're going to communicate more about it as we get closer. All right. Cindy and Jay, you're up. I meant to give you a preview, a warning that I was coming next. Not surprisingly, there are questions about visitation, and now the questions are swung more towards, are we thinking about restricting visitation more with the increasing numbers that John talked about? Granted, he also said maybe we're plateauing. Cindy, I'll start with you. Had there been discussions about changing visitation and response to the rising numbers?

Cindy Sayre:

Yeah. I'm not aware of any conversations for the restricting visiting right now. I'm looking right at John because there might be discussions in med tech, so no. I do want to add though that we need to make sure that visitors are masked in the rooms at all times because we've had some situations where we think that patients have contracted COVID from their N mass visitor. I would like to see us preserve our visitation policy as it is right now, and to do that we need to be as safe as possible.

Trish Kritek:

Okay. So that's a good setup. I'm going to ask both you and Jay, just, can you go over what the inpatient and outpatient policies are in terms of visitation and testing and masking?

Cindy Sayre:

Yes. So we're at one to two visitors for inpatient. So really no change from the last time that we talked. And for outpatients, it's one, there are some clinics that have exceptions to that like our transplant clinic, where we need to at times have a second family member or caretaker in with the patient. And the vaccination rules are that anybody entering the medical center as a visitor or as a caretaker has to be vaccinated and have that evidence or have evidence of a recent negative test, and the antigen tests are accepted for that evidence.

Trish Kritek:

Okay. And I think that's consistent with what it's been. We'll hit the high points of that, which is one to two on the inpatient setting, one in the outpatient with exceptions, vaccination or recent test including antigen and wearing a mask all the time when you're in on the site. And Jay, is there anything different about that at Harborview?

Jay Sandel:

No real difference. Except at Harborview, we do have time limited visitation. So we are not open 24 hours for our visitors here, so that's the only difference. Otherwise, I think the visitation policies are across sites the same mostly.

Trish Kritek:

Okay. So ours are different, but otherwise the rules are the same. And then Cindy brought up this thing about, we really want everyone to keep their masks on. And I think people ask like, "How are we helping make that happen? And what are your suggestions for how we make that happen?" And the word enforcing was used in several questions. And I'm wondering if there's something you could... I'll start with you, Jay, and then Cindy if you have other thoughts you can add. How do we help make that happen to make our spaces safe?

Jay Sandel:

Yeah. When I think about it Trish, it's really everyone's job to ensure that we are enforcing that... Enforcing is probably the word we're going to use, but reminding folks that they do need to mask up while they're here in our organization. I think it's up to everyone, leaders, front side nurses, everyone who is out there that interacts, visitors we need to remind them if they are not being compliant with our policy. I was just walking around today and just so happened to see someone that was not mask. So I went up and reminded them that they needed to mask and they didn't have one, so I was able to give them one. So I just think it's everyone's job. We can't just rely on our frontline bedside providers to be able to help us enforce this role.

Trish Kritek:

Yeah. Okay. I think it's all of our job. You can kindly remind people, you might provide them a mask if they don't have one. Anything else, Cindy, that you would suggest on that?

Cindy Sayre:

Well, one thing we're seeing at Montlake is a little bit more resistance to having somebody walk up. And for example, yesterday I was in our lobby and saw somebody with a mask off and I said, "Oh, we need to put a mask on in the medical center." He put it on under his chin, and then I said, "Over your nose." But he put it on over his mouth. I said, "Over your nose." And he was trying to walk away from me, but I walked with him. I will say, we should disengage quickly. If people aren't listening, I don't want staff in harm's way, either verbally or physically. So then that's when you would just go get a supervisor if somebody looks like they're not going to agree with you. I probably had too much moods, but yesterday, if that's a word I can use in really making my point with that visitor, but we want staff to be really safe. Yeah.

Trish Kritek:

Yeah. I appreciate that. And I think there are moments of tension around this. So I think it's worth asking. Sometimes people do forget, they take it off to drink their coffee and then they don't put it back on and you can remind them, it turns into conflict escalate and get some other help instead of pushing it. So thank you. I appreciate that. All right. I may come back for a question, but I'm going to go to Tom quickly because there are a bunch of questions Tom, about numbers are up, but they're not up crazy, but our census is still super high at Harborview, really, really high, at Montlake, very high, Northwest has been high, high census. I think that's a two part question is, why do we think it's so high still? And what are we trying to do about it?

Tom Staiger:

We continue to have a lot of demand for our services, mostly because of the quality of care we provide. But also I'm pretty sure that in the regional, a lot of facilities continue to have some constraints due to staffing. And so the demand for transfers continues to be high across the region. I think this has gotten a bit better but placement of patients in skilled nursing facilities and adult family homes continues to be somewhat constrained due to their staffing challenges. What we are mostly focused on certainly the hospital levels is implementing best practices to improve our throughput based on what we can identify as well as what we learn from others, including a consultant that we've got helping us a bit to implement best practices and are very focused on how do we improve our capacity utilization and our throughput. The other thing we're doing is focusing on recruitment and retention. And we've got committees led by our two hospital executive directors that are looking at what do we do to help better recruit and retrain our staff so that we can be as fully staffed as possible in the midst of these challenges.

Trish Kritek:

I appreciate that. So high demand, maybe pent-up demand, demand from a large region, maybe still some issues with leaving the hospital to skilled nursing facilities. And then a lot of the work we're working on is staffing, which I gave Cindy and Jay a break from today, and then throughput, including working with a consultant. I think I'll keep asking about this because it is still something that we keep hearing about and it's clearly impacting people's wellbeing across the board. I see the questions and we'll keep coming back to it, as there's new things, we'll continue to share them.

Tim Dellit:

Yeah. Trish, I would just add, this is nationally. If you talk to any healthcare system around the country, they're facing these same things, right? Length of stay, meaning the time that patients are in the hospital has gone up is become increasingly difficult to find that next level of care when a patient is medically ready to be discharged and staffing is a challenge nationally. And so, we're facing the exact same challenges. We're all trying to learn from one another and how best to address those. But I just wanted to raise this, that it's a universal challenge within healthcare in this country right now, not just unique to UW Medicine. And certainly if you ask any of our colleagues around our region, they're experiencing the exact same thing.

Trish Kritek:

Yeah. This is a national problem, as is the wellbeing and burnout issues and the issues around retention and people leaving the field. It is part of all of healthcare. So I appreciate you making that point. All right, Santiago, welcome back. I'm going to ask you a question about therapeutics to start with, because you've answered a lot of our therapeutics questions, and actually this was a very common question and it's about this recurrent symptoms after people get Paxlovid that they then have, I don't know if it's a recurrence or recrudescence of their symptoms and what they're supposed to do in that setting. What does that mean? So maybe you could talk to that for a moment.

Santiago:

Yeah. Thank you, Trish. I think this is a really important question and one that very frequently Shireesha and I answer for folks. CDC submitted, released an alert alerting the healthcare professional community about the potential for rebound of symptoms after completing the full course, the five day course of Paxlovid. Again, Paxlovid is this highly efficacious regimen that is five days. And the main goal of that regimen is to really prevent death and hospitalization.

Santiago:

So although we have seen rebound symptoms, either from two to eight days after completing the course, those symptoms tend to be mild and they haven't been associated with any progression of disease. But there's something really important, which is the CDC recommends that if you get rebound symptoms, you reisolate for at least five days. I'm going to share link with the full alert where you can see more details for people to read, but it's really important that they reisolate because they could become again, infectious. And this is why some folks who retest may have tested negative on an antigen and then retest positive. That indicates that they have a viral load high enough to be contagious. So I recommend that folks read where I'm going to post here from CDC.

Trish Kritek:

I'm going to try to summarize what you said, which is the therapy that's particularly effective for keeping you out of the hospital and preventing people from dying from COVID. And we're seeing people having symptoms two to eight days later. And if that happens, you need to reisolate for at least five days. Is it stopping us from prescribing it? Are we still using it?

Santiago:

No, not at all. It's a highly efficacious medicine and it's safe. We have to be careful with interactions. The other thing that I wanted to point out, a lot of clinicians raised the point, should I retreat? Should I repeat the course of... Should I do 10 days and not five? I want to be very clear about this. It is not recommended to retreat anyone, and that would be a violation of the EU way. So we really need to stay within the guidelines and not retreat any patients.

Trish Kritek:

So isolate, but don't retreat and don't treat for a longer course than five days. Excellent. Okay. I'm going to shift gears and ask something I've never asked at Town Hall, which is remarkable to me because I've been doing this for two and a half years. And I think I've asked every question multiple times. However, one big theme of questions was around a different disease. And I'm going to do a verbatim question from one of the people who submitted a question, and it was simply this, what's up with monkeypox? So maybe you could give us a little bit of a sense of what's up with monkeypox. I have a couple follow up questions after that.

Santiago:

Yeah. So monkeypox is not a new infection. It's an infection caused by a virus, by an Orthopoxvirus that's endemic from countries in Africa. What we're seeing is that there are outbreaks of this infection outside of the endemic areas. So this is what we're seeing cases in the UK. We saw cases in the U.S., we have a case confirmed here in King County. In the manifestations typically we think of this infection in endemic areas is typically fever and large lymph nodes, more of a flu-like infection. And what we're seeing in the non-endemic cases is that patients are presenting more with genital lesions, that in the setting of a potential sexually transmitted infection or STI, and that's this setting where we're seeing, and we're also seeing this, not all of the patients, but most of the patients are folks who identify themselves as men who have sex with other men.

Santiago:

And again, I want to be cautious because I don't want to stigmatize this, but I really think that we need to give the population, the community, the right information. And it is true that if I'm a gay man, if I'm a man having sex with other men, I need to know this information. And if I'm a doctor, a nurse caring for a patient, I need to advise them about this potential risk. One more thing that's important is how do we get this? It's transmitted through skin to skin contact or debris from the lesions or discharge from the lesions, but it also gets transmitted through large droplets. Remember that large droplets fall within six feet of you. So this is not like COVID that gets airborne and suspended in the air, this is not that. But obviously if you are within six feet of a patient, you might have contact through the airway.

Santiago:

But what we're seeing is that most of these folks are thought to get the transmission through that intimate sexual contact. What's interesting too, is that there's been no flight associations with this. So there's been no cases associated with flying of these folks who were actually confirmed to have the

infection. That's also very positive. So this is not COVID and this has not the potential to be COVID, does not have the potential to be COVID. So I just want to make sure this is not a reason to panic. This is a reason to be aware and help our patients and community and try to remove the stigma while we inform.

Trish Kritek:

Okay. That was an awesome what's up with monkeypox, and I'm going to try to summarize some key points. You said it's endemic. And I just want to say that means that we see it all the time in certain communities, and those are mostly in Africa. And in those settings, it's usually like a flu-like illness with fever and swollen lymph nodes. Now we're seeing it in places where we don't usually see it. And in that setting, it's mostly a sexually transmitted infection. And in those populations where that's happening, we're really talking about skin to skin transmission, or droplets coming from a lesion that bursts and releases the virus. It seems like hand washing would be really important in that situation. Is that right? Okay. And washing is always important.

Santiago:

Yeah. And then the healthcare setting, I'm looking at John too, but we ask providers and the care team to implement airborne precautions. Why? Because you're within six feet of this person and you can aerosolize when you're seeing the patient. But also remember that the differential diagnosis is VZV, it's the virus that causes chickenpox, right? Again, you want to take precaution measures that are a bit bigger than what you think you expect, especially given the differential, it's all these vesicular or blistery lesions.

Trish Kritek:

Blistery lesions, which look like chickenpox, you might think about chickenpox. We're going to take the precautions like we do for people in the hospital with chickenpox, which is do the airborne precautions and wear the mask as we would normally. Okay. Two last questions on monkeypox. One is, are people dying from it?

Santiago:

No. No. What we're seeing is that it tends to be mild, but again, the non-endemic cases have been very few. So I think we're going to learn more, and there's different strains. So I would say the cases that I'm aware of have been mild and not fatal. Some strains carry a 10% fatality, but not what we're seeing for now.

Trish Kritek:

Okay. I appreciate that. I want to reassure people. It's not COVID, it's not affecting people like COVID, and I also want to reemphasize, you're saying let's not stigmatize people who have this. I think that's a really important message as well. So thank you for all of that. The last question I came up at least three or four times, and it must be all people my age or older asked if a smallpox vaccine is protective.

Santiago:

It is thought to be protective. The problem is what titles are we talking about? What do people have? I'm originally from Argentina so I actually have the shot, have had the shot. The question is how long would you have that protection? And I was just talking Shireesha about that, it's unknown right now.

Trish Kritek:

Okay. Maybe. I'm going to leave it like that. We're not going to start vaccinating people. All right. Thank you for taking on monkeypox and I appreciate your clearing it up. It's been so much in the press that I think people were thinking about. And I think it's good to talk about it and also bring down the anxiety. All right, John, I'm going to try to sneak in a few questions with you before we hand over to Anne. Really kind of question and Santiago is talking about it. People want to know, how do I know when I'm not contagious anymore? And is there some way that I can know if I'm no longer contagious?

John Lynch:

There's no tests for showing that you're not contagious, right? If you had a few negative engine tests after a positive PCR and your symptoms were improved, that would be very helpful. I think we can feel pretty darn confident that almost everyone is not contagious after 10 days. The bell curve, there's a few out, maybe a day or two longer. And there's definitely people on the other end who are not contagious even after just a few days of symptoms. And that's what lies behind the ability for us to bring people back to work after five days of a positive test or their symptoms with resolution. Symptoms are a huge driver, not only because it tells us about the state of disease, but it's also how we transmit through coughing and similar that drives that transmission. So symptoms and time.

Trish Kritek:

Symptoms and time, and 10 days is pretty good for most everybody. Is that-

John Lynch:

It's a really good one. I think we're still sticking with that. And even after two and a half years, with all the changes we've made and learned about with this virus, the 10 days for isolation is still pretty, pretty strong.

Trish Kritek:

Okay. And then I don't know whether you're going to have an answer. I'm going to ask it anyway. How long after you've been infected can you get... Are you at risk for reinfection?

John Lynch:

This is an ever-evolving situation. And I didn't talk about it earlier, but the other thing that's unique about the surge we have right now, which is due to BA.2, the January one was BA.1. BA.2 is more infectious than BA.1. And that's what's driving things right now, plus not being masked. But underneath this, we actually have another variant, BA.2.12, it's actually the predominant variant in the United States now. Here in Pacific Northwest and Washington State it's about maybe 15%, but it's going to come up because it's even more infectious than BA.2. And so we actually have a surge with another variant underneath it, which we've never had before.

John Lynch:

And so that's going to lead to some of this lack of clarity, but I think we will be seeing people. And what we've learned from Omicron is that yes, you can probably get reinfected. You go from Delta to BA.1 definitely, or Delta to Omicron. And then even within these Omicron strains, there's reinfection risk. And it's not only dependent upon how long since your last infection, but also your vaccination booster status, probably your age, and obviously the groups you run in.

Trish Kritek:

Yeah. So I think the answer is it's complicated. It definitely is true you can get reinfected and there's a lot of things that are going to play into the risk of that. So hard to give an estimate on that. I'm going to ask you one last hard question, which probably doesn't have an easy answer, but a short answer. Why is it that in a household everyone's living together-

John Lynch:

I know where you're going.

Trish Kritek:

... one person doesn't get it. What do we think is the deal with that?

John Lynch:

No one knows. It's just true.

Trish Kritek:

It is true.

John Lynch:

We all hear about these friends and family members where someone in the house gets COVID and one other person gets COVID and two don't, or three get COVID and one doesn't. There is amazing things we're going to learn about our immune systems and how we respond to infection, all those questions you asked earlier, to vaccination, combinations of vaccination infection that have to do with the genes that make us who we are and the things we experience over our lives. And so we don't know, but it's definitely true that some people don't get COVID in their households. Now that doesn't mean they may not get COVID next time, right? Doesn't give you a get out of jail free card, it just means that time for that variance in the dose that's circulating it didn't happen for you.

Trish Kritek:

I have a good friend who's a scientist who has had three family exposures and keeps not getting, he's like, "I need to study myself." And I agree.

John Lynch:

He does. Yes, they do.

Trish Kritek:

We need to understand this over time. And I appreciate it. I'm asking because it comes up and I think it's just worth acknowledging. We see this and we don't understand it yet.

John Lynch:

It sounds so silly, but it's a really, really important question.

Trish Kritek:

It is so interesting.

John Lynch:

It's a wildly important question, but we don't have information on it.

Trish Kritek:

Okay. Well, we'll end it with that. And I'm going to hand it over to Anne to chat with Santiago.

Anne Browning:

Excellent. All right. We've got a lot of questions again that keep bubbling up that are based on where we are right now, what decisions are you making? So Santiago, we're going to start with kids, and I know you don't have little people, but you can extrapolate. And I left these questions pretty much in your words. So would you send your preschooler to an outside summer camp if they haven't had any vaccine doses by the time the camp starts? Fingers crossed relate June.

Santiago:

If this is outdoor only, I would feel more comfortable provided that I know that there's going to be more intimate contact. I would say, I would like to know what the precautions of the camp are, are all the adults vaccinated and masked around the kids? What are the other layers of mitigation? What about ventilation? Where are the kids going to be sleeping? Probably the average parent doesn't ask these questions, but I would probably ask these questions. And depending on that, and also the desire that my kid has to play with others, then I would probably go for it.

Anne Browning:

Sounds good. Again, thinking that late June, we might start seeing some vaccinations for littles, would you take a toddler on a cross country flight if they couldn't tolerate a mask at this point?

Santiago:

Honestly, I would say if they could tolerate a mask, I definitely would. I'm not too sure traveling, especially just having travel myself and seeing the airports and seeing just a number of people. And I would feel a little uncomfortable with the toddler unmasked currently in those indoor spaces, not necessarily the plane, but just everything else, the bus, the taxi, all those things, right? It would have to be a really compelling reason to go. It wouldn't be just a vacation.

Anne Browning:

So wait if you can if there's June on the horizon. Okay. We're back to big people now. Would you fly to New York this summer for a bachelor party?

Santiago:

I would. I would.

Anne Browning:

Would you travel to go see older parents that you haven't been able to see in the last three years? Have you been able to travel to them?

Santiago:

Honestly, I've been doing some of that and I've been meeting with friends, but I always test before. Although we're not obliged to test before we leave the U.S., I test when I get there, I test before I leave. Again, it's not perfect because I'm asymptomatic and the sensitivity of the test may not be great, but it is an extra layer of protection. It's not always possible, but I choose outdoors and I try to keep it small smallish. So I'm thinking bachelor party meeting with a small group of people will be small, smallish, and outside. And also when you look at the weather, but not specifically today, but in general, what we're going to be seeing is that people should hang out more outside.

Anne Browning:

Good. I've got a couple questions around life as we know it. Memorial day, would you go to an outdoor barbecue? Let's say 10 people. Would you mask, if you weren't going to necessarily keep six feet away from folks? How are you feeling now?

Santiago:

If I'm outside honestly, I don't put that much emphasis on... Of course I'm not going to be super close, but I would say I would feel comfortable outdoors at a table with other people without masking for sure.

Anne Browning:

Okay. Thank you. Folks want to know, are you eating inside restaurants yet? How are you feeling?

Santiago:

I have only when I had to, and that is when I go on vacation and there's no other opportunity and I balance that. I check the space and I make sure that I'm close to a door or window where I get a little draft. And it's a gamble, but at the same time, it's that risk benefit assessment that John always talks about, which is how much do you really want this? And are you willing to deal with the potential consequence and then who else will suffer from this? Right? If I'm supposed to cover the hospital, maybe I should skip the dinner, but if I'm on vacation and not have to be anywhere, maybe I would go. And I have done that in Europe, not here. In Seattle I feel like I always manage to find outdoor sitting and sometimes it's chilly, but I feel like it's fine.

Anne Browning:

Good. Two more quick ones. First, how are you feeling about going to a play or a movie right now knowing that... I don't know about your age, but Top Gun Maverick, I'm fired up. I know John got fired up for good, but I might actually go.

Santiago:

I would. I would go to the movies. I would probably not eat... In Argentina people typically don't eat at the movies, so I would just stay masked and watch my movie or play. Yeah.

Anne Browning:

Last one I got for you. Would you go to folk life unmasked? And most importantly, would you participate in dancing?

Santiago:

This is outdoors, right? So I would probably semi. Again, if I'm outdoors, I'm going to be unmasked, unless it's a really massive number of people, and I would be masked if there's no air really. It's all about air flow. I would definitely dance.

Anne Browning:

Awesome. Awesome. Thank you, Santiago.

Trish Kritek:

I think that's the take home. I would definitely dance. Thank you both. And as always thanks to everybody who sent in their questions, these are wonderful for us to think through these scenarios. I want to take a moment to say congratulations to all the medical students who are graduating this weekend. I'm a little sober, because I think that's the third time I've said it at Town Hall, which is crazy to me, but this is a momentous event and these folks did a lot of their medical school during a pandemic. So a huge congratulations to the medical students, a big thank you to all the faculty in Seattle, across WWAMI, in our classrooms, our clinics, our hospitals who taught them, the staff who have supported them in so many different ways. And most importantly, their parents, their family, their friends, without whom none of us could graduate from medical school. So congratulations and thank you to all of those folks.

Trish Kritek:

Thanks to the folks who are going to make this a celebration in person again for the first time this year, I think that's a really big deal. So thank you all. And I hope everybody has a wonderful celebration. Thanks as always to the panel. It's great to have folks back and answering questions. Thanks to everybody who writes in questions. And I'll end by saying again, it's so important for us to continue to take care of our patients, their families, come together as a country and take care of the little folks in our world and keep taking care of each other. That's what we talk about all the time. We'll be back at the end of June to talk about the next set of vaccines probably, we'll see you then. Bye.