Trish Kritek:

Welcome back to UW Medicine Town Hall. I'm Trish Kritek. And with us today, we have Tim Dellit, our chief medical officer, Anne Browning, our assistant dean for wellbeing, Santiago Neme, medical director at UWMC Northwest. Seth Cohen, thank you for being here, representing infection prevention and employee health. Backed by popular demand also, Shaquita Bell, the senior medical director for the Odessa Brown Clinic.

Trish Kritek:

I think your title changed since the last time I said it. Tom Staiger, medical director for UWMC. Cindy Sayre, CNO for UWMC. And Rick Goss, medical director for Harborview. It's a little pivot today, because the world's a little different than it was yesterday with the overturning of Roe v. Wade. And so I'm actually going to turn to Anne to start us off with a wellbeing message, and to be honest, with that in mind, because I think it's been on many of our hearts and minds today.

Anne Browning:

Thanks, Trish, everybody. About nine years ago this Sunday, the Supreme Court voted five to four to overturn DOMA, The Defense of Marriage Act. And I'm going to actually have Trish share an image with you all that I think kind of captures the sentiment of that moment for me. To me, it's Bert and Ernie, and they're looking at the TV and seeing the Supreme Court. And it's such a powerful image, and it's one that my wife and I have hanging in our house.

Anne Browning:

And it represents to me the power of the Supreme Court to really recognize the humanity and the dignity of all of the citizens within our country and beyond, and it makes today much, much harder to sit with. Trish, you can take down the image if you'd like. Thank you for pulling that up. Today it felt like a gut punch, even though we had some signals that this was coming. And it shows that choice, that agency, that humanity and dignity can be revoked. And significantly, we know that the decision today disproportionately impacts folks in our community that are the most marginalized.

Anne Browning:

And it's in a domain that is so close to our hearts, which is access to healthcare. And that makes this powerful for all of us across our community within UW Medicine as well. Whenever I feel a little disjointed from the country in which I live, I think back to a quote from the late great, Ruth Bader Ginsburg, she said, "We're not experiencing the best of times, but I am optimistic in the long run."

Anne Browning:

She said, "A great man once said," and she was actually quoting her husband on this, "that the symbol of the United States is not the bald eagle, it is the pendulum." The pendulum swung pretty hard today in a direction that is really hard for those of us who are very invested in access to healthcare for all. And I trust, I stay optimistic that in the long run we will see that pendulum swing back.

Anne Browning:

It is hard to see the power of the court shift that pendulum, but we know over time that it will come back, and that we can all hold the humanity and dignity of each other and do what we can to respect that. The Office of Healthcare Equity next Thursday, I think it is, on the 30th, will be holding caucuses for

affinity groups. I'll put the information about that into the chat for folks who would like to gather and have some conversation around these topics. A hard day. And with that, Trish.

Trish Kritek:

Thank you. And I know you're away and felt passionately enough about this that you wanted to be here to speak to it, so I appreciate that. And Tim, I'm going to turn to you next. There was a message that came out from UW Medicine today, but maybe I'll ask for your thoughts in this moment as well.

Tim Dellit:

Yeah. No, thank you. And again, I just want to reemphasize what Anne just mentioned. This has been a very difficult day for many in our community. At the same time, I also want to acknowledge that there is a wide range of views around the topic of abortion, but I want to talk a little bit about the impact from our perspective as UW Medicine, an integrated clinical research and learning healthcare system.

Tim Dellit:

We know that this decision by the Supreme Court is going to impact access to healthcare. It's going to impact access to healthcare across our country and disproportionately impact women, people of color and those individuals who are not able to travel to other states to receive healthcare. And so we did send out a message earlier from a UW Medicine perspective affirming an individual's right to have an abortion.

Tim Dellit:

When we think about this, we think about access to healthcare. We very much believe all individuals, all people should have access to the full spectrum of healthcare, that includes reproductive healthcare and that includes abortion services. As a teaching environment, we very much believe that our students, our residents and fellows need to be trained in reproductive services in all healthcare, and again, including abortion services.

Tim Dellit:

Now, for our medical students, this is not going to change our medical school curriculum. We teach about abortions within the classroom setting. We do not require medical students to participate in the clinical performing of abortions. Those individuals who desire that level of training will still have access to that training within Washington. And it's important to emphasize that with this ruling, it does not change the access to care here in Washington state.

Tim Dellit:

However, we have a unique role within the WWAMI region and we will be monitoring the impact in other states. We know some of our surrounding states are what are referred to as trigger states. We need to watch how they implement this change at the state level and then adjust. Because we anticipate if a state does change their approach, it could limit not only access to care, but also limit potential training opportunities within that state.

Tim Dellit:

But collectively as a system, we will ensure that those opportunities for training are available. This isn't going to affect our obstetrics and gynecology residency training, which is mostly if not all within

Washington state or some of our fellowships. And again, we'll continue to monitor the impact in other states. The last thing I would just say is just ... And I'll say this from a personal perspective.

Tim Dellit:

Again, as a father with four young women, very strong women, I've been reflecting a lot on not only the impact in terms of access to healthcare, but what I worry about could be broader implications, particularly for our young women, not to mention others within our community. Again, I think all of us are wrestling with what this means.

Tim Dellit:

We certainly will continue to follow this, particularly from the legal perspective in what happens in the various states and we'll continue to update our community as we go forward. But we really felt it was important for us to, again, reaffirm our belief in access to care for everyone, and that includes reproductive services and abortion care.

Trish Kritek:

Tim, thank you. I appreciate that. And I encourage people to take a look at the statement that was sent out. I could put the FAQ link into the chat, actually. I think there's a great set of FAQs that went with it as well, and I think that would be a good thing for folks to be able to see as well. Okay. Obviously we could keep talking about this, and I think it has been on many people's hearts and minds, as I said, all day, and it will continue to be. It's not going to disappear after today.

Trish Kritek:

I also want to talk about stuff around COVID, because we got a lot of questions actually since the last time we met. And something big happened, right? We have a new vaccine for a whole cohort of folks that didn't have a vaccine before, so we want to talk about those things. Seth, I'm actually going to start with you and say thanks again for joining today. Maybe you could go through kind of where we are with current numbers in the system, and then we can ... I have a bunch of questions after that.

Seth Cohen:

Yeah, sure. Sounds good, Trish. Thanks again for having me. Our numbers of hospitalized patients are, they're unfortunately continuing to go up. As of yesterday, we had 35 patients at Harborview, about 12 at Montlake, six at Northwest, 15 at Valley. As a UW Medicine system, that's about 68 total. A minority of those were in the ICU. It's about 14.

Seth Cohen:

But just to put that in perspective, that's higher than our spring surge peak from 2021. Children's also sent us their data. Their inpatient census has been, it sounds like pretty steady. Over the last two weeks, they've had about four children a day who have had COVID.

Trish Kritek:

Can I ask a quick follow-up question on that?

Seth Cohen:

Yeah.

Trish Kritek:

And I think you know what it is, because I primed you. And that is, I think the question that keeps coming in is like, how many of these people have the symptoms of COVID versus were tested positive and were in the hospital for something else? Do you have an idea of that?

Seth Cohen:

It's hard to know. I would say it's a mix of people who are incidentally found to have COVID and some people who are just admitted for COVID care. But I will say our inpatient test positivity rate, everybody gets screened on admission, so that positivity rate is about 5%. And that's really, that's like the second highest it's been since our first Omicron wave in January. I would say there's a lot of COVID out there. I think the acuity thankfully is slightly lower than it has been, but we still see a number of folks who have complications related to COVID.

Trish Kritek:

Okay. So more COVID than actually, I think, we had last time. And the percent positive in the hospital is 5%, which is really quite high. Not as sick, not many people in the ICU, which I think is reassuring. Why do you think the numbers are kind of bouncing around in this range?

Seth Cohen:

Yeah. I mean, I think there's several things going on. We've got the new Omicron sub-variants, but also, everything's open, people are traveling and socializing as we'd expect them to do this time of year. And I also think in some areas booster uptake is very, very low. And so, yeah, I will say we are, as a system, we continue to deal with outbreaks at some of our facilities and that also contributes to increased numbers. And it's a trade off, right? I mean, we want visitation to happen, but visitors also potentially pose a real risk to our patients, particularly if they're not adhering to masking.

Trish Kritek:

Okay. Folks who aren't fully boosted. We're going to talk about boosters, more. People doing stuff with each other, which we all really want to do and trying to do it safely, but maybe not always doing it as safe as we can. And then maybe some outbreaks within our hospitals. And that actually was a source of some questions, so I'm going to come back to that in a minute. Let me talk about variants though, because you asked about it. And there were at least a couple questions about BA.4 and BA.5 for seeing them here, and if we know more about kind of how they're behaving as viruses.

Seth Cohen:

Yeah. There are a number of variants that are in circulation. There's BA.4, there's BA.5, there's one that's called BA.2.12.1. It's a mouthful. And that one actually makes up probably about half of all infections right now, about a quarter BA.5 and probably the rest are split up between the other ones. And here in the Northwest, we're probably seeing a little bit more BA.5.

Seth Cohen:

I think the important thing to know is BA.4 and BA.5 really show substantial immune escape compared to the others, and so I expect those will probably become dominant in the coming weeks to months. And it's really hard to know what the risk of reinfection is with these variants. I think it's too early to say whether one is more severe than another.

Trish Kritek:

Okay. And so don't know about the severity necessarily, though in general, the folks who we are taking care of right now aren't as sick. We're seeing more BA.5 Five here. It sounds like a quarter. And then you use the phrase immune escape, so I'm just going to ask you to explain what that means.

Seth Cohen:

It just means they are probably not as well covered by our current vaccines or monoclonal antibodies, so they're more likely to cause infection even in fully vaccinated folks.

Trish Kritek:

Okay. So more likely to cause infection in fully vaccine folks I think is important and I think is relevant to some other questions that I'm going to ask you in a second. You talked about outbreak. There was a couple questions about an outbreak at Harborview. And I realize you don't work at Harborview, but I know that maybe you chatted with folks there. Do you want to just talk about what we think led to the outbreak on one of the units there?

Seth Cohen:

Yeah, I'm happy to. As you mentioned, I don't work there, but we do have very, very close colleagues and good collaborations with Harborview. I would say it's still pretty early days, but there are two outbreaks there. One is on 3 East, the other is on inpatient psych.

Seth Cohen:

And again, all of our facilities have dealt with outbreaks, so it's not obviously just Harborview that's experiencing this. But in this case, I think both outbreaks seem to be coming down. The initial impression is that neither outbreak seems predominantly related to either patient-to-patient or to visitor-to-patient transmission.

Seth Cohen:

And so really the take home is that as much as we can, everybody should be wearing respirators, and that's really because respirators provide the best source control. So if a healthcare worker is asymptomatically infected or even as mild symptoms but hasn't tested positive yet, if you're wearing that respirator, that really helps protect our patients.

Trish Kritek:

Yeah. Okay. So two outbreaks at Harborview. I will reemphasize what you said, outbreaks have happened at all of our sites. And we think not related to folks bringing it in or patient to patient transmission, which means it's related presumably to us, and so wearing that tighter fitting mask, the respirator, so that if we happen to be asymptomatically infected, we're not spreading COVID.

Trish Kritek:

And I mean, I know I speak for everybody here. I know a ton of people in my world who have had COVID in the last several weeks. I think it's really, really common, so I think we all have to think we could have COVID. The majority of my questions about vaccines are going to go to other folks, but I'm going to ask you a few.

Trish Kritek:

John actually said something different at the last town hall. He originally kind of wasn't sure if you needed to rush out and get a vaccine if you were over 50, and then he said, "I've changed my opinion. I think you should get vaccinated if you're over 50." So if someone asks, like, what do the ID docs think about if you should get vaccinated if you're over 50, I'm going to ask you Seth. I don't think you are over 50, but you can speak to those of us who are.

Seth Cohen:

I can. You're right, Trish. I'm not yet 50, but I'm happy to speak to it. And I'm actually going to give you a theoretical answer, but I'm also going to you a really practical answer for healthcare workers at UW. John may have alluded to the fact that the CDC strengthened its recommendation to get a second booster. We're in a period of very high transmission, as we mentioned, and so folks over 50 are eligible for a second booster.

Seth Cohen:

I think we are really potentially headed into a very rocky fall. And so one, we want to make sure that we're protecting everybody over 50, but two, the newest issue is that UW Medicine is fully aligning with CDC guidelines about when healthcare workers can return to work.

Seth Cohen:

And so when we get back to conventional or what we call normal staffing levels, staff who have a high risk exposure, and if they are not up to date with their boosters, per the CDC, they're going to have to quarantine at home for 10 days.

Seth Cohen:

That is a long time for staff to be out of work. And the CDC doesn't differentiate between high-risk community exposure or high-risk workplace exposure. So if somebody's not updated with their boosters, they could potentially be quarantined for quite a while even if they are asymptomatic.

Trish Kritek:

Okay. Guidelines say, "Get a booster," and you're recommending it. And you're pragmatically saying there will be longer periods of quarantine than we've had in the near-ish future for those folks who aren't fully boosted, if that's what's recommended for them. And then I think the other part you said, which I think somewhere later in this town hall we'll come back to it is that you're concerned that there probably will be more infection come the fall. I think there's the other cohort of people who are like, "I'm under 50 and I want to get another booster. When can I get another booster?"

Seth Cohen:

I have no idea. We'll have to wait and see. I think as you may know, there is another vaccine candidate, it's called ... There's a bivalent vaccine, which is sort of half the dose of what we currently got and half of an Omicron dose. We think that'll probably be available by the end of the summer.

Seth Cohen:

Right now the data we have on that is really sort of press release format, but I do think it's the front runner vaccine candidate for the fall. There's still a lot more data for the FDA to process. But I think late summer, fall will probably be the time for that vaccine candidate to come out.

Trish Kritek:

And that's a Moderna vaccine, is it?

Seth Cohen:

Yeah, exactly.

Trish Kritek:

Yeah, Moderna, part Omicron vaccine. So maybe late summer, early fall we'll be thinking about that being on the horizon. People did ask about that. They've probably seen the same reports.

Tim Dellit:

Trish, can I build on something that Seth has been-

Trish Kritek:

Yeah, of course.

Tim Dellit:

... discussing, again, related to the high transmission. And certainly the second booster for those over 50 is one approach to further your potential from an immune response. But I also want to just highlight, even in the absence of quarantining people, we went up to 221 staff in our clinical environments out today. That has a tremendous impact on our ability to continue to provide care.

Tim Dellit:

And what I'm reflecting on is while outside of our hospitals and clinics, it is strongly recommended, but not required that people wear a mask. Or certainly in our community I think people are exhausted. They're just, they've had it right, and so you see much less mask use in there. But there are things that we can do. In addition to that second booster to decrease and mitigate some of that risk, including masking particularly when you're crowded indoors, or even here in the health sciences I've seen far more people unasked in the last week than I have in the last two years.

Tim Dellit:

And I totally understand that sentiment, but we also have a balance that we're seeing a lot more people being out. Now, fortunately, they're not sick, but they're still out of work and unable to really help with our healthcare teams. And so I think it's just something that all of us are incumbent upon, that we've got to recognize we have really high transmission ongoing.

Tim Dellit:

The proportion of hospitalized patients is up to over 8% of staffed beds now in king county. If that hits 10%, we flip into the high category where we're in the medium, and that may trigger other public health interventions as well. We're in a real kind of a really challenging situation right now, where we all hope

that we're over it, but we're clearly not. And I just urge all of us to really think about precautions, mitigation strategies to help get through this period of time, let alone what may happen in the fall.

Trish Kritek:

I appreciate that. And I think it is that overwhelming tension. I think everybody wants it to be done. And how do you kind of embrace some of those parts of life that are really important, and still protect yourself and all the folks around you? I appreciate that. So a re-encouragement to wear your masks indoors. My office is in health sciences, and I think we try to do exactly that. I would encourage people to do that as well.

Trish Kritek:

Seth, I want to clarify one last thing before I go to Shaquita. What is the current recommendation for masking in the patient care areas, not in the health sciences where we're recommending it, but it's not mandated? And what mask specifically?

Seth Cohen:

Yeah. Thanks for asking this. I know this is a point of confusion. I see a number of questions about this in the Q&A. I just want to be really clear that N95 respirators are the universal mask of choice, and that there is a regulatory requirement that staff are always wearing a fit tested respirator, meaning an N95 or a PAPR around any aerosol generating procedure.

Seth Cohen:

There's a regulatory requirement for it around AGPs. I will say, I'm on service now, it is a pain to wear a respirator all day. I know that people are sick of it. But I also want to put this in the context of we do have outbreaks at many of our facilities, some of which are related to staff-to-staff or staff-to-patient transmission. And for the reasons I mentioned before, we really want people in those respirators for source control.

Seth Cohen:

Then I think there's the other issue where, from the employee health perspective, we recognize that some people have skin conditions or medical reasons why they can't wear an N95 for their entire shift. And so in those cases, if people really can't get around the issue with scheduled PPE breaks, we would say that staff are permitted to wear the best fitting mask possible, which could include a home care N95 or even an orange Level 3 Mask, which are much more robust than the blue kind of flimsy surgical masks.

Seth Cohen:

But I will say Omicron just moves so quickly that we really need to be treating every patient like they could be infectious and making sure that we're protecting them from our staff. Yes, N95s are our mask of choice, but we recognize there need to be some exceptions in our workforce because some people just can't tolerate them.

Trish Kritek:

Okay. Yeah. I think that last part is the big take on. It's not that, and I'm going to say it a little bit differently, not to diminish your message, but it's not that you absolutely have to be wearing an N95,

but that is the strong recommendation that everyone wears. And there are some select exceptions to that because of issues where people can't wear it all day. Is that right?

Seth Cohen:

Perfect. Yeah.

Trish Kritek:

Okay. Thank you. Okay. I said I was going to Shaquita, but I'm actually going to go to Tim. Well, yeah, I'm going to go to Shaquita first. I'll come back to you, Tim. There were lots of questions about this. As you can imagine, there's been two plus years of people waiting with questions about this. I'm going to start off with actually asking if you can walk through the differences between the Moderna and the Pfizer vaccine, because people had a lot of questions about the differences in those two different vaccines.

Shaquita Bell:

Sure. First I'll start off with they're both mRNA technology, so really similar in terms of how they work, the process of the protein entering your body, encountering your immune system, helping it train to learn how to fight infection from COVID and then leaving your body. So very similar between the two.

Shaquita Bell:

The biggest difference is dosing, both in how much product is in the vaccine and then how many doses you need. Moderna is approximately a fourth of the adult dose and requires two vaccines. And then Pfizer is approximately a 10th of the adult dose and requires three vaccines. Those are the biggest differences.

Shaquita Bell:

The efficacy rates are pretty comparable if you take the whole series. Three doses of Pfizer compared to two doses of Moderna are pretty equivocal, with Pfizer being a little bit better at the third dose. But if you compare two dose to two dose, then Moderna is more effective. The other differences that we've found that are not yet statistically significant, but probably will be over time is that there are more side effects from the Moderna vaccine than there are from the Pfizer vaccine.

Shaquita Bell:

None of those side effects have been serious or certainly not fatal. Otherwise, they would not have been emergency use authorized. And the thought behind that is because the Moderna is in fact a larger dose in those first two that, that is why we think there are more side effects. Those are the big differences. My advice remains the same. I advise people to get the vaccine that they can get as soon as possible.

Trish Kritek:

Okay, we're going to come back to that, so I'm going to hit the high points. Two doses for Moderna, three for Pfizer, bigger dose with Moderna then Pfizer. Pretty close in terms of efficacy. Maybe Pfizer a little better at the three doses, and more side effects. We'll talk about side effects a little bit more. With Moderna, we think maybe because you're getting a bigger dose. That's super helpful. I'm going to pivot to Tim for one quick question, because-

Shaquita Bell:

Can I say one other caveat?

Trish Kritek:

... Yeah.

Shaquita Bell:

The CDC has said in the last week that they will likely recommend a third Moderna shot for a six month to four-year-olds in the fall. This two versus three is not guaranteed. If that's the way people are making the decision, I will not recommend making your decision based on that.

Trish Kritek:

Okay. So there's probably a third dose of Moderna coming. And so I'm going to come back to you for a lot of things. But Tim, there was a super common question, which is why does UW Medicine only have Pfizer? And so I'm going to ask you that now.

Tim Dellit:

Yeah, it's simply a supply chain issue and what was available. And so unfortunately, as this got approved, the federal supply has lagged. And so initially the only thing we could order through department of health was Pfizer. We subsequently now have ordered Moderna. That will be, we anticipate in our system by middle of next week. It's just a supply issue. It wasn't a choice from us. We should hopefully have both as of Moderna next week.

Trish Kritek:

Super helpful. I think there's so much tension about this because folks have been waiting so long they're like, "I want every option, and I want them as quickly as possible." And I appreciate that we just didn't have it yet and then we will have it. So thank you. I'll ask them more later, but I'm going to come back.

Trish Kritek:

And I wrote this question. Should I get my child vaccinated when it seems like it's so low risk if they get infected? Because many, many people ask that question. You already said that you recommend getting vaccinated with whatever vaccine is available ASAP. But can you talk a little bit more about that tension?

Shaquita Bell:

Yeah. I mean, I think it's a little bit more philosophical, right? Not a lot of children get cancer either, but all of us would do everything in our power to prevent our own child from getting cancer. And COVID is along those lines.

Shaquita Bell:

There's no guarantee whether it'll be severe, fatal or mild or even undetectable and asymptomatic. We have, one, an illness that we know is dangerous that is spreading throughout our population at pandemic and endemic levels, and we have a vaccine that we know is safe and we know is effective.

Shaquita Bell:

To me it is the same as tetanus and hepatitis B and polio. It's a vaccine preventable illness, and that's why I recommend doing the vaccine. The other thing we know now with having given millions and

millions of vaccines is that it is safe and effective. So just to like restate that again, which I do say all day every day is this ...

Shaquita Bell:

At the beginning of rolling out vaccines, it was this new thing and this unknown thing, but now we have vaccinated hundreds of millions of people across the world, and we know that this is a very safe vaccine and very effective in terms of preventing mortality. To me, it's really a no-brainer. I mean, always happy to have the conversation and always understand that we want to do what's best for children, but absolutely people should get their child vaccinated.

Trish Kritek:

Yeah, I appreciate that. And I think I appreciate people continuing to ask. I think these are important discussions to have. What are those side effects that you might get when you get vaccinated? Because I think one thing I heard you say is there's not a lot of bad side effects, and so maybe you can talk about what people could expect.

Shaquita Bell:

Yeah. I will say just like when we got the approval for the five to 11-year-old doses, there was no myocarditis found in the Moderna nor the Pfizer vaccine trials. Again, not a statistically significant enough population to know for sure that there is no connection, but it was not seen in the trials.

Shaquita Bell:

The most common side effects people are reporting are against soreness in the smaller children. They're sort of equating that with irritability, not specific. I mean, if anybody remembers having a six month old, they don't do a whole lot of talking. If they do, then we should talk.

Trish Kritek:

I thought you were going to say, "Don't you remember when you got vaccinated and you were irritable, Trish." I was like-

Shaquita Bell:

Yeah, there you go.

Trish Kritek:

... "Yeah, that's true."

Shaquita Bell:

Well, that's true too. But yeah, I mean, that's one of the joys of my job is a lot of our patients can't tell us what's going on. We are seeing kind of soreness, low grade fever. We're talking like 99 degrees. And then irritability. But the other thing I think we have to take with a grain of salt and why I think side effects are hard to measure in children is they're just much less likely to report them. Right? They have to be pretty unhappy to stop doing whatever they're doing. For the most part, kids are doing really great.

Trish Kritek:

So minimal things, kind of the same things we've seen in adults. Sore arm, not feeling great, maybe manifest as irritability, low grade fever. And maybe we don't appreciate all of them-

Shaquita Bell:

Yeah. Yeah. Kids are very unlikely to report headaches, whereas adults are very likely to report a headache, for instance.

Trish Kritek:

I do regularly. I want to follow up on something I asked you before about kind of when to get vaccinated. You said right away. And some people said, "Well, they're thinking like Seth, and there's going to be a potential surge later on." Should I time the vaccination of my child so that I'm getting my peak immunity right in September, October, or something like that?

Shaquita Bell:

Yeah. I don't know how many people have listened in when I've been on before, and John Lynch and I have gone back and forth. I don't like to protect the future. I think it is really challenging to try to time your vaccine based on any sort of wave, right? This infection has continued to play a very large role in our world. And if anybody could predict it, we certainly would've controlled it by now.

Shaquita Bell:

I think it's important to get vaccinated when you can get vaccinated, and know that the CDC and the FDA and the scientists who are studying how our immune systems are doing are keeping track of when we need boosters in order to protect us. It's not necessary for you to try to predict your vaccine timing based on our infection rates or our pandemic rates, because there's lots and lots, thousands of people whose job it literally is to do that. And then we'll adjust the vaccine and the booster schedule based on those rates.

Trish Kritek:

Okay. Get vaccinated now, I think that's the take home, and I think maybe a theme that I heard from Seth too, which is we're trying to follow the recommendations of the CDC. Let's just kind of follow that along and not try to suss out what's going to happen in the future. Okay. Now, there are people who are anxiously anticipating getting their children vaccinated and they had a bunch of questions. If my child has sniffles, because they always have sniffles-

Shaquita Bell:

They do. It's true.

Trish Kritek:

... can they get vaccinated now?

Shaquita Bell:

Yes. Yes. They can get vaccinated.

Trish Kritek:

Yes, so take your child in. My child just-

Shaquita Bell:

Yeah, or any vaccines. That's the other thing is we have to remember that we want to do all childhood vaccines and keep kids on schedule for all of their childhood vaccines, and it's totally okay to do them at the same time as their COVID vaccines.

Trish Kritek:

... Beautiful. You already answered one of my next questions. If you are getting a COVID vaccine, you can do your other immunizations at the same time.

Shaquita Bell:

Exactly.

Trish Kritek:

Next one. My child had COVID. When can they get vaccinated?

Shaquita Bell:

Yeah, the recommendations are the same as they are for adults, so ideally you would be feeling better out of quarantine obviously. You don't want to infect the people who are vaccinating you. And then if the child needed to be treated in the hospital, for instance, got antibody treatment, then we need to refer to the CDC recommendations, which I think are currently 80 days after finishing antibody treatment.

Trish Kritek:

Okay. If in the hospital it's going to be further out, otherwise, go ahead and get vaccinated basically. Okay. I don't know. Multiple people ask this question, so I'm curious about it. Is there going to be a drive through option for getting vaccinated, and where can ... I'll ask you first where can people get vaccinated and I'm going to ask Tim the same question, because I think people ask about at UW Medicine where people can get vaccinated. But you know many drive through vaccine options?

Shaquita Bell:

Let me tell you, I personally would never want to do a six-month-old vaccine in a car. There is a lot to consider when vaccinating children of this age. And the biggest considerations are their comfort and safety. And I think the best places for children of this age to get vaccinated are places where children get vaccinated.

Shaquita Bell:

I mean, that's not the car, right? That's not where we usually vaccinate anybody. I mean, I think as an adult, I can make that choice. But as a child, it just feels like, "is there anywhere safe at that point if you're assaulting me in my car?" So-

Trish Kritek:

And I think people are worried about exposure, right?

Shaquita Bell:

... Yeah. I think that's a good call out. And so clinics like ours, So Odessa Brown is offering the COVID vaccine because of that reason. We know, one, we vaccinate kids all day, every day, of all ages, so we're very experienced in helping a six month old, for instance, through the vaccine experience. Although I'm more worried about those two and three and four.

Trish Kritek:

Two year old. Yeah, me too.

Shaquita Bell:

And then a lot of places like ourselves are doing vaccine-only events. You walk in, you get your vaccine, you do your weight period and then you leave. And so that's one example. Odessa Brown is offering the six month and up for all ages, all boosters at Odessa Othello. And we are accepting walk-ins and appointments. And we have a large event tomorrow. So if anybody is really anxious to get the vaccine, we will be open from 1:00 to 4:00 tomorrow.

Shaquita Bell:

I can put the address in the chat, but we have the ability to do 600 shots. We welcome you to come on down. And then DOH still has their vaccine finder. So Seattle Children's is vaccinating, UW is vaccinating. Most states limit the ability for pharmacies to vaccinate down to a certain age. What I've heard in Washington is it's 18 months.

Shaquita Bell:

Some pharmacies are saying three years. I think CVS and Bartell is three years, and then Rite Aid and Walgreens might be down to 18 months. But no pharmacies are vaccinating six-month-olds, so you would need to look for a healthcare setting to vaccinate those children. And then, yeah, I'd welcome more UW information.

Trish Kritek:

Before I get that, that was super helpful. So smallest children, definitely not at a pharmacy. Pharmacy for older kids. In general, we want to do it at a place where we're used to doing it so we can do it safely, and maybe not have a bad experience and never want another vaccine. That's probably not in a car. But we also appreciate that people don't want to be around a lot of other folks before they're vaccinated, so there's these vaccine-only events like you just talked about, which is awesome. And I will ask you to put the information in the chat later, so thank you for doing that. Tim, across UW Medicine, how are we supporting vaccinating children under five?

Tim Dellit:

Well, I think as Shaquita was saying, the vaccination of this age group is different than the others. This is not a group that a mass vaccination site really works well. And so in discussions with public health and obviously partners around the community, we're really trying to vaccinate these children within the pediatric clinics. It is a shift because of this difference with this population.

Tim Dellit:

Within our system, we're utilizing our pediatric clinics at Roosevelt, UW Medical Center Roosevelt, at Harborview, our family medicine clinic at Harborview, and then within our UW Medicine primary care

clinics at Shoreline and Kent-Des Moines, where we have pediatric practices. The other piece I would just say, because I know this comes up, well, why can't we do it at all of our clinics or all of our family medicine clinics?

Trish Kritek:

That is exactly what came up.

Tim Dellit:

But it's really a balancing of resources, so vaccine supply, staffing, having enough volume to warrant doing the vaccinations in that area, especially now when supply is limited. We're really trying to focus in those areas that we can do this most effectively, safely and efficiently for that age population.

Trish Kritek:

Okay. With limited supply, we're trying to focus in the places that are used to taking care of kids and distributed in different clinics, but not in all of our clinics to be more efficient. You did anticipate that question. The last question I'll ask you before I go back to Shaquita is, did we consider offering expedited vaccines for our frontline workers' children? And I think we actually had that question before, but I'm going to ask it again.

Tim Dellit:

Yeah. We did consider this, but as we considered this, we also really have to think what is our responsibility within our community in terms of how do we have equitable access for vaccination? And quite frankly, part of our agreements with public health is that we would provide vaccine access to everyone in our community, and that's who we are.

Tim Dellit:

What we have done though is think about ways that we could expand potential access, including both for children of our employees and children out in the community. For instance, even though we're encouraging people to get vaccinated where they receive their primary care, if you happen to have a child and your child's care is outside of UW Medicine, you can still schedule that within our system.

Tim Dellit:

We're trying to accommodate that. But we think for this population, it's really best to get that vaccination where you receive your care and then we're making some additional access available. Shaquita talked about the additional access, both through her clinic, through Seattle Children's and there are a number of other areas within the community as well.

Trish Kritek:

Okay. And we've talked about this before, that it's an effort to stay centered on equity and that we're trying to expand opportunities. I appreciate that you can come to one of our clinics even if that's not where you usually get your health. I think Shaquita you just wrote that in the chat about the clinic at Odessa Brown, that you can come if you're not a usual patient of Odessa Brown as well. Okay, thank you both.

Trish Kritek:

Shaquita, I'll ask you one last question that's actually a pivot from this new vaccine and just ask, in your experience, it still seems like five to 11 year olds, a lot of them aren't vaccinated. I'm just curious your thoughts on why do you think so few five to 11-year-olds are vaccinated?

Shaquita Bell:

Yeah, it's a great question. I don't know for sure. You're right, our rates are at about 30% nationally speaking, which is really low compared to 80% of adults who are eligible nationally. I think Washington is above 90 at this point. One thing I do wonder about, and I think we might see something a little bit different in the six month to four-year-olds is that age range actually doesn't go to the doctor very often. Right?

Trish Kritek:

Okay.

Shaquita Bell:

The six month olds, between zero and two, you're at the doctor all of the time, probably many of you with children remember that. And so I wonder about having this established relationship that you're seeing that clinic and that provider so often, you're getting your questions answered and you're getting the information reinforced. I am curious about that.

Shaquita Bell:

I do think that our national focus on elderly and adults at the beginning of this pandemic did sort of backfire into the like, "Oh, kids don't get sick and it's fine, and it doesn't affect them," which I think is still a hard mental thought to get out of people's heads.

Shaquita Bell:

Because to me, anything that affects children, even if it's one in a million is something that we should all care about. I think there's several levels to it, but that's what I've sort of been guessing. I'm going to be really curious about the six month to, my guess is six month olds to two year olds are going to be very well vaccinated for COVID.

Trish Kritek:

That's very interesting. So frequency coming to the doctor and then I think the other point is are really great one. I think we actually celebrated that kids didn't get sick that much at the beginning, because we were so relieved that, that's what the pattern looked like, and maybe it has some untoward downstream effects when it comes to vaccines. Okay, I'm going to give you a break. Thank you so much.

Shaquita Bell:

Okay. Actually, I do have one more thing. If we have time, I'd like to cover the age, like if your child is aging out of one age bracket.

Trish Kritek:

Oh yeah, I was going to ask you that question. I forgot it. Yeah, I'll ask you right now. The question that came in was, "If my kid started their vaccines at age 11 and now they're 12, what should I do for their next dose or their booster?"

Shaquita Bell:

Yeah. Here's the thing, the CDC went and made this even more complicated.

Trish Kritek:

Uh-oh.

Shaquita Bell:

For the 11 to 12, you should get the dose of whatever age you are at the time of your dose. If you get your first dose at 11, and your second dose you're 12, you should get your second dose as a 12-year-old.

Trish Kritek:

12, dose.

Shaquita Bell:

Right.

Trish Kritek:

Okay.

Shaquita Bell:

So big asterisks. That is different for the four to five-year-olds. The FDA and the CDC are now saying that you can choose. You could get your child who's turning five in the middle of their four-year-old series, you could choose to get them all three Pfizer, for instance, or you could get them two of the five and over, or you could do two Moderna because they're approved to six.

Shaquita Bell:

Correct. It is extremely, extremely complicated. My best advice for everyone who has a child who's going to go from four years to five is to have a conversation with their healthcare provider. We are going to recommend getting the dose that you are at the age you are of the dose.

Shaquita Bell:

That's going to be our recommendation. We'll obviously be willing to flex as families feel strongly, but it is so much simpler to say, "Let's give you the vaccine for what age you are right now."

Trish Kritek:

I agree, and so I'm going to summarize it as, for 11 to 12 year olds, it is get the dose of the age you are when you're getting a shot. And our recommendation for the younger, four to five, is exactly the same thing, though the CDC has made it more complicated, which I won't try to summarize because I couldn't if I tried.

Shaquita Bell:

It's this long.

Trish Kritek:

Yeah, exactly. Okay. We actually had a bunch of questions that weren't directly about vaccines and numbers of COVID, so I'm going to pivot to our CNOs and our medical directors to answer some of those questions. Cindy, I'm going to start with you. There was a question about kind of two parts. Are we hiring more PCTs at Montlake? And then kind of where do we stand with travelers in general as what portion of our staffing at this point?

Cindy Sayre:

Well, thank you for those questions. So answer, yes. We are actively hiring patient care technicians. When I last looked, I think we had just shy of 200 of those positions open right now, so a significant shortage of our patient care technicians. Also, I want to just say that we are very focused on recruitment. We were just in a meeting today looking at things even to the degree that our website isn't necessarily user friendly when you're trying to apply for a job.

Cindy Sayre:

So reviewing the entire recruitment process and trying to make that as easy as possible for everyone that wants to work here. And then also focused on the retention side, which is so important. We just have received the results of the Press Ganey survey, so we're reviewing all of those things. No huge surprises so far in terms of the comments that we're getting really related around pay and staffing that's across groups.

Cindy Sayre:

A lot of work on recruitment and retention. And the other thing I did want to raise was that we've been very successful hiring nurse techs. These are people that are in nursing school that can even do a little bit more for us than patient care technicians. And I think we will be onboarding more than 50 of those people across both of our campuses, UW Medical Center and there's many at Harborview as well. That will help us, I think, in the summertime for sure.

Trish Kritek:

Okay. Before you give me the other thing, I'm just going to summarize. First of all, thank you for saying patient care technician when I use an abbreviation. I appreciate that. But we're hiring for up to 200 more people, and we've already hired a bunch more patient care technicians, but also these nurse techs, you said 50 coming on, really focused on applying for a job here easier, or finding the jobs to apply for easier as well as working on retention across the board.

Cindy Sayre:

Right. Yeah. And those nursing technicians are also great, because that's a very solid pipeline for new nurses that want to answer the system. Yeah.

Trish Kritek:

We want to make a good experience for them when they work with us.

Cindy Sayre:

Yeah.

Trish Kritek:

Absolutely. How about where do we stand in terms of percentage of folks who are travelers and our staffing at this point? And I know you're only speaking for UWMC.

Cindy Sayre:

Right. And the last time that I looked at those data was about 16, I'd say about 16% across UWMC, much higher than we wanted to be, while we're really grateful for their assistance, because that's how we're able to take care of patients. And as we talk about employees that are out with COVID and for other reasons, we really do need those travelers as a backstop right now. And very focused on hiring classified nurses. Recently have seen increases in our sign-on bonuses for new nurses coming into the system, which I think will be helpful.

Trish Kritek:

So about 16%. And do you have any idea what it is at Harborview?

Cindy Sayre:

I don't.

Trish Kritek:

Okay.

Cindy Sayre:

Yeah.

Trish Kritek:

And Jay couldn't be here today, and that's okay. And really trying to do things to bring him. I want to emphasize what you said. Really important, because that's how we can continue to take care our patients, so we're appreciative of the folks who are joining us on a traveling contract. And we want to get to the durable teams that we have where we know each other and work together for long periods of time, and so continuing to hire as much as possible

Cindy Sayre:

That's right. And can I say one more comment?

Trish Kritek:

Yeah.

Cindy Sayre:

Sometimes I do hear people talking about the staffing shortage being a budget type of strategy, that we are not hiring because of budget reasons. I just want to say one more time that's really not the situation. We're in a supply and demand situation. A nursing shortage not just here but across the country. So that is the difficulty. Those positions are posted and we're actively recruiting.

Trish Kritek:

Yeah. I think that's a really important message. We're not trying to save money by not hiring. We just don't have the people to hire. And all the hospitals and clinics across this country are desperately trying to hire nurses and other members of the healthcare team, because it's a shortage nationwide. I appreciate that.

Cindy Sayre:

Correct. Thank you.

Trish Kritek:

I was going to ask you the question about, are we thinking about changing criteria for visitors? I'll ask though. Based on what Seth was just saying, I'm going to guess that's not the case. But are we changing any criteria for visitors?

Cindy Sayre:

No changes right now.

Trish Kritek:

Okay. I think we're going to go with that, and I'm going to say that's good enough for right now. Tom and Rick, I think people, I ask you this every town hall, are still really feeling the issue of the census. The census at Harborview has been incredibly high. The census at Montlake has also been high. I'll start with you, Tom.

Trish Kritek:

One of the questions that came in is, how are we managing trying to get the people who we need to into our hospital, but also not continue to overwhelm our services? So maybe you could talk about that a little bit and then go I'll to Rick.

Tom Staiger:

Sure. One of the things we are doing, focusing on regularly, daily is trying to figure out what can we do to improve throughput to the hospital to get people out. Sayre and I rounded on one of our units yesterday, harvested a bunch of good ideas from frontline folks about where we might have opportunities.

Tom Staiger:

We had our care capacity executive meeting at noon today that Cindy and Santiago and I were a part of. We've got a project pilot starting next week at Montlake to do a universal patient progression pathway. We've got a bunch of ongoing work to improve our throughput and improve placement to create capacity.

Tom Staiger:

We are also actively looking at who needs to come to Montlake and to UWMC that will most benefit from our services working with our service chiefs, cardiology, oncology I've exchanged messages with this week about who are our high priority patients. We continue to look at that in the face of high regional demand for our services driven by the quality of the care we provide and by staffing challenges that places are having.

Trish Kritek:

Yeah. A lot of work on that throughput, a lot of harvesting ideas from folks trying to implement them, talking a lot in terms of trying to bring people together to make these tough decisions about who should be brought in as quickly as possible. Rick, I feel like Harborview has always been the place that takes lots and lots of patients. It has been incredibly high census recently, and I wondered if you wanted to reflect on kind of what you're doing around that.

Rick Goss:

Sure. Yeah. Well, thanks, Trish. And yeah, as we say, Harborview is always running at a high census just to fulfill our mission, and be available for the sickest and the most vulnerable. And there are indeed times where we are at such peak levels of census that we really have to take kind of what we call critical high census status procedures, and today is one of those days.

Rick Goss:

And it's really a convergence of what I would say is the beginnings of the season that we affectionately call the trauma season, which is where people start going out into the nice weather and risk taking behaviors and so forth. And we have not only this weekend coming up, but the 4th of July that we're anticipating. We have the continual, as Tom talked about, just pressures from the larger environment.

Rick Goss:

One reason, I think, and this ties in with some staffing related issues, that as many of the hospitals are having shortages with staffing, they in fact aren't using all of their physical beds. And today is a really good reminder of that when many of the hospitals in the area that could do work, they're declining to take patients and transfer saying they are full, they are staffed. They in fact are closing beds.

Rick Goss:

Okay, that puts even more pressure on the UW system, right? And with COVID exposures, we talked about some rising numbers within the hospital, really culminates on days like today. And I think as you had also noted it's the first day for many incoming residents, the new interns. And today when I rounded with our CMP, capacity management physician, Dr. Ashley Amick, and other members of the team, and had a chance to meet face-to-face, I gave everyone a nice congratulations that they've received their first high census email from the medical director.

Rick Goss:

But really just tried to say that this is part of the way we work day in and day out. Today is higher than usual. But that we work as a team. No one has to make really hard discharge decisions on their own shoulders. We have a lot of resources, a lot of good ways to make difficult decisions. And we don't want anyone to feel like they're making an unsafe discharge. But we do look for alternative solutions, ways that we can be creative, that we can succeed in a safe discharge.

Rick Goss:

And you have a sense that, that sort of notion that we're all in it together across our nursing, and our care management and our medical teams is ultimately how we succeed day in and day out. We stick together, we work as a team and we just know that no one is going it alone. That's sort of another day in high census world, and we have some real challenges going into the nice weather, and the rise of COVID,

and the challenges with our nursing workforce and the availability there. So yeah, some challenging times.

Trish Kritek:

Yeah, I appreciate you acknowledging the challenge. I appreciate you acknowledging coming together to support each other, and that we're going to have to kind of continue to think of how we get through these, because we need to keep taking care of folks and we need to keep taking care of our folks who are doing this work, which is really hard at these times. I appreciate those perspectives.

Trish Kritek:

Okay. I'm going to sneak in two last questions, one to you, Santiago. Last town hall we talked a lot about monkeypox, and I just wondered if you could tell us have we seen more cases, have we seen any cases?

Santiago Neme:

Yeah. We've seen two cases at UW Medicine, one case outside of UW Medicine. And both cases treated by Shireesha Dhanireddy. We are ruling out a lot of cases, because again, you want to rule out, you want to look at rashes and you want to make sure that patients don't have this, and so far just two confirmed.

Trish Kritek:

Just too confirmed. Okay. That's good. I'm sure there'll be more questions if there's more, but I just wanted to make sure we checked in, because last time that was the most popular question. I'm going to pivot quickly to Seth to ask you a question, which probably I'm not being fair to give you not that much time.

Trish Kritek:

But we had a dramatic change in pre-operative testing, so I wondered if you could just talk to that for a moment. There were questions about it before your email yesterday. But could you explain where we stand with pre-op testing for COVID?

Seth Cohen:

Sure. I'll just plug we're having a town hall next week, so we could definitely give more context around this. But I'd say the bottom line is our universal PPE is just much more reliable than testing during Omicron era, and so clinics are really tying themselves up in knots trying to get people tested. And a test these days that's two or three days old is just not super informative.

Seth Cohen:

The policy change right now is people who are going to be discharged after their procedure. These are outpatients who are asymptomatic, who are getting procedures in the operating rooms do not need to get pre-op tested. Everybody else, if you got symptoms, if you're going to be an AM admin who stays in the hospital, those folks are all going to get tested either on admission or symptomatic testing.

Seth Cohen:

But otherwise, we're relying on PPE and really the excellent air exchanges and quick room turnover in the main ORs. People who are getting procedures outside of the OR, so PFT lab, bronchoscopy, cardiac stress tests, those are totally different spaces with fewer air exchanges than the main ORs, and so those

are places that we need to think a little bit harder about what our policy is going to be there. This change really just impacts the main ORs.

Trish Kritek:

So main ORs only. Patients who are going home after their procedure, after their surgery, they don't need to be tested. If you're getting admitted, you have symptoms, if you're having something in the other suites, bronch suite, endoscopy suite, other places, you do need to be tested.

Seth Cohen:

Correct.

Trish Kritek:

And universal PPE. Thank you. That was actually super succinct. I'm going to tell John you did that. You're going to notice I didn't leave enough time for Ask an ID doc. And that was a strategic decision by Anne and I today because we wanted to spend a little bit more time at the start. And I think that was important, so I appreciate the folks who sent in questions understanding that.

Trish Kritek:

And I also want to close with a couple thoughts. It is the end of an academic year and the start of a new one. It's a time of transitions. As was alluded to last night, I went to the graduation of the fellows from my training program. It was fabulous. We were outside and lots of open air. Monday, I start with a team in the surgical ICU with new trainees.

Trish Kritek:

And I want to say welcome to the new interns, residents and fellows who are joining UW Medicine. It's a wonderful place to work and train, and I hope that you have an outstanding time here. I'm super excited to work with you next week. I also want to say that transitions are also times for us to reflect on this town hall. It's been something that's been on my mind for a long time, and we've been talking about this.

Trish Kritek:

And as opposed to ask an ID doc, I'm going to ask a town hall participant today. And that is to help us think about what happens to town hall. I think that for now we're going to go to an as needed basis, a PRN basis for town hall, and see how things are going and have a town hall about COVID when we need to do that, not regularly scheduled at this point.

Trish Kritek:

That doesn't mean that we think COVID is over because you just heard for an hour. We do not think COVID is over. And we suspect we will come back together to talk about COVID as needed. But we don't know that we need to have the same regularity. It's important to have chapters, and it might be okay to close that chapter and move on to a next chapter.

Trish Kritek:

I will say that we've had mixed minds as we think about the future of town hall, because we do believe in closure and next chapters and transitions. And COVID is unique in that it impacted everybody in our

community in so many different ways that coming together made all the sense in the world. And I'm hoping we never have anything like that ever again in our lives that we have to do that. That being said, there was a huge plus to it for us, and that is that we got to hear your questions.

Trish Kritek:

We got to hear your questions. We got to hear your concerns in the form of a question. We got to hear your feedback in the form of a question and got your ideas in the form of a question, and it affected what we did across UW Medicine. If there's some way we can hold on to hearing those questions, and talking about what you want to talk about and answering your questions, even the hard ones, we'd like to do that.

Trish Kritek:

We're going to pose this to you, give us your thoughts, and just we'll post it in the chat a link to a very short survey where you can say, "Keep town hall in some way," or, "It was good." And we won't be offended if you say, "It's okay. You can close this chapter." If you think we should have town hall, what should we talk about, the wellbeing of our healthcare system, all of you, the things that go on in your lives, new initiatives, possibilities for change?

Trish Kritek:

I don't know, but we welcome your thoughts. Today I'm going to say this is the end of our regularly scheduled town halls. We'll be coming to you as needed, and we want to partner with you to think about how do we move forward from here. Because at the end of the day, it is still so important to come together to take care of our patients and their families, and what feels like to us a way to keep taking care of each other. Thanks so much. We'll check in soon. Bye.