

Trish Kritek:

Welcome back to UW Medicine, Town Hall. Really welcome back it's been a while. I'm Trish Kritek, vice dean for faculty affairs. It's rough when I can't remember my own title. And with us today, are Santiago Neme, medical director at UWMC Northwest. Tom Staiger, medical director UWMC. John Lynch, head of infection prevention and employee health at Harborview Medical Center. Jay Sandel, interim chief nursing officer at Harborview medical center. Anne Browning, I was going to say some other title for you, associate dean for wellbeing. I'm excited to have Shireesha Dhanireddy back again, she's a professor under the department of medicine division of infectious disease and our lead on monkeypox and a lot of other infectious disease issues. And Tim Dellit, who I save for the last because he has a new title since the last time we were here. He is now the interim Dean of the school of medicine and CEO of UW Medicine. Though, he's still the same Tim, so glad to have you back. We have a lot to talk about and so I'm going to jump right in and ask Anne for a wellbeing message.

Anne Browning:

Sure. Thanks Trish. The summer in the Pacific Northwest is glorious and it's been heartwarming for me and check ins and meetings in the past week to just ask people what's bringing you joy in the summer? And to hear about so many people getting outside, getting on hikes, like Trish just did. And really, really trying to enjoy this time and this moment that we have. I would say those moments of joy, they also come in a time when we're seeing some results from surveys that we've been sending out across UW Medicine, School of Medicine, where we're hearing that things are really, really hard. Especially in our clinical settings, we're hearing about staffing challenges, we're hearing about census challenges and those are topics that we're going to talk about more and more today. But I'll say that it's nice in that I am hearing about and seeing folks getting breaks as well.

Anne Browning:

And I would say whether or not you can take kind of an extended break right now, or just a short one, or even just be intentional about giving yourself some time outside when and where you can, it's good to kind of find that joy and find those moments of kind of coming back down and reconnecting and kind of finding some peace and some happiness, even when things within our workspaces can be pretty challenging. So thank you all to the folks who are really, really working, especially in our clinical spaces that have been really challenging right now, we hear you, we see you, thank you so much for giving us feedback and we're all collectively working to try and improve kind of our work environment for everybody. Thank you.

Trish Kritek:

Thank you. And thank you for highlighting the fact that it is beautiful outside and I really hope people can get outside. If not, you can look at Anne's shirt, which is a vision of the outdoors right now. Thank you. We're going to talk about COVID, we're going to talk about monkeypox. Those were lots of topics, but in the last 24 hours, we all, and in the community, UW Medicine got an email that talked about the fact that Harborview went on basic life support divert or BLS divert. And I think actually we're going to start off with that topic because we got a bunch of questions about it. And Tim, I'm going to look to you to maybe just start off by, can you explain what that means and what the implications are of it?

Tim Dellit:

Yeah. Thank you Trish and again, welcome everyone. It's great to be back with you here today. Just as a little bit of a context, and we've talked about this before in Town Hall. Over the last year, we have

continued to see escalation, both in hospital census where throughout the state of Washington, most hospitals are really at capacity as well as combined with staffing challenges. As we've talked about in numerous times as well. When you look at what is causing this increase in patient volume, it's probably a combination of factors. One of them may be postponed or delayed care throughout the pandemic. And when those patients are presenting, they often are presenting with more complicated and more severe disease. One of the other big challenges that we've also talked about here before are those patients who no longer medically need to be in the hospital, but we can't find the appropriate level of care for them to go upon discharge.

Tim Dellit:

When you look at the post-acute care setting within our community, there's a paucity of beds, staffing. And in some cases, the cost of caring for more complicated patients is more than a long-term care facility may get reimbursed and that has caused challenges in terms of that transition. In fact, if you look at Harborview, often 20% of the patients within Harborview medically don't need to be in the hospital and are ready for that next level of care, but it's just not available. And so that is causing a significant backlog within our hospitals. Now that census has continued to escalate, especially over the last few months. Now keep in mind, Harborview, as an example is licensed for 413 beds. Throughout this past year, they've been running roughly around 500, then it's gone up to the 520, 530. Earlier this week, we hit 560.

Tim Dellit:

And Harborview and UW medical center, all of our hospitals have been doing everything they can to maintain the ability to care for this increased number of patients who really need our services. And I give a lot of credit to our teams, to the leadership and all of our clinicians and staff for doing that over this period of time. What changed yesterday and led to this decision is that, we not only had a very high number of patients, but when you look at the number of ICU patients, the critically ill patients, it got to a point where they were boarding outside of the ICU in a manner that raised concern for us about potential patient safety. That combined with the fact that where we had to care for those patients gave risk to our ability to respond, to say if there were a mass trauma or a mass casualty event within our community.

Tim Dellit:

And that is a service that Harborview absolutely must be able to preserve in service for our community. And so based on those factors, we made a really difficult decision to go on BLS divert or basic life support divert. What that means is basically, that Harborview is really only taking the most critically ill that trauma patients, that high level of acuity still comes. But the more basic care that may be coming by ambulances rather than coming to Harborview, they will be going to other hospitals. Now, prior to implementing this, we had numerous conversations with the other healthcare systems, particularly those on first hill, but other hospitals throughout our community, as well as multiple discussions internally, both with Harborview leadership, UW Medicine leadership. And this was really a combined decision from UW Medicine and Harborview based on patient safety and our need to preserve Harborview's critical role within our community. Recognizing that this is very difficult because it has a ripple impact on other hospitals, pre-hospital care, ambulance services, but we just reached that point where we felt that we had to do this, unfortunately.

Trish Kritek:

Okay. So it means that we're taking in patients who have the unique needs that Harborview can support like trauma and not the kind of average patient coming by ambulance. I think you already responded to some other questions, a bunch of questions we had about why is the census, 560 patients in a 413 bed hospital is really crazy? Why is that, due to delayed care, maybe sicker because of that and then no post acute care spaces to go to. So I have a couple follow up questions, first about the BLS divert. The first question is like, how long will that last? Do you have an idea?

Tim Dellit:

We're reassessing this day by day. We did tell our healthcare partners that anticipate this will go through the weekend. We want to come off divert as soon as possible. So no one likes to be in this situation and we are constantly monitoring this. I know Jay, the other folks at Harborview are very closely watching this, but I anticipate it could be through the weekend and then we have to continue to assess on a daily basis.

Trish Kritek:

Okay. So it's day to day, probably through the weekend. And in that time, what about transfers of patients who are non-trauma patients? Who are at a critical access hospital or something like that.

Tim Dellit:

Again, we continue to work through our transfer center. The medical directors are very involved in coordinating and determining which patients need to come within our system, which patients can stay there. We have the WMCC that is based out of Harborview that continues to coordinate those individuals. And we have in discussions with other healthcare systems, they understand where we're at. They understand we've done everything possible to avoid this. And they also understand they need to step up and take some of these patients. Again, I just want to emphasize, one of the things we've talked about, the increased use of contract labor as an example, right? If you look at Harborview and UWMC, we have expanded to where 20% of our nurses are contract labor. We've done that not because we like contract labor, we really want our own permanent staff, but we have expanded to safely care for that increased volume of patients that have come in to our system.

Tim Dellit:

In some situations, other hospitals are starting to make decisions of do they continue to do that or not? But we have been committed to continuing that, to be able to care for these patients. But even with all of that effort, we just reached a point where we no longer could safely care for increased number of patients, at least for a brief period of time. And it had to go on divert with BLS. Again, trauma, other critical illness that must come to Harborview is continuing to come.

Trish Kritek:

Okay. So the key populations will continue to come and we're assessing a day to day. Last couple of questions before I actually come to Tom and Jay, because I think both of you can speak to this topic before we switch to COVID. Is, you talked about not having skilled nursing facility beds because of staffing issues or cost and things like that. One question that came up a couple times is, have we thought about creating our own skilled nursing facility or LTAC as part of UW Medicine?

Tim Dellit:

You so I would describe some of the things that we've done. So Harborview has a bed readiness program as an example where we already essentially pay for 80 beds in long term care facilities that are reserved for our patients. That's cost by \$8 million a year. That Harborview is doing to help move patients through with plans to increase that likely up towards 150. So in some ways we don't plan to own our own long term care facility or manage that, I don't think that's what we would do best. But we actually are buying and paying for a significant number of beds in the community to try to help transition those patients. There was some good news about two weeks ago from the governor's office where they did talk about trying to help expand post acute care services through kind of rapid response staffing in critical areas, trying to help with care management, to get patients out, financial incentives for long term care facilities to take some of these patients.

Tim Dellit:

Those are a good first step, but we really need more. Because we haven't seen enough movement with those initial steps. And so again, we're continuing to work, not only with our healthcare partners, but with King County, with the state, and particularly the governor's office. One of the reasons we had a press conference yesterday is because we wanted to share where we're at. We view this as a public health emergency, this is not a hospital issue, this is a public health emergency that limits the potential access to care for those who need it in our community. And so we are working very closely with the state to address this. It's a situation that no matter how much level loading and coordination we do within our system, which is still absolutely critical, we must partner with others to really help address this crisis that we're in.

Trish Kritek:

Okay. So I think what I heard is, working with the state, working with other institutions, working across our system, but that's not enough to deal with the situation. And earlier you said, and we're basically subsidizing skilled nursing facility beds and other institutions, not with a plan to have our own, but we're paying for a bunch of them to have a place for folks to go. We could keep going on this, but I'm going to pivot to Tom and Jay for a little bit and come back to you in a little while, Tim give you a tiny break. So Jay, I'll start with you. When you have that many extra beds, there's obviously a need for more staffing and we were already having challenges with staffing. So I wonder if you could talk about what we're doing to support the staffing of the hospital in general, but also kind of these extra beds that people are in.

Jay Sandel:

Yeah. I think one thing to make note is that we always realized that during trauma season our senses is going to go up. So we've been preparing for that for quite some time. The main way we do that as Tom was saying was that we bring in agency labor. So we've brought in agency labor to be able to help supplement our staffing to care for those individuals. We did reach a point where we were, even with all of those practices, we were not going to be able to care for the number of patients that we had, which is why we're having this conversation. So really the first thing we do is we look at agency and supplemental staffing. We've also been trying to incentivize our own staff to come in and pick up extra shifts. We have double time shifts available, so really working with our own staff to kind of make it a little bit more attractive to come in and pick up extra shifts. So we do that as well.

Jay Sandel:

Really, we've been doing a lot of rounding this week. Really checking in on staff, making sure people have the things that they need to be able to successfully come in and do patient care. So really from an all kind of leadership front, just making sure that we're going out there and touching base with people, because this is stressful for our employees and we know that. So we just want to make sure that we're available to take care of them as this extra work has come upon them.

Trish Kritek:

I appreciate that very much. So checking in supporting people on real time, agency support and then extra shifts and incentivizing that in a way that feels like people can actually do it and doesn't feel like it's too much. In the spirit of that, I don't think it's going to fix it for the weekend, but are we doing anything new to try to get new nurses? Because I think we heard people say, we want to have, other members of the healthcare team right now.

Jay Sandel:

It is not going to help us this weekend, but I think this is another kind of area that we've worked really hard on for the past, I would say six months to a year. Is just really how we are recruiting people back to Harborview as well as to the UW system. I mean, there are many things that I could talk about, about incentives that we are trying to give people to come back to the UW system that's relocation practices, sign on bonuses, referral bonuses. I would say something that's new over the past week and a half is the referral bonus for RNs, it went up to \$3,000. So that could be anyone that makes a referral for an RN to come back into the system and work here will receive that \$3,000 referral bonus, which is great. We're having weekly job fairs through HR to try to really recruit people in a quick manner back to work here. Utilizing media and tech, to really highlight the things that are special about working for the UW system.

Jay Sandel:

So we're doing all of those things to try to pull people back as well as we're working with HR to really expedite the process for hiring. So we have managers at all facilities at any given time ready to interview for any position that people apply for. So HR has been a great partner to work with us on trying to just be ready at any point to hire and interview candidates. We've increased the frequency of orientation. Here at Harborview, we have put a lot of our orientation using electronic platform to really just move people through that system as quickly as we can so we can get them on the floor and training as quickly as possible. So really creative things like that is what we've been working on to try to increase the amount of permanent staff members that we can pull in.

Trish Kritek:

Jay, thank you for going through all that in such detail ranging from job fairs to this new referral process. I think Anne just put a link in the chat about that trying to expedite from, we hire you to you can work and how can we make that happen in partnering with HR? So lots going on to try to increase the folks which are essential, right? Is like the people who become part of our team long term. So thank you for all of that. Tom, I know that you're at UWMC and not at Harborview, but as has been alluded to there's a lot of collaboration. So I wonder if you could talk about what the strategies are we're doing within the system to try to mitigate this extreme shortage of beds.

Tom Staiger:

Sure. So in general, we are working on implementing and refining best practices to improve our processes for capacity utilization. One process for load leveling across systems, we're up to two or three

huddles a day. Santiago has helped coordinate some of this. We've got representatives from Valley, obviously Harborview, Montlake and Northwest that are meeting regularly to identify where are their excess patients? Where is their capacity where we can move patients? I think Northwest may have taken seven or eight patients over the course of today, which was a huge help. And that process sometimes still doesn't work as well as we would like. So we're going to be reflecting on that and seeing what we can do to further improve that. We are continuing to look at staffing and right skill mix for care utilization, care management that our exec team at UWMC. Just last week we approved the social work assistant to help with the teams to free up a social worker, to do things that social work is required and to have a social work assistant, do some other things to help improve capacity utilization.

Tom Staiger:

We've got a universal patient pathway pilot that has started, that was a recommendation out of some Vizient consultants, pre-pandemic that got put on hold that started a couple of months ago that Carolyn Keller, our associate medical director for capacity management and Nichole Gogna one of our outstanding nurse managers had been leading. And we just saw preliminary results of that in which basically we're getting a shared mental model of who's supposed to do what to advance the patients and the control unit on six Northeast had a drop in length of stay in the first month or sorry, the intervention unit and the control unit actually had an increase. So too early to tell if that's a trend, but saw some encouraging early results, and we're already looking ahead to the next unit that we're going to roll that out to.

Tom Staiger:

So continuing to work on improving collaboration, improve, improving our processes, identifying best practices. And we've got a system wide length of state committee that's getting ready to start here shortly to help better share some of those practices.

Trish Kritek:

Okay. So regularly coming together to huddle and talk across systems on multiple times a day, new initiatives that we're testing out to try to shorten length of stay. We're appropriate augmenting teams with new folks to try to facilitate people doing the things at the highest level of their licensure or their training, lots going on. And I think also still being felt by everybody that this remains a significant challenge. I will say when I was on service in the surgical ICU at UW, I had a steady flow of neurosurgical patients coming over from Harborview to UWMC. So it was apparent to me, there were people moving all the time, trying to get into the spaces where we can help. So thank you for all of that. We could keep talking about this for the whole hour. I'm going to move forward because we had lots of questions about both COVID and monkeypox. So John belatedly, I'm going to turn to you to maybe start with just what we usually start with, which is what are our numbers around patients with COVID in our hospitals right now?

John Lynch:

Yeah, sure thing. Thanks Trish. And I'll start with our hospital numbers and maybe I'll hit on the county and state numbers if that's okay. If we look at UW Medicine as a whole, we're down to 32 patients in our hospitals, both acute care and ICU, which is the lowest number since I think mid-May early to mid-May, which is pretty remarkable. 29 of those people are in acute care and only three in the ICU. Harborview's got seven people, six in acute care. Montlake has eight with eight in acute care. Northwest has four people with three people in acute care and Valley is at 13 with 12 in acute care and the rest in

the ICU. I should also point out, we have data from Seattle children's hospital too, is that's another important place. This the last time we reported out at the end of June, there were about five patients per day and then came up over the last six weeks to about 15 to 20 inpatient pediatric patients.

John Lynch:

And now they're back down to about five again. So as we saw our surge, they did as well. Not quite as big, but pretty important group of patients out there. When we look at king county, if for those of you look in the dashboard, you've seen this trend over the last few weeks. We've come down about 15% in the last seven days, compared to the prior number. Hospitalizations have also decreased consistent with what we're seeing in UW Medicine and the death rate is pretty stable. We're losing about one to three people per day in King County to COVID-19, which has unfortunately been the same for many months now. Across the state, similarly about 174 cases per hundred thousand over the last seven days and losing about one Washingtonian per day to COVID 19.

John Lynch:

And across the US, we seem to be sort of stuck at around a hundred thousand cases per day at COVID-19, with between 400, 500 people dying per day and about 6,000 people are requiring hospitalization per day. So definitely there some good news trends in the right directions, some stubborn data around hospitalizations and people dying from COVID-19 right now.

Trish Kritek:

Yeah, I think those numbers are stable. Our numbers in our hospital are down and within our system, which I think is encouraging and the numbers in King County are also down, which is encouraging. That mortality number seems kind of flat in all the different spaces. One question that came up a bunch of times was, do we feel like the numbers are really coming down? Or is this because people aren't reporting it? They're doing home antigen tests. Is this actually a decline? And I just wanted you to comment on that for a second.

John Lynch:

Yeah. Really important question, Trish. So if you look at the overall absolute numbers, sort of the whole shape of the curve, it is definitely lower than what's truly happening. There are people who get PCRs out there who maybe not get the dated people who have symptoms, who never get tested. And there are lots of people doing antigen tests and a lot of that data doesn't get to the public health folks in the reporting databases. But what I would say is more important rather than the absolute size of the curve, which I think is actually much closer to what we saw in January in terms of the absolute numbers is the trend. And the trend is definitely heading in the right direction. When you look at day after day, week after week, month after month, we are definitely seeing a trend downward without necessarily a lot of known differences in the way people are going about testing.

John Lynch:

The access to testing still remains good. I think people are still getting tested for illnesses, for travel, for exposures. And I think all together, the most important thing is the way it looks day after day, week after week. And I would say those are very positive numbers right now.

Trish Kritek:

Yeah. So I think big things is, for sure it underestimates the total number. And despite that, the testing's the same so we've been consistently underestimating it and it's coming down. And I think that's an important thing for everybody to hear.

John Lynch:

I should say the hospitalization numbers are also pretty solid, right? Those are really good data.

Trish Kritek:

So yeah, exactly. If you're not in the hospital, you're really not in the hospital. I didn't prep you for this because it came in overnight. But yesterday the CDC offered new guidance about this. And so I wonder if you could briefly summarize the changes.

John Lynch:

Why is everyone laughing? I don't know why everyone's laughing. Okay. Really briefly. So the CDC came out some new guidance yesterday, I will say right up front that not everyone agrees on the guidance. There's a fair amount of controversy. I've mentioned time and time again, that the phases of this pandemic and the quote unquote end of the pandemic are not medical decisions. They are public decisions. They are decisions we all make as a group. And I think the CDC to some extent is reflecting that sort of public sentiment about our stage. So with that being said, the big changes here are kind of continuing to put more and more of the decision making on the individual. So some of the concrete things. If you have COVID 19 and you feel better, you can return to life after five days of isolation, as long as you feel better. There's no recommendation to do any additional testing, but they do still recommend that you wear a mask for 10 days.

John Lynch:

So you can go back out into the world after your infection. And if you want to not wear a mask, you can get two negative tests separated by 48 hours in there, two negative antigen tests. So that's one way to go about it. If you're exposed, regardless of your vaccination status, there's no recommendation strongly to test. What they want you to do is to wear a mask for 10 days. You can do an antigen test in there on day five, if that's positive, then obviously you have COVID and you should isolate from the first day of the test. But basically they're like, if you're exposed, go about your life, but wear a mask. There are some new data that I think is really important to get out there around antigen testing with symptoms or without symptoms. And I'll be really brief here and then I'll be done. Is that if you, we all have heard a lot about people with symptoms, with negative antigen tests.

John Lynch:

And I've said a bunch of times this, and I think others on this call have said the same thing. It's really about repeat antigen testing. And I think the CDC provides some good sensible evidence based guidance here. So if you have symptoms and your first test is negative, the recommendation is to repeat that test 48 hours later. So what they're looking for is two tests before you can sort of say at home, "I probably don't have COVID." Because we know there's other viruses circulating out there. If you don't have symptoms, but you are either prepping to meet with people who may be at higher risk or you really want to make sure you don't have COVID before you go to some other gathering, then they recommend three tests separated by 48 hours.

John Lynch:

So one on Monday, one on Wednesday, one on Friday. And then if you're getting together for, since a family gathering that weekend, or you're worried about a high risk exposure and you really want to be sure you don't have COVID in your life. And so those are the key things, it's multiple tests separated by about 48 hours is the take home.

Trish Kritek:

Okay. That was a lot. That was awesome. And it was concise. I'm going to try to say it back quickly. If you have co COVID five days of isolation, if you feel better, go you can go out and about wearing a mask for a total of 10 days. If you're exposed, there's no quarantine recommendation anymore, but to mask for 10 days. And there's some stuff about testing in there that I'm not going to get into. If you are symptomatic, you need to test twice within 48 hours before you say you're really negative, ie if you have one test-

John Lynch:

Separated by 48 hours. Yep.

Trish Kritek:

Separated by 48 hours. Yep. If you have one test that's negative, you need to test again in 48 hours. If you are doing the asymptomatic testing, because you're going to get together. It's three tests, each of them separated by 48 hours. Okay. There's a lot there. Thank you for kind of going through that. I have one last question for you about this and I'll come back to you to talk about the fall, because I think there's a bunch of questions about the fall for you and for Tim. And that is, what about using antigen tests to see if you're contagious after you had COVID? So is that the one where you're saying that after five days, if you're not symptomatic, you could test twice and then feel like you're not symptomatic.

John Lynch:

Yes. And so the basic idea here. So even after two and a half years, we don't have all the answers to how COVID-19 transmits or even when we're contagious. And so what a lot of people are looking at is using antigen tests as a, what's called a proxy of whether you're infectious or not. We know that a lot of people who have a positive antigen test after five days, if you take samples from them and go into a laboratory, you can often grow virus, like virus that replicates. The question is we don't have solid data that, that means that person's infectious. It may be really tiny amounts of virus there, but we know that it's so to speak live virus. And so the idea there is antigen test could be used as one sort of clue. You may still be infectious compared to someone who has a negative antigen test. Right? And so that's the idea with that approach.

Trish Kritek:

Okay.

John Lynch:

We also, the other place I don't want to get into this now and maybe, or unless wants to talk about at some point. Is there around, you maybe hearing, because I do want to throw it out there because people are hearing about it is rebound infections. President Biden just had this, treated negative test, positive test. And that's another tricky area where that same idea is at play.

Trish Kritek:

Yes.

John Lynch:

I'll stop.

Trish Kritek:

We will come back to that. But I think the take on there is we are using an antigen chest after you're infected as a proxy for whether or not you're contagious and it's imperfect, but that's kind what we're extrapolating to. Okay. More COVID to come, going to pivot to monkeypox because monkeypox was super popular in terms of questions too. So Shireesha thank you so much for being here. I'm going to start and end with you on monkeypox and Santiago and John may want to chime in as we go if they want to add to this. I think the first thing that by far were the most questions is like, do we fully understand how monkeypox is transmitted? So maybe you could talk about how it's transmitted and then I have some follow up questions about that.

Shireesha Dhanireddy:

Yeah. Thanks Trish for inviting me to talk about this. I think COVID and monkeys are very different in terms of their transmission. And so we're not going to see the number of cases that we have with COVID and I want to make that clear. Monkeypox is really spread by closed personal contact. So we know that skin on skin, sharing of body fluids. There have been reports of people who have had intimate contact with people or contact with things that have been and into contact with this person, like clothing that had monkeypox on it or sex toys or things that had, had very intimate exposure with someone with monkeypox. So we know that again, unlike COVID where we can see it spread when you're just eating at a restaurant with someone or out in a pub, and close indoor spaces, this is really about contact. And so that's why it's very different than COVID.

Trish Kritek:

Close personal contact. Skin on skin or, or maybe something that has been very close to skin. It sounds like.

Shireesha Dhanireddy:

Or bodily fluids that-

Trish Kritek:

Or bodily fluids. So that was one of the follow up questions. Do we consider it a bloodborne infection?

Shireesha Dhanireddy:

Yeah. I think people probably are viremic when they get ill. And so we haven't seen that as far as I know, but if somebody is actively ill with systemic symptoms for monkeypox and have a needle stick with that, then I think you can potentially get infected. But I have not heard about that in particular as an actual cause of spread.

Trish Kritek:

Okay. So not a common or even heard of type of spread, but like make sense that if you were sick it would be in your bloodstream and could get it that way. How about, the other one is like fomites and that's where the kind of stuff that's been on your skin. Is that known whether or not fomites transmit it.

Shireesha Dhanireddy:

Yeah. So I think if you are sharing, bedding, clothing, towels, the CDC has put out that can be a cause for spread. And so, which is why we ask people to isolate and not share any of those things. If you do have monkeypox or if you have been exposed to monkeypox that you don't share towels or bedding or clothing with other people.

Trish Kritek:

So avoiding sharing towels, bedding, and other things that are up against your skin on a regular basis. I think that leads into, I think people are worried about this. And I think maybe I want to reiterate, first thing that Shireesha said is like, this is different than COVID. It's not transmitted like COVID, it's not as at of the same risk of getting it in those ways. One of the big questions that came up was, something that we've talked about with COVID is, transmission on public transportation. Is public transportation safe?

Shireesha Dhanireddy:

Yes. Public transportation is safe. And actually the CDC has just updated their risk assessment for particularly for healthcare workers. But just in general we have been saying it's okay for people to come to the hospital if they have concern for monkeypox. But just wear a mask, cover up your lesions, use a lot of good hand hygiene. They shouldn't be able to spread it if they're doing those things. If you have lesions on your hand wearing gloves, that sort of thing. Again, it's not like COVID.

Trish Kritek:

So we think it's safe for people to come into the hospital if they had this. This is one thing that people are worried about. They should be wearing a mask using hand hygiene, covering their hands. If they had lesions on their hand and always using good hand hygiene, that's something we've been saying for two and a half years, probably many years before that.

Shireesha Dhanireddy:

The other thing that I would notice that the screeners and at the contact center, when they're talking about scheduling in person appointments is, that one of the questions is, in addition to the COVID screening questions, is we added, do you have a new rash?

Trish Kritek:

Okay. So we started screening for that on the phone calls, when we're making appointments. Do we screen for it at the front desks of our clinics right now?

Shireesha Dhanireddy:

We are at Madison clinic and I think there is... We were just talking about expanding that to all the clinics. Just adding that on top of the routine COVID screening questions, because even the new fever and those symptoms could be also monkeypox. So getting two for one in terms of screening, when we add the rash as well.

Trish Kritek:

Okay. So we've added rash and we're talking about expanding that screening questions to all of our clinics. Santiago, you were nodding, did you want to add to that? I don't know if you had something you wanted to say.

Santiago Neme:

No, no, no. I was just agreeing. Yeah.

Trish Kritek:

Okay. Okay. There were some questions about risk of this disease for children. And I just was curious, is there something specific about risk to children with monkeypox, Shireesha?

Shireesha Dhanireddy:

Yeah, I think there is a concern, there have been reports in the UK of children getting this. Again, I want to emphasize that most people will have a self limited type of infection where they'll have lesions and those lesions will scab over and heal. The groups of people that we're concerned about that may have more severe infection are pregnant women and people who are immunocompromised, that could have more severe infection. I think people are concerned because kids get a lot of rashes, but again unless they've had contact with someone who has monkeypox or concerned for monkeypox, I don't think we have to be worried that all these children in daycare are going to have monkeypox.

Trish Kritek:

Okay. You understand, you're a mom, you know what it's like-

Shireesha Dhanireddy:

I am a mom and my kid had hand, foot, mouth recently. I did have a moment of panic, but it was fleeting.

Trish Kritek:

I appreciate that honesty. And I think that is the thing that people are worried about what you just said. And again, to reiterate what you said, for most people, it's a self limited rash basically that cross over and resolves. And then we worry about it more in pregnant women and people who are immunocompromised getting more sick from monkeypox. Do folks who have monkey packs have to isolate. I know that you just said they could come into an appointment, but otherwise are they supposed to isolate?

Shireesha Dhanireddy:

Yeah. I mean, if you have concern of monkeypox, we really want people to come in and get tested. If there's a concern, that's why I say I don't want people to not come in or show up in the emergency department when symptoms have progressed or they have pain. I want it to be in a clinic setting where it can be controlled with PPE, because we can follow the right protocol. And if they just let us know that's their concern. For the most part, with people with confirmed monkeypox, we're doing telemed visits for follow up, particularly to initiate treatment and do follow up from treatment. But if for some reason they need to come in, we recently had someone who, just unrelated broke their leg, not related

to monkeypox, but had monkeypox and broke their leg. We of course want them to come in and get their care that they need.

Trish Kritek:

Yeah. So they can come in. We do use telemedicine for ongoing care, but it's safe to come in. Last couple of questions. The first one is kind of a philosophical question. And that is how do we raise awareness about monkeypox which occurs most of the patients that we've heard about are men having sex with men without creating a stigma associated with this disease? And I wanted to understand kind of your, and the team's kind of thoughts about how we do that.

Shireesha Dhanireddy:

Yeah. And I'd invite Santiago to chime in too. I think we've really been trying to emphasize the types of exposures and the increased risk of exposure from the acts that people are doing and the activities that they're engaging in rather than their sexual orientation. I think that doesn't define the risk, it's really the activities that define the risk. So if you have multiple sexual partners, you have an increased risk just because of the more exposure, especially if those partners are having multiple sexual partners. So venues where there's multiple sexual partners or group sex act going on, that's going to be a higher risk. So those were the initial reports and like raves and bath houses where there's a lot of close, intimate contact with multiple people where you can have this spread. And so I think that's where we're really focusing the initial efforts in terms of prevention is really these higher risk individuals that may have lots of exposure potentially, and or have a history of STIs that may be a marker for having more exposure and being more at risk.

Trish Kritek:

So focusing on behaviors that are behaviors that put you at risk for sexually transmitted infections. Santiago, please.

Santiago Neme:

Yeah, no, I completely agree with Shireesha. Of course. I just wanted to emphasize that it's really not about who we are, is what we do. And when I say what we do is not about stigmatizing, what we do, it's just what happens, it's what life is. And I think that a clear message to the community that's currently being mostly affected right now with just the community of gay and bisexual men who have sex with men. I think it's really important because what we want is to make sure that folks have the tools to prevent this and to identify this and then get treated, get tested, and get also the vaccine. And it's really not attaching anything to who we are, because viruses don't really choose straight versus a homosexual person. It's really about the activity it's about that close contact and the message that we're trying to give to the community is that, it's really about reducing your risk.

Santiago Neme:

Particularly now that the vaccine supply is very limited. So we want to ask folks to try to reduce their risk by avoiding exposures to other folks with confirmed monkeypox or those who they don't know well, and I'm talking more about casual encounters. And I think it's important to give a very clear message because although this can happen to anyone, biologically, this can happen to children, this can happen to women. What we're seeing right now based on US and UK data is that more than 98% of folks identify themselves as either gay or bisexual men who have sex with men. So I think it's a tight balance, but it's important to be completely transparent. And we don't want to relive the times of the initial HIV that was

full of fear and stigma and homophobia. We really want to inform folks, for now at this moment, it is mainly, a gay bisexual men impact. We don't know where it's going to go. Hopefully it continues to shrink, but that's where we're at.

Trish Kritek:

Yep. I appreciate your thoughtful response. And I think, again, we're focusing on the awareness and the populations that are at highest risk so that they can think about those mitigating factors in terms of the behaviors that we know are where, the transmission of disease occur, so thank you for that. Santiago brought up vaccines, and that's my last question for you Shireesha. There were a bunch of questions about vaccines and maybe you could just first say for whom are we prioritizing the vaccine? And then the second part is, are we thinking about vaccinating healthcare workers?

Shireesha Dhanireddy:

Yeah. So as Santigo alluded to this already is that we're really focusing on highest risk groups and that is really focused around mainly men and as he mentioned that the majority, the overwhelming majority are men who have sex with men. So we've really tried to prioritize this group and it not everyone in that group, but people who have additional risk, not just their sexuality. So multiple sex partners, group sex venues, history of gonorrhea or syphilis as markers of being at increased risk.

Trish Kritek:

Okay. So that-

Shireesha Dhanireddy:

Or if you've had actually an exposure to someone with confirmed monkeypox.

Trish Kritek:

Okay. So exposure to someone who we know has monkeypox or men who have sex with men who are engaging in behaviors that we said already were high risk, or have a history of sexually transmitted infections, probably correlating with those same things that we talked about. Are we going to vaccinate healthcare workers?

Shireesha Dhanireddy:

Not at this time. I think we have the tools we need to prevent infection and healthcare workers. And again, I mentioned that the CDC put out the risk guidance and healthcare workers who wear the proper PPE are not really at risk. And so I really want to emphasize that. So when we are seeing patients, if there's a concern for rash, to make sure you always examine something with gloves, that we're using gloves for anyone who has a suspected rash or rash. We've had to talk to our clinic staff about not hugging patients. I know that we are trying to get past COVID and really bond with our patients, be able to touch them again and handshake and things. But we really want to make sure that people are cautious about that and not to have unnecessary contact if there's a concern, particularly for monkeypox. But just now in general, I think just a heightened alert.

Shireesha Dhanireddy:

We actually, in the Madison clinic, because we have had so many patients who've come in with monkeypox, we are suggesting for people that are coming into triage to maybe just use PPE. We've had

and just as a default, particularly if they're concerned about risk. There have been a number of patients who haven't necessarily realize they have a rash until they come in. But again, we should all be using masks as a default and using gloves if we're touching a rash or anything on a patient.

Trish Kritek:

So we're all masked in the clinical spaces anyway. So we're going to stay masked and gloves in this situation. And obviously hand hygiene when we take off our gloves and before we put them on. And with those in place, we don't need to vaccinate healthcare workers for this.

Shireesha Dhanireddy:

And I think Trish, the issue is also the vaccine supply is pretty low. I know that healthcare workers have been really concerned, but again, we have the tools to prevent ourselves from getting it in the healthcare setting. We really want to focus on vaccinating people at high risk that don't have these other ways to protect themselves necessarily. Of course the messaging is to try to minimize that contact, but that's not always a reality.

Trish Kritek:

Yep. So limited supply, prioritizing the people with the most need. We understand this, because we just did this for COVID. So I think it's not dissimilar to what we talked about before. Thank you. Shireesha that was a lot. And I appreciate Santiago adding in, I thank you both. I'm going to go back to COVID, I'm going to do rapid because I got so many questions and I'm never going to get through them all. So John, I'm coming back to you. Lots of questions about boosters and about when to get a booster and whether or not we're going to have an Omicron version booster. So maybe you can just update on where we stand with what you know about fall boosters.

John Lynch:

Sure. And I touched base with Shireesha on this. So Shireesha jump in too if I miss anything.

Trish Kritek:

Yes. You need a break.

John Lynch:

Yeah, yeah, yeah. For sure. Especially if I say anything wrong. The most important thing, it's only about one third of eligible adults in the United States have gotten boosted. So we really need to continue pushing boosting not only among for ourselves, our family members, but we really, our relatives, our friends, our community, we really strongly got to get people boosted. I think going to your question, Trish. Yes, if you're eligible for a booster, you should get boosted. I don't think there's any... Don't wait. There's no reason to think that there's going to be some big delay. I do recognize that when we've had boosters, there's been a period four to five months that they put out there to wait between boosters or your vaccine, your booster. That may be put into place with the Omicron specific vaccines, but I don't think so.

John Lynch:

Because it's not going to be the same situation. The antigens going to be different enough that I think that the FDA and CDC will make a recommendation to just get that next dose. Whether you want to call

it a vaccine or a booster to broaden your immune response. So I'm not worried at all. I'll just say I'm eligible for two boosters. I got them both. And I'm not concerned at all about my eligibility for that Omicron specific vaccine. The other thing is, yes, we hear a lot about, oh, it's going to be available in the fall. The fall's a pretty big window. Is it October, November, December? I don't know. And so I think kind of waiting for that, doesn't make good sense as we move into the respiratory virus season.

Trish Kritek:

So if you haven't had boosted and you're a candidate for boosting, you should get boosted. Do you have an idea of when you think the next version of vaccine will come?

John Lynch:

I don't know. Shireesha, what do you think? October, November, December.

Shireesha Dhanireddy:

It's hard to say. I don't know. And I don't know, like in what quantities it'll come out initially either. So I think that's an unknown.

Trish Kritek:

Okay. So we don't know yet. We know they're making them and we'll keep asking this question. John, are we expecting a new surge in November?

John Lynch:

I expect to see more cases in the fall. And I'd say, there's a couple things there. One is this appears to be the pattern we're in for the foreseeable future with pups and downs. The second thing is that we have a big player here is congregate settings and this most important one is schools, daycares and similar. So we bring a lot of kids together and part of the FDA things that I didn't talk about, and I'm not going to talk about is that the CDC sort of backed off a lot on our recommendations for monitoring schools and tests to stay and so forth. So I think we're going to see cases in Congress spaces like schools and universities. So when they come back in, we're going to see those, that transmission rates go up.

John Lynch:

The second thing is, Omicron continues to evolve. I apologize for my dog. And there is another variant out there that's sort of in the back that we're going to have to keep an eye on. That's the BA2.75. You may have heard it called Centaurus. And we're going to see, what that looks like. It is definitely moving along fast in some parts of the world. And it may lead us to an increase in cases as schools go into play.

Trish Kritek:

So likely that will go up in numbers again, particularly when people go back to school. And there will be new variants, there's one already out there that we're following. Tim, I'm going to pivot to you. We were just talking about next vaccines, do you think that we and UW Medicine will require a next booster when there is this next Omicron variant targeted vaccine?

Tim Dellit:

Well, I think we have to wait and see. We have to wait and see one, when it comes out, what the recommendations from the CDC are, and also what the state may or may not do. So I think it's too early

to say for sure. I would just say, as an example, right? We continue to really require influenza vaccine or you have to go through a declination process that requires education. Right? And we do that for influenza. So there could be a good likelihood that we consider something like that, but I don't think we've made a final decision.

Trish Kritek:

No decision yet. Could look a lot like what we do for influenza, more to come on that. Thank you. There's more questions. I'm going to ask one last one. And I apologize for the questions that I didn't get to Santiago. A bunch of people asked about, should they take Paxlovid or who should take Paxlovid? I wonder if you could briefly say for whom we think right now who should take Paxlovid?

Santiago Neme:

Yeah. So plod is really indicated for folks who have mild to moderate symptoms of COVID who have tested positive. And the drug can be started within five days of symptom onset or diagnosis. It's very important to say that this is only for confirmed cases with symptoms and also not in all of them. It's really for patients who have risk factors for increased severity. And that includes things like age, asthma, obesity, et cetera, diabetes. So it's not for any patient, so I would on the COVID therapeutics website, we have all of the information on this.

Trish Kritek:

Okay. So people with confirmed COVID, mild to moderate symptoms and at risk for getting worse disease are the people we recommend it for. And then-

Santiago Neme:

And within five days.

Trish Kritek:

And within five days, thank you for adding that. And then, we have heard about this rebound phenomenon and it seems like there's more and more reports about that. I just will ask you quickly, your thoughts on what does it mean when somebody has rebound?

Santiago Neme:

Yeah. So rebound is basically having new symptoms or testing positive again, after a negative test in the process of recovering from COVID. And this typically happens within the first two weeks. It doesn't happen later on. So if it happens later on, it might make me think of a potential reinfection. I do want to say the initial rates for this on the Pfizer studies were about one to 2%. What we're seeing now that it's more common it's affecting about five to 10% of folks. The key thing to remember is that if this happens to you, you might be contagious, still contagious, or again, become contagious. So you need to isolate further. And there's a nice guideline from CDC on this that I can put in the chat about who needs to do that. Remember that it could present only as a positive test, it's like we had our president just have that without the symptoms, but it could be symptoms and a negative test, or it can be symptoms and a positive test. So it could be all three flavors.

Trish Kritek:

Okay. So if it's within two weeks and your test positive, or you have recurrence of symptoms, you need to treat it like you're contagious again, and we're seeing it more commonly than we ever initially saw. Thank you very much. I know you want to say something else, but I'm going to hand it off to Anne to talk to you about ask an ID doc and maybe you can weave it in to your ask an ID doc. Anne, go.

Anne Browning:

Perfect. So despite our best efforts, COVID happens. Santiago I know that recently this has happened to you and your husband. I want to check in and just see, how are you two doing?

Santiago Neme:

Thank you, Anne. I'm actually recovering very well. I'm pretty fortunate. I have to say, I feel very grateful to have received all the vaccines that were, that I was eligible for. Because for me it's been, I'm on day four and a half now. And I had three days of fever that wasn't too high but now I'm feeling much better. So my husband went to Minneapolis on a business trip and that he had to really make, and no one was wearing masked, there were a lot of social events, restaurants, et cetera. So he got it there basically flew home on Thursday night, he got tested when he got home, it was negative. The next day he got tested, it was negative. On Saturday, he got tested it was negative. And then on Sunday he was symptomatic and tested positive. So that's what happened?

Anne Browning:

How about Paxlovid and what was your decision making around that? Did you end up using it?

Santiago Neme:

Yeah, so I happened to work really closely with Shireesha around Paxlovid and I basically barely meet one criteria, which is my BMI is excessive right now. So it's 29.7 and 30 that cut off, so. But honestly, just thinking about the fact that I'm fully vaccinated and boosted, I felt like I don't meet the criteria, so I didn't take it. That being said, my husband has asthma, so for him, this became a lot more serious in that it was more... He had a high fever persistent, but also became congested and wheezy. And again, he met criteria so he started. Today, we're kind of both doing the same as well, so that's great. So I think Paxlovid really helped him. I did want to say that rebound can happen after Paxlovid, but it's an incredibly powerful medicine. So I would not discourage people from taking Paxlovid and I would also say that people should not seek a second treatment, a second round because that's not being approved.

Santiago Neme:

So you only get treated for five days, you don't get a second course. So that's really important in question. And we also don't want to prescribe someone Paxlovid just in case they go on a trip. We need the positive test, we need the symptoms and we need the risk factors for severe disease.

Anne Browning:

One last question. Since you now have it, or thankfully in recovery and you guys are doing okay, does it shift how your perspective on how you plan to move through the world for the rest of the summer and into the fall?

Santiago Neme:

Actually, no. Unfortunately this type of exposure was kind of inevitable because it was within the home. I would say, I don't want this again, I don't want this for my family either, I don't want it for my coworkers. So I will continue to do what I've been doing. I still haven't eaten dinner inside a restaurant. And although I have some extra protection now from the infection, we are seeing that reinfection is actually becoming more frequent. So I'm not going to change anything.

Anne Browning:

Santiago, thank you. I'm glad you both are feeling better and thank you for sharing kind of your own experience, I appreciate it. Trish.

Santiago Neme:

My pleasure. Be safe, everyone.

Trish Kritek:

Yeah. I'll thank you too, Santiago, for being so willing to share personally, I appreciate it very much. I want to thank a lot of people for sharing. Lots of people went online to tell us what they thought about Town Hall. Lot of people emailed me directly or grabbed me in the hall when I was on service or stopped by my office and shared their perspectives. Thank you. Lots of feedback, lots of ideas about how we could make it better, who we could invite to be here, how we could broaden our topics. And what I would say big take homes, is that people felt like it was important to keep having Town Hall on some kind of regular cadence, which we're still trying to figure out and to come together when new things happened. They felt it was important to hear from these experts, these leaders, these people in front of you right now, and to have that sense of community and we heard you. I so appreciate all the input.

Trish Kritek:

There were a few people who were like, enough of Town Hall and I heard that too and I get it. And I think a lot of that was like, can't we get past COVID and I feel it too. So I think the long and short of it is, many people said it was important to come together on a regular basis still and I want to acknowledge that and say, thank you for giving us that feedback. We will be back in September for exactly that reason on September 9th. And then we'll figure out what our cadence will be moving forward. We'll we will figure it out with you and we really appreciate your partnership. I'm going to end as I always do by saying thank you, a special thank you to the whole community at Harborview. It is crazy right now there.

Trish Kritek:

So thank you all for all that you do from the leaders in the institution to everyone in our acute care, our ICUs, our EDs. All the care in spaces that aren't places where we usually take care of patients, thank you, really. For continuing to take care of our patients and their families. And right now all of us has to come together to continue, as Jay talked about, to take care of each other. It's a pleasure to be back. We'll see you in about a month. Please keep sending us your thoughts and questions. Take care.