

Trish Kritek:

Welcome back to UW Medicine Town Hall. I'm Trish Kritek, vice dean for faculty affairs. It's a pleasure to be back with you. And by far, the biggest thing that we're going to talk about today is boosters, because there are new boosters. So thanks to everybody for all your questions about boosters. I'm going to start off by introducing the folks in the room. With us are Anne Browning, our associate dean for wellbeing, Santiago Neme, medical director at UWMC Northwest. Tim Dellit, interim CEO and dean of the School of Medicine, Jay Sandel, interim chief nursing officer at Harborview. John Lynch, head of infection prevention and employee health at Harborview. You'll note that Tom, Rick and Cindy aren't here today because they have other obligations and/or vacation which we always celebrate. And I'll save the last introduction for Keri Nasenbeny who is our associate CNO at UWMC Northwest. And as of today, the announcement went out that she will become the CNO at Harborview starting in a few weeks. So Keri, welcome. We've had a variety of title changes during town hall and you are the latest title change, so congratulations on your new role. Very exciting.

Okay, well, we can give you a hard time about that and give Jay a hard time about that more later. But John is back, I think, and I'm going to start off with you John, so that while we have you.

John Lynch:

Sure.

Trish Kritek:

... connection we can make the most of it. So I am going to ask a bunch of questions about boosters, but before we do that, it's always useful to understand where we stand in terms of COVID within the system and within King County.

John Lynch:

Yeah, sure. Can you hear me okay?

Trish Kritek:

I can, yeah.

John Lynch:

I do not know what's going up here around my house, and my phone and my computer are giving me a little bit of hard time. So right now at UW Medicine, we have 27 total patients with COVID-19, which is a pretty sizable decrease from where we were at last town hall. At Harborview, we have 15 in ICU and the rest, two to five people.

Trish Kritek:

Yeah, it's-

John Lynch:

Can you still hear me?

Trish Kritek:

... hard to hear you.

John Lynch:

Yeah, I can tell that it's not working.

Santiago Neme:

John if you turn off your camera, just turn off your camera.

John Lynch:

Yeah.

Santiago Neme:

Perfect.

John Lynch:

How about that? Can you guys hear me okay?

Trish Kritek:

Let's go for it. Yep. This is great. So you'll be able to see my face but we won't be able to see yours, which is sad but true. Okay, so 27 patients across the system.

John Lynch:

Oh yes. Okay. Yeah, 27 patients across the system. 15 at Harborview, only two people in the ICU. Five people at Montlake, none in the ICU. Two people at Northwest, none in the ICU. And actually they got down to one at one point, which is great. And five people at Valley, none in the ICU. Also important to keep an eye on our pediatric teams at Seattle Children's Hospital. They have six patients total and none are in the ICU right now. And these numbers are pretty consistent with what we're seeing across King County, with an overall decrease in the absolute number of cases. Across the county, hospitalizations are fluctuating maybe a very slow decrease across all the hospitals here. But it is important to know that our total number of cases, even with all the caveats to the counting, is at the lowest number at 86 per 100,000 people with COVID-19, which is the lowest we've been since around March of this year, so pretty sizable decrease.

Trish Kritek:

Those are wonderful news. It's wonderful news that our system is low, the number in the ICU is really low, and the number across King County is at its lowest and been in quite a while, so that's great news. I appreciate that. And thank you for putting in the Seattle Children's numbers as well. With that, the biggest news of the last couple of weeks is that we had these new bivalent boosters. By far the most questions we got were about the boosters, so I have a bunch of follow up questions about the boosters for you. And we're going to see if we can do as many of them as possible now and then give you a break. Who is eligible for the new booster right now?

John Lynch:

Yeah, pretty much everybody over five years in age and over is eligible for boosters. For the new bivalent booster, it's everyone 12 years and over. So boosters are very widely available and recommended at this time, including the bivalent, the new booster which we can talk about.

Trish Kritek:

Yeah, that's the one I want to talk about more. So I just want to clarify, you're saying boosters for everyone five years and older, but I think for the bivalent it's 12 years and older. And so that's who's eligible. How long after your most recent booster should you be getting this next booster?

John Lynch:

Yeah, so actually I'm going to learn from you, Trish. When I say bivalent, what I'm talking about is a booster that... Are you missing it or is it-

Trish Kritek:

No, it's good. I love that you said you're learning from me because I didn't fix what bivalent was. So yeah, teach it.

John Lynch:

Yeah, just to quickly say, all the vaccines we've had for COVID-19 up to this point have been targeting the original COVID virus, the original SARS-CoV-2, the spike protein, the part on the outside that attaches to our cells. And what this new vaccine does is it has both that spike protein, the original one, and the one that's like the BA.5 are very similar to the BA.5, which is the Omicron variant we're dealing with now. So it has two targets for our immune system to respond to, that's why it's called bivalent. Like bicycle, two wheels, two spikes. And so the timing question that you asked is as soon as two months after your most recent vaccine or booster.

Trish Kritek:

Okay. So I appreciate your explaining bivalent, targeting both the original virus and the Omicron variant. And what you just said was two months after your most recent booster would be a time for folks who are eligible 12 years and older to get this new bivalent booster. How about if you've been recently infected? Because we all know lots of people who've had an infection in the last few months.

John Lynch:

I think it's the same as it has been for all the other vaccine doses. As soon as you're recovered and feeling better, you're eligible for any of the vaccines, boosters or otherwise.

Trish Kritek:

Okay. So you wouldn't recommend waiting a few months after a recent infection before getting this new bivalent booster? That's a question that was super common.

John Lynch:

Yeah.

Trish Kritek:

Okay. So the answer is go ahead and get this when it's available. Santiago, would you like to add to that?

Santiago Neme:

Just one addition in discussing this with Shireesha Dhanireddy, she reminded me that there is a suggestion on the CDC recommendations that if you've had COVID recently, like my case, you may consider waiting three months. It's a suggestion, it's not a rule or hard recommendation, but it would make sense that if you recently had COVID, meaning the same BA.5 that I probably got, then you may wait three months based on this suggestion.

Trish Kritek:

Yeah, I think that's exactly what people were asking about, so thank you for clarifying that. So I think the answer is if you wanted to get boosted, you can get boosted as soon as you don't have symptoms from your infection and the CDC says it would be reasonable to wait three months after that recovery to get this next booster if that is what you opt for. Does that sound right? Okay, thank you for that clarification. John, is there a reason to choose Moderna versus Pfizer for this one?

John Lynch:

I looked this question and I defer if Santiago has other comments, but I have not heard any recommendation whatsoever to support mixing and matching as a recommendation. If you wish to do it, you can do it. There are data from earlier on from vaccine studies that there was no harm in doing, so it's entirely up to you.

Trish Kritek:

Okay, so there's no recommendation to mix or match. I think the real other question I'm asking, and Santiago, if you want to weigh in you can, is there a benefit to choosing Moderna versus Pfizer regardless of what you got before?

Santiago Neme:

No, not that we know of. But what I would like to say in discussing with Jenny Brackett this topic this morning, we have a lot more Pfizer. So for me, what I typically do is I get the first vaccine that's available to me, and I've gotten all Moderna, but if I were, let's say, eligible to get the booster for myself, I would go ahead and get whatever is available because they're excellent products.

Trish Kritek:

Okay. So we think that they're probably equivalent. And right now at UW Medicine we have more Pfizer, so if someone's is in the right window, in the right age group, we'd probably go ahead and get the Pfizer. Okay, I appreciate that. Does anyone here know if we're going to get the AstraZeneca vaccine?

Santiago Neme:

I don't. I don't know.

Trish Kritek:

Okay.

John Lynch:

Yeah, I don't either.

Trish Kritek:

Okay. We'll follow up on that. I just saw that as a follow up question. A couple more questions John, before we give you a little bit of a break. Is there a different strategy for boosting kids and teens versus adults versus seniors? Or are we all following the same pathway now? Because there had been some differences in terms of ages and boosters.

John Lynch:

Yeah, so it's a little complicated, and I'm going to post a link in the chat or Q&A, whatever you want. And it actually has a little tool that you can put in your age, your vaccine status, and it coughs out what you should do. It includes whether you're immunocompromised as well. Because right now, it's again a little more complicated than I could probably really nicely describe. But the main thing here is that if you are six months to four years, we want you to have a primary series. If you are five years, we want a booster. But if you're five to 11, it's the monovalent, the original booster. And then if you're older than that, we want you to get this new bivalent vaccine no sooner than two months from your most recent vaccination.

Trish Kritek:

Okay. So for smaller kids, we're talking the original vaccine as their booster. For older people, we're talking the bivalent.

John Lynch:

Well yeah, I mean, over 11 years old.

Trish Kritek:

Over 11 years old. Okay. I appreciate that. I think that's actually helpful, and thank you for putting that link in the chat. We'll put it into the email that we send out to folks for those who are watching this recording. What about boosting if you're pregnant? For pregnant people, what's our recommendation?

John Lynch:

So when I went through all of the materials here, there is no specific call out that differentiates our approach for pregnancy. So it falls by age, immune status. So go ahead and get it if you're more than two months from your most recent vaccine.

Trish Kritek:

Okay. So yes for pregnant people to move ahead with boosters. And do you have any idea about boosters for small children, the under five folks, is that coming? Are we thinking there will be boosters for them?

John Lynch:

I suspect that they'll eventually align with the adult booster program. The study's looking at the early Omicron vaccines are ongoing right now, just the adults are a little bit ahead of the kids.

Trish Kritek:

Okay. So probably yes, though we're not ready to say that right now. Okay. I have some questions about the studies around these vaccines, but I'm going to pause for now, give you a little break. I know it's challenging when you don't have a great connection. Maybe the AV gods will smile upon us and your

connection will be better. And I'm going to pivot to Tim for a little bit. Tim, we got a bunch of questions actually in the last 24 hours after Jay Inslee said that the emergency proclamation is going to end. And people were wondering what the implications were about that for UW medicine. Specifically they ask, "Will that mean a change in our vaccine requirements or our masking or our work from home possibilities?" Could you speak to that?

Tim Dellit:

Yeah, and I think I would look at this as a positive sign that the governor feels that he is able to discontinue that public health emergency phase. It doesn't mean that the COVID 19-pandemic is over or that we can just forget what we've done to get us to here. But it is another positive step in terms of our hopefully moving forward. We've known that these waivers were going to end. So this public health emergency, part of it is tied to a number of waivers with respect to the hospital. And we've actually been working with Washington State Hospital Association of the health systems to mitigate that impact. Some of this is for instance, what hospitals can do in terms of temporary surge capability and we're able to preserve that should we see increased numbers of cases. With the respective vaccines or maskings, it's not going to make a significant change within the healthcare environment.

My understanding is that it may have an impact on some of the mandatory requirements around vaccination from a state perspective, but each employer is able to continue to require vaccination as they see fit. And particularly within the healthcare environment. I anticipate that the healthcare environment as a whole will continue to require vaccination. We don't anticipate it. I look to John or Santiago to correct me, but we don't anticipate any change in our current approach. So our approach, for instance, with this new booster will be that we require individuals to participate. We strongly encourage everyone to get boosted. If individuals do not want to receive that booster, then they have to go through the online declination process similar to what we do with influenza and similar to what we did when the last booster rollout occurred.

So that's really not going to change. There's no change in terms of masking requirements within the healthcare environment. And so that's not going to change for us either. And so again, when I look at these, it doesn't mean that the pandemic's over and we just stop everything. It is a positive sign that we are continuing to move in the right direction. There are certain waivers that we have to look through from a regulatory standpoint, but ultimately, we want to continue to do those things that we know protect our patients and protect our employees. Vaccination, boosters, masking, those sorts of things will continue as we have been doing.

Trish Kritek:

Okay. I think that's really helpful. So positive news impact on some waivers which are beyond the scope I think of what most people were asking about, but I think the things they were curious about were vaccines, we're still going to require them, we're going to require this booster, but you can, like what the flu vaccine, do a formal declination, decline it formally and that's okay. But again, we're strongly encouraging people to get boosted. And then masking stays masking. I'm going to ask John some more nuanced questions about that later.

Tim Dellit:

And Trish, I should clarify. What I'm saying, those two pieces, those are for in our healthcare environment. Within our hospitals and clinics, the vaccination requirements are for those individuals who use our hospital based employee health services. So again, individuals in non-clinical spaces within our school of medicine continue to follow university guidance from Environmental Health and Services.

So I do want to just make that distinction that healthcare environment continues to require masking. Outside of the hospitals and clinics, we follow the university guidance such as in the health science buildings where it is recommended but not required. And the same thing with vaccination. Again, we encourage everyone to get the booster, but those within the hospitals and clinics have to go through that declination process if they don't want to receive it.

Trish Kritek:

So I think that's a really good nuance. Hospitals and clinics, unique in terms of the process around vaccines and the masking. Non-hospitals and clinics, parts of UW Medicine, we're still recommending both things, but they're not required at this point in time. Okay, that's super helpful. Santiago alluded to this, but I'm curious if you could talk a little bit about what our status is of these new bivalent boosters because I think people went online and it seemed like the appointments disappeared very quickly, so they asked some questions about where we stand in terms of supply of these boosters.

Tim Dellit:

Yeah, no, that's a great question. And again, we ask for everyone's patience. Every time we have a new booster or a new vaccine rollout, we always have a high demand and more limited supply. That supply will increase. Right now, we had appointments out I believe for two weeks just based on the current supply. And so that's when people may look now and not see available slots. I can say that the demand was quite high. I think after 24 hours, we had about 4,500 individuals on our wait list.

Trish Kritek:

Wow.

Tim Dellit:

We will get to everyone. Again, I ask for everyone's patience. The good news is the vast majority of people, especially again within our healthcare environment, you've been vaccinated. The vast majority of you have already received boosters. Those alone will continue to help protect you from severe disease, from hospitalization. And again, as the supply increases, we will quickly work through that waiting list and more slots will open up in terms of being able to appoint online for our healthcare workers. So again, I just ask for people's patience as we work through the supply issues, which again, we experience every time we have a new rollout.

Trish Kritek:

This reminds me very much of before. We have lots of people on a waiting list, we're waiting for more supply. We will put out more appointments as soon as we have more supply. I think that that makes sense. I will tell you that I was getting texted by Andy to get my act together and sign up quickly and I also was like, "Wow, there's not a lot of appointments left," but I'm coming out to UW Northwest to get my booster later next week. How did we decide specifically about that? What clinics we would have open for boosters?

Tim Dellit:

Well, we've gone back more to the mass vaccination sites for this rollout. If you recall, prior to this we had gone through our very young children where we utilized our pediatric clinics because mass vaccination sites aren't the best environment for really young children. But because now we're going back to the essentially 12 and older for Pfizer or 18 and older for Moderna, we've gone back to the

larger vaccination sites, especially for this initial rollout when supply is limited. When you have limited supply, it's hard to get it distributed out everywhere. And so we're concentrating it again just as we've done with the other waves, the other boosters, particularly for our adults through the mass vaccination sites.

Trish Kritek:

I think that's really helpful because I think people are like, "Why not go back to the clinics?" And I think the answer is because we're trying to consolidate the limited supply we have and get it out to people. So thank you for that. Did we prioritize healthcare workers getting access to it this time?

Tim Dellit:

Well again, when we open this up because our healthcare workers can go online and essentially self-appoint and pick their time, they do have that preference. But we also, again, as we've talked about before, we need to be equitable in our access and have this available for all individuals who are eligible. And so we sent message out both to all of our employees as well as to all of our patients. And that's where the phone number, just as we've done before, to get on the waiting list. And again, we will get through this as quick as the supply allows, but because the healthcare workers are able to self-appoint, it did give a little bit of an edge in terms of how they're able to do that. But ultimately, we want this available to everyone who's eligible.

Trish Kritek:

So we're trying to get it to everyone. We got the ability to go in and make our own appointment, which I just talked about. So that gives you a little bit of a head start I think. And we're going to have enough eventually for everybody to get boosted, it's just going to take a little bit of time. And are we going to have both Moderna and Pfizer eventually? I heard we mostly have Pfizer right now.

Tim Dellit:

I think eventually we will. Again, it's just a matter of the supply. It just happened to be more Pfizer initially, but I would fully anticipate we'll have both available similar to the last time we did boosters.

Trish Kritek:

Okay. I'm going to follow up again about the policy. So two things I want to clarify. Is there a due date? Is there a time by which people will need to either decline or get boosted with this new booster? Have we set a date for that?

Tim Dellit:

I want to look to John or Santiago. I don't know if John can hear us.

Santiago Neme:

Oh John, you want to reply?

John Lynch:

I moved around my house so maybe this is working better.

Trish Kritek:



This is good. We get a tour of the Lynch household.

John Lynch:

I am now in my basement. So we have not yet to determine a date because of the supply issues that were just outlined. But something like the flu deadlines. But to be determined because we want to be fair to everyone, the goal here isn't to create more stress.

Trish Kritek:

Okay. So there will be a date, but that date is not set yet because we don't have enough supply to really do that, so more to come on that. And the other thing I wanted just ask you about Tim, before I give you a break, is a long time ago we had lots of questions about people who didn't want to get any type of vaccine. Will you be able to decline an initial set of VA initial vaccination at this point in time or we still require everyone must be vaccinated with the original series?

Tim Dellit:

I believe it's everyone. But again, I'm looking at John who oversees this from a clinical-

Trish Kritek:

Go ahead, John.

John Lynch:

Yeah, so thanks, Tim. And you're right, that's the same approach for the primary series. That is a requirement to work at UW Medicine outside of those specific roles that Tim already described.

Trish Kritek:

Okay. So it remains a requirement to have your original series of vaccination, and then after that with boosters, there's ability to decline that booster with a stronger recommendation to still get that booster is what we're consistently saying.

John Lynch:

Yes. And declination can take a variety of forms. But most importantly, there's an educational declination whereas if you don't have a medical or similar reason, you go through the educational process. You just understand the ramifications of not getting boosted.

Trish Kritek:

So you might decline because of a medical or some medical reason like we've had along the way.

John Lynch:

Sure.

Trish Kritek:

But for most people, we're asking them to do some education to understand what the implications are of that decision?

John Lynch:

Correct.

Trish Kritek:

Got it. Okay. Tim, one last question for you, and this is a philosophical question and you can decide, other people may want to chime in too. But when do you think we'll start treating Omicron or COVID like the seasonal flu in terms of our behaviors? What are your thoughts on that one?

Tim Dellit:

Oh, that is a great questions.

Trish Kritek:

That's why I gave it to you.

Tim Dellit:

That is really hard to predict. There's both individual choices of what we do outside of the work environment, where people, now that they've had the opportunity to be vaccinated with multiple boosters, which really significantly mitigates the risk of severe disease. I think people, and we see this, are starting to transition more outside of the work environment. Again, the health environment, that is a little bit harder to predict because again, we have immunocompromised patients, we have risk of transmission from patients or from healthcare workers. And so that is a very different environment. I also think that we anticipate many of us, and again John or Santiago may have thoughts on this, it's likely, even though we're at a lower stage now, we may well see another rise in cases this fall. Fully would anticipate that. And in that setting, again, I think using those mitigation factors and tools that have gotten us this far will continue.

So I don't think we're quite there yet. I think it's a great question. At some point, and it's always harder coming out of the pandemic. It's easier to escalate and ramp up procedures. At some point we will transition. But I also think, and again look to John and Santiago, that for instance, the use of mass may be much more common going forward than it was pre-pandemic. I just think we are much more cognizant in terms of just the benefit of wearing mask, particularly during respiratory seasons as an example. So I think some of these practices may continue. Now to what extent they continue and where in terms of requirements? But I just feel like that is something that we are going to see more of going forward than we did pre COVID-19 pandemic.

Trish Kritek:

Yeah, I appreciate that. I appreciate the nuance of the thoughtful response. I won't summarize all of it. I will just say we're getting in some spaces where we're starting to think about it, and we might think that there is a likely rise in cases in the fall. The life outside of the hospital and clinics is different than life inside the hospital and clinics. And then I'll just say, and I think people's behaviors may change long term based on some of this by choice, like me wearing a mask when I'm on a plane for the rest of my life. I'm just going to affirm that right now, and I just feel better and I probably will be less likely to get the cold that I got every time I got on a plane for many years of my life. Okay.

Tim Dellit:

I think that's something that people are realizing, right? We've seen less flu. Many of us, you haven't had perhaps as many colds and, a lot of that is because of some of these measures. And so people see that and, "Oh, that may be beneficial." So that's where I just feel like some of these practices may just linger on.

Trish Kritek:

Yeah, I hear you. Thank you for that. Okay. Carrie and Jay, I've given you a break for a long time. I'm going to start off with a question that I've asked many times and I'm going to just ask you, how are we doing with staffing at our hospitals? Start with you, Jay, because Harborview has had the census that I think has been the most challenging for sure.

Jay Sandel:

Yeah, I think staffing is still one of those things that's at front of mind every time I think about Harborview. I would say that we've seen some positive recruitment to many of our areas here on campus. We're still challenged many days and nights on having the correct amount of staffing that we need and we have a long road to go. But I do think that we are seeing some positive impacts to some of the recruitment maneuvers that we've done. And when I predict and look at the fall of what's going on, I see a lot of people in the pipeline to come through orientation across many disciplines. So I think again, we have a long road to go, but I think we are seeing some positivity there.

Trish Kritek:

That's great. So slow and steady progress and still a challenge day to day that we're attending to. Keri, anything you want to add to that?

Keri Nasenbeny:

Yeah, I'd say we've experienced a similar trend here at Northwest and I think at Montlake. I just looked at our numbers for Northwest. In the last 20 weeks, we've been able to hire 114 nurses and 30 CNAs. And then next week actually, we have 20 experienced nurses starting in orientation. So we're really excited about that. And in fact, I think we'll be able to, we were just running the numbers, release either at the end of the contract or early, I think, 14 travelers across acute care and then more than that, including the OR, ED, and labor and delivery units. So I think making progress, still a lot of work ahead of us. And staffing, I think generally day to day is much better. It's not perfect, it never was. It's just to say that from the start. But we're in a much better place, I think, where we were a couple months ago.

Trish Kritek:

So a bunch of new folks transitioning from travelers to full-time regular staff. Making progress and acknowledging that it's still a process. First of all, I just had an epiphany that I totally spaced Anne's wellbeing message. I just want to acknowledge that to the people who have been sitting here saying, "What the heck did you do?" So Anne, be ready. I'm going to give you a space for that at the end. But as I thought about that wellbeing message and bonked myself on the head, I said, "One of the things I've been worried about people's wellbeing is that many of our schools didn't start when we thought they were going to start." So we got some questions about how are we supporting our staff whose kids didn't get to go back to school in the Seattle public schools or the Kent public schools before they settled their strike? So Jay or Keri, what are our supports for people who thought their kids were going to be in school and still have to work?

Jay Sandel:

I know here on the Harborview campus, we have our Bright Horizons that is just across the street that is open for emergent access for people who find themselves in the situation not having childcare one day. So that's one option we have. When I looked at this, I wanted to see if it's impacting staffing, and it doesn't look like our sick calls have really gone one way or the other compared to this. So I've asked different people in different units and it seems to be a non-issue to the people that I've talked to. I'm sure that it is affecting some people, but I haven't seen a massive problem-

Trish Kritek:

Okay, that's reassuring and I appreciate the resource. Keri, did you want to add to that?

Keri Nasenbeny:

No. Yeah, I'm good.

Trish Kritek:

Okay. The last question I'll ask you is, and I didn't give you this one in advance because this is one that came in as we went. Have we changed how we're screening people as they come into our healthcare environments at whether it be clinics or the hospitals? Has that evolved at all recently or do we plan to change that? Keri?

Keri Nasenbeny:

Only thing we've changed, and this happened a while ago, is that we're not asking for vaccination status anymore. But other than that, we are still screening, doing symptom screening. And in fact, actually I think the UW MC campuses are moving away from the stickers and moving to the arm bands that Harborview has been using for the inpatient areas. I don't think that ambulatory areas will use those. Just doesn't make sense. So that's really the only change to screening people as they come in for symptoms. And then really encouraging that use of mask. I think that's probably one of the most key pieces of that screening is that encouragement of mask use.

Trish Kritek:

Mask use and screening for symptoms with an armband to be in parallel with Harborview. Jay, same thing? True still there?

Jay Sandel:

Yep, same thing.

Trish Kritek:

Okay. I will ask you one last question, Jay. We spent a long time last town hall talking about the census at Harborview and wanted to check in and see how things are going in terms of census, because I think a lot of people wanted to find out.

Jay Sandel:

I think census, it's really what perspective you're looking at it through. We're on the tail end of our trauma season, so we have seen a slight downward trend with our census. Still very high. I think we usually are trending around the 470s to 500s depending on what day it is. So it's still somewhat in a

state of fluctuation. I think we will really see how our census pans out more towards the end of September when we're out of trauma season totally. I think that's when we'll really get a true sense of where we're going to land moving forward with our census. So right now I would still say a state of fluctuation.

Trish Kritek:

Still fluctuating, still really high, less than it was at the highest when you went on divert. And maybe we're going to see some coming down as the season evolves. So thank you and thank you for all the work that folks keep doing in a really stretched system. Okay. Santiago, last town hall I alluded to, we talked about Harborview census a bunch, we also talked about monkeypox and I'm going to come to you. I know Shireesha answered some questions, but you've been a partner on that. Got a handful of questions. One of them I think is a similar one to ones that people have asked before, which is can monkeypox be transmitted on surfaces other than things like bedding or clothing? So on gym equipment or on things that people might be interacting with regularly?

Santiago Neme:

Yeah, thank you. That question does come up a lot. For monkeypox to really be a risk, you have to have that skin to skin contact and you have to have a time component that's prolonged, not so fleeting or transient like grabbing a doorknob or a dumbbell at the gym. At the gym getting, staph aureus would be more of a concern. So again, clean the equipment, wipe things, wash your hands, but it's not the primary driver of this infection and how people acquire this infection. We would have a lot more cases, and honestly, that's not the history that we get when we talk to our patients.

Trish Kritek:

Okay. So less of a risk, good to use good hand hygiene and wipe down equipment because bacteria are there and you can get infections like staph aureus. But in general, it's skin to skin contact that we're worried about.

Santiago Neme:

And prolonged. Yeah.

Trish Kritek:

Prolonged. I'm going to come back and ask John questions about flu vaccine and COVID vaccines, but I'm going to ask you, can you get a COVID vaccine and a monkeypox vaccine at the same time?

Santiago Neme:

Absolutely.

Trish Kritek:

Okay. And should healthcare workers be getting monkeypox vaccine?

Santiago Neme:

We're now actually seeing a drop, fortunately, in the number of cases. Today in King County, we have confirmed only 400 cases since the beginning. So as you could see, it was going up pretty fast initially and now it's starting to come down. The number of referrals we get are lower, the number of negative

tests are greater, so I think we're seeing a decrease. For the healthcare professional, monkeypox doesn't really represent a high risk really at all. Because number one, we're trained that whenever we are seeing a patient with a rash, we need to put on gloves. Because of COVID, we're masked all the time. We're also washing hands. We have good questionnaires for our clinics where people ask about new rashes. So the risk is really, really low in the healthcare setting. Now on the personal side, it's important to know what are the risk factors for monkeypox and what activities are linked to monkeypox. At least for now what we know. But yeah, so I would say the risk to healthcare professionals is extremely low, and also the vaccine supply is not great yet. So we still have some difficulty getting the vaccine and that's why we're doing all these popups. We had one at Montlake, we had one at Kent-Des Moines, and we're planning on doing more.

Trish Kritek:

Okay, so big things. Lots of things we do already protect us, including our masks, our hand washing and our gloves. And the risk is low for healthcare workers and we have a limited supply. So we're targeting the supply of the vaccine for the people who are at highest risk because of behaviors that we know are associated with high risk of transmission of monkeypox. So thank you. And I think that's reassuring and I think it's a benefit of the things that we do all the time, like wear a mask now too. One clinician asked, does monkeypox vaccine proctitis present with traditional monkeypox symptoms? Because I think people have heard in the news about people presenting with proctitis.

Santiago Neme:

Yeah. So sorry, the question is whether proctitis presents with other symptoms?

Trish Kritek:

Yeah. Will they have the other symptoms of MPV?

Santiago Neme:

So I actually discussed this with Shireesha too because she's seen most of our patients in the clinic, and she agreed that most of the time, what we see is that the proctitis is associated with other lesions or with the febrile problem first.

Trish Kritek:

Okay.

Santiago Neme:

It's rare to have isolated proctitis. She has seen a couple cases, but what happens later is that five days later you actually get more skin lesions. So they happen later, but they do happen.

Trish Kritek:

You see the same consolation just a little bit. There's a sequencing of the febrile illness, then you might have symptoms, then you might have more of the skin lesions, the pox that we talk about. Okay, thank you.

Santiago Neme:

Exactly.

Trish Kritek:

And thank you for the clinician who asked that question that made me have to read it off my piece of paper here because I couldn't just flow with it. All right. Keri, I'm going to come back to you for one question before I go back to John. There was a question that was written in about volunteers and volunteers coming back to UW MC. Do you know if there is a plan or a policy that's being discussed about having volunteers come back to the hospital?

Keri Nasenbeny:

I don't. And I told Katie that I would happily find help for her. So yeah, I will do some more research on that. I'm not sure on this. I think we have maybe brought some volunteers back in specific scenarios, but I don't know.

Trish Kritek:

Not yet.

Keri Nasenbeny:

Yeah. So let me find out and I will report back.

Trish Kritek:

Thank you. Appreciate it. Okay John, we're going to see how the basement wifi is. So I didn't ask these questions before, but I want to ask them now. There were number of questions with people having concerns about the data supporting the bivalent vaccine. And with concerns that, have there been studies in humans about this vaccine and is it safe? So I wanted to give you a moment to comment on the studies that support the use of this vaccine.

John Lynch:

Yeah. So the world we live in has changed a lot over the last two and a half years, and our approach to getting vaccines out to populations has also changed. Historically as we've all learned and now know that a lot of vaccines, we spent a long time going through lots of processes and we had this really accelerated, although complete approach to the first Pfizer, Moderna, the first mRNA vaccines that was very successful in the midst of the pandemic. Now we learned some of those things, what things work. What were associated with vaccination, they appear to be related to protection from disease from COVID-19. One of those things is like neutralizing antibody titers. Now we know that vaccines elicit immune responses for many parts of our immune system, but one thing we can measure are these neutralizing antibodies. How much of the antibodies out there that attacks the coronavirus?

We also learned a lot about safety really quickly. And now we've got lots of experience around the safety of these type of vaccines that in 2020 were brand new. And now we now got a lot of experience with the potential side effects. So I think one of the things we've learned is that we could use this technology, it's very safe, we can update it, and we have some markers that influence whether they work or not. So where are we? We recognize with all these new variants coming out in 2021 and especially in 2022 with the new first Omicron variants that we needed to start doing and the company started looking at and the scientists started researching. Things that would link back to those original experience. So things like what are the neutralizing antibody titers that we use in Omicron? What are the adverse event rates?

And we found that the new Omicron vaccines in humans was really well tolerated. We also learned that the neutralizing antibodies went up. And if we look back to the first round, we knew that those neutralizing antibodies appeared to be associated or correlated with some level of protection. We also learned over the past couple years that our immune response wanes, whether it's after an infection or it's after vaccination, and so with the coronaviruses, we knew we were going to need boosters. And we see with subsequent vaccinations really good data now, especially in the single or double boosted individuals, depending upon age, really great protection along with those neutralizing antibodies. So this is all leading up to answering your final question here, which is for the BA.5, the specific bivalent vaccines we have now, we actually don't have a lot of human data. We have BA.1 early Omicron data around the benefits, like the boost in neutralizing antibodies.

But for the BA.5, because we're trying to move through things very quickly, we're really relying on that experience we've had with prior vaccines, the mRNA vaccines, and animal data. And the animal data clearly demonstrate a boost in neutral antibodies against the BA.5 variant. And so what we've entered into is I think a new phase where we're balancing moving quickly, using all the data we've accumulated over the last two and a half years around safety and effectiveness around neutralizing antibodies as a proxy, to move quickly into new vaccines that have the potential to really improve our protection at the individual and population level as we move into this next winter season. So the alternative is to wait and go through some of the hoops that we went through before, but if we did that, we'd be looking at introducing vaccines months and months and months from now.

Trish Kritek:

Okay. So I think the short version of that is there aren't trials in humans and we're using data from animals, but we're anchoring on what we've learned over the last two and a half years about the response to these types of vaccines in terms of neutralizing antibodies, which we see in those animals, and the fact that these vaccines are well tolerated. And maybe most importantly that we know that we need to be nimble in this situation in order to get people a booster as immunity wanes and don't really have the time to do long trials like we did before. So I appreciate that. I think it's important for us to talk about it because I think people worry about it. And I also will say, I think we're going to be, as you said, moving into a new phase about how we think about these vaccines. Which brings me to the other vaccine that people asked about a lot, which is flu vaccine. So three questions. Do you know when they'll be available, can you get it with your COVID booster, and do we think it's going to be a bad flu season?

John Lynch:

Yeah, so first question, I think we're getting in our supply in the next few weeks. I'm hoping by the end of this month, we'll have a big supply and we'll be pushing those out as we do every year. So that's supply. Number two is can you get them at the same time? Yes. This question comes up because in prior years, when we're pushing out initial vaccine, we recommend people take a couple of weeks between the vaccines, but that was really to get that experience that I just referred to around, "Hey, how much fever, sore arm, so forth, fatigue was associated with the COVID vaccine versus influenza vaccine?" Now we know that data. We have it pretty well laid out, we've all experienced that in healthcare. And so you can get it, go ahead if you wish to get influenza vaccine and a COVID vaccine or booster at the exact same time if that's what you want to do. Recognizing that both are associated with a little sore arm, sometimes a little fatigue, sometimes just maybe not feeling awesome and you're just going to get a little bit of both when you have both at the same time.

But if it's easy for you, go for it. Get it done and move forward. The last question you have is, do we know what this next season is going to be like? No, we do not know. I've been tracking influenza



epidemics and pandemics for, this is my 12th or 13th year really concretely, and every single one has been unique and unpredictable. We have some data from Australia this year, which had a very large influenza season in their winter. They're in June, but it's hard to know what it's going to look like here. The things that have changed are that we have people in congregate spaces, indoor public spaces, schools are unmasked, right? Daycare is unmasked. We know these are all places where influenza transmits, but there's a lot of unknowns as well around the interference when you have COVID and you have flu in the same population. So I don't know, but we have to prepare as if it will be a big player this year.

Trish Kritek:

Okay. So coming in the next few weeks, can get them together, and don't know. Australia's had a fair amount of flu and maybe we will, but we'll see what happens. Get your flu vaccine. I got them together last year, it was fine. I'll just say that out loud. A couple last questions for you and a little bit of a potpourri. Lots of questions about masks, and as always, they go both ways. The biggest one though is are we considering transitioning out of requiring N95s in our-

John Lynch:

We are going to continue to recommend the highest level of respiratory protection you can comfortably tolerate in your job, your position and your activities.

Trish Kritek:

Okay, let me be a little bit clarifying on that. If what I feel like I can tolerate is a surgical mask, that is within our guidelines at this point in time?

John Lynch:

Outside of specific areas like the operating room or in direct patient care in the ED where aerosol generating procedures are done, where fit tested respirators are required, outside of those areas, if that's the best you can do, then that's what you can do. But the goal here is to get the highest level you can tolerate.

Trish Kritek:

I hear you. And so we're still recommending if you can tolerate N95, wear an N95. If you need to wear a KN95, wear that, et cetera. But outside of places where you need a fit tested respirator, we're saying where you can wear the best you can do comfortably. Is that fair?

John Lynch:

Yes. That's fair.

Trish Kritek:

Okay. I'm going to go back to boosters. I missed this one before. What is the recommendation for people who have long COVID and boosters? Are they recommended to get boosted? I think we have a number of people with long COVID.

John Lynch:

Yeah, there's no change in that. I will point out, and this is when we just think about boosters and the push we're having now, about only one in three of eligible folks in the United States have gotten boosted. There is a huge gap around this and a huge need to provide additional boosters to those individuals. So I know a lot of people on this call have friends and family who they share information with. Please share this town hall, the information, and try to get people boosted because those are really, really important. When I think about all of us on this call, I think most of us, not all of us have been boosted. Very different than what we're seeing out in the rest of the world and why things like this new bivalent booster is so important to get out there.

Trish Kritek:

So long COVID or not, it's good to get boosted. So I think that's good. It's important for people to hear because I think they're concerned.

John Lynch:

And link to that, there are some data, still early, that vaccination boosting specifically is associated with probably decreased rates of long COVID. And even when long COVID happens, less severe long COVID. And there are some data now emerging that somewhere between, I wrote it down here, one in eight to one in 13 people in the US have long COVID. It is a potentially massive, massive problem. That's somewhere around seven and a half to 8% of all Americans with long COVID. And that's a serious problem they're going to be dealing with in healthcare as well as our families and friends for many, many, many months, if not years to come.

Trish Kritek:

Okay. So first of all, I want to remind myself that maybe we don't want to call it long COVID, that we want to call it symptoms that persist after a COVID infection. But that's extremely common and there are data emerging that vaccines help prevent getting it. And vaccines are associated with a shorter duration of those persistence symptoms, if that's the case.

John Lynch:

Yeah. Or less severity, yeah.

Trish Kritek:

Or less severity. Thank you for that clarification. Okay. I think since I shorted Anne on a wellbeing message before, it's her time for ask an ID doc, and I'll give her the latitude to intersperse wellbeing into that or end with that, however she wants to do it. It's a new challenge for you, Anne. The floor is yours.

Anne Browning:

Hopefully I can rise to it. I will share a little bit about what I was thinking earlier in terms of a wellbeing message. I read an article earlier this week in the New York Times that just stuck with me and I wanted to share just a couple of thoughts from it. It was on the unexpected power of random acts of kindness, and it was by Catherine Pearson, if you want to look it up. But essentially, the kind words, the kind gestures, the smile we choose to give someone, we often stop ourselves short from doing those random acts. And the article was looking at the why, and it came down to this idea that we have this negativity biased towards human connection that comes out holding us back from really connecting with folks sometimes. And it looked at what gets in our way.

And what it said is that we tend to wildly underestimate the positive impact of a random act of kindness we can do for someone. And with that, we also sometimes get stuck overthinking how somebody might react or how it might be received. But by and large, the research, they said it in this article, it said that essentially that the acts of kindness we have, it's hard for us even to accurately think about how positive that can be received and how impactful our random acts of kindness can be on other folks. And to me, there's a second piece that they mentioned that we often actually underestimate just how powerful it is for our own wellbeing to be kind to others. So that dualing impact of getting connection between folks, making others feel better in ways that we often underestimate, and often underestimate how much we feel better when we show up and be kind.

And we know we've been in it, we've been in some really hard times lately and are still in them in many ways, but the kindness we can show to each other will help others and ourselves to really stay in community as we are pushing through a lot of heavy lifts right now. So that was my very quick wellbeing piece. Now I get to put John Lynch on the hot seat yet again. So I'll say at some point this summer, I think I made it through a day. And granted, I've lived my life mostly outdoors this summer when not at work, but I think I made it through a day without really thinking about COVID and trying to mitigate risks and having that coming to the forefront of my mind. And that's a big change. I mean, that's a huge change for me even from six months ago.

So there's something that feels fairly different about now. Now we're not post-COVID by any stretch of the imagination, but as one of my good colleagues recently referred to it as, we're through the scary phase of COVID for the most part, unless we have other health concerns that are weighing on us. So the big question, John, that's the overarching one, and then I'll get to some specifics. How are you living now in this post scary phase of COVID? What precautions are you still taking? How do you move through the world?

John Lynch:

Yeah, Anne, it's a really great question. I have an interesting perspective on it. I should say it's interesting to me, but may not to everyone else. But it's like I just returned from a trip with my family to South Korea and it was fantastic. We had a wonderful time. We've traveled internationally once before, pre-pandemic, and actually it was great. In South Korea, everyone wears masks in the airport, everyone wears masks indoor, public transportation, the subways, which we took every day all day, museums and so forth. It was nothing. When we went to restaurants, you wear a mask, the food comes, and this is actually the first time I've eaten in restaurants for real, was in South Korea and it was great. And then when you're done with the eating, you put your mask back on and the wait staff have masks on. And in part, I felt great about it because it worked really well.

Everyone was on board and COVID rates were really low. So even when you take your mask off, the risk was low. And it felt very natural and normal in many ways. And so I didn't think about COVID because I just did what everyone else did as a routine practice. And it actually felt very consistent with the way I'm doing most of my stuff. So here, it's funny, we haven't really reengaged in public indoor things like eating out. It hasn't clicked back in for my family yet. We have gone to a few films and we wear masks when we watch movies. When I go to the grocery store, I pull it out of my pocket and I put it on. I have to be clear, I'm not wearing an N95 in those places, I'm wearing a surgical mask. But I do it all the time.

It's just easy. And I think to some extent, relating to what you said, Anne, and I don't think about it, I just do it. It's just something that it's automatic for me. And I don't really think about COVID so much, I just think about wearing a mask. Now there is one place that I am a little bit, and this is where I maybe push my own boundaries, is that, as everyone knows, I like to go to a climbing gym a lot. And it's a big part of my community, it's where my kids practice, it's where a lot of my friends are. And when I'm on the walls

and some people on this call probably have climbed in there with me and seen me, I don't wear a mask in that space because I'm exerting myself. I know the ventilation standards in those areas, and it's the one place where I've decided that I'm going to take that bit of a risk. Now one of my daughters doesn't and my wife doesn't. They're very comfortable wearing masks in that situation. So we've hit of an equitableness there, but that's the only place where I really changed things in my life over the last few months.

Anne Browning:

I'm going to try and ask two quick follow ups, and I worry that this one won't be too quick. For parents who are concerned about their kiddos going back to school in a non-masking scenario, do you have any thoughts for them in terms of how to mitigate that concern or sit with it?

John Lynch:

No, because I'm struggling with it as well. I have two teenage kids and I want to respect their decision making. They know the risks. They have a doctor and a nurse as parents, and a lot of it has to do with proximity to other people. COVID in the facility, ventilation and social milieu, right? And you're right, we may be through, for some of us, the scary part, for many of us, it's still absolutely frightening and life threatening. But I don't have awesome advice, to be honest, for those folks. Aside from let's keep it front of mind, let's pay attention what's going on in the community and let's think about taking steps, like I said before on this, speed bumps. Maybe it's not school, but maybe it's when you go to the grocery store or go to movie theatres or on the airplane. Maybe it's not all the time, but it's ways that you slow down that one to one transmission.

Anne Browning:

Good. Last question. I think this one will be quick. I'll read it verbatim.

John Lynch:

Not with me.

Anne Browning:

"Is John getting the booster? Lol. I'll do what John does."

John Lynch:

Yeah, I'm going to get the booster. I think the safety profile looks good. The neutralizing antibody data look good even in mice. And I think it makes a lot of sense biologically to do this.

Anne Browning:

Awesome. John, thank you> Trish, I'll hand it back to you.

Trish Kritek:

Anne, thank you for rolling with a new format and thank you for the really wise words around wellbeing. And John, thank you for answering the questions. Thank you to the whole panel, as always, for coming together to answer the questions from our community and all the folks in our community who've asked questions. I want to pause for one second and say it's the beginning of a new school year in a lot of ways. We've had a lot of exciting things happen in UW Medicine recently that I just want to thank

people about. We have two new buildings for medical students to learn and one in Spokane and one here in Seattle. Thanks to all the people who are involved in making those buildings reality. I watched one of it grow in front of my eyes over the last several months. It's super cool. Congratulations to a whole group of new physicians assistants graduating from the first MEDEX program that is in Hawaii.

And congratulations to all the people who got to go there and celebrate that. I'd like to go next time. I want to say a special thanks to the folks who do have children who couldn't start school. It is hard enough at the start of a school year, it's really hard when school doesn't start. So a special thank you to all of you. And then I want to say congratulations again to Keri. I think this is a great opportunity and I feel like the continuity of continuing the stuff that you've been doing at Northwest and the partnerships across the system are great in doing this. And a very special thanks to you, Jay. Jay to step in into an interim role in the setting of lots going on between census and pandemic and staffing, it was outstanding that you did that, and our community is so much richer for you having stepped in that role.

I know Keri's not letting you go anywhere, so we may still see you at town hall, but I wanted to personally thank you for all that you did for so many members of our community and for our patients and our families. And I'll end by thinking everybody out there, as I always do, for continuing to take care of those patients and families. And as we go into new phases of the pandemic, so important to continue to keep doing random acts of kindness and continuing to take care of each other. We'll see you when we come back together next. Thanks so much. Bye-bye.