

Trish Kritek:

Welcome to UW Medicine Town Hall. I'm Trish Kritek, Vice Dean for Faculty Affairs. And with us today we have John Lynch, Head of Infection Prevention, Employee Health at Harborview Medical Center. Tom Staiger, Medical Director at UWMC. Anne Browning, Associate Dean for Well-Being. Keri Nasenbeny, new title, Chief Nursing Officer at Harborview Medical Center, welcome in your new role. Cindy Sayre, Chief Nursing Officer at UWMC. Tim Dellit, interim CEO and Dean of the School of Medicine and Leslie Hampton, interim Associate CNO at UWMC Northwest. And you might notice there's somebody I didn't introduce yet and that's because we have a special guest today and that's Dr. Kim Stone who is the Associate Chief of Operations and the Clinical Director of the Emergency Department at Seattle Children's. And she's joining us today because wow, there's a lot of kids with respiratory viruses and they're impacting...

John Lynch:

Well that's a first.

Tim Dellit:

This could be a major problem for Town Hall today.

Anne Browning:

She's right through the wall over there so I can... I'll go check on her and then she can come present from my office if needed. One second.

Tim Dellit:

I think what Trish was trying to start to say is that we invited Kim Stone to join us here today because of the significant increase in RSV that we're seeing within our community and the impact certainly being seen at Seattle Children's. And so we received a number of questions regarding that and so again, we are really pleased to have Kim join us here to be able to share what's happening there and answer some of those questions that we received from all of you. Perhaps while Trish is trying to either rejoin or join. Anne maybe we can start with a well-being message.

Anne Browning:

Absolutely. I just checked in with Trish through the wall and her computer shut down magically during the start of Town Hall. So welcome everybody. Well-Being message. We're about to run the gauntlet of another holiday season and for many folks this will be one that has spent around more people than has been the last couple years. And I've been thinking about the holidays and doing so common themes that come up as general kind of excitement and stress and often those two things happening close to equal measure. So I've been thinking about why are the holidays stressful. I'm sure there are different reasons for all of us, but one idea I was thinking about this week is that when we come back together as a group, whether it's family or friends, we tend to revert to expecting each other there to show up as we were the last time we all hung out.

But a lot of times passed and we have likely changed quite a bit as have the folks we're likely to holiday with over the next couple months. So maybe we can give them and ourselves the gift of being curious about how folks have changed and give folks permission to grow and show up differently than they have. And maybe with that some of the stress will be replaced with some positive energy of meeting folks in new ways and building some new rituals around how our holidays are shaped and what's to

come. So whatever you're raising a glass to in the next couple months, a cheers from all of us at town hall and may you find some very cool things in the people you've known for a long time. With that I see Trish's back so I'll hand it to her and then I will also see if she wants to come in and just present from my computer if that's easier. Trish, how you doing?

Tim Dellit:

Yep. Trish, as we have seen throughout the pandemic, we are adapting and flexing now you just have to figure out how to unmute yourself.

Trish Kritek:

I think I'm unmuted and I think my computer is kind of working again but not entirely. So I'm going to start from here and try to switch over. That is a first in all of these Town Halls. Kim, I'm not going to attribute it to you being here, but it was in the midst of me introducing you that the computer Gods did something. So sorry everybody, that was kind of crazy and thank you so much for being so adaptable. Wow. Okay. I'm going to start off and I'm actually going to start with John because it's easy and he's used to it. So let's start with you and we'll go to Kim maybe relatively shortly after John. But John, can you talk about numbers of COVID for right now across UW Medicine?

John Lynch:

Sure. So COVID inpatients right now across UW Medicine we're at 30 patients, which is up from the last time I spoke to you. We have 24 patients in acute care, six are in the ICU. UWMC's got six folks in acute care, one in the ICU. Northwest campus has seven in acute care, one in the ICU. Valley is at seven as well on acute care, one in the ICU. And Harborview has four people on acute care, three in the ICU and one of those acute care patients is in our behavioral health unit.

Trish Kritek:

So a little bit up from where we've been but not dramatically different. Two questions. One is, are we sequencing the viruses in our labs and so do we know what kind of variants we're seeing of the folks that are getting admitted to the hospital or maybe even just in the community?

John Lynch:

So we don't do sequencing of our patients who are in the hospital, but our UW laboratory medicine team is actually global leaders in this area and do a huge amount of sequencing and contribute not only to looking at what's going on here but nationally, internationally. And so we do have data on that. I think most of this data probably most up-to-date is at the national level through the CDC variant tracking dashboard. And so yeah, we do have a lot of good information on what's going on out there and that's impacting lots of really important decisions we're making around things like therapeutics and other decisions.

Trish Kritek:

Do we have a sense of what variance we're seeing in the area?

John Lynch:

Yep, so if we look at that dashboard, so just to, again, ground people in these terms, everything I'm talking about are Omicron variants this whole year. So the January surge was BA-1, this summer surge

was BA-5, and what we're seeing right now is BA-5 is being pushed aside as more infectious, more transmissible variants emerge and this has been the same story throughout. And the variance we're seeing now, so BA-5 is probably down around 30% of all the variants. This is sort of a rough estimate because of the time delay and so forth. But around 30% of everything out there is this BA-5, which we've dealt with all summer. And what's really emerging are two other variants, BQ-1 and BQ-1.1, which are both around 20-ish percent. And then there's another one called BF-7 which is around 10%.

So what we're going to be seeing is this BQ-1 and BQ-1.1 as the predominant variants, but I want to be cautious here. And when I say that and that there's actually a whole bunch of variants at much lower percentages and it really feels like we're in a different phase where we're really what people are calling the alphabet soup variant phase of this. Where we have lots of different variants with a few really standing out and we're going to have to see how they battle it out and which ones will emerge in the coming months.

Trish Kritek:

So as opposed to before when we saw one Delta wave, everyone was getting Delta, now we're seeing a bunch of different variants of Omicron. Appreciated. Relevant to all the different soup, one of the questions we got was about reinfection and what is the risk of being reinfected as we see different ones. I think there are folks who sent in questions and actually sent links to papers. I sent you the link to one of them. So maybe you could speak to the risks associated with reinfection.

John Lynch:

Yeah, so this is actually a pretty difficult and challenging question to answer because it depends on lots of things as it often does in medicine and epidemiology. It depends upon what variants you're exposed to. It depends upon what your vaccination status is. It depends upon whether you've been infected before and with which variant. So I think that the take home here and what we understand at this point is that being boosted protects you from infection at some level, not as good as it did way back when, but still at a reasonable level and definitely helps prevent serious COVID disease, so hospitalization and death.

The issue about reinfection is hard to sort take apart. And I think what that paper that you sent to me was a study in the VA administration data looking at almost 6 million people and looking at reinfection. And I think the take home here is a little bit challenging but what a lot of people read of that is that getting subsequent infections is like additively worse. And I think that's not what is the take home message. The take home message is that if you get infected, there's a whole host of things that could happen to you. You can have mild infection, asthmatic infection, you can have serious infection in some proportions we will go on to develop long COVID symptoms that persist after infection.

And the issue is that what that paper showed us is that there are people who get reinfected and all those things can happen again. And so getting reinfected is worse than not getting reinfected and we know that vaccination interrupts reinfection or infection to begin with. So it isn't so much that getting a second infection's worse than the first one, it's just the getting COVID twice is worse than getting it once and once is way worse than getting it not at all, right? Does that make sense?

Trish Kritek:

I think so. I think the big take homes are one, as you said, boosters help, you can get infected with after you're boosted but it helps you from getting sick with infection. And every time you get infected you can either have no symptoms, mild symptoms or severe symptoms. So if you get infected multiple times, that risk of those different outcomes is there each of those times.

John Lynch:

Right.

Trish Kritek:

Okay. Thank you. I think that was actually very clear. So thank you for going through that.

John Lynch:

Thank goodness.

Trish Kritek:

I do have one other follow up for you and that is how about boosting and long COVID. Because I think a lot of the things that people are worrying about now is it seems like you don't get quite as sick if you've been boosted, but what about long COVID?

John Lynch:

So this is another really challenging area. So I think the bottom line up front here is that a lot of people who get infected get long COVID. The issue is we haven't firmed up what the definition of long COVID is. So that's one challenge here, exactly what it is and there's no lab test for it so we still have to figure out what we're calling it. But a lot of people having long-term symptoms, well past, weeks past their acute infection, it's happening a lot more than we ever would've guessed. And we know that not getting infected means you're not going to get long COVID. So being vaccinated, boosted, protecting you for infection, protect you from severe disease is going to protect you from long COVID. So there are data now that even with breakthrough infections in people with COVID, so you're vaccinated, you get a breakthrough infection compared to people who are not vaccinated. There is now a few papers out there and again we need a bit more data but our signaling, there's a good signal that being vaccinated and having a breakthrough infection has a lower risk of long COVID.

Trish Kritek:

Okay. I think that-

John Lynch:

That's a really good take home I think.

Trish Kritek:

Yeah, I think that is the take home and yes we will continue to gather data but in general the data suggest if your vaccinated and boosted now fully vaccinated and boosted that you are less likely to get long COVID.

John Lynch:

Right.

Trish Kritek:

Okay, that's great. Last question for you before I pivot to Kim for a few. I meant to ask this last week and or last time I forgot, that the King County COVID dashboard has reflected that there's higher rates of cases, hospitalizations and deaths among folks who are boosted and people are like, "Is that right?"

John Lynch:

So again-

Trish Kritek:

It's complicated.

John Lynch:

No. So yeah, I love you throwing all these questions to me. So here again, bottom line up front. If you look at the populations of folks who end up in the hospital and the folks who end up dying, they're not the same as everyone else. If you look in King County, the people who end up in the hospital and people end up dying are people with risks. So people and one of the biggest risks is age. So people as they get older are at higher risk and you know, look at the populations who are vaccinated and or boosted and those aren't separate. So people with higher risk, people at older age groups in our area, this isn't true everywhere to be clear, are more likely to be vaccinated and boosted. And so when you have a lot of people who are boosted, more numbers are going to end up in the hospital.

But the take home here, and this is the really important point, is that if you look at the rate, you take that number and you put it over, the total denominator being boosted or being fully vaccinated is highly protective for those groups. So if you look at just hospitalizations, the one you asked about the rate of hospitalizations among boosted individuals is 0.17 per 100,000. The fully vaccinated 0.13 per 100,000, which are basically the same. And if you're not fully vaccinated for that same for hospitalization is 1.3 per 100,000. So being fully vaccinated, being boosted is highly protective against being hospitalized. And same thing for people who are dying from COVID, highly protective.

Trish Kritek:

So the reason that we see... First of all the rates are higher for hospitalizations and for death for people who are not fully vaccinated. And we see higher numbers of people who are boosted in these hospitalizations and death because so many of the people around us are already boosted. That's the majority of the people around us. So I appreciate you clarifying that and I did give you a bunch of hard questions to start with. So thank you for doing that and I'm going to pivot to Kim and start easy. So that-

Kim Stone:

Thank you.

Trish Kritek:

You're welcome. But I'm really grateful for you joining us and I'll just say now and I'll say it again and grateful for your leadership in a time of a lot of stress in the emergency department and throughout Seattle Children's. So can you tell us about the numbers like John, I just asked about COVID, but in general the numbers that you're seeing in the ED and being admitted to Seattle Children's with you know, RSV and other respiratory viruses.

Kim Stone:

So probably you've been hearing a lot through news media through our own internal channels about the skyrocketing rates. We are seeing unprecedented volumes coming into the emergency department. So just for comparison, the best year for us to compare to was 2019, given all of the weirdness with COVID and pediatrics as it originally started. And on average we would see in Seattle Children's Emergency Department about 130 to 140 kids per day. That's new arrivals coming into our emergency department every day. A busy day was about 150, so peak winter volumes were somewhere in the neighborhood of 150. You might get up to 160, 170 was really, really, really, really busy. We are so far beyond that now. Our busiest day ever was during H1 N1 several years ago and we peaked at 250 patients at that time. We now, and it's climbing each week, we now are routinely seeing somewhere in the neighborhood of 250 patients per day, new arrivals showing up in the emergency department. We just, last week the average was more like 230, we're going up each week and we peaked just under 300. We're going to cross the 300 threshold sometime here fairly soon at about 293 new arrivals per day. Our census how many patients we'll take care of in that total 24 hour period because that includes the midnight to midnight time is well over 300 patients in a 24 hour.

Trish Kritek:

That's nearly double.

Kim Stone:

Exactly. I was going to say we've nearly doubled our new arrival daily and they're continuing to rise.

Trish Kritek:

And I know that your main focus is the folks who are coming in the ED. Can you reflect on what the admissions or the census is at Seattle Children's?

Kim Stone:

The hospital census also has been climbing, I mean I think the highest census that I've heard from us is somewhere in the neighborhood of 330 for the hospital census. So the hospital has been opening new spaces, refurbishing old spaces and repurposing spaces as fast as they possibly can. And so the hospital capacity is running over 100%, we're adding new rooms so that we're not hitting quite 100% but really over 100% daily. A lot of this right now is RSV. Our rates of RSV are skyrocketing somewhere about 40 to 50 ish percent. I'm trying to remember numbers off the top of my head. Of all of our lab tests that were done for the entire hospital over the last couple of weeks have been positive for RSV. I can tell you that at any given time you look at the census in the ED, about 50% of them are there pure respiratory illness.

Trish Kritek:

So this huge doubling is really driven by respiratory illness and it sounds like the majority of it are is RSV. And one of the questions that came in from a lot of people is, and we've touched on this, but why do you think we're having such high numbers right now?

Kim Stone:

Yeah, so we've had during COVID we've had little bits of RSV peaks. We usually peak more like January, February and that timeframe. So I think, and I will look to infectious disease and immunology people that might know better, but I think what we're seeing really is the fact that kids haven't gotten sick as much over the last two to three years. And so it's just like John was saying in terms of a new infection,

their immune systems haven't seen this, they haven't had a chance to develop any immunity from this. Most kids usually will have had RSV infection by the time they're about two to three years old. That's a typical viral illness that a young child will have. And so you have children that were born during the pandemic and have gone through the pandemic and really never seen this virus as well as some of the other common ones.

We're talking a lot about RSV but we're seeing flu rise, I'm sure you guys are as well. We were hit just very recently, it's kind of a little bit on a down trend now, but enterovirus D68, which caused a lot of respiratory symptoms in kids. So there's a lot circulating right now and we just haven't had much onus in kids over the last two to three years. So now masks are off, kids are in school and they're transmitting and it's spreading. I think about it as if anybody's had a kid that the very first time they put them in daycare and they keep getting viral illness after viral illness or the first time they go to kindergarten, we often get a slew of families that come in at the end of September, the first time that they go to kindergarten, they're like, "They've been sick for a month," and they just get repeated viral illnesses. This is what's happening but on this giant scale, because everybody's been a little bit naive to illnesses over these last two to three months.

Trish Kritek:

So people haven't been exposed and now everybody's getting sick and some of those folks are getting sick enough to be in the hospital. And in a former life I was a first grade teacher's aide for a year and I live that experience. I got every bug there was known to man. And so I can completely relate to that. So you said that most folks are coming... a lot of the tests are positive for RSV. Are you using rapid testing for RSV and rapid testing for COVID and influenza all at the same time? How does that work?

Kim Stone:

Yeah, the platform that we use is a combined rapid COVID, flu and RSV. We have started. So that is our rapid, we don't do just the rapid COVID or just the Rapid RSV we-

Trish Kritek:

All together.

Kim Stone:

... have the three. But because space is at a premium, we're actually cohorting admissions as well. So we actually are doing as a baseline, another rapid platform that actually includes some of the other common illnesses. So parainfluenza, the influenza, all of the influenza viruses, coronavirus, rhinovirus, enterovirus. So that way we can cohort patients and families to preserve space. So we're capturing a lot, especially for our admitted population. We're capturing a lot of the viruses that are out there right now and they're all there. I'll tell you they're all there.

Trish Kritek:

So you're doing rapid testing for RSV, COVID and influenza plus a broader spectrum of viruses because when you say cohort, what that means is patients and their families being in similar spaces or in group spaces for care because things are so tight and I'll just-

Kim Stone:

Yeah, because some of our rooms are double rooms, you want to have patients and families rooming with light viruses so that they're not going to catch something else. So if we need to use double rooms, which we do.

John Lynch:

Trish can I just add one quick thing to this.

Trish Kritek:

Yes please, John.

John Lynch:

Really good demonstration of how the vaccines are working around COVID because these kids aren't coming in with COVID yet they are getting other respiratory tract, other respiratory viruses. And I think this is a real world example of the power of the vaccines in these pediatric, the smaller population. So I think it's just real world experience.

Trish Kritek:

I appreciate you saying that. Thank you John. And I think that that is a really good point that I think you heard, said Kim, maybe some COVID but that's very tiny compared to how much RSV you're seeing.

Kim Stone:

Yeah, we have a small Rs, I didn't grab our numbers from today before I got on this call, but we've been in the single digits for patients with COVID and for the most part for pediatrics, it's not primary COVID disease. They have a co-infection, they're being admitted for another reason and they happen to have COVID.

Trish Kritek:

Yeah. Are also COVID positive or SARS-COV-2 positive. Okay. I'm going to ask you one more question now I may come back as we pivot around and this one's a little bit philosophical. So I usually tell John he can't wax on too long. I'm going to give you a little latitude on this one. And that is, can you speak to the impacts of lots of kids with viral infections? Obviously there's the impact on that individual child who's sick and particularly if they have to be admitted to the hospital, that's a big deal. But what are the downstream effects of a kid being sick?

Kim Stone:

Yeah, I mean think that we're all feeling already the staff shortages, but across the board on a give... I'm trying to remember right after school got back into session, we had a couple days where our nursing staff and other groups, they had a giant number of call outs and we actually did a little bit of an investigation and figured out that for the majority of the staff that were calling out, they had kids sick at home and they couldn't come to work. And so you do, you have teachers who are of course being infected just like as you said when you were a teacher's assistant, Trish. As well as healthcare staff, as well, who are not being able to come to work. And that just of has a ripple effect through everything. And also everybody's testing for COVID and paying attention to symptoms. But of course as we all know, people, kids are infected and back in school and what have you before they might have symptoms and all of this, so the transmission is happening very rapidly.



You're seeing kids and whole classes that are coming in and saying that, "Oh yeah, I got to notice somebody in my class or some of my daycare, whatever has RSV." And so it's rapidly transmitting and then you're seeing all the effects of having a system that needs parents to stay home to take care of them.

Trish Kritek:

I appreciate you speaking to the impact on the many parents who are parts of our system as well.

Kim Stone:

Absolutely.

Trish Kritek:

Okay, I'm going to ask you, Anne's harassed me to ask you two rapid fire questions. These are rapid fire now though.

Kim Stone:

Rapid fire. Okay.

Trish Kritek:

The first one, is there a risk of RSV reinfection and if so, how much of a risk is that?

Kim Stone:

It's not as high. So common cold you get reinfected frequently with, there is some immunity built up. So John can sort of chime in probably a little bit more. I say I never say never, but it's not a frequent thing that you'd see.

Trish Kritek:

Okay. And if you have more to say about that, John, I'll come back to you in a little bit, but the other real quick question Kim is, what are the age groups that you're seeing most commonly?

Kim Stone:

Yeah, this is a great question because this is different this year. So the vast majority of years RSV affects two and under most significantly the younger you are, the sicker you tend to be and some complications. But because we have older kids, school age kids four to eight that may never have really encountered this because of the pandemic. This is a whole new population of kids that we're actually seeing with RSV type illnesses. And I hear actually from my adult colleagues that they're seeing adults also getting RSV and getting sicker and having sort of more respiratory viral, lower respiratory viral illness as a result of RSV than in past years.

Trish Kritek:

Okay, that's super helpful. So usually we think of RSV being kids who get really sick, the little less kids and now we're seeing a broader array. And John, I'll just follow up with you. Thank you Kim, so much.

Kim Stone:

Of course. Thanks.

Trish Kritek:

I will follow up with you with just one question real quickly that Kim just prompted, which is are we seeing RSV and influenza in our adult populations now?

John Lynch:

Yeah, so we're definitely seeing influenza. Just a quick snapshot is over this week I think we had six people hospitalized with influenza at the Montlake campus, at least one at Northwest. Three or four at Harborview. So severe enough to be hospitalized, definitely see in the outpatient setting. RSV, we haven't seen them inpatient as much for the reasons that Dr. Stone mentioned, but when these tests are done, we have the same sort of tests where we do flu, RSV and COVID. We actually have, because we're biased away from kids in UW medicine to some extent-

Trish Kritek:

We're not biased against kids, but-

John Lynch:

No, not biased-

Trish Kritek:

Just wanted to clarify that.

John Lynch:

Our testing is, we're adult centric and so we are actually seeing more positive adults.

Trish Kritek:

Oh, interesting.

John Lynch:

Hundreds with RSV, since this respiratory virus season started. Actually way more than even kids, despite seeing both. And historically, like Kim said, it was really a kid infection and now we're seeing it, a lot of it in adults.

Trish Kritek:

That's interesting. So more adults, starting to see flu in adults and even some patients admitted with flu. I'm going on service in the MICU on Monday, so things that I'm paying attention to particularly. All right, thank you John, I'm going to come back to you and Kim in a bit probably. Tim, I'm going to come over to you and I ask him that question about the impact on folks because I think we got a series of questions about still feeling the impact of the pandemic and maybe it's feeling the impact of other things too, like RSV and whatnot. One specific question we got was whether there was any chance that the UW COVID emergency fund could be revived, because I think people are feeling the financial pressures still as well.

Tim Dellit:

Yeah, just a couple of comments and again, there's information available on the university website as well. So with the end of the state of emergency by Governor Inslee on October 31st, there was a message that was sent out for those last applications for the emergency funds to be submitted by October 14th. Now that's from the university perspective. We do have some residual emergency funds within UW Medicine that we received from donors and we are looking at how can we use those funds particularly to support wellbeing efforts for our community, our faculty staff, trainees. I don't think there's going to be an extension of emergency funds just because of where we are in this phase and hopefully emerging from the pandemic, recognizing it is still really challenging from a financial perspective, particularly from many of our employees given the inflationary pressures. But I think we're just trying to figure out, okay, the formal process is done through the university, how can we best utilize those residual funds to best support our people?

Trish Kritek:

Okay, I appreciate that. So that fund ended when the emergency from the governor ended and so that's closed and there are some other funds that will be thinking about how we will continue to support our community with a focus on the wellbeing of our community, which I very much appreciate. We appreciate hearing about what's happening at Seattle Children's and our faculty, many of our faculty from UW School of Medicine, our faculty at Seattle Children's. How does UW Medicine check in with what's going on at Seattle Children's?

Tim Dellit:

Yeah, I think that's a great question. I mean certainly on the medical staff leadership there's communication so that we have a sense of what is happening and we've done that throughout the pandemic. We would have communication with the leadership at Seattle Children's. Our infection prevention teams are constantly in communication around what everyone is seeing. I think one of the challenges is that Seattle Children's is really challenged from a capacity standpoint. Our other hospitals within UW Medicine, even though we may not be seeing as much RSV, we're still continuing to be challenged in over 100% capacity as well. And so this is one of our concerns and we knew this going into the respiratory season, that our hospitals across the state are at capacity. And so there's just not that wiggle room in the healthcare system in general within the state in terms of where do we flex to try to help one another when all the hospitals are facing similar capacity and staffing challenges, even if they're slightly different causes.

Trish Kritek:

I appreciate that ongoing communication we try to keep that communication open and finding a bed anywhere around right now is so hard, whether it's in Seattle Children's or any of the other hospitals that we talk about as part of UW Medicine. Thank you. I'm going to ask you, we actually didn't get many questions about Mission Forward, but I did get one that I wanted to follow up with you on and that was a question about what is the connection or lack thereof between Mission Forward and Fit. That was an initiative that we had earlier, is that ongoing, are they connected? Could you clarify that?

Tim Dellit:

Yeah, no, that's a good question. Fit was based on kind of financial transformation pre 2019. I think it started back in 2017 when we also faced some significant financial challenges. Through the pandemic again, and then coming out here with Mission Forward, I would see these as not necessarily an extension of Fit because there are some shared similarities in terms of how do we ultimately sustain our

ability to really advance our mission, to serve our communities and do that in a fiscally responsible manner. But they're really, I would say, Fit as sunset. But those principles, some of those principles are still important within Mission Forward when we think of supply chain as an example. How do we, where it makes sense, standardize our processes, become more efficient in the care that we deliver? How do we try to decrease cost where possible while also really looking at those growth opportunities from a revenue improvement? And so it's not one and the same, but there's some shared principles and I would consider Fit sunset at this point and focus on the Mission Forward work.

Trish Kritek:

So FIT has sunset focused on Mission forward, some similar principles and we'll talk more about Mission Forward as we get more questions about it. But I thought that was a good thing just to clarify. Okay, I'm going to keep popcorning around so you're off the hook for a little bit, but I have more for you because I have more on the list there. I'm going to follow up with Tom because Tim just commented on the census and we got some questions about the census. And so the simple question that came in a couple times is has our census at Harborview or UWMC improved at all?

Tom Staiger:

I can comment on the UWMC census and we are continuing to operate at high levels of census and higher levels of census than we did last year. And I expect that to continue for the foreseeable future for at least a couple of reasons. One is the number of patients with complex illnesses that would benefit from our unique services seems to be if anything, growing. Second is, as Tim alluded to there, there's a great number of other facilities that are having challenges fully staffing their beds. And we know at least anecdotally that there are some facilities that aren't utilizing all of their beds because of staffing challenges. And that leads to those facilities when they've got very complex patients reaching out to us that much more often. So we are continuing to operate at very high levels and that is going to continue for quite some time.

Trish Kritek:

So I think this is what we're thinking we're going to have to keep working with and for the reasons you just described. And I think also continue to think of ways to try to mitigate it. So is there anything new that we're working on to try to mitigate the pressure of that census?

Tom Staiger:

Yeah, I think we are making some progress. We are continuing to identify and implement best practices in terms of the throughput of our patients to try and standardize and use our capacity as well as possible. Figure out how to overcome barriers to get patients out when figuring out how could we provide procedures in a timely manner when that might be holding up their progression. And some meetings have occurred just this week around that question. Other things we've done, and it really just started this week, is a huddle around high census. So when our ED gets to a certain level of capacity at either of our campuses, a group comes together to figure out what can we do. Where can we board patients? How can we identify capacity that we can utilize? I think we're doing a better job partly because we're getting more practice at it, in figuring out what do we do when we get to these really high levels of census and how can we manage in a way to have the least negative impact on our patients as well as on our staff who's working at taking care of these patients.

Trish Kritek:

Yeah, I appreciate that. So some of them are long term strategies to try to expedite throughput, making sure people get the things they need to get while they're in the hospital as quickly as we can do it safely, and also these real time coming together to try to strategize. Yeah, I appreciate that. This is going to be an ongoing challenge and I also appreciate that ongoing work to come up with new strategies to try to mitigate some of this. I'll ask you one more question. We had a couple people who were curious about how we're doing with vaccinations amongst our medical staff and then I'm going to ask our nursing leaders the same about our staff.

Tom Staiger:

The Dan I got just this morning for UWMC across both our campuses shows that 82% of our medical staff, we have a record of them receiving their flu shot and their COVID Bivalent booster.

Trish Kritek:

Okay.

Tom Staiger:

That's an underestimate of the actual numbers. There's some data entry time lag, there's people who have gotten their vaccines who haven't responded to the emails. There's a little bit of list cleanup of people who no longer work here that will winnow out. So it's north of 82% and we're working on getting it up to 100%.

Trish Kritek:

Okay, so we're at 82% and Cindy, maybe I'll turn to you next. Where do we stand with staff at UWMC?

Cindy Sayre:

Yep. So we have 82% of our staff current on their flu vaccine and 75% on the COVID booster. And I think to Tom's point there's also been a data entry, I think you said this data entry lag. So there people can be getting these vaccines outside of our system and it's taking, as you can imagine, our employee health team time to catch up. So I think we actually are doing better than that, than those numbers.

Trish Kritek:

So 82 for flu, 75% for COVID booster. We think we're lagging on actually knowing that truth. Does that cover both campuses, your number?

Cindy Sayre:

yes.

Trish Kritek:

Okay. Keri, how about at Harborview?

Keri Nasenbeny:

Harborview's also at 82%. It's a magical number today. We still have some work to do with COVID, though I agree Cindy and Tom that this is an underestimate. We're only at 50% compliance with the COVID booster here at Harborview, so definitely have some work to do in that space. We're actively working with our teams to get that number.

Trish Kritek:

Okay. So 50% right now with the COVID Bivalent booster and some work to do there and 82% is the number on flu vaccines right now, evidently. Okay, we'll come back to that, another Town Hall, I got this question and these are the kinds of ones I love. Can we open up the water fountains in our hospitals and clinics again? And so I'm going to ask each of you, Leslie, are the water fountains open at Northwest?

Leslie Hampton:

No, and we don't really have plans to open them at this moment. I think if we could have a wave of magic wand, we'd have those water bottle fillers replacing all of the water fountains. But no plans right now.

Trish Kritek:

No plans right now. Cindy is the same true at Montlake?

Cindy Sayre:

Same for now.

Trish Kritek:

Okay. Keri Harborview?

Keri Nasenbeny:

The water fountains at Harborview have been open since May of 2021. I don't have any of that context, but I think John does. And Vanessa said that, Vanessa Makarewicz she's our Infection Prevention Manager and nursing guru here said, "That we felt like it was safe and just needed to flush those before," obviously we're using those.

Trish Kritek:

Okay. So sounds like John agrees with that. And so it sounds like we have a disparate water fountain practices. I'm going to guess this person works either on the Northwest campus or at Montlake. And I guess I would challenge us to think about whether or not there's opportunity there. I'm not sure water is important, safety is important, both are important, but differences in practice. And so more to come. The other question I have for the three of you, and maybe I'll turn, look to you, Cindy. We've talked about a lot of work to recruit and efforts to bargain and have our incentives to hire people or to keep people. And one of the questions we got is what are we doing to incentivize our non union employees and staff? And so maybe you could talk to that a little bit and then I'll let Leslie and Keri add to it.

Cindy Sayre:

Yeah, sure. Well, I think it is really important, and we've learned this lesson that the salaries that we offer need to be competitive in the community so that we can attract and retain the best healthcare team. So without a doubt. We had almost every one of our contract was bargained in the month of September and our compensation team did incredible work to run through each of those contracts working tirelessly.

Trish Kritek:

Yes.

Cindy Sayre:

They are. And then there's a group of people that weren't covered and were aware of that, whether it's pro staff or classified non union. And so they're looking at those positions now, but it takes them time to do all of that data. To gather all of the data, look at the community comps and decide how UW Medicine is going to proceed. I don't know, Keri, if you would say it differently.

Keri Nasenbeny:

Yeah, I mean, I guess the only thing I would add is that I wish we had more information to share. Unfortunately we just don't have anything quite yet. But certainly we have that information. I think this is a top priority for all of us, is ensuring that our wages are competitive and that we're keeping our staff and able to recruit new ones.

Trish Kritek:

So what I heard was a lot of focus on all of the bargaining that we needed to do and it was a priority and that's a lot of time and energy and we're already shifting our focus to looking at the folks who weren't part of that negotiation. And that's an ongoing series of efforts to make sure that we're being as competitive as we can be for all of the employees that we have. Does that sound about right? Okay, Leslie, I didn't give you a chance to add, is there anything you wanted to add? You're good. Okay. Thank you so much. All right, now it's time to go back and ask some more questions. John, I'm going to turn to you for a minute. Had a bunch of questions about masks. So N95s and aerosol generating procedures. So I think we've said many times that you need to wear an N95 if you're doing an aerosol generating procedure or you're in the room. But how about in the spaces around where those are happening? Are people-

John Lynch:

Really it depends upon the spaces and how people move around those things. So for example, at the Harborview PACU, there are AGPs done in that space. It's basically a lot of PACUs, essentially one very large room. And so our requirement is that everyone wears an N95 in that larger space because there's no way to constrain where the AGP is happening. Now you can definitely make an argument that say as you distance away the risk drops dramatically because of air handling, ventilation, filtration and so forth. But with something at PACU, everyone's moving around and so it doesn't really work well. So we've looked at each of those spaces and tried to make it fit, not only the risk to healthcare workers, other patients, but also the space and how people move. And so that would be the take home.

Trish Kritek:

So in general, if you can compartmentalize it, then it can be in that compartmentalized space. But if it's a big open space, we're saying everybody in that area needs to wear an N95. And I think we've talked about this before, but one person asked, where can I find the most recent masking guidelines? So I'm going to start with that question.

John Lynch:

So all of our intranet sites have a COVID-19 button on the front, or you go to the infection prevention and control site on the intranet and there's a COVID-19 button there and our masking policies are available there. They're all kept up to date and they're consistent across UW Medicine.

Trish Kritek:

Intranet COVID-19 button, that's where you can find them.

John Lynch:

Yeah.

Trish Kritek:

Thank you. And right now, a question that we get every single Town Hall is are we thinking about stepping down the requirements on masks?

John Lynch:

Like Tim said earlier, we look at all this data every single day and think about all of these questions every single day. Again, bottom line up front that you like Trish, no, we're not changing any of our masking requirements. And it has to do with a bunch of things. One is the COVID rate out there remains, the transmission level remains, high. So there's a lot of COVID still going on. We have patients who come in who don't appear to have any symptoms and there are found subsequently who can have COVID. I do not want any employees getting COVID in the course of their work.

We aerosol generative procedures can happen on people with no symptoms who have no previous testing and can have COVID and then we know that could create a higher risk there. So at the moment we want to keep that in place. In addition, for all the things that Kim talked about, there is a lot of RSV out there, there's a lot of enterovirus out there, and there's an increasing amount of influenza and masks stop transmission of all of those things when we wear them universally in healthcare settings. So it feels like it's even better reason for universal protection and source control with masks right now.

Trish Kritek:

I appreciate it.

Tim Dellit:

I just wanted-

Trish Kritek:

Go ahead Tim, yeah please.

Tim Dellit:

I was just going to emphasize that too. I mean I think many of us think this is going to be a really challenging respiratory virus season. We're seeing this already, not only the magnitude of cases but early, as Kim was mentioning at Seattle Children's. And whether that's going to go up and hopefully plateau, but will it sustain over a prolonged period of time? We just don't know. And even if we don't see as much COVID-19 coming in, I fully expect we're going to see more influenza and we're going to see more of these other respiratory viruses. So I think changing and going away from universal masking at this stage as we go into this respiratory virus season further just doesn't make a lot of sense. And I think we're going to... I would think, and again, it's up to John and Seth and all of the team, but it's probably going to be a reassessment once we get to the other side later in winter, spring. Quite frankly, just being realistic in terms of what we're seeing now.

Trish Kritek:



I think it's good to set expectations that we think it's going to kind of hold steady the way it is. I will ask one follow up question to that, John, because it's a question that is always a follow up question.

John Lynch:

Sure.

Trish Kritek:

The distinction between universal masking and wearing N95s and I think that the current guideline is the highest level of protection that you can continue to wear while you're doing your work. Is that right?

John Lynch:

That's right.

Trish Kritek:

Okay. So some people are going to be wearing a surgical mask because that's what they can tolerate and we're hoping that if you can wear an N95, you wear an N95, is that.

John Lynch:

That's right.

Trish Kritek:

Okay.

John Lynch:

Yeah, you got it.

Trish Kritek:

Okay. You've only told it to me 20 times so I finally got it. So good. One question for you and then I'm going to go back to Kim for a quick one and Tim for a quick one and then hand it over to Anne. High dose flu vaccine, who should get it?

John Lynch:

Oh, you asked me this question and I forgot to look it up. I haven't asked this question for a while, but I think Tim was it, it's over 50.

Trish Kritek:

I love how you just said asked you Tim.

John Lynch:

Tim forgets he's an ID doctor too. He's an ID doctor too.

Trish Kritek:

Okay, someone's going to put it in the chat and we'll say it out loud. It's good.

John Lynch:

People my age or older, I think.

Trish Kritek:

That's a great guideline. Everyone older than John get a high dose.

John Lynch:

Everyone who's indicated should get the high dose.

Trish Kritek:

We'll clarify that one.

John Lynch:

I totally spaced on that. Sorry guys.

Trish Kritek:

That's okay. No worries. It's all good. Kim, I kind of think we've answered this but I feel like I want to ask it to you because it came in a couple different times and that is people are like, "Well since kids haven't been exposed and now they're getting infected, should we just get them exposed? Should I have my kid go play with other kids and not worry about it and not wear a mask?"

Kim Stone:

Well I think this is a complicated question and I think the answer to that really is unique to each child and each family. I mean there is a burden of disease that is born by the child and by the family and you can't predict that your kid's going to have a mild form or a more severe form. So the idea of the chicken pox parties or what have you as well as then the transmission. So there's a balance between wanting to have kids interact and have that social interaction and be part of a family and do family things Thanksgiving's coming up, being part of the gatherings and things like that. But that whole, hey let's go get everybody and just like, let's get it over with. I mean that's a huge burden of societal disease. And then you can't predict what your kid's going to do with any of these and then you don't know what that impact is going to be like on you and your family as well.

And so I'm fully in support of families getting together, but we've learned through the pandemic how you can safely mitigate these things. If you are feeling sick, then stay home. Because yes, we can test for COVID, but we don't have as universally widely available tests for RSV, flu and all of the other things that are out there as well.

Trish Kritek:

If you're sick stay home. You probably don't have an RSV party. It's that risk benefit of you need your kids to be with other kids and socialize and we also don't know what's going to happen if you get infected. So yeah, some caution. I appreciate that it's nuanced and I appreciate you talking it through. Okay Tim, I'm going to squeeze one more in for you because I forgot it last time and it's totally different and I invited all kinds of questions. So what is the strategic goal for continued partnership across WWAMI? And the person asked that question in light of the fact that it's the 50th anniversary of WWAMI.

Tim Dellit:

Well that's a long question, but WWAMI was created about 50 years ago, first in Alaska, then Montana, Idaho, and then in the nineties Wyoming was added. It was built on partnership with local organizations. And with that in mind, I actually just want to acknowledge the real tragedy that we're seeing in Moscow, Idaho, and the death of the four students at the University of Idaho, which is our partner there. And so those relationships, whether it be University of Alaska, University of Idaho, Montana State, University of Wyoming, those partners are critical as are all of the volunteer faculty that we have throughout the WWAMI region that help provide supervision and training and education for our students. So we can't do this alone.

WWAMI is built on partnerships with the local institutions. We have shared faculty particularly in the foundation phases, and then we really rely on the local practitioners and local healthcare systems to help train our students. And then we also have residents within WWAMI in the same manner. And so the partnerships are critical. Now I do think WWAMI will continue to evolve over the next 50 years, but it has to be built on partnerships with the local organizations and people.

Trish Kritek:

First of all, great job on a short answer on a whole huge topic and I really appreciate you calling out what's been extremely traumatic for folks in Idaho and including many of our students. And so thank you for acknowledging that and it's been a scary and distressing time. Okay, Anne, I'm going to hand it over to you. I think it's still Tim. So Tim, I think you can keep yourself unmuted for ASCA and ID doc.

Anne Browning:

Thank you Trish. Okay, so we had a couple questions come in around the ASCA friendly infectious disease doc, really around holidays and then kind of learning to live with COVID-19. And in that kind of learning to live with COVID-19 section, it really came down to this idea that we've been recommending masking and ways to kind of mitigate transmission, but people are seeing fewer and fewer folks masking up on planes and conferences and galas. And so it's creating a bit of a stressful scenario for folks to try and figure out what should they be doing versus what is humanity in their local area doing right now. So I'm curious, how are you navigating the nuances of masking? When do you decide when to mask and when not to right now?

Tim Dellit:

Yeah, no, that's a great question. And it's easy at work within our hospitals and clinics where you know that you're going to be wearing a mask and I still wear a mask when I come into work, when I meet with people, even in my office using a mask. I think outside of the work environment, it's really that risk balance. You've got to think about, okay, as an individual, what are my risks for more severe disease? Who are the individuals that I may be around? And I have to say my mindset has shifted a little bit in part because with COVID-19, when you look within our region at the relatively high rates of vaccination, boosters as well as if people haven't been vaccinated and boosted, then they may have had natural infections. So we have pretty good baseline immunity and so we're seeing a little bit less severe disease around here.

I wear a mask when I go to the grocery store. I wear a mask when I go to most stores. I will say back in mid February or mid October, there was a gala that I attended and I did not wear a mask there. Now I did look at what were our local rates of transmission at that time as part of that, but it was a judgment call in terms of what did I feel comfortable doing there. And so there are some environments where I

haven't worn a mask as much as perhaps I would have a year ago. Now where we are though a month later with the respiratory viruses going up, if I were going to that same gala, I would wear a mask.

So there's a little bit of a difference of what's happening within the environment. I can say when I go to the airport, I still wear a mask. On the plane, I still wear a mask and I probably am not going to change that for quite some time. But I fully acknowledge there are some times when I have now not worn a mask where perhaps a year ago I would have.

Anne Browning:

I agree with that. I've sensed that myself. I'm going to get to see my parents over Thanksgiving, so I'm being a little bit more cautious right now, in this build up to actually seeing folks who are older adults in my life. But I sometimes have worn a mask less frequently when I know I haven't been around, won't be around any kind of higher risk populations in the foreseeable future. But yeah, still mask around the office mostly because we don't want to get Trish sick. She's like our holdout on not having COVID around here, so we have to stay strong. Would you, I'll ask one or two specific ones. If you went to an outdoor concert like Taylor Swift, would you wear a mask?

Tim Dellit:

If it's outdoors, probably not.

Anne Browning:

Okay. Indoors like Lizzo, would you mask?

Tim Dellit:

I did. I'll confess, I went to the Dave Matthews-

Anne Browning:

You did.

Tim Dellit:

... concert and I did not wear a mask. Now I've had a non COVID cold the following week after that, so I probably paid the price for that, but it was a judgment at the time and so I'm doing my whole confessional here.

Anne Browning:

Yes. Okay. So a little more Dave Matthews and Lizzo. I probably don't know if I would've guessed that, but I probably could have. Last set of questions here in the last minute I've got with you. Thinking about the holidays, folks are wondering, should they take rapid tests before they go hang out with family? How much do you trust them? Is that a good kind of policy? What would you recommend?

Tim Dellit:

Yeah, I think the rapid tests are much more available now. There's probably not a lot of downside to doing them, especially if you know that you're going to be around individuals like grandparents or people who may have higher risk factors for more severe disease. I'll be honest, the characteristics of the tests, again, if you're not having symptoms, they're not that great compared to if you have symptoms I think they're more reliable. So I wouldn't say that I personally test every time before I may

interact with someone, but I think again, you have to think about who's going to be at that family gathering. And especially because grandparents are often there, it's not an unreasonable thing to do testing, or you can do testing for a few days going up to that to increase the proportion of capturing something. But everyone has to make that judgment. And I think the other piece is that you want to make sure that everyone who's at that gathering is comfortable.

So is everyone who's there comfortable not being masked? Or there may be some individuals who feel like they will mask either, again, because they have underlying risk factors. Maybe they're a little bit older and that's okay too. And so I think that's the biggest piece here, is to be able to have grace for people to make decisions based on their own assessment of risk. And again, I feel like we're in that transition phase compared to a year ago, two years ago is very clear cut. Now it's much more of that individual decision making, particularly outside of the work environment.

Anne Browning:

Cool. Thank you, Tim, with that Trish I'll hand it back to you.

Trish Kritek:

Thank you, Anne. Thank you, Tim. And now, not surprisingly, we know Tim would prefer Dave Matthews to Lizzo. I'm going to end by saying thank you as I always do. Thank you. Special thank you to Kim for joining us and for all the work you're doing to take care of the patients and families at Seattle Children's Hospital. Thanks to all the panelists. Thanks for the questions that folks send in. And I just wanted to reflect for a minute that I was reflecting, I didn't hear Anne's wellbeing message today, but I had a guess of what she might say about the holidays. And I am working in the medical ICU at Montlake for this Thanksgiving. And the last time I did that was in 2019. And I was kind of sad about it, to be honest. It was a hard holiday for me to work.

And I find myself feeling entirely different about it this year. And part of it is because I feel like one of the greatest lessons of the pandemic is that we're able to celebrate and make it work in a lot of different ways by being creative. And so creating community and being with each other, we make it work however we need to. And I thought about it and I was like, the nurses have done that in the medical ICU for all of my career. They have always made, and all the other people too but really, the nurses. Have made Thanksgiving, really Thanksgiving or Christmas, Christmas or Hanukkah, Hanukkah or whatever it is that you're celebrating, really a holiday because we care about each other and because we care about patients and families who are celebrating important days in a way that is not ideal. That they're in the hospital when they don't want to be in the hospital.

And it's even harder on holidays. So I want to stop by saying a special thank you to everybody who's going to be working over this holiday and other holidays over the next several weeks. Because it's because of you that patients and families can make it feel as good as they possibly can at a really challenging time. And it's because of you that people like me are like, "It's okay to be working in the hospital over a holiday because I'm with the people who make it special." So thank you all as always, for continuing to take care of our patients and our families and doing special duty as we move forward to take care of each other. Thanks, and we'll see you again soon. Bye.