

Trish Kritek:

Welcome back to UW Medicine Town Hall. I'm Trish Kritek and it's a pleasure to be back with you. Happy 2023 to everyone out there in UW Medicine.

As it is on many town halls, we have the same folks that we always have, minus Tom Staiger who's away this week.

So welcome to Santiago Neme, medical director at UWMC Northwest; Tim Dellit, our interim Dean of the school of medicine and CEO of UW Medicine; John Lynch, head of infection prevention and employee health at Harborview; Keri Nasenbeny, chief nursing officer at Harborview; Cindy Sayre, chief nursing officer at UWMC; Rick Goss, medical director at Harborview; and Leslie Hampton, interim associate CNO, UWMC Northwest.

Thank you all for being here. It's great to see you all again, and again, happy New Year. And with that, we'll kick off, as we always do, or at least when I remember it with Anne Browning and her wellbeing message.

Anne Browning:

So happy 2023. When the whole pandemic started, I remember joking with Trish that if and when we ever made it to 2023, I was planning to take a long sabbatical to catch up on all the living that I felt like we were missing out on.

But over time a kind of strange thing happened. We learned how to live and really how to live pretty fully in a pandemic. We adapted and life is different, but there have been some really beautiful moments along the way and as we welcome 2023, I don't feel as though I've been missing out on living the last couple years, but part of my prediction of that 2023 moment has felt kind of oddly on point and in many ways in which we moved through the world, it's felt closer to their kind of pre pandemic selves than previously.

And it's been interesting to reflect on this January on the year that's passed and it's had me thinking about where we were just 12 months ago with Omicron. And a year ago today, I actually just pulled this up, we had 188 positive patients in our system and King County transmission rate was at 1800 per 100,000 over seven days.

So I am thankful for just how different today and this January feels, but COVID is still here and we're still adapting and learning to thrive in this environment.

Well, I might not be planning my giant extended sabbatical in 2023. I'm still really grateful to be able to plan time to connect with family and friends near and far and importantly to really continue to rebuild some more community and connection within UW Medicine.

So cheers to you all as we start 2023, and I'm looking forward to hopefully seeing more and more of you face to face as we move through the year.

Trish Kritek:

Anne, thank you. I want to say all the work that you've done certainly warrants a sabbatical and I'd like to keep you around. So let's strategize on that before you decide suddenly to take a sabbatical. But in all seriousness, your message resonated with me and I think that spirit of also needing to take a breath and happy to engage in a new year that seems a little brighter is actually really nice. So thank you for that.

Anne mentioned COVID, I'm going to stay true to form. Though, I will say that we had a really broad array of types of questions that people asked. So we're going to start off talking about COVID because

that's kind of where we've always been anchored and then I'm going to broaden beyond that as we move forward.

So John, I'm going to start with you and maybe you could just start off by talking about where we stand in our system about COVID, patients with COVID and numbers.

John Lynch:

Sure thing Trish. And thanks Anne. I actually had... I think my heart rate went up about 50 beats a minute when you talked about last January's numbers. I'm still recovering a little bit from that comment, but I appreciate everything else you said except that part.

So across the system right now we have 58 patients as of earlier this morning who are hospitalized with or for COVID within our UW Medicine four hospitals. At Harborview, we have 17 folks, two in the ICU; Montlake has eight with two in the ICU; Northwest has 11 with four in the ICU; and Valley is up to 22 with one person in the ICU. So again, overall 58 total with nine folks in the ICU and the rest in acute care.

Trish Kritek:

We used to have town halls all the time and so people could feel how that's changing. And I just wonder if you could give a little bit of perspective on how that is compared to the last few weeks or month or so.

John Lynch:

Yeah. And so, within UW Medicine people think back to sort of September of this year. We get down in the kind of 20 range for all of the hospitals and I think...

Santiago may recall better. I think we've even had a day or two with no COVID patients at Northwest. There were a few and there were fleeting but they happened. And so, it's definitely been a trend upward, which we can certainly talk about.

Trish Kritek:

Yeah, okay. That's kind of how it feels I think in general for folks and I think people are probably hearing about people who have gotten COVID recently. Before I leave the local numbers, do you have any data on Seattle Children's?

John Lynch:

Yes, actually thanks to you Trish. We got some messages here from Dr. Shugerman over at Seattle Children's.

So they've, as we all know, have been struggling with a lot of infectious diseases, lot respiratory tract infections. So over there they are seeing a slight increase around COVID-19 cases, but they continue to really... their big challenges continue to be influenza and RSV although much better than they were.

They've definitely come down from a very, very intense peak both with their inpatients but also their emergency department capacity.

Trish Kritek:

I appreciate that and I thank the folks at Seattle Children's for sharing with us because a lot of our faculty and learners and trainees are over at Seattle Children's, so we want to make sure we know what the environment is there and it's nice that it's a little bit better.

We got some questions about now that that testing has evolved and maybe people aren't testing as much or they're testing at home, how do we feel about understanding like King County numbers or national numbers when we talk about COVID?

John Lynch:

Yeah, and I think that's a really important question, Trisha. Remember there's three major numbers or metrics that we've been following throughout the pandemic that I think have each of them strengths and weaknesses.

One is the number of cases, one is the hospitalization rate, and one is the death rate. And each of them, as I said, have different challenges. So as you mentioned, when people aren't testing as much or are using antigen or home-based tests and not reporting them, our ability to know what's truly happening in the community in terms of actual infections is very limited.

There are data, I've mentioned some past town halls that we may be catching something around one in 25 infections out there, so probably less than 10% of all infections. And so, when we look at the rates... And mentioned, last January when we're doing tons of testing and tons of asymptomatic folks and we really didn't have a lot of access to antigen testing, that was a pretty useful number.

Now, we're down around 80 per 100,000 in King County. In general though, it does reflect the shape of the trend. So that number goes up when our case counts go up, our hospitalization rates go up, and our death rates go up and it comes down.

So the trends I think are useful in case counts, but we've really... And what I tend to use as a much more useful number is our hospitalization rate and the death rate.

And so, our hospitalization rate, again, follows those same trends but I think is a much more accurate indicator of how big, how fast those numbers are changing over time.

So for instance, right now we're about three and a half per 100K hospitalizations, per 100,000 in King County; and about 5.2% of all of our hospitalized or all of our beds are occupied by someone with or for COVID.

And we had come down to just in terms of that percentage, November down around 2%, so doubled the number of beds in King County are now occupied by folks of COVID-19. I think that's a much more... That's the number we can really track much more accurately for all of us. Yeah.

Trish Kritek:

That's really helpful. I think what I heard you say is the actual numbers of cases or that case per 100,000 isn't as useful as how it changes with time. And we're seeing that go up and that tracks with how many people we see hospitals where we can actually trust the numbers more, and those have also gone up. How about the death rate? What does happen with the death rate?

John Lynch:

So if we actually look at the death rate across King County, and this is true across really the United States, we've seen it been unfortunately stably elevated and actually increasing recently. It's kind of gone up and then maybe come down a little bit but up over that low point we had in the fall.

One of the things that's really evolved over time is increasing separation with who's ending up in the hospital and who dies. And what we're seeing are folks over 70 years of age predominantly be the ones ending up in the hospital. The next group are over 60 years of age and it sort of marches along with age like that.

And so, we're seeing a bigger separation in the hospitalization and death rate associated with age almost like we were seeing before we had access to vaccines. If people remember back in 2020 we saw the same pattern with older adults getting sicker and having the worst outcomes. And many ways, we're back at that as more of the population has either been infected, been vaccinated, or both, and protecting them particularly in younger age groups.

Trish Kritek:

So we're seeing that pattern of older folks more commonly getting hospitalized and really sick if they are going to get sick with COVID. I appreciate that and I think it's good context for people as things continue to evolve. I'm going to ask you a handful more questions before I pivot.

John Lynch:

Sure.

Trish Kritek:

The one that we probably got the most questions about is the current picture locally around this new variant that people have been talking about and I wondered if you could give a little context on that.

John Lynch:

So Trish please as you usually do, if I get too nerdy on this, please reign me in.

Trish Kritek:

Yes.

John Lynch:

So all the variants we've seen since basically January of 2022 or all Omicron variants including right now. And we've gone through a whole host of different ones with all kinds of numbers and letters that are hard to remember.

The big one last year that Anne was referencing was BA.1. The big summer phase was BA.5, and there were a bunch between all of those. And then over this fall it was a mix of a whole bunch of different variants.

You may have heard of these BQs and BA.7s and all these things. And what we're really looking at right now is sort of the emergence of, we're going back to one big variant that's really starting to kick in and knock out all the other ones, which is different than we were in the fall. And that variant is when you may have heard it in the news as the XBB1.5. I've heard of this Kraken term use.

Trish Kritek:

I've heard it called Kraken too, which I think is disturbing.

John Lynch:

I don't think that's official. I do not think that's official, but you may-

Trish Kritek:

And I don't like it.

John Lynch:

Well yeah, I don't know if the hockey team feels about it but the... You may have heard that way, but what they're referred to as XBB.1.5 and this is a homegrown US variant.

It's still in that big Omicron soup, it's kind of related to BA.5 and similar in terms of its structure and its genetic structure. And what we know right now is that it's really displacing all the other variants, particularly in the northeast and mid-Atlantic where it's the predominant strain now.

And what we've seen with other situations like this, other sequencing of the variant spread is it will probably start displacing those other variants as it moves westward.

Right now here, you look at... The United States actually wrote this down. Across the US, about 43% of all variants or this XBB. If you go up to that region one, region two, that northeast section, it's about 82% of all the variants out there are XBB.

And here Washington, Oregon, so that what we call region 10 is around 8%, so a lot lower than we're seeing in the northeast. It's actually a very broad range between over across the country, but I expect that XBB to sort of march across and displace other variants and we'll probably be the one we'll be looking at for the coming months.

Trish Kritek:

So new variant, XBB.1.5, dominant variant particularly in the east and potentially going to move here, not really the case here yet. And then one last question about it, focus question, what is different about it?

John Lynch:

Well, all these variants, there's the sort of genetic variation where they develop just different mutations that make and then that lead to their biological impact. And I think that's the problem.

Trish Kritek:

That's what I really mean. What's different for us as people because-

John Lynch:

You know what -

Trish Kritek:

... transmissible, do people get sicker?

John Lynch:

So what it means is... Basically, the take home here is it's more transmissible. Every time a new variant comes out and displaces other variants, it just is able to out-compete the ones that are there already. So it's able to just transmit more easily and that's a lot of different reasons that happens.

The good news right now just... I do want to emphasize, right now no evidence, it's more pathogenic and right now it looks pretty good, especially the Omicron boosters, those bivalent boosters which hopefully everyone on this call has availed themselves of, looks like really good protection against it still just like the BA.5 and other Omicron variants.

Trish Kritek:

Okay. So big points: more transmissible, doesn't look like it makes you sicker, and the bivalent booster seems to be protective against it.

John Lynch:

Yep.

Trish Kritek:

I think those are all really important to hear and I want to emphasize, I wasn't suggesting that ID doctors weren't people, I was just suggesting the average person, what's their understanding of this?

Trish Kritek:

Thank you. I have a follow-up question that's relevant to what you just said though.

John Lynch:

Yeah.

Trish Kritek:

Is there a new booster on the horizon and when will we expect it?

John Lynch:

So I have not heard of any new booster on the horizon. As I said, there are more and more data, we may get to this later if we have time, but there are more and more papers coming out demonstrating the real world effectiveness of the booster vaccine.

So again, I want to send home a very clear message. The real benefit of COVID vaccines is a primary series plus the booster. That is really where the win is here and it's like you haven't gotten that booster, that's what you want to do because it's going to protect you against hospitalization, severe disease, and death, and everyone around you from infection.

So really, really powerful and more data's coming out around it. And right now, I haven't heard about the need for either re-dosing that same booster or a new booster.

Trish Kritek:

Okay.

John Lynch:

But I would also like to point out just in case, I don't want to forget this, is that in December the booster got approved for under fives. That may be a later question but I just want to package it up right now.

Trish Kritek:

No, that's fine.

John Lynch:

If for six months, the four years old, the FDA approved it on December 9th. So again another great population of folks who can be protected not only just from infection but also reduce their risk for transmitting to grandparents and other folks in their family and their community.

Trish Kritek:

So I think that's great. I'm glad you included that. So really important thing is the booster seems to work and that's the thing that's probably most protective and now small children can also get that booster. So very helpful.

Last question I'll ask you right now and I will come back is relevant to what you just said. Are we still seeing asymptomatic transmission? Are there still people who are not symptomatic and transmitting? And I think it's relevant to the kid part of it too.

John Lynch:

This is a really fascinating question Trish, because there's still so much to learn about this virus and how it moves around and the changes in variants and our changes in our immune responses.

There's lots of people out there who have been infected, lots more people have been vaccinated and are boosted and so forth. And so, it's actually a very challenging question to answer.

I pulled up a few papers and it looks like depending upon whether there's a big surge or in those lower times, there's a paper that came out of Japan where they looked at screening and when there's no surge, sort of like where we were in the fall when numbers are low, in testing, they found about 0.03% of people had a positive test when they're asymptomatic.

When there was a search, it went up to about 0.3%. So in both cases less than 1%. There was not another study done in Canada where they just did screening of all the students in a high school and they actually found almost the same numbers, 0.3%.

Trish Kritek:

Okay.

John Lynch:

So it's out there, it happens. We know that people asymptomatic can transmit and in fact I just took care of a patient in the hospital this last week who came in completely fine, for another reason.

They actually came in for a surgery, we do our screening test, his was positive and we check what's called cycle times. It sends a proxy of how much virus was there and he had a lot of virus.

He felt completely fine at the time of testing. He felt completely fine throughout his entire hospitalization, and he was obviously put in the right space and we used all the right PPE and kept everyone safe.

So it was a great outcome but really fascinating to see someone who felt perfectly well with a very positive test even happening right now, and a person fully vaccinated and boosted by the way.

Trish Kritek:

Okay, so can happen, you just had it happened. But the numbers are pretty small-

John Lynch:

The numbers-

Trish Kritek:

... of people are very asymptomatic and I think that that's helpful numbers and consistent across studies.

All right, there are more COVID questions to ask. I'm going to pivot because I... Questions we got from people across the community kind of covered lots of different spaces.

So I'm going to broaden out today and I'm going to go to Tim, you're up next. And Tim, we got a handful of questions but I'm going to paraphrase into one question which is: what is the current financial picture for UW Medicine?

Tim Dellit:

Great. No, thank you, Trisha and welcome everyone. Happy New Year, as we head into 2023 as Anne mentioned.

So through November, the UW Medicine hospitals lost roughly \$136 million, \$92 million at UW Medical Center, \$28 million at Harborview, and \$16 million at Valley.

And when I think of why we are in this state, and I would say that all healthcare systems across the country are facing many of the same challenges. I think there are some that are unique to UW Medicine simply because of our role within our state and our region; particularly as a safety net, organization, caring for the most vulnerable within our communities as well as the most complex.

In FY21, as an example, we did \$729 million of uncompensated or under-compensated care. The number of projections just came out for FY22 and that is now over \$800 million, and so for our unique role as a safety net for our state.

Our teaching mission training 65% of the residents within the state of Washington, the staffing challenges that we have talked about, and the expenses related both to contract labor but also the increases just in the labor market.

And again, I want to emphasize, we absolutely believe that all of our employees should have a fair and equitable raise and so our earnings, be able to live where they work. And so, those increases I think we want to support. But the rapidity of that rise in the labor expenses is outpacing the revenue and creating challenges.

And then the last, as we've talked about here are those patients who are ready to go to that next level of care and be discharged from the hospital. But the lack of post-acute care availability has been challenged and that as Harborview has experienced, when 20% of your patients are medically ready for that next level, that creates challenges both in terms of access and the cost of carrying those patients is far more than what the reimbursement covers as they stay within our hospitals. So all of those collectively have created a significant financial challenge.

Now, what are we doing about this? And I think of this in big buckets. So one of them is around FEMA recovery, so the reimbursement for the expenses related to our response to the pandemic over the last three years. And I do have good news there. We believe by the end of this fiscal year, so by June, we should receive at Harborview roughly \$91 million; at UWMC, roughly \$77 million.

Now, that's one time funding, but it definitely helps bridge during this period of time. We also are very fortunate to have creative finance team. Our government relations last year worked on a new payment program through the legislature and with the healthcare authority that essentially brings federal dollars into the state to reimburse us for that difference between what we get for a Medicaid managed care and average commercial in the outpatient setting.

That was approved by CMS in December for Harborview and UWMC. That will be roughly combined \$90 million per year ongoing. And so, again, for this fiscal year, UWMC should get about \$32 million of that. Harborview will get about 13 because it's \$45 million in the half a year that we have left.



Now because of the success of that, we're also working with the legislature now this year on an inpatient directed payment program that if we get that approved by CMS next December we'll be 120 million per year. Again, won't start till January of 24, but we're already getting that in the works.

Trish Kritek:

That's great.

Tim Dellit:

We have big work ahead of us in the legislative session. I will be spending a lot of time in Olympia over the next few months. We have big ass, one of them is \$100 million in what we refer to as a secondary supplemental budget. The good news is that was in the governor's budget.

Now, we have to continue to work to ensure that it stays there. We also are looking at the one time funding that we received in the last by ENIUM of \$40 million in trying to make that permanent, recognizing our role as a safety net and our teaching responsibilities within our state and region. So, those are very important.

Trish Kritek:

Can I interrupt just to summarize that part because I know you want to say more, which I love, but there's a lot for me to keep track in my head.

So what I heard so far is: still really challenging nationally and locally, and the good-nings are a payment from FEMA, which is significant and one time, federal money to cover the difference between Medicaid managed care and commercial; that difference, which is going to be around 90 million; and then a lot of work to get some extra money from the state, both one time a hundred million hopefully, and then enduring. All right, so keep going. Is that right? Did I get all that right?

Tim Dellit:

That is correct. And I just want to highlight, even those numbers seem big, even when you add in that outpatient payment program, you add in FEMA, UWMC would still be projected to lose more than \$60 million by the end of this year.

So there is still a significant gap there, which is why we're working with the legislature. Ultimately, we recognize that these expenses are going to continue to go up both with the labor market, inflationary pressures. And so, while these numbers that I've talked about are helpful to get us through this short period of time, fundamentally, we have to change how we do business and adapt to this changed healthcare landscape that we find ourselves coming out of the pandemic. Hence, the mission forward.

And again, as I mentioned before, the mission forward, to me, is simply how do we continue to serve that unique role within our community and how do we do it in a sustainable manner going forward.

So where we are with that engagement, which is absolutely critical with Huron is they will complete their full assessment later this month, beginning of February, we'll then move into the design and implementation phase, again, working with everyone and everyone's input as we go forward.

However, recognizing the critical need around our cash in the short term, in December, we launched our 90-day plan that is really running from mid-December through mid-March.

And the things that we are really focusing on, and the teams are huddling literally every day, absolutely pushing these as quickly as we can, looking at where those opportunities from a revenue cycle standpoint, meaning how quickly can we bill, collect, work through denials, work through those work

clues, and get pre-authorization for the surgeries and procedures that we do, what can we do from an access standpoint?

Now we started that work before the pandemic, but we're accelerating it now as we come out of the pandemic working directly with the clinics to really ensure that we're using every available spot to increase access for our patients and getting them the care that they need.

What can we do to maximize our utilization of fixed resources such as operating rooms until we can build more operating rooms, which we do have plans over the next several years, but until we can do that, we have to be very efficient in the use of our current rooms.

And this has been an ongoing effort, but we are, again, escalating that to ensure that we really utilize every minute if possible within the ORs. Some of that simply becomes, if someone has a last minute change in their plans that they're not using their block of time in the OR, how do we quickly get that filled so that it doesn't go unused? How do we ensure that we turn around rooms in a timely manner between one case and another to maximize our efficiency?

We're also working with our workforce and the good news here, we've talked about contract labor before being with our nurses upwards of 20, 22% at UWMC and Harborview being travelers. In November, we did see a reduction by 2%.

Now, that may not seem like much, but that is very important in terms of both that plateau going down. We haven't seen December numbers yet. Those should be coming out any day and I'm hoping that that will continue to go down and reduce our contract labor.

One of the good news here, and I look to our CNOs here is that... my sense is that we are, right now, able to hire more permanent staff than perhaps where we were a few months ago.

And so, really working on what is that onboarding, getting those new permanent staff in place because we recognize that's important from continuity of care, from our teamwork, not to mention the finances.

And so, we're doing everything we can to really shift contract labor to more permanent staff when possible.

Trish Kritek:

Okay. I asked that one question and you answered about 10 of them, so that was great. Thank you for all of that wisdom. So I just want to see if I can capture what you just said, which is-

Tim Dellit:

I'm in a lot of conversations around that question.

Trish Kritek:

I love it. So I think what you said was: okay, we have this concept called mission forward.

Tim Dellit:

Yeah.

Trish Kritek:

Predominantly, we're finishing the assessment phase, but we're also doing things right now which include an emphasis on making efficient billing, collection, pre-authorization to be paid for the work that we do in a timely fashion; access for patients, which is good for patients and it's good for us because then we can get people in and get the care that they need; maximize utilization of the places that we

have to deliver care, including our operating rooms; and decreasing our contract labor as we work towards having a more stable workforce.

And that's the short term stuff, not the bigger picture stuff, which we'll come back with as that assessment completes. Is that about right?

Tim Dellit:

It is. I would say a lot of these sprints and the 90-day will continue into that full assessment as well.

Trish Kritek:

Okay.

Tim Dellit:

Absolutely.

Trish Kritek:

Okay. But we're getting going early, but they'll keep going on. Okay. I have a bunch more questions for you, but since you mentioned our chief nursing officers, I'm going to pivot to them for a second and ask a follow-up question.

And I'll start with Keri, do you want to comment on what Tim was just asking about in terms of our evolution in terms of contract versus more permanent hire staff?

Keri Nasenbeny:

And of course I would also welcome Cindy and Leslie chime here. I think hiring is... I know one of our top priorities for all the reasons that Tim mentioned. We really need to rebuild our teams and fill the need and gap, we really want our own team members on our teams.

And so, we are seeing I think some incremental improvement. It's still less than perfect and it's still a highly, highly competitive market that really hasn't changed.

So we're doing everything we can though to be really sufficient in our hiring and making sure that we're not losing candidates because they're getting picked up very quickly.

And so, making sure that we're reaching out the day they apply, make contact, interview and really get that process moving. And then I think also on the onboarding side, making sure that really smooth and good learning for our stuff. So not perfect though seeing some improvements, and I think we're also trying to improve our process to match the market.

Trish Kritek:

Okay. I'm going to have you lean into your microphone a little bit more, but I think what I heard you say is that we're working on efficiencies in terms of when people apply, getting them in and then once they're hired, getting them working so that we can deal with a very competitive market.

Leslie, do you want to add anything to that about Northwest? And I'll have a follow-up question for you.

Leslie Hampton:

We definitely have areas that are now to where they have no travelers, which is exciting. Our specialty areas still struggle with recruiting experienced nurses, and we'll be training people from straight out of nursing school.

So I think I agree with the way Keri put it. We've got a lot of progress, but also some areas that we need to get really focused on helping get them up to speed with their staffing,

Trish Kritek:

I think irrelevant to that... And I'll turn to you, Cindy, and then I'll ask Keri and Leslie if they want to add in. We got a bunch of questions because it's been in the news with concerns about a nursing strike, there was in New York City. And so, I wondered if you could comment about your level of concern about that.

Cindy Sayre:

Yes. Well, that's something nobody would ever want to see. So really that was very sad to see that happen. I'm so pleased that UW Medicine has been able to come to agreements with all of our labor unions, and that happened back in July. It was July.

With significant raises, and Tim alluded to this, the contracts were very generous this time, which I think is a good thing for all of our staff. So I feel like we're in a much better position here at UW Medicine than these hospitals in New York where they were just coming into their contract negotiations.

I do want to give a lot of credit to all of our leadership, my leaders and their leaders for recognizing the value of the healthcare staff and committing to those increases.

So I feel like we've averted that. At the same time, we have still a lot of work to do around healthy work environment, around resiliency for our staff and making sure that they have everything they need emotionally to continue this really hard work. But I don't see a strike on the horizon.

Trish Kritek:

Okay.

Cindy Sayre:

Can I add one thing, Trish to when we're talking about hiring?

Trish Kritek:

Yes.

Cindy Sayre:

Because I agree with Leslie that for the Montlake campus, we've had great success in some areas. Our labor and delivery unit, I believe, is going to be traveler free within the next few months, which is fantastic. We've done a great job hiring.

But the other thing I want to bring up is that we are accelerating our workaround nurse techs. So these are nursing students that can come in to the hospital and they function as a PCT with a little bit more responsibility than that, but that it's a really important pipeline for then hiring new nurses because they get a chance to experience our environment.

So I'm really pleased about that and want to give credit to Sue Tyler for all of the work that she's done in that space.

Trish Kritek:

So I think reassured that we've recently negotiated a contract, at least at UWMC and asked Keri about it in a second, that we're in a better place and we still have work to do and we want to keep working to make it a place where people can thrive and want to work.

And then you said another remedy that we're working on is nurse techs who then could become our future nurses, which I think is great. Keri, Harborview, anything different that you want to add there?

Keri Nasenbeny:

I think all of our contracts actually were renegotiated this summer and so closed all of those contracts. And I think they're now all good for two years.

I think the only thing that I would echo a hundred percent, what Cindy said, and the only other thing I would add is that I think another piece of work that's been really important to us is really maintaining good relationship with our labor partners, with our unions and making sure that we're partnering with them and in all aspects, not just around salaries, but healthy work environments like Cindy mentioned, and really the whole piece of it and really making sure that we're maintaining good relationships with them, because I think that's the other piece that we think about, what's going on in your York City that's different here is that that's a really important piece. Correct.

Trish Kritek:

Yeah. Partnership and good relation in a durable way, in a longitudinal way as opposed to just at the times of negotiation. So thank you for adding that.

The other question that came up in the... that I'll ask you to continue with Keri is: what about our professional staff nursing? How are we working to retain them because they're not part of those negotiations? So maybe you could comment on that.

Keri Nasenbeny:

Yeah. It's a really important question and I can get top of mind for all of us. And so, on the compensation front, our compensation team is actually doing a systematic review of all of those job classes and really looking at to see if compression exists and where compression exists. And there'll be some changes that are made.

And then in addition to what Cindy talked about, we're also looking at their work-life balance. How much are they being called after hours? Are they getting good time away from here? What are the expectations? How can they flex their time?

All the same things that our staff want, our core staff want too, professional development, et cetera. So definitely a compensation review that's looking at all of those job classes or as underway and then addition.

All those other things that I think are as important are sometimes even more important. So really looking at that holistically and making sure we're doing everything with, again, our union leaders because they're critical to our success. For sure.

Trish Kritek:

Yeah. Thank you. So compensation review and kind of an analysis about how the creep of the job into all these other spaces and how we support making sure that folks can stay healthy in their roles in all ways. Leslie, I know you work a lot in this space. Did you want to add anything?

Leslie Hampton:

Well, what was going through my mind when Keri was talking about that is that we really want to support our leadership in their development of skills over time. And I think with that comes a lot of engagement and feeling supported.

So leadership development is what I'm saying. It's really important. And then working with our teams to work on our quality measures, helps people stay engaged and makes them feel really proud. And that's something that we'll be focusing on too.

Trish Kritek:

So developing leadership skills, something that's near and dear to my heart and then continuing to work on improving our care makes us all excited about the work that we do.

Leslie Hampton:

Yeah.

Trish Kritek:

So I appreciate that. Thank you all so much. Cindy, I'm going to ask you one last question, which is completely different, but I got so many questions about it, I feel like I have to ask.

And that is, are we going to undo, open up the drinking fountains in UWMC again? Is it some reason other than COVID that they're not open? People keep asking, so I'm going to keep asking.

Cindy Sayre:

Yeah, thank you. Well, thank you for giving me a heads-up on this question because I had a chance to research and thank you, Santiago, for being my researcher.

The current understanding, the fountains were still closed because of COVID transmission rates. There's now consideration to open those up, but it needs to be part of our water management plan, right?

Trish Kritek:

Okay.

Cindy Sayre:

Because now we have a device that hasn't been used in three years and we know that that creates risk. So I think that it's being evaluated. I'm not sure the timing and Santiago, I invite you to weigh in.

Trish Kritek:

Santiago. So I heard a glimmer of hope for drinking fountains. Go ahead.

Santiago Neme:

Yeah. The thing also has to do with at Montlake, we see a lot of severely immunocompromised patients and family members, et cetera. So we really try to pay specific attention keeping those hosts, those immunocompromised hosts in mind because again, of the risk.

I hope we don't take long to do this because I think it's important and it's part of the new phase, but we need to do it with our very thorough water management team.

Trish Kritek:

Okay, I appreciate that. So we're starting the process, we're doing it carefully and we're moving towards drinking fountains again. I'm going to tie that one up with a bow. I'm sure it will come up again, but I appreciate the process and the progress on that.

Since you're unmuted, Santiago, I'll actually pivot to you and say one of the questions that came up, and I think it's relevant to everything we've been talking about is how we communicate about how high the census is and feeling like we say critical a lot. And then if we say critical all the time, it doesn't feel critical anymore because it loses its meaning. And so, I wondered if you could comment on that a little bit?

Santiago Neme:

No, absolutely. I think it's a legitimate question. I think the messages really started when a critical census was something of lower occurrence, but as you know, we've been full a lot of the time. So it does lose its meaning.

I do want to say that we have received some mixed feedback about these emails because some teams actually use the emails to prioritize or reprioritize our work. So I do think that there's room for improvement.

I think we could include other things that are going on at UWMC for instance, or the innovative care that we provide, et cetera. But I think it's a time as we are shifting gears in terms of the pandemic and the what's going on in the healthcare environment in the country, I think it's an opportunity to readjust and get some more feedback from folks and maybe communicate the same but in a different manner, so then it's helpful information but not overwhelming.

Trish Kritek:

Oh, I appreciate the willingness to kind of reconsider it and that there's value in situational awareness. Rick, I think you also sent out an email that's focused on situational awareness. I don't know if you want to comment on that.

Rick Goss:

Sure, sure. Well, the high census at Harborview is really a very longstanding issue for us. So we have many forms of communication and have had different versions of a daily email over time.

I think now we tend to use something that's sort of factual that gives people the information and realizing that to say, "Hey, today would you really work on some enhanced discharging?" I think people know that that's cornerstone.

So we really then target sort of further outreach during the day around where we might have unique challenges, for example, ICU transfers to acute care or ED options for admissions and other solutions for taking care of patients, and so many of those.

And I think as we've been doing on so many fronts, our hospitals working together of late, we've been really sitting down with the transfer center with our nursing colleagues and again, working with Keri now at Harborview, really welcome her onto the team. It's really wonderful.

But just the partnerships, we try to transfer across our sites when that helps. We're all super busy and probably at unprecedented levels of census, so there aren't as many options maybe as there once were.

So I think, again, Trish, it's really how do we keep working together, compare our strategies, and really thank people for the hard work day in and day out for working through this census challenge.

Trish Kritek:

I really appreciate that gratitude and that collaboration and I think there is value in situational awareness. The other thing I heard you say is really focused attention to the places where maybe there's more work that's needed on that day or in that week or whatever it is. So I appreciate that.

I thought we would have not enough questions for today and I was completely wrong. So I'm going to start pivoting around and go to people. And I'm going to just say right now to people who send in questions, I'm not going to get to all of them, I apologize, but we're answering lots of great things and having good discussions. So thank you.

Tim, I'm going to pivot back to you and I'm going to ask you a question that came from a medical student. So I have a little bit of soft spot, sends a medical student actually send in a question and their question was, will the future leadership of roles of CEO and Dean stay together, which kind of is how you're doing in the future or will there be separation of those?

And I think the voice that I heard in that question was, "I want to make sure there's somebody who's advocating for the school."

Tim Dellit:

Yeah. No, I think that's a great question. It's great to see our medical students submitting questions and I'm going to preface this by saying ultimately President Cauce will make this decision. So what I share is really my opinion and really may have no bearing on what actually may happen.

When you think back on the history of combining this, it actually dates back to 1992 for our organization when we combined the dean role with what was then the vice president for medical affairs.

The reason behind that is still a very strong reason today in terms of ensuring the coordination and alignment between the school and the clinical environments. That is why we currently have that combined role of dean and CEO of UW Medicine.

Now, with that, I also appreciate what the student says that you have to ensure that you have adequate focus on the school. There are different ways, if you look across the country that places have done this. Most places that have this combined role such as us, or Michigan, Hopkins, Penn.

They typically then have a position that really focuses on the clinical environment. For us, that's our president of hospitals and clinics, and they often have an executive vice dean that really focuses on the school, works with the other vice deans, other leaders within the school focusing within that environment.

So I do appreciate the need to continue to ensure that we have really equal and really valuable focus both in the clinical arena and within the school so that all aspects of UW Medicine, our research, our education, and clinical activities receive the attention and support that they need.

There are different ways you can get there, even with the combined position such as we have now.

Trish Kritek:

I really appreciate. I think the big take home is President Cauce gets to decide, but I think that part about-

Tim Dellit:

That's the answer.

Trish Kritek:



That's probably where we want to make sure that we have a strong voice for our clinical enterprise and a strong voice for our school. I think that that message is clear. So thank you for clarifying that. And there sounds like there'll be some kind of tweak in how it looks in the future.

I'm going to try to sneak two more questions into you before I go back to COVID. That could be turned into one. There's been national discussion about getting rid of non-competes in general, in this country, from the Federal Trade Commission.

And I'm wondering, or I'm not wondering, but somebody was wondering, have we been discussing that all at UW Medicine at this point? And I think it's around physician non-competes that the question came.

Tim Dellit:

I think there are ongoing discussions ever since our non-compete policy was first adapted back in 1999. And again, that is a UW physician policy. And I'll just say that if you speak with individuals across our 18 different clinical departments, there is a wide range of views around the non-compete.

Most recently around the FTC announcement, we are in a, I would, say public response phase. So they are seeking input on the proposed rule. We don't know what they ultimately will come out with.

And so, as that continues to evolve, we'll adjust our approach as well. I would say even here locally within the Washington state, there has been legislation trying to frame some of these.

And over time we've contingent to evolve our non-compete, we have decreased the geographic mileage and range. We've decreased the time, it used to be two years, it's 18 months now.

So that policy will continue to evolve. And so yes, we monitor this closely. Ultimately, it'll be the UWP Board of Trustees that will have that discussion and determine the future of that policy and any modifications that need to be made.

Trish Kritek:

That's super helpful. So it's a decision of the UWP Board of Trustees, which is predominantly our clinical chairs. It is also something that has evolved a lot over time and continues to be a source of conversation because there are differing opinions across our clinical departments. And then finally we're watching what's happening with that public discussion part of with the FTC and we'll respond as that evolves. So thank you.

Okay, one last one. And I think this relates to the census stuff that we've been talking about. I should have linked it in before, and that is there ever discussion about having an additional level I trauma center like Harborview to support the needs that are at times feeling overwhelming to folks at Harborview?

Tim Dellit:

So I'm going to make a few comments and then obviously I look to Rick here as well. And first I just want to say from my perspective, and I think it's supported by data, we have the best trauma center in the country at Harborview.

If you look at the outcomes, the mortality, Harborview is right there leading the country. And in fact, our trauma system, even though we have level I trauma program for adult and pediatric population, we have multiple other level II, III, IV, V trauma sisters.

And when you look at the trauma system as a whole for this state, it has really been a model that has been used and looked at for replication in other parts of the country.

The real critical piece and why Harborview excels is because when you concentrate that experience and the volume of cases, particularly for the subspecialties, so eye trauma, cranial facial trauma, pelvic trauma, those are subspecialties that you have to ensure adequate volumes of cases to ensure the quality and expertise. And that's one of our biggest concerns.

Now, we are actively working with the Department of Health as they develop their trauma rules and look at the overall designation of different levels within our state, but we need to ensure that Harborview really maintains that outstanding excellence really serving our community. And that really comes around volumes, particularly for those subspecialty areas.

And so, this is why we have been very active in our support for Harborview as the only level I trauma program within our state. Again, there are six level IIs as an example, right? And multiple level IIIs, IVs, and Vs.

So it's not just Harborview, but the way we are structured has been incredibly successful in serving our community with the best outcomes in the country. And so, we want to preserve that excellence.

Trish Kritek:

I'm going to ask Rick for further comment. I'm just going to highlight. I think the emphasis on... There's actually a trauma center network of level I here, but that level IIs, IIIs, IVs, so that supports up to Harborview where there's people who have the expertise and the repetition on the subspecialty things that we need to do to be the best trauma center we can be, which is outstanding in a national model. Rick, did you want to add anything to that?

Rick Goss:

Yeah, just a couple comments. Tim covered it really well. I think the point about the level IIs as part of that system moving up from Vs and IVs and up to the IIs and then a I is really important because a level II truly has clinical expertise for many if not most of those conditions.

Level I is truly designed for that highest level, but a level I is also more than the clinical availability 24/7 for those specialties. It also is an educational facility and it is a research facility and a public service educational facility.

And so, Harborview provides all of that. And again, as you try to create additional level Is, you have to fully support that whole spectrum. And that's why we feel Harborview just excels at all of those, very collaborative with the network, and we continue to represent all of this at meetings and agencies and so forth.

Trish Kritek:

I really appreciate that emphasis on all that a level II can do and how that's part of a network again, and I think that's good reference for folks in our community. So thank you for going through that.

Okay. I'm going to sneak in a couple last COVID questions. I'm going to ask John, you, a couple; and Santiago one and then I'm going to hand it over to Anne. So John?

John Lynch:

Yeah.

Trish Kritek:

I got this question a bunch, is there understanding why some people just haven't gotten COVID?

John Lynch:

No.

Trish Kritek:

Okay. That's me. I'd like to keep it that way.

John Lynch:

Yeah, I don't think I've gotten COVID. I've had no symptoms. I've talked to this with Chloe Bryceson, another ID doc here. We talk about it all the time.

And as far as I know, I never got COVID. I've been tested in Korea, got the full brain tap there at one point multiple times. And so far they've all been negative and no one in my family either.

Trish Kritek:

So, we don't know. Okay.

John Lynch:

We don't know.

Trish Kritek:

I'm just going to say that to people. It is what it is.

John Lynch:

I do believe that there are people including in the UW system who are studying folks like this. I think Dr. Chu and maybe others are looking at individuals have not been infected.

Trish Kritek:

So, we'll learn more. And the other thing that people ask about every time that I'll just touch on is, is there anything new about long COVID with respect to new variants or vaccination? Do we see anything new in that space?

John Lynch:

It's still too early around the variants, but what it looks like, there was a paper actually just published in a very well known journal called JAMA that actually looks like vaccinations do reduce the risk for long COVID up through basically the third dose and then it's sort of plateaus. So getting more and more vaccines including boosters, doesn't increase that-

Trish Kritek:

Protection.

John Lynch:

... protection, but overall it does compared to unvaccinated folks. So it has an impact, but it doesn't just keep getting better and better.

Trish Kritek:

So get to three doses, that's kind of where you get a protection from long COVID. It's not incremental after that.

John Lynch:

Right.

Trish Kritek:

That's helpful. I think that's great. And I'm going to ask Santiago one quick question. And since Santiago we've talked a lot about therapeutics, I think the other question that came up is, are therapeutics still effective against these new variants?

Santiago Neme:

Thank you, Trish. Briefly, I know we don't have the time. Currently, we're not recommending any monoclonal antibodies because they've lost efficacy and the NIH is really not recommending them. So we stopped around November including Evusheld, the prophylactic monoclonal.

Trish Kritek:

Okay.

Santiago Neme:

There is a new Evusheld that's probably going to come up later this year, but more information we'll see later.

In terms of two regimens that are really effective, again, Paxlovid and Remdesivir. Paxlovid, as you know, has contraindications for some solid organ transplant patients.

So we're now launching a program where we're going to do Remdesivir, which is an IV infusion for three days. So three doses over three days. And we're going to do that at Northwest seven days a week.

So then we care for our SOT patients with solid organ transplants. FHCC has already launched that for cancer patients. And there's also a new Remdesivir that's oral being studied. Actually, there was a recent publication that looks pretty good, but again, more information will be forthcoming. Thank you.

Trish Kritek:

Okay. That's great. That was very focused. Thank you. No more antibodies; yes, Remdesivir; yes, Paxlovid; and operationalizing outpatient Remdesivir for patients with solid organ transplant and it sounds like malignancy as well. So thank you for that. And with that, Anne, I'm going to hand it over to you for a quick ask an ID doc.

Anne Browning:

Awesome. And I've got John Lynch with me today. John?

Trish Kritek:

Yes.

Anne Browning:

I'm curious, we have some questions from folks just wanting to know how you're moving through the world now and so I'll some specifics, but overall, does this feel like a new normal to you in terms of how you're moving through the world?

John Lynch:

Yes.

Anne Browning:

All right. Are you eating in restaurants these days?

John Lynch:

I am going to dinner with my family for the first time in Seattle out this coming Sunday for my birthday.

Anne Browning:

Yay. Happy birthday, and again-

John Lynch:

And my first Seattle one. I did eat out in South Korea last year, but we have not eaten out really besides that.

Anne Browning:

Awesome, awesome. And happy birthday.

John Lynch:

Thank you.

Anne Browning:

Are you still masking in airports and on planes?

John Lynch:

Absolutely.

Anne Browning:

If you were a solid organ transplant recipient, would you get on a plane at 2023?

John Lynch:

Yes, with a respirator on.

Anne Browning:

Okay. Broadly speaking, where are you masking and not masking these days? Do you find yourself unmasked in any public spaces, indoors? Or...

John Lynch:

So with one exception, I'm masking all indoor spaces and even when I go to the restaurant, we wear a mask until we're seated and then we'll probably take our mask off.

I go to the grocery store, other stores. I was in Target this morning, I wear a mask the whole time. It's very easy, pretty normal for me. The place I don't wear a mask, as I've talked about before, I go to a climbing gym a lot and when I climb, I don't wear a mask.

Anne Browning:

Got a question come in around considerations for long COVID. When you think about your own risk mitigation or risk management, do you worry about long COVID and those implications as you're weighing what you do and how you move through the world?

John Lynch:

Yeah, I mean, I definitely think about it. I mean, it is a complication of an infectious disease that we can get through the air just by being around another one that we've never really had a struggle with before. Right?

It's sort of a new thing for us, and I just think about how I like my life, the level of activity that I enjoy. I think about the same thing for my children, my spouse, and how not being able to engage in all those things would impact us. Not each individual, but our whole family. And it definitely makes me very concerned.

So definitely think about it. It's why I'm masked pretty much all the rest of the time when I go in these spaces.

Anne Browning:

As you see more folks trying to come together, gather, what do you think about using some of those rapid tests just to check asymptomatic gatherings? Do you think that's a good idea?

I've heard of some folks catching themselves in asymptomatic matter before coming together. So, it's-

John Lynch:

Yeah. I think if you go to any sizable gathering, if you're going to be going to gathering with older adults, I mean, again, the data in who's getting hospitalized is dramatic.

So older adults, people who are immunocompromised, to me, I think even like little babies, neonates, any of those situations. I think getting tested once or twice before going to a gatherer like that just makes good sense. I think it's just a normal thing.

I think we still have access to, at both the federal, state level, free antigen tests and we should avail of ourselves with those as just one more layer. None of these things is perfect, right? It's just one more layer to help keep people safe.

Anne Browning:

One last quick one. What's something you're looking forward to in 2023?

John Lynch:

Spending more time with my friends. I think doing the things that you talked about at the top of the hour and more just normalization, more gatherings that we can do safely, more activities that I enjoy,

and maybe a few more outdoor meals. I'll let you know next time how my dinner goes, but I have to say I'm very excited for that event.

Anne Browning:

Awesome. And happy birthday in advance, John. Thanks for everything you're doing. Trish.

Trish Kritek:

Happy birthday from me as well. And I want to say thank you as always to everybody who was on the panel and for all your wonderful contributions. It's deeply appreciated.

As Anne noted, a time for reflection at the start of a new year, and I've been thinking back as well, as we enter into this new year, I'm greeting it with the natural self that I am with optimism that this is going to be the best year of the 2020s for us.

And with that in mind, we're going to pivot to quarterly town halls because I think that that makes sense for where we are in this pandemic. We want to keep answering your questions and also react to the time.

That being said, I'm also a realist. I've been an ICU doctor for a really long time and I know that things change. I remember a year ago in December, we weren't going to have another town hall, and all of a sudden we needed to have one right away because of what was happening with Omicron.

So we will still respond, and if something new happens, whether it's about COVID or something else, we'll come together and make sure that we answer your questions then.

So with that in mind, our intent is to come back in about two and a half, three months to talk again. And in between, feel free to reach out and send questions. And if this doesn't sound good to you, can always give me your feedback. I always appreciate feedback from everyone in our community.

And with that, I want to say thank you. Thank you to everyone who wrote their questions and sent them in. Thank you to the panel and thanks to all of you for, again, continuing to take care of our patients, their families, our learners, our trainees, and most importantly, as we enter into this new year, continuing to take care of each other. Thanks, and we'll see you soon. Bye.