Town Hall Transcript: March 27, 2020

Dr. Patricia Kritek (Associate Dean – Faculty Affairs, Pulmonary & Critical Care physician): I will begin with thanks to everyone who is a member of this community for all that you are doing to take care of our patients — and with how much we all really appreciate that. We also appreciate how you are taking care of each other and how you are taking care of yourselves.

We are going to start the way we started last time with a well-being check in with Anne Browning, the assistant dean for Well-being and my colleague in working to support all members of the healthcare team.

Dr. Anne Browning (Assistant Dean – Well-Being): I want to thank you for the introduction as we start the conversation on how we are sustaining ourselves for the long haul in this work. We are just going to hear from a couple of folks: What are you doing to sustain yourself?

One thing I've been doing is to try to anchor myself every day, and I've actually found a lot of calm and pleasure in just washing my dishes at the end of the evening. The house is quiet, I'm not holding a device, and I just let myself wash the dishes.

John Lynch, I know you're on the line. I'll let you say what you do John. So, what do you work on and what do you do to take care of yourself?

Dr. John Lynch (Head of Infection Prevention and Employee Health at Harborview Medical Center, Infectious Disease physician): Sure, my name is John Lynch. I'm an infectious diseases physician and I'm based over at Harborview. I've been working on the COVID-19 response at both Harborview and UW Medicine for the last six or eight weeks. You may see my name of a lot of emails you get.

What do I do to take care of myself? I've been a life-long reader and I always, always, always historically read before I went to bed. In the last six or eight weeks, I've kind of fell off that habit. Just recently I stumbled upon my older daughter reading "Game of Thrones," which I've never watched or read. She had the book, and I just borrowed it from her and started reading again before going to sleep. It has been fabulous to rediscover that in those 15 minutes I can keep my eyes open before I go to sleep. And it's been wonderful to rediscover that habit; it's brought me a lot of happiness.

Dr. Anne Browning: Excellent, thank you. Cindy Sayre, I'll let you say what your role is as well and what you do to take care of yourself.

Dr. Cindy Sayre (Chief Nursing Officer – UWMC): I'm the Chief Nursing Officer for UW Medical Center — Montlake. What I am doing to take care of myself is I am letting myself be human in all of this. That means that I'm really relying on the love and the care of my family, my friends, my colleagues, and I'm not trying to be uber strong. I'm just being myself and being human. I

think in healthcare we think that we have to power through everything and not show any emotion, and I'm just letting myself be human. I'm just letting myself be loved by people who love me.

Dr. Anne Browning: Awesome, thank you very much.

Dr. Patricia Kritek: The other thing we are going to do today at the start is something that I think also brings many of us resilience, which is focus on the bright spots. Keri Nasenbeny is going to share a very brief story of a particular bright spot in what we are doing.

Keri Nasenbeny (Associate Chief Nursing Officer, UWMC-Northwest): Good afternoon, I'm Keri Nasenbeny. This a picture of Ray (below), he was one of our very first patients at UW Medical Center — Northwest.

Just to tell you a little about Ray, he's a 55-year-old man from North Seattle, born and raised here. He talked to me about spending time here on the Northwest campus as a kid, both receiving care and just being on the grounds. He's a father, a son, a husband and he has three beautiful daughters, the oldest of which is at UW. His middle daughter is celebrating her birthday today, and that's really special because he was actually just discharged. A bunch of our staff from the ICU went down to see him leave and really cheer him on.

He was one of our first patients admitted though the ED. He had upper respiratory infection and some shortness of breath. He pretty rapidly declined. He was transferred to the ICU within 24 hours, intubated there shortly after and spent several weeks on a ventilator. There was a lot of concern in our ICU, a couple of late-night phone calls, people not sure if he was going to make it.

Slowly but surely, he turned the corner. He self-extubated; he said to me, "I didn't know that tube was so long." He needed to be re-intubated, but then a couple of days later he was successfully weaned and liberated from the ventilator. When I talked to him yesterday, he had that same smile on his face and the bigness of his heart showed through.

He said a couple of things to me that really struck me. One, he never knew how hard it was to need care and help. And he appreciated everything that everyone did for him. He was going to take that forward and make sure that he was caring for his aging parents and his family and his community. Two, just the overwhelming gratitude that he had for everything and everybody. He teared up several times; he was just overwhelmed with emotion. He never expected to get

COVID, and I think he knew very little about it coming into this. It was super early; I think most people in Seattle didn't know a ton about it. He was just so grateful for us. That smiled has sustained me. I wanted to share that share that story of someone who recovered and all the good that came through that.

Dr. Patricia Kritek: Thank you. And thanks for all the folks who are part of the care of him. Could you tell us who is in the picture?

Keri Nasenbeny: Sure, on the left is Cameron Muir, he's one of our ICU nurses at Northwest, and on the right is Dr. Padmanabhan, who is one of our intensivists here. They are two of the folks who took care of him quite a bit of the time that he was in the ICU.

Dr. Patricia Kritek: Thanks so much for sharing the story, and thanks so much for sharing the picture. I think it is inspirational for all of us. I think it's easy to focus on what is scary and not going well, but there are lots of things that are going well. Patients are being discharged and getting better and that's so important to hear.

Keri Nasenbeny: I just wanted everyone to know that I shared that with his permission too.

Dr. Patricia Kritek: Thank you for clarifying that.

We are going to jump into some questions. I'm going to ask Dr. Tim Delitt for an update of the week to start with. He is the Chief Medical Officer of UW Medicine and an infection disease doctor who practices mostly at Harborview.

Dr. Tim Dellit (Chief Medical Officer – UW Medicine): Great thanks Trish. I want to extend my thank you to everyone. It's hard to believe it's been four weeks now since we first heard about the death of a patient at Evergreen who had presented with pneumonia of unknown etiology, when we realized that we had ongoing community transmission. We've been working so hard over the last four weeks. It's been amazing given how difficult and trying this has been for all of us, both at work and all the changes that have been happening in our personal lives and in society with social distancing.

This week has been focused on a lot of surge planning. We have been very fortunate to have the Institute for Health Care Metrics here at UW Medicine. Early on when we started to do work with them on modeling to try to predict when that surge would happen, the initial estimates were that this was going to occur around April 7, with an extra estimated 950 patients across our system. Now these models continue to get refined.

New information was shared with us today and what's very interesting is that the peak date for us has been pushed out from April 7 to April 17, and the peak volume of anticipated patients has decreased from 960 to 760. Now, again, these models are imperfect, and they will continue to evolve as we get more information, but that may be suggesting that all of that social distancing that has been done may be starting to have an impact. It's also reassuring that when

you look at the IHME website, they have a great tool up there that shows you the predicted curve not only for the entire U.S. but also for each state. When you look at Washington, as challenging as this is going to be over the next few weeks, we are fortunately in a much better place than many states are.

As part of our modeling and surge planning, we have been working on the medical staff side, thinking on how we identify resources for critical care, acute care, and emergency department and urgent care. Our nursing colleagues have been working very hard to think about the surge planning in those areas, such as respiratory therapy. We've spent a lot of time identifying who are additional clinicians who could bring support and about all our employees, who all have a role in this potential surge planning. There has been a lot of coordination this week anticipating the next three weeks.

When you look at what's happening within our hospitals right now, this morning we had around 67 positive patients across our four hospitals, 21 of which were in the ICU. Last week we probably had around 40 to 50 each day; this week it's been a little bit higher. But when you look at where we are compared to the model, we are still under where the model would have projected us. In fact, when we've talked to partners at other healthcare systems in our region, they are also seeing volumes that in general are lower than what was in the modeling. We will see what this means but that's where we are — we are seeing some increase, but it's still manageable. We recognize it is a toll on everyone. But we have gone through this week, and again, just seeing everyone come together in support of each other has really been powerful to watch.

Dr. Patricia Kritek: Thank so much. With that I'm going to start questions. We had over 350 questions, and I'm going to try to put them into the categories of numbers, more details around surge plans, discussion around protection of the healthcare worker, asymptomatic spread, and then some questions about clinical care.

Dr. Lynch again is an ID physician at Harborview and coordinating much of the clinical aspects of COVID response. Can you start off by telling us about patients in discrete hospitals as well as numbers around testing, how many tests we are doing, percent positive, et cetera?

Dr. John Lynch: Sure, happy to do that. If we look at the last 24 hours, across the four hospitals, Harborview now has about 11 patients; Montlake has around 15; Valley is up around 15; and Northwest has actually had the most patients, around 26 to, on some days, 30 — today was actually fewer patients. These are imperfect numbers. People get discharged and new patients come in over the course of the day, but in general that's where we were earlier this morning.

As Tim mentioned, what we are really seeing is a trend. As of last week, two of four of those hospitals were in the single digits. For the past three to four days, every hospital has been in the double digits, and we saw that every day we were adding on a few patients. What that really means is one, new patients are being diagnosed that need care in the hospital and two, it's also a reflection of patients who come into acute care or ICU and need to stay in the hospital for a

week or two, or if you're very ill, maybe three or more weeks. Patients who came in last week are still here, and as new patients come in, they are adding onto that population. As Tim mentioned, our population of patients in the hospital is just getting larger and larger as time progresses.

Dr. Patricia Kritek: Can you talk about how many patients are in the ICU versus acute care?

Dr. John Lynch: Based on my numbers from this morning, there are roughly 21 cases, about a third of those patients were in the ICU. The other two-thirds were in the acute care. People in the ICU tend to be in the hospital for longer periods of time. Our findings are consistent with many other sites around the world with that population.

Dr. Patricia Kritek: Thank you. And again, that information is available through the password protected site on the Huddle and the COVID site. The second thing that I wanted to ask you to reflect upon was our testing number, the turn-around time for the test and the percent positive.

Dr. John Lynch: Absolutely. When I looked at the data this morning on yesterday's testing, we had done 560 tests in UW Medicine, both the hospitals and neighborhood clinics. I would like to point out that the neighborhood clinics did over 100 COVID-19 tests yesterday, and they are definitely finding people in that population with positive tests and handling them in the ambulatory setting. Of the 560 or so tests that we did all throughout UW Medicine yesterday, granted I haven't looked for the last couple of hours, 48 of those individuals were positive. That gives us a running average of about 7.5% are positive.

Dr. Patricia Kritek: Thank you. There were also a bunch of questions about the sensitivity and specificity, as well as the false negative rate of the test that we are doing. I wondered if you could reflect on that for a moment.

Dr. John Lynch: Sure, I will just caveat that I am not a laboratory medicine specialist but have consulted with my colleagues.

The way you figure out how good a test is to compare it to a gold standard, or the best definition or guarantee that the disease is there. For the PCR that we are using in UW Medicine, and truly everywhere in the world, there's not a gold standard. For something like COVID-19, to create a gold standard, you would need to do a deep sample of the lungs, what's called a bronchoscopy. Then for every positive one, you would need to see how many times that nasopharyngeal swab is positive. Or you could do a serological study, that's a blood test that looks for antibodies, and look at everybody that has been positive and how many of them had a positive and negative nasal swab test. As of now, those studies have not been done. As of now, we don't have a measure of sensitivity and specificity.

What we do know now is that the different tests we currently have, for instance the DOH and UW Medicine tests, are 100% concordant, so the different PCRs are working very similarly.

That's good news. The second thing is we do know is that sometimes there's what we call a false negative, or someone gets more than one test in a row, maybe separated by a few days, and one test would be positive and the other test would be negative. That probably has to do with one of two things. First, the nasopharyngeal swab wasn't deep enough or twirled around enough, indicating a problem with the quality of the sample instead of the test. Or second, the test's ability to detect low levels of the virus may vary on alternate days based on the level of virus a person has built up as they developed symptoms or as those symptoms were resolving.

Dr. Patricia Kritek: And you know that we've had some false negatives?

Dr. John Lynch: Right. And it is important to remember every single test we use in clinical medicine has a false negative rate and that's why we really have to think hard about the clinical context in which we are ordering the test. That's a big part of it.

Dr. Patricia Kritek: I want to ask one follow-up question that came up about inpatients who test negative. Are there any groups of patients that we are testing again because we are particularly concerned about them?

Dr. John Lynch: So I think that, yes, in two places. First, it is very, very important to recognize that the incubation period from the time someone is exposed to the time they develop symptoms is up to 14 days. You may have a patient that comes to the hospital and is tested for some reason and then later in their hospitalization they could develop symptoms of a respiratory tract infection. We in the hospital need to get into the practice of remembering, "oh, this person may have been exposed at some point in the past and they are only now developing symptoms." It may be later in their hospitalization that we need to be thinking about COVID-19 as a possible disease process, and then retest them there.

The second place we may be retesting is when people we know have COVID-19, whose symptoms have resolved but they need to remain in the hospital. We are testing those people in our hospitals. What we are doing right now is doing two tests separated by at least one day. As soon as those tests are negative and the person's symptoms are completely resolved, then we can take those people out of the precautions we use for COVID-19 tests.

Dr. Patricia Kritek: I think that's part of the conservation of PPE, which is something important that we are trying to do. So, retesting if we think someone might have been early in their disease and testing twice to clear someone, saying that they are no longer COVID positive. Okay thank you. The last thing I'm going to talk about in terms of numbers is going to lead us into our surge plan discussion. Do you have a sense right now of our supplies of PPE and numbers that you can share with folks?

Dr. John Lynch: Sure. Our supply chain colleagues are doing a good job at providing numbers. There are probably 16 or 18 items on a list that we can check to see how much stock we have on hand, on the shelf. And then we can also look at how much we've used on the prior one day,

three days, seven days, two weeks and 30 days. We can say, “If this is how much we’ve used in the last three days, how long will that last for the next three days?”

Our supply numbers fall into two groups. One group we have really great supplies, it goes out many days, you know a month or two or three. For instance, we have a few months of our basic procedure masks on hand.

Then there are other places where things are less common, and those of you who are doing clinical work may see this. The masks with the integrated face shields have come into very short supply, and our supply chain folks have had a very difficult time finding additional opportunities there. So instead of using the integrated face shield and mask, what we’ve done is move to our mitigation or contingency plan. We try to use other supplies we have, so the regular surgical mask with eye protection that’s separate. It’s not as easy for the healthcare worker, but we are mitigating risk by using other materials in combination. The other place we are paying close attention is our gowns, and even things like our disinfecting wipes are being tracked really closely. That’s another area that our supply chain colleagues are working really hard on finding more opportunities.

Dr. Patricia Kritek: Thank you, that’s really helpful. Do you know the age distribution of people that our being admitted to our hospitals?

Dr. John Lynch: You know, I really don’t. We had that initial early experience with that SNF in Kirkland, and we saw a lot of older individuals that were severely affected and were in the ICU — and that was consistent with was reported nationally. When I look at the patients that are in our hospitals right now they tend to trend toward an older demographic, but we are seeing people in their 30s and 40s. I don’t have a good separation of ICU versus non-ICU for those patients right now. Santiago, Tim, Rick, I don’t know if you have any additional data in that?

Dr. Santiago Neme (Medical Director at UW Medical Center — Northwest, Infectious Disease physician): I agree with you. Our experience at Northwest has primarily been with the elderly. We have had some younger patients in the ICU and that coincided with the two cases that were successfully extubated that were younger than 65 years of age. I agree, patients tend to be older, and those tend to be the patients that get admitted to the ICU. That’s true also for what Montlake is seeing.

Dr. Patricia Kritek: Okay, so I think we are seeing a spectrum of folks. More to come on that. I’m going to shift gears. Tim, do we have a sense of the number of beds that we have, the number of ICU beds that we have and the number of ventilators that we have?

Dr. Tim Dellit: As part of the surge planning, as I mentioned, we are looking at a potential peak of around 760 patients around April 17. The good thing is that when we’ve looked across our four hospitals, we have been able to identify roughly 750 beds. We are actually very close to being able to meet that anticipated surge.

Now, some of this is also because since March 16 we stopped doing elective and non-urgent procedures and surgeries. With that, we've seen a significant build-up of capacity, and in some places like Harborview, where we've had borders, we have built capacity in anticipation of that surge.

From an overall bed standpoint, we look pretty good, based on each hospital identifying additional beds. In some situations, we've bought beds; we've bought another 260 beds across the two UW Medical Center campuses. Harborview already had another 100 beds available.

We are actively, with our supply chain, trying to acquire additional ventilators. If you look at the numbers, we do have over 200 ventilators within our system, so we are pretty close there. We are always trying to get more because we don't want to be in a situation where we don't have enough ventilators, but it looks like a pretty good match.

When you look at the surge planning from the medical staff side, for instance the critical care arena, we actually have really good reserves of medical staff who can perform critical care because we have faculty from the pulmonary critical care, surgery and anesthesia arenas. And we have the ability to create teams that are led by critical care specialists with other members of the medical staff participating.

My biggest concern is really on the nursing side, in terms of potential shortage in the critical care space. There is a lot of work being done to build that capacity and to look at changes in terms of our staffing ratios, which now maybe are 1 to 1.67 I think, but that will change in that scenario and we are looking at how we extend those capabilities. Staffing on the nursing side is one that we are really focusing on right now, and I'd look to Cyndi for more information.

Dr. Patricia Kritek: Perfect segue. So I'm going to ask Cyndi and Keri to talk about the planning for the surge in terms of nursing and some specific questions. That is, if I'm ambulatory staff what does that mean for me? The other part is, sick time, vacation time and flex time. Let's start with what is the nursing strategy and what are we doing with that?

Cindy Sayre (Chief Nursing Officer, UWMC): We've been working on our surge plans and crisis standards of care now for a couple of weeks. We've been so fortunate across UW Medicine to have a lot of resources over the last couple of years, and we provide an excellent level of care. Sometimes we do things that we don't even have to do because we have the staff available and our patients are first and we've been doing all of those things.

We are now trying to re-conceptualize what its look like when you have surge of patients, when you have more ICU nurses required but you don't have all the ICU nurses you need, how do we re-conceptualize a team model of care? Similar to what Tim was describing, we are looking at a team model of care led by a critical care nurse with maybe an acute care nurse as a secondary, and then ancillary people from across the hospital to help with other care tasks. For example, could we use a PT or an OT to do some of the ADLs that patients need. We are looking across

the whole organization for who we have available and putting together team-based models of care.

Right now, we are conceptualizing this in three phases, and it would be in phase three at the peak of the surge that we would go into those models. When that happens, the region would declare a crisis or a disaster, and then we have a plan in place that says if we are in a disaster, we might not do vital signs on every single patient every four hours, or we might not do the Braden Assessment for skin on every patient. We are making modifications to the care and delivering the highest level that we possible can with the resources available.

Dr. Patricia Kritek: Thank you, that's really helpful. Keri, maybe you can tag onto what Cyndi was talking about. Can you talk about folks who are ambulatory nurses or roles that aren't usually in the inpatient setting and how we might be thinking about collaborative work for them?

Keri Nasenbeny: I think it's a great question and I really appreciate Cyndi giving that overview. As we think about, for example, our OR cases here at Northwest, almost all of our cases were cancelled because they were elective or moved to Montlake, so that's created a lot of capacity within our OR nursing staff. What we've been doing with that group of staff — our ambulatory nurses and PACU nurses — is to connect with them, understand what their background is. So if you're an OR nurse, have you ever worked in an inpatient setting or have you spent your whole career in the OR? And if you've had an inpatient background, was that critical care or acute care?

We've been using folks here for reorientations. When I was up on the ICU today, every single nurse had someone that they were orienting to critical care. And the expectation isn't that they become experts, but that they become familiar. Some of our Special Care Unit nurses were there orienting to sedation with ventilators, with how you suction a patient, and what it's like to be in that environment so they can work together with an experienced ICU nurse to care for a patient. That's been our tactic thus far, assessing that group of nurses, understanding their skills and abilities, and then seeing how we can retrain them to bring them up to speed. We are also during that with our CRNAs with a little bit of a different capacity as to how we use those folks in an ICU. We are trying to think creatively. And while we have this window of opportunity, we want to get those folks the experience they need to work in these environments.

Cindy Sayre: Specifically, for ambulatory care, I think we can expect to see ambulatory care nurses working in the inpatient environment in some capacity. And to Keri's point, we are trying to evaluate people's experience, and we are looking for people who are volunteering to come into some of these higher levels of care. That's always where we were go first.

Keri Nasenbeny: I would just add that the number of people who have stepped forward has been truly overwhelming and heartening.

Dr. Patricia Kritek: I think we are going to hear the same things from Tim, Santiago, and Rick Goss (Medical Director at Harborview) and Tom Steger (Medical Director UW Medical Center). I'm going to pose the question to the three of you in terms of what we are doing with medical staff and how we are getting ready for the surge in terms of medical staff.

Dr. Tom Staiger (Medical Director UW Medical Center): I would also start by addressing my admiration and appreciation for the outpouring of assistance and support across the organization to address this highly unusual and unprecedented challenge.

In coordination with Rick, Santiago, Tim and Chris Kim (our Associate Medical Director), we have been very focused this week and the last week or two on developing a surge plan for our medical staff that will be sufficient to address the realistic scenario and informed by information from the IMHE — and that we've also got contingency plans in place for worse case scenarios.

We are getting ready build out, if needed, teams at each of our campuses to expand ICU and/or Med-Surg capacity. We are coordinating across campuses to make sure that we've got an appropriate deployment of resources. We are working with leaders in GME, in our departments, and service chiefs to gather names and, in the coming days, to start developing early deployment plans. That way, if we need to expand beyond our current service capacities, we have people that are ready to do that and are assigned to given team roles.

Dr. Richard Goss (Medical Director at Harborview): I too want to acknowledge the incredible outpouring of volunteerism, people stepping in and saying, "I can contribute." It's also just really valuable data from IHME, and the particularly good news that Tim spoke to. So that encourages us to continue with our efforts around physical distancing.

I just want to add to what Tom said. The way we are conceptualizing getting from where we are today to an eventual surge capacity is certainly tracking with the prediction models that we have that are, in fact, changing day by day.

But if we have our current structure that we are all aware of, and if we are going to get from here to there, we are going to go through a couple of different stages. The first stage is the first time we have to activate another team, whether that's the ICU or the inpatient. Then if the trend continues and we reach some much, much higher level of COVID disease, we would then need to further escalate. That's sort of that sequential framing of the team models. I know here at Harborview, working with our central committee, Tom and many of our leaders within the ICU, the ED, and the acute care, we are trying to develop this staged model in a coordinated way.

I really appreciate Dr. Chris Kim's leadership and all of those that are participating. We are doing our best work. This is a very complicated modeling project, and like all things, if we stick together and communicate well, we will achieve this. Thank you again to everybody so willing to extend your efforts.

Dr. Patricia Kritek: Thank you. I will just add that last night Tim and I spent time with Byron Joiner, the leaders of GME, and the residents and fellows across our institutions who are also part of this plan —many of whom who are anxious to jump in there as soon as they can. I'm going to switch my question to Santiago because there was a question that came in about whether or not leaders are going to participate in care. Could you tell folks what you've been doing in terms of care recently?

Dr. Santiago Neme: Hello everyone. I think it's always been critical for leaders to practice and be engaged in what we are doing, which is healthcare. I had the opportunity to do so early on. There was a patient that was admitted to our hospital that had been a resident of one of the nearby adult family homes. When he became positive and was diagnosed, immediately the big question was about the health of the other residents that live in the same facility.

Within 24 hours, we mobilized and went ahead and tested all of the residents and all of the staff. Then we implemented a plan based on the testing and results. I will say our testing also included patients without symptoms because this was in the setting of an outbreak investigation. We ended up testing approximately 130 people that night. That lead to a very detailed and targeted approach of isolating the patients that were positive. Then a week later we went back and retested. I'm talking too long maybe, aren't I?

Dr. Patricia Kritek: You are (laughter). I wanted to highlight that you are going out and testing people. And everyone here is talking so much and that's because you all care so much and want to be really clear what's going on.

Dr. Santiago Neme: I just want to say, we went back and found out that there were no other infections. So the plan actually worked.

Dr. Patricia Kritek: I love it. The reason I want to highlight it is Santiago is out there testing people. The other day he was out there testing people. I want to you know that is happening. I personally worked in the medical ICU at UW and took care of the first COVID patient that we had there. My significant other is in the COVID unit at Harborview right now. So we are part of the care team too. I am on the schedule for more ICU time starting next month. So we are part of the team and we think that's an essential part of this.

Okay I have a whole bunch more stuff I want to get through. Tim, there's still lots of questions about PPE and there's a lot of consternation and discussion over universal masking. I want to give you an opportunity to talk about that briefly.

Dr. Tim Dellit: Brief is going to be a challenge. I think we first have to acknowledge is we are learning a lot, and as we see new evidence, we will continue to look at how to best to keep our healthcare workers safe. That is our main priority.

The question of should everyone who comes to work in a hospital wear a mask is a very complicated one. There are multiple elements there that you have to look at, both the pros and cons. Fundamentally, the main priority is to keep all of our workforce safe. That is just one component, all of the other pieces are absolutely critical. How do we ensure, for instance, that all healthcare workers are well and don't have symptoms? We've implemented a screening process. We've limited the number of visitors and we screen visitors as they come in. We are ensuring that people who are caring for patients with diagnosed COVID-19 have the appropriate PPE to care for those symptomatic patients.

We also have internal testing, which is critical. Many places around the country don't have the ability to quickly test patients who come to the hospital, which delays how long they have to stay in isolation, but also impacts testing the workforce. We rapidly had the ability to test our symptomatic healthcare providers through the drive-through clinic, especially up at Northwest. We were able to do that screening and identify who had COVID-19, which was only 4%, while the vast majority did not.

When you look at the question of whether people should wear a mask all the time, we have to look both at what is our supply — we currently have 3 months of supply, but we don't know if we'll get more — and how do we ensure that we will have adequate supply to care for all those symptomatic patients over the next couple of months, particularly if we see that surge of over 700 patients. That's one factor that we have to look at.

I talked about the testing component. We looked at what can we do around cleaning the environment, hand hygiene and all of those other elements. Santiago alluded to this — we do know there are people, whether they are pre-symptomatic or asymptomatic, that either have minimal or no symptoms. If you test them, particularly in elderly patients, you will find people with positive tests. There are different views on what that contributes to transmission.

We know that if you wear a mask if you are symptomatic with influenza, it decreases the spread of virus if you cough. If you don't have symptoms and are not coughing and wear a mask, does that actually decrease transmission? I don't know. I think that's an open question, but it's one we are continuing to learn about. If people are wearing a mask, we have to remember that mask is not protecting you, it's really to protect others from you if you happen to asymptomatic or pre-symptomatic. So you have to think about why are you are using it.

The real piece is to think about all of these aspects. Then it's a really challenging and tough decision. It's really about how to best protect our healthcare workers and ensure that we can protect them through the duration of this period of time. Many hospitals, if you look around the country, they've run out of the supplies. We have a few hospitals in New York that are wearing garbage bags because they don't have gowns. I've seen a number of comments around sewing masks. We have hospitals in our area that are sewing masks. We don't know how good those are and how impermeable those are to fluid. We also have an obligation not just to protect our own healthcare workers within UW Medicine, but all the healthcare workers within our community. And so there will be a question about shifting allotments of PPE, I'm almost

positive. If we see another hospital that has run out of masks and if we have masks, we will want to be able to help them because we want to ensure that their healthcare workers are safe too. Definitely the highest risk is caring for symptomatic patients. And so, all of those factors have to come into play.

I think it's a very good question. There's a lot of debate nationally about that. A lot of different viewpoints. I'm not sure if there's a right or wrong answer there. We are doing our best to think about all of the different elements as we make that decision.

Dr. Patricia Kritek: I feel bad that I said "be quick" because I think the thoughtfulness of that response is really important. Particularly your acknowledgement that there's uncertainty and that we are dealing with a bunch of different things and trying the best we can to make the best decisions for as many people as possible. I appreciate you walking us through your thinking on that.

I want to follow up with a couple of questions that came up repeatedly. One you alluded to, which is the screening of employees as they come in and the fact that we are having an attestation. At other institutions, other measures are being taken, so people are curious about the decision and whether or not we should be taking temperatures for our healthcare team as they come in.

Dr. Tim Dellit: You know we tried to model our attestation for healthcare workers on what our experience has been at the Seattle Cancer Care Alliance. We've done this for a number of years with our oncology floors at UW Medical Center, and so we've tried to model that and really make attestation a pause. All of us are so committed to our jobs and our patients, and we don't want our colleagues to have to cover for us, and sometimes we come to work when we still have mild symptoms. Having to attest that we don't have symptoms is a pause to think, "Do I really feel well, do I have symptoms?" before I start my day.

If you look at some areas like airports, when they've tried to do screening for temperature, they pick up very, very few individuals. So we did discuss this. We discussed, "Should we be using temperature? How would we do that?" If we had easy technology where you could just walk through, maybe we could think about doing that. But how you implement that and the likelihood of identifying someone were factors that went into our decision. And it's also a change for us too.

Dr. John Lynch: To mention this pause idea, we are really just counting on the professionalism of everyone in UW Medicine. Again, just take that moment, check themselves, "Yeah I'm feeling good, I'm ready to go to work." That's really the goal. No one is running that whole list of names and running back and seeing who might have had symptoms two days ago. It's really just you stating it to keep your patients safe and to keep your coworkers safe.

Dr. Patricia Kritek: Okay, I think I'm going to try to fit in one last thing. There are a lot of questions about wanting to know the names of the people in the workforce who are testing positive.

Dr. John Lynch: I'm an ID doc that works on infection, but I'm also the Medical Director for Employee Health at Harborview, so I really do have a role and responsibility for keeping people safe at Harborview and throughout UW Medicine.

We don't disclose the names of individuals who have a positive test for a couple of reasons. One is it's not historically what we've done with other infectious diseases. We recognize that people may have gotten infected in the community from family members, friends and what have you. For other infectious diseases, we don't share those names with individuals. We do let managers know that people on their service are potentially infected. But we also recognize that once a unit or a team learns that someone on their group has COVID-19, it is often quite easy to then figure out who that person may be. And sometimes that may be challenging. It runs into the privacy and respect issues around sharing that information.

We recognize that people want that information and to make a risk assessment, at the same time, I think we have to recognize that risk assessment is true all the time, no matter what, and it really shouldn't be targeted to "was I around this person at that time." It's really about approaching your whole day in a way that is thoughtful, keeps you safe, keeps your coworkers safe and keeps your patients safe.

One other thing that's come up is around why that person got infected. We have put out messages that we do not think this was acquired in the hospital or was a part of the job. And the flip side of that is we can't tell you, the world or the team that we think this person got infected from their spouse. Or from their child or from a friend. Which is what they may have told us. They may have had someone at home who has similar symptoms or who is known to have COVID-19, and we don't share that material because, again, it's out of respect for our coworkers. But the flip side is that the only thing I can say is, "We don't think this was associated with acquisition of the workplace" because I can't share where I actually think it came from. And I don't want people to think that I'm hiding or we're hiding hospital acquired transmissions, but we often have information that we don't share about the transmission.

Dr. Patricia Kritek: Thank you. I very much appreciate that. I think the last part is important, and I do think we care about the privacy of the folks that we work with. We care about everybody who is part of our team. And part of caring about folks we work with is respecting their privacy.

There are so many more questions. My commitment to the people who are listening is that we will work to try to get these up on the website with specific questions and answers. That does not mean that all 350 question are going to be up there, but we will try to tease out some things.

I know there are people who wanted to ask about the reuse of N95s; I know there's concerns about having to do extra work or overtime; I know there's lots of questions still about parking and resources. It's not that those questions are not heard; they are heard, and we will work toward answering them. I will try to prioritize what we start with at each townhall. I thought today it was most important to start with talking about the surge planning because it's been the big focus of this week.

I'm going to end the same way that I do every time, by thanking all of the folks who came together to be speakers as part of this townhall. I gave them a hard time but that's because I so appreciate all of them, and I know they have the same sense of humor that I do. I want to thank all of you out there, including those who are taking care of our healthcare team, because I think there are lots of significant others and family members listening. We so appreciate all of you.

And finally, most importantly, I want to thank every member of the healthcare team. Because as we've said before, we have to be a strong community to get through this, and I'm proud to be part of this very strong UW community. Thank you all. Thank you for all the questions and we will keep providing answers. We will be back here at 3:00 p.m. on Friday again. Take care.