

UW Medicine Town Hall Transcript: April 10, 2020

Patricia Kritek, MD, EdM, associate dean for Faculty Affairs, UW School of Medicine: Welcome back. It is our weekly UW medicine town hall. Again, my name's Trish Kritek. I'm a pulmonary critical care doctor and I am the Associate Dean for Faculty Affairs for the School of Medicine. And the same folks are joining us that have been joining us each week. I will remember to introduce them as we go and if I forget, they'll introduce themselves. I'm going to begin like I do every week first by saying thank you to everybody who's been part of this effort. And it really has taken everybody, it takes our whole community. I'm going to call out a few folks that maybe don't always get a call out intentionally and I'm sure I'm going to forget people and I'm going to invite you to well to tell me who I forgot. I'm happy to hear that. But I think it's important to say thanks to folks like our environmental services teams who are doing so much work to keep our environments clean and safe, to our nutrition folks who are helping us feed everybody every day and doing that in an incredible way. Our operations and maintenance teams and our engineers who have done a ton of construction to make our spaces safe as we take care of our Covid patients and all the folks in our clinics who we don't always see here in the hospital but are interacting with patients in a variety of different ways all the time. So I'm calling those folks out because I think sometimes we don't acknowledge them. There's lots of other people that we would probably don't acknowledge. So I'm happy for you to remind me for next week who else I should or who else I should specifically thank but thanks to all of those people that maybe don't always get as much obvious acknowledgement. I also want to say thank you for the feedback again. I'm going to highlight two pieces of feedback that we got and I'm always appreciative of it. The first one is the people who tell us that we keep touching our faces. You're right and we're all working on it and I so appreciate you telling me. And I hope you tell me in real life too, because it's unbelievable how difficult it is to break that habit and we're all going to work on it. So thank you. The second one is the people who said, you know, in those pictures where people say thank you for various things. Who are parts of our healthcare team, they're not six feet apart. You're right. And that's another thing that we're really struggling with and trying to get ourselves to break our habits of being close to each other, particularly in the hospital and in our clinics. And we are going to and empower all of us to do remind each other to stay six feet apart as whenever we can and maintain the physical distance. But keep narrowing our social distance because we want to stay close as people even if we're staying six feet apart. So, thank you for the feedback. Keep it coming. We listen and we respond to it. I'm going to hit it over to Anne Browning for just a couple of words about wellbeing and then we're going to jump into a bunch of questions that folks have submitted. Again, this, this week, again, up to 300 questions I think, and we'll do as many of them as we can, so an sure.

Anne Browning , PhD, assistant dean for Well-Being, UW Resilience Lab;

affiliate assistant professor, UW College of Education: Hi everybody. The weather has been tremendous and we've definitely been encouraging people to get outside. I wanna give everybody a heads up that Seattle has closed its major parks, like 15 major parks starting this evening through this weekend. And to echo Trish's comment, we really do need to maintain that physical distance. But one thing I wanted to kind of reflect on is I've noticed, you know, Seattle and flattening the curve, uh, the Seattle freeze is, has definitely helped us. Essentially we are out of all 50 States, we are 50 or 48 for extroversion and we also ranked 48th and likelihood to be in frequent contact with our neighbors. So the Seattle freeze has definitely help out I want to acknowledge like when we are passing each other on the sidewalks and we're keeping that physical distance it's okay to make eye contact and it's OK to wave and it's okay to smile. And really kind of allowing ourselves to have some, hopefully some Seattle thaw

that comes out of all of this as we're going to working together through COVID-19. So be safe, be distant, but connect and see each other and see each other's humanity through this. So thank you.

Patricia Kritek: Thank you. I have taken that to heart and have greeted everybody on my morning runs and I think they think I'm the crazy lady in the neighborhood now, which is fine. I'm very comfortable being the crazy lady in the neighborhood. Okay we're going to jump right in cause there's lots of things to talk about. I'm going to start with going to Tim again and Tim, I'm going to ask you to give us a little bit of an update and I'll tell you some words that came up in a lot of questions or phrase questions around that. **So where are we with surge? How do we piece, some people have heard about applied tell our when moving towards recovery. Can you talk through where we are and where we're going with all of that?**

Tim Dellit, MD, chief medical officer, UW Medicine

President, UW Physicians: Great. Yeah. Happy to do so. And again, uh, thank you everyone for joining us here this afternoon. I'm Tim Dellit, the Chief Medical Officer for UW Medicine. I also want to extend my thanks to the entire team. As Trish mentioned, every member of UW Medicine plays a critical role in our response and supporting the care of our patients that care of each other during this pandemic. So thank you to everyone. This is an interesting week. We mark the hundredth day of the outbreak from when it was identified in China. And over that period of time, we've now seen 1.6 million infections worldwide. We're almost up to half a million infections in this state and nearing 10,000, or should say in this country and nearing 10,000 in this state. We also had some good news, uh, at the beginning of this week and really starting to see potentially the light at the end of the tunnel. On Monday, April 6th, the newest IHME projections came out. And when you look at those for our state, we continue to flatten that curve. And actually those predictions suggested that the surge of patients may actually have been on April 2nd and that we really are at that plateau phase. What we have seen within UW Medicine and keep in mind, we still have 117 confirmed cases within our four campuses. So we definitely are still caring for a large number of patients. But if you think back even three or four weeks ago, we were anticipating over 900 patients and then over 700 patients. And because of the collective work of all of our community, we have continued to lower those numbers and flatten that curve. And we really do believe now that we are at that plateau we got as high as 122 patients within our system and we've been hovering in those mid 100 and teens all week. An important point of that though is that this is not going to be a rapid descent either. We've been pretty consistent and flat all week, a manageable volume, but still an elevated volume. And so we really have to see over the next a week or two how this continues to trend. So it's reassuring. We're cautiously optimistic that we're not going to see those very high surge volumes that we had initially anticipated. But we still have a lot of activity and are actively focusing on our COVID19 response. At the same time we are starting to pivot to thinking about what will this recovery actually look like and taking advantage of the opportunity to re-imagine what this care will actually look like in the future. And the reason I say re-imagine is that there are some things that have occurred as part of this pandemic such as tele-health, where we are doing now doing over 1500 telehealth visits a day, rapidly escalating that volume. That's going to be an important component as we go forward as well. Thinking about how that gets integrated, particularly in our clinic care. We had an earlier meeting this morning with all of the clinical chairs thinking about what will this recovery look like. And I think in big buckets and I think of it of our staff and how do we through our incident command, start to think about both disassembling some of the pools that we started. Not yet because we still need to see where the patient volumes are going. Let's start to think about what will that look like. We've done a lot of work around the centralized pools to support the search. What will it look like in terms of our de-escalation from that, but maintaining that incident command structure because we fully anticipate that there may well be a second surge in the fall with the return of respiratory virus. All right, so this isn't

going to go away. We don't think. We also are looking at how do we coordinate with other healthcare systems and our state. Keep in mind we have the stay at home order from Governor Inslee through May 4th. So we're now looking at starting to schedule clinic visits after that day when we're looking at our elective surgery and procedure volumes. And we have an order again from the governor through May 18th. So doing the planning to put us in the position to be able to increase those volumes as we get closer to that date. So a lot of preparation now to think about how do we move in that direction. Also a lot of work on the finance end- this has been an incredibly costly response. Absolutely appropriate and everyone has done what we need as we also think about the finances going forward and how do we achieve that stability and a lot of work by finance teams to look at that. And again, this is not unique to our healthcare system, but all healthcare systems. The other piece that we started to think about, how do we connect what we're going to do in the ambulatory clinic space with some of our previous strategic refresh work as we think about what that new paradigm will look like, as well as again, working with the ORs and our surgical leadership and thinking about how do we bring back those surgeries and procedures. And so again, it's an interesting time because we have to maintain our focus and diligence on response to COVID19. But because of what we're seeing within our community, we can also start to think about that next state. And so it's an interesting transition during this time and a lot of, a lot of thought on this. And again, we very much look forward to and welcome your input as we do that planning going forward.

Patricia Kritek: Thanks Tim. I'm going to ask a couple of follow up questions to that. And just to be specific. So, **the clinic date that we're looking at is May 4th right now?**

Tim Dellit: Correct. There was some question we had initially looked at this around May 1st but we want to stay in alignment with the governor's Stay at Home Order. And again, if something changes we'll have to reassess. So that's based on what we are anticipating now that we will begin to start scheduling clinic visits after May 4th.

Patricia Kritek: **And surgeries is May 18th?**

Tim Dellit: That's part of the governor's order for elective and non-urgent surgeries. **I think in the interim we're looking at in those urgent cases, how do we better define those between now and May 18?** Keep in mind when we did our postponement, we looked at those cases where uh, there would be no harm to the patient within the next four weeks. The governor's order is actually no harm within the next three months. And so we took a more conservative route to build that capacity and preserve our PPE and looking at are there other urgent cases that should be considered now during this interim until we get to that elective period in May.

Patricia Kritek: Okay, thanks. I have more things to ask you, but while we're talking about surge and where we stand with, I'm going to come turn to Cindy Sayre who's the Chief Nursing Officer for UWMC and ask kind of **how is this transition in search planning affecting what we're doing with training of our staff.**

Cindy Sayre, RN, chief nursing officer, UW Medical Center: Well thank you. I do want to start by saying thank you not to the entire team and I really appreciated your comments, Tim, because I, this is how

we're approaching it or our nursing services as well. Just like I said last week, you know, we are hoping for the best and we're cautiously optimistic. We had done a lot of training this week for potential redeployments and we probably will continue to some of that within the next couple of weeks. But we're, we're scaling back on that training just based on what we know right now about what might be needed. And I know for like the emergency departments, there was a conversation this morning about, you know, are we ready to take the tents down, for example, things like that. We're, we're thinking very carefully about that because there are still cases use cases that are coming and certain hospitals like Valley Medical Center that are more impacted than others. So we're taking a cautiously optimistic approach. But we're keeping all of our plans and adding to them so that if we do have a surge, we're ready to call right away.

Patricia Kritek: Thank you. So tents not coming down right now?

Cindy Sayre: Not coming down right now. It will be re-evaluated as we go forward. But there's still cases, especially where I'm hearing in the South King County and Pierce County areas.

Patricia Kritek: Yeah, we've seen it kind of geographically move at different spaces.

Tim Dellit: Another thing I want to add to, we still have a lot of activity in our long term care facilities and so we are actively partnering and in fact many of our physicians are going in and doing that assessment evaluation testing not only of the residents but also the staff. And so as long as we're still seeing those pockets of activity, I think we really have to maintain our diligence because we could easily see an increase in the number of cases just from a given facility. So we're very much partnering with public health and trying to prevent that and doing everything possible to do so.

Patricia Kritek: Thank you for hitting that. I know that Santiago has done some of that testing before in the skilled nursing facilities. And it's good to know that we're going to continue to partner with the state to, to assess those areas. Before I leave surge/ recovery, Tom Steiger, Medical Director of UWMC-- changes in terms of how we're planning for medical staff and surge planning. Have we stuck things down? Where do we stand?

Tom Steiger, MD, medical director of UW Medical Center: Consistent with what Tim and Cindy said, we seem to, for the time being be at a plateau phase. So we want to maintain a state of sufficient readiness should there be some uptick which we're not expecting, but we want to be ready for. Meanwhile we want to be able to maintain, you know, potentially for a fair number of weeks a level of activity that we're seeing that's keeping all of our campuses, fully occupied both in our ICU and in our med surge areas. So we'll be rotating some people through teams to keep them refreshed and, as well as needed. And scheduling in teams that we could deploy quickly if we had to. While, as Tim said, starting to figure out how do we start looking at taking on some of those additional urgent cases using some of our capacity, especially as things start decreasing with the total number of inpatient cases as we anticipate.

Patricia Kritek: Thank you. Rick. I'm actually going to ask a slightly different question, but it relates to what Tim was talking about in terms of supporting other groups, you talked about supporting skilled

nursing facilities. Rick, I was wondering if you could just give us a little bit of an update on Harborview Hall. So Rick Goss, Medical Director of Harborview Medical Center.

Rick Goss, MD, medical director of Harborview Medical Center: Sure. Happy to. Again, I think just the overall effect of the promising news of the trends and the predictions that perhaps we're at least a plateau, maybe still slightly rising depending on, which vantage point you look at. So that keeps us very much, completely focused on the need to ensure the best services to the most people. We have been really pleased at the just tremendous work Dr. Saug, Dr. Dueber and so many others in the ambulatory and in the work with some of the homeless individuals. And in last week or two, we've been able to, restructure, reconfigure, Harborview Hall to serve as a shelter but for individuals that have either tested positive or are awaiting a test, this has just opened, within today or yesterday. And people are staffing that now. And that will work in close harmony with the emergency department tent where anyone can come to the evaluated through there. But if somebody is homeless and does need the services, our review hall, it's literally just across the street. So we will have testing, we will have some medication available for those folks. So we are really pleased that that is in effect. And we do know that in some of the shelters that have been tested, there are higher rates of acquisition perhaps than we had anticipated. So, we do think this infection and, some of the groups that are most vulnerable, we'll continue to see high rates. So we have to stay very, very focused on this work. So thank you.

Patricia Kritek: Thank you. I have one last vulnerable population to ask about, which came in through the question and answer, which is do we, does anyone here have an update on King County jail and where we stand with the King County jail.

John Lynch, MD, medical director of Harborview's Infection Control, Antibiotic Stewardship and Employee Health programs; UW associate professor of Medicine and Allergy and Infectious Diseases: We haven't actually heard from them for quite a bit. Others on the call may have. But they were doing really well. They did have some cases but they had a really firm plan for segregating folks with a positive test. I have not checked in with them this week so I don't have an update to share.

Patricia Kritek: Okay. That's fine. And we can think about whether or not we want to check in on it for next week as well. Thank you for, for winging it. Okay, so surge--we're kind of peak plateauing. We're taking the peak plateau seriously. And we're also thinking about how we might move into recovery. I think there'll be more discussion about that over the next week. So I appreciate this, this tension of doing both at the same time, just to say it out loud. That's a tension for everybody in this room and it's potential for everybody who's part of our community as we try to figure out where we are. And I know there's some people who are feeling I'm really still in it and I, that is my whole focus and there are some people who are like, I'm really hoping we're moving to recovery because it's going to impact what I do every day. So we hear you and we're going to keep working in both of those at the same time acknowledging that tension. I'm going to go to John Lynch who is actively managing transfers as he's, as he's doing this with us today and ask him for some numbers. John Lynch, Head of Infection Prevention and Infection Control at Harborview Medical Center and Medical Lead for our Incident Command. John, I wanted to ask you people asking some of the same stuff we asked before. So could you just give us an update of where we stand today? Tim gave us a little bit of it and then I have some specific questions.

John Lynch: Yeah, sure. Thanks. And thank you everyone who's calling in and everyone who's not calling in. I appreciate all your fantastic work. Yeah, so I'll just run down some numbers. These are from today and as Tim mentioned, they've been fairly stable within five or eight of this number over the last week. So, we right now, UW Medicine has about 117 people at our four campuses who are hospitalized with COVID 19. About just over about three quarters of them are in our acute care. So 75 people in acute care and 42 people are in our ICU. Valley right now has the largest with 44 people hospitalized 29 in acute care 15 in the ICU. Northwest has 27, with 23 in acute care and four in the ICU. Harborview is tied with Northwest of 28 individuals, you care and 15 in the ICU. And Montlake has 18 people with 10 people in acute care in eight in the ICU. And so as Tim mentioned, things, you know, these have been fairly stable, more watching them really closely on a, on a daily basis.

Patricia Kritek: Thanks John. There are folks who asked about specifically, **do you have a sense of overall how many patients have been discharged and overall how many patients have died in our system?**

John Lynch: Yeah, so I don't have a full number of the discharges, but I can give you a sense of, for instance, what's happening this week, which I think is probably the most stable week we've had. You know, when you add up all these numbers, one of the big challenges is that at the very beginning of March we had very few people admitted, and as time has gone on, we've kind of, you know, increased the number of people in the hospital. And so the total number of discharges and the total number of deaths is tricky because it's really based on how many people you have in the hospital. So over this last week, we've had approximately, when I look at all my numbers, about 21 deaths. On a daily basis, we range between zero and one to a high of about five people who are dying from COVID19 on our four campuses. We actually have fewer discharges than that. And on a daily basis, we range anywhere from probably zero to one to probably I think a max of a five or six people discharge us. But most days it's, it's on the lower end, one or two. And I think that this is, you know, reflects what we're seeing and what is going to continue to be a challenge as Tim said, is that our hospitals continue to admit people and transfer people in with COVID19 who go to our acute care floors and our ICUs. And it's taking a long time for them to really get well to the point that they can be discharged from the hospital.

Patricia Kritek: Yeah, I think that, thank you for kind of giving the nuance of that because cause those can be kind of sobering numbers to hear. We have a lot of people who are moving towards getting discharged, but it's going to take us time to get there. And we know that when patients are admitted to the ICU they have a higher mortality. And so we've had an enriched population for ICU patients who get transferred into our system from other places. So I think it's worth noting those two aspects of it. So I appreciate you giving the nuance on that. Relevant to that. **Can you speak to transfers in from outside hospitals and maybe transfers within our system because we've been doing more of that this week?**

John Lynch: Yeah, sure. So let me focus on our system for just a minute. So what's been really fantastic over the past few weeks is recognizing where our system is seeing greater numbers of admissions. And what's really been remarkable in this last week is our colleagues at Valley, both in the acute care and on their ICU. I've really seen a large increase in number of patients, which to be honest, and we can talk about this later, is probably a reflection of where this epidemic is heading in Western Washington, the populations it's disproportionately hitting. And so what we've really been working on, and Rick and many others on this call, I've been how do we help, for instance, in the last week, our colleagues at Valley, make sure that they have enough capacity throughout the day, but especially at night to take

both acute care and ICU patients. So over the last week, we're moving patients from both acute care and ICU over to Montlake, Northwest and Harborview to provide that care. And I think it's really been, that's been the major focus and that's allowed us to maintain capacity site and keep Valley doing its normal work but also take care of COVID patients. From outside one thing that I really like to emphasize and Rick and Jerome and others in this call are part of, is the launch of the Regional COVID Coordinating Center or RC3. And this is really a huge effort that many people have been involved in. It is based at Harborview. And it is really an effort to look, to have access and visibility into the capacity throughout our region and to look at where we can potentially in a coordinated way support the movement of patients. This has a history for our disaster response. So the, what's called the DMCC or Disaster Management Coordinating Center, over many years has been working on this way to how to respond to acute disasters, but really the, the recognition that we need to coordinate at a regional level over a long period of time is a brand new paradigm that we've entered into. And I'm really pleased and amazed at the amount of work that's been done over the past four weeks to get this center launched and is currently open on the Harborview campus right now to help with this work.

Patricia Kritek: I think that's great. And you know, there have been lots of questions about how we're helping other people and how we're collaborating. And maybe next week you can give us a sense of how we compare to the other hospitals in the area in terms of how we're doing because I think people are curious about that as well. So I'll ask that as homework because I know that there's already questions about it. I will add, I think we do have folks going out to other places in the country now and we can talk about that more later as we try to support our colleagues in New York and in new Orleans, Chicago and Detroit, places that are hit more dramatically right now. I want to pick two things on what John said. The first is there is lots of discussion about disparities in the COVID positive patient populations across the country and in our region. And I have asked Paula, Houston, the Director of Health Care Equity to join us next week so we can talk about this more cause I think it's a really important topic and I'm seeing some of those questions come through. So I hear you. Those are really good questions and we want to talk about it both nationally and locally. And so I've already asked Paula to join us next week. **The second thing is I do want to give numbers from our other sites where UW faculty work.** So Children's continues to have low numbers of patients, which is wonderful. They are currently at two patients who are hospitalized. They're running with a 1% positivity rate on all of their tests. And for them their workforce positive rate is 4%. **John, I don't know what our workforce testing numbers were in the last week or so.**

John Lynch: My last update at the beginning of this week was around the same, about four and a half percent. We are active validating the database and we'll be giving an update to the community right away.

Patricia Kritek: Okay, great. So we'll come back to that. And then we also obviously always have our VA colleagues as well. And our peers who work in the VA. The VA currently has four acute care patients in one in the ICU. Who I hear is turning the corner. And that's great to hear as well. So thank you for all those numbers. I have one last thing to ask you, John and I hope I can give you before you have to get a call and that is **how do we stand on PPE? Cause there are lots of questions about how do we stand on PPE and PPE stands for personal protective equipment.**

John Lynch: Yeah. So our supply chain colleagues are working tirelessly the last five or six weeks on this and we're actually doing okay. We've had to make some modifications about the primary tools we use.

For those of you who work on clinical floors, you may be used to the masks with the face shields or the eye protection built in and that's become quite short. But we have similar masks and other tools we can use to protect our eyes. So it's really, the focus now is really on using other products where we may run short of what we're used to. But as of right now, we're doing pretty darn well with all of the parts of the personal protective equipment. One place where we're going to be probably thinking really hard over the weekend and might be challenged coming into the next week is around cleaning agents. And you had started off this whole conversation with our support for our EVS colleagues, which is, I totally agree and I can't thank their work enough, but they might be needing to look at alternative tools for doing the routine and special cleaning we do for COVID areas in the near future, over.

(Laughter)

Patricia Kritek: Thank you. So whenever John is on the incident command call, he ends with "over" and so he's now gotten into incident command mode. Thank you. Relevant to testing there were lots of questions about antibody testing and the whole spectrum of do we have it, when will we have it, how will we use it, what is the role? And I asked Santiago in advance actually to do a little bit of work on understanding where we stand with antibody testing, he has already been part of those conversations. I know he's talked to other folks. So I'm going to turn to Santiago Neme, an infectious disease doctor and Medical Director at UWMC Northwest campus. **can you tell us where we stand with antibody testing?** Let's start with that.

Santiago Neme, MD, MPH, medical director of UW Medical Center – Northwest Campus;

Division of Allergy & Infectious Diseases, UW School of Medicine: Hi everyone, so this morning I had a nice conversation with Dr. Mark Wenner, he's the medical director for the UWMC lab and he gave me an update on things. First, currently there isn't an FDA approved antibody assay currently available. So the lab is actually has an assay that they're using for research purposes only right now. They've notified at the FDA and that's pending and the main aspect in which they are using this is actually a convalescence plasma study.

Patricia Kritek: **Can you explain what convalescent plasma is?**

Santiago Neme: So basically it's the antibodies that you generate after you've been exposed to an infection and the immune system interacts with the organism, that creates antibodies, and these antibodies are supposed to help folks who are infected in the recovery. Similarly with, you know, other immunoglobulins that we give when folks are acutely infected to something like chicken pox. So there's research going on and utilizing this assay currently that's been led by doctor Anna Wald and also Dr. Mark Wenner. You will see there's some point of care tests out there like kits that are similar to the home pregnancy tests. But there are some concerns around the quality control of those so that UW Medicine lab does not recommend them at this point to be used clinically. So just keep an eye on those. Something very interesting that's happening is that the UW lab is in conversations with CDC to become a CDC reference lab for multiple purposes, including potential surge and of patients where you need to test massively. So that's something exciting that's in the works. And then lastly, I wanted to point out that CDC hasn't really released any clear guideline as to what would be the clinical indications for this assay. So still the clinical implications of this, how are we going to use this clinically outside of

understanding kind of the epidemiology of the infection, like the zero prevalence of an area it is, it's unknown. There will be some very select indications, but that hasn't really been defined, so.

Patricia Kritek: Yeah, let me, let me pull out a couple of things there. So one, I heard you say we have a test. It's not FDA approved. We're trying to get it FDA approved and there are no FDA approved tests yet. Right?

Santiago Neme: Right.

Patricia Kritek: Which again, kudos to UW Medicine for being ready to go I think that's super exciting. The second thing, which is what a lot of people ask about was, you know, I think there's a lot of healthcare workers who think maybe I've been exposed and I have antibodies or I was infected and I think I might have antibodies. I think the two questions are asking is, are we using it to assess that right now? And the answer to that is no, not right now. And the second part is, would it say that I'm immune and we've talked about this before and the answer there is?

Santiago Neme: It's unknown right now because the presence of antibodies hasn't been demonstrated to give you immunity at this point. It's been studied but it hasn't been demonstrated yet. So there are niche professionals where you can see this happening. For instance, in the fishing industry before you send someone out for months or weeks then there could be an implication for that select group of folks to know that they're immune. If we can prove that that's demonstrated. So that's, that's one application, right? Where I think, actually our lab is looking into these possible applications but we haven't really launched it in that regard. And again, currently it's only research based.

Patricia Kritek: Okay. I think that'll be a topic people will want to keep hearing about. So I'm going to look for another update next week as we see what happens with the FDA. And I get it. People want to know am I protected, does it change how I can come back to work, et cetera, which ties into a question that I have heard a bunch. Questions about if someone is COVID positive, what they should do at home. I know that you hear this question a lot from as an infection preventionist, and I think particularly what I've heard is in folks who have two healthcare workers in their house what they should do. So could you talk to that a little bit? And I, I'll say I live in a two health care worker household. So I'm particularly interested in your guidance here.

John Lynch: Yeah, sure. I can, I can go first on this and I look to my other colleagues as well because there isn't any official guidance on what to do to be honest. And so I also work in a two health care worker household. We recognize that both of us have a commitment and a responsibility fulfill for our work. And so I think that the only thing I can really look to is a really, I thought pragmatic and thoughtful guidance the CDC is giving for what to do when someone is infected at home. Some of this is a little bit challenging because not all homes are the same. And in fact, not everyone has access to the ability to do the work that I'm about to recommend or the space to do that. The basic idea is that if you think that someone is at home and has COVID19 or is diagnosed with COVID19, the I the best possible scenarios that is we can physically, not socially right but physically move people to different parts of the home and to try to you know, provide some looseness between folks. When that affected individual if they can wear a surgical mask or I should say should a face covering in the home when they're within six feet or,

or closer to other family members, that would be optimal. The cleaning the disinfection are all really important parts of this, as is hand hygiene. So within any home, whether it's a health coworker or not, if you're dealing with someone who might have COVID19 it's really if you can have space in your home, we can put them where you can create some physical distance. If there's an opportunity to use a face covering can you do that creating of the environment and have really easy access to hand hygiene? Those are all the optimal tools. Now again, there has to be a lot of applications to allow for different housing situations and home situations. And within two health care work for homes I think really the goal is to do the same thing, right? We currently need our healthcare workers to respond to the call to work. And we've gotta be closely monitoring our symptoms. And I think being really, really thoughtful about any remote symptom, particularly for our UW Medicine workforce, any symptom that is concerning should trigger a plan to stay at home and to access the employee testing either up at Northwest or here at Harborview or potentially out in Issaquah. **Other things you want to add to that?**

Santiago Neme: No, I think that's great. I want to say, just to say it out loud, intimacy is challenging in these situations, right? When you are with your partner and then the other person is in healthcare and that's, we acknowledge that it's a problem.

Patricia Kritek: Yeah. We've had some drop in sessions for spouses and partners of healthcare workers. And I think trying to make your life normal with your significant other and your family in these situations is hard. And I think we're all thinking about it. It includes the people in this room. I think about it as well. I definitely do. And struggle with some of those challenges. The topic of being COVID positive brings up this topic that was, has been brewing, which is what happens with sick leave for folks who are healthcare workers who are positive. **And so Tim, I'm going to look to you to talk to us a little bit about where we stand and you know, in terms of sick leave and the law that was, or the bill that was just passed in the government.**

Tim Dellit: You know, and I'll say a few comments and then there also will be broader and communication coming out later today on this, so people can look at that in a little bit more detail. And **I'd also preface this that we have had a lot of discussions within UW Medicine on how best do we protect our healthcare workers and ensure that if we have a healthcare worker who is diagnosed with COVID 19 illness and needs to be out of the workforce, how do we ensure that they continue to be paid while they are outside of work?** What Trish alluded to is a governmental, leave plan that allows the consideration of is that the appropriate way to manage healthcare workers. And because of some of the nuances within that bill, we have actually excluded our healthcare workers from that language in part because we need to ensure not only the protection of our healthcare workers and being able to pay them, which we're committed to do if they're out with illness. But we also have to have the ability to have our healthcare workers within the work environment to respond to the potential surge of patients. With that said we have worked with our HR colleagues, both within UW Medicine as well as upper campus. And our plan would be if someone is diagnosed with COVID19 illness and needs to be out of the workforce we would help them in terms of applying for workers' comp, but we would pay the difference, say if workers' comp pay 60%, we would pay that difference. Or if workers' comp doesn't decide to cover it, we will pay that full amount while individuals are out for that period of time recovering and we are doing so without consideration of whether that was acquired in the community or whether that was acquired at work. First of all, we just want to take care of all of our staff regardless of where they may have acquired it. So I think that actually is a benefit to help protect and ensure that

our workers, if they do become ill, will receive payment for that period of time while they're recovering. And again, there'll be more details that'll come out later today.

Patricia Kritek: Thank you for going into that detail. I don't know if there's anyone wanted to add to that, but I think, but I think I heard, and I'm just going to say is that we're going to take care of people if they're sick and they're going to be paid if they need to stay home when they're sick.

Tim Dellit: Correct.

Patricia Kritek: I think that's what Keri told us last week, but we're saying that again and we're going to keep saying it and we want people to understand that it's really important, I think relevant to that there've been some questions that folks have asked if we're going to furlough workers right now. I'm going to introduce Keri Nasenbeny, Associate CNO for UWMC-Northwest to address that somewhat challenging topic.

Keri Nasenbeny, associate CNO for UW Medical Center — Northwest: Yeah, thanks Trish. And I will to just start by extending my thanks to everyone who, you know, who's out there caring for our patients in whatever capacity, whether that's strictly at the bedside or in a supporting role. Just really appreciate everyone's efforts. I will say that question has come up a lot and I know that's obviously a concern, but furlough is not a strategy that we are deploying right now. So I do want to reassure folks about that. I think as other people have said, we're in this really sort of interesting place where I think we're still concerned that we could see more patients and we do, I think any of our campuses have extra people hanging around. So how do we manage that tension of you need to prepare, wanting to make sure that we have the right amount of staff and also making sure that people have jobs to do. And so I know some messaging went out earlier this week and what we're really encouraging folks to do is if you're an area that is seeing low volumes and you're not needed through either the local labor pool or at the labor pool at the Kronos central level, that we were to think about taking time off. I think, you know, one of our concerns is that as we move into the summer and we start, you know, doing surgeries again, there's going to be a lot of pent up demand. And then it's going to be another place where we're going to need all-hands-on-deck, right? Because people have delayed surgeries, et cetera. So I think at this moment, you know, I'll just reiterate that furloughs, not a strategy that we're deploying at this moment and you know, to think about if you're not, if you're in an area that's seeing low volumes, and you're not needed through one of the labor pools as a dofficer or in some other role, maybe to think about taking some time off.

Patricia Kritek: Okay. Thank you. I think, I mean, it's impossible to be living right now and not notice that people are losing their jobs, right? We're talking about it everywhere right now. And I think truthfully, it's impacting all of us because people that we care about and love are having to deal with that. So it's normal for us to think about it and be concerned about it for folks in our community as well. We'll keep talking about that as well as we move forward. I want to try to, well I know there was one quick follow up question to Santiago about antibodies and I'm going to switch to people come into the hospital. But I know there was a question through the Q&A about this one test developed by Cellex. And if you want to comment on that, that's an antibody test.

Santiago Neme: Yeah, just really quick. And that's one of the point of care tests that Dr. Wenner and I discussed today and that there are some issues with the sensitivity, the specificity and some quality control issues and it's not widely recommended.

Patricia Kritek: So maybe to correct what I said before, maybe that is FDA approved that test?

Santiago Neme: Yeah. It's not the fully validated, it's kind of an abbreviated,

Patricia Kritek: Abbreviated approval. Beyond the scope of my knowledge right now, but thank you for whoever threw that in as part of the conversation. We appreciate that and give people a chance to respond to it. I want to talk about people coming into the hospital. First of all, I want to talk about screening cause there are a bunch of questions about screening of folks coming in the hospital. I'm going to look at to you Jerome Dayao, Chief Nursing Officer at Harborview. A lot of people want to know what, what are we asking folks as they come in the door? And I'm going to just ask you that question first and I have a follow-up question.

Jerome Dayao, chief nursing officer at Harborview: Thank you Trish for that. I mean I think this is very important and we really appreciate the patience of our staff being a part of this screening process and volunteering to be screeners. We ask patients or family members who come to our doors simple questions about symptoms. I mean, if they're experiencing any of this respiratory symptoms like cough, sneezing, any fever, and we go over those questions and if they are positive and visiting we discouraged them from visiting. And if it's a patient, we do our processes to make sure that they get checked. So it's very important.

Patricia Kritek: So, there are still questions about why we don't take temperatures. And I think the other question, and I'm going to look at to John for this question. Jerome, I'll take you off the hook. And then I think the other group, the other thing that people are asking is like, why are we asking about travel still? Should we still be asking about travel? Should we ask about GI symptoms? Cause sometimes people present with GI symptoms. Should we ask about not being able to smell because we know that some patients present with not being able to smell. So do you want us to comment on that for a second?

John Lynch: Yeah, sure. I'll try to be brief. So the temperature question is that it actually is linked to your other points is that the presentation of COVID19 is really, we're learning something new every day, at least every week. But if not every day. And the spectrum of disease is so broad that we can't include temperature as a really reliable tool for someone with this infection. And we, we know this from our own experience within the UW Medicine system, but we also know this from the huge screening programs that were done across the United States with travelers and screening people with these scanners. They were very ineffective. And then they actually, I don't think detected anybody with COVID-19 infection by using these large temperature scanners on hundreds of thousands of people. So we don't want to have a threshold like that. In addition, our screeners aren't clinical people necessarily. Some of them may be volunteering, but many of them do a lot of other jobs within UW Medicine. And to sort of ask them to make a clinical assessment on the fly for a tool that probably doesn't have a lot of utility or questionable utility, I think is probably not the best opportunity. But it doesn't mean you can't do it. It just means that it's maybe not the most powerful tool we have. The other part around just the

spectrum of symptoms. Yeah. We're learning about people reporting the loss of smell. We call that anosmia or the loss of the ability to taste, ageusia.

Patricia Kritek: You're doing a great job using your doctor words. (Laughter)

John Lynch: Well these aren't the words that we are actually used to using, right. And also people presenting with diarrhea. So, we're getting lots of case reports and communications with colleagues, both around the country and locally. We are rolling them as possible, as quickly as possible into our guidelines and questions. So we are trying to roll those things in. I would say though, that the big challenge we have is that these are all people telling us this is their experience. So we're trying to incorporate those and trying to balance with what we really know well, right, what we see in our literature and, and, and other sort of systematic reports with what we're hearing, you know, and, and it's always that balance of trying to be, uh, keep moving fast and to try to use as much evidence based approach as possible.

Patricia Kritek: I appreciate that, and I think I appreciate the kind of coming back and thinking about it over and over again. I think we are doing that. We keep reexamining stuff. And that's a segue into me asking a question that I ask every time because I would be remiss if I didn't have some questions about masks because there are still a lot of questions about mask out there. So I'm just going to ask about cloth masks. Tim. Where do we stand with people in cloth masks and how we're using them in our institutions? Cause there were some questions about that.

Tim Dellit: And as people recall this was a late release last Friday with CDC recommending that in public if you were unable to keep a six-foot distance to use a cloth mask for protection. And, and keep in mind when we use those masks, they're largely to protect other individuals from us. So if you have symptoms, it helps keep the splatter from going out further and decreases the viral shed. And the thought is maybe even if you don't have symptoms and are infected, could that do the same. From our standpoint we are allowing cloth mass in the nonclinical areas. The distinction is in those areas where we are providing patient care. So if you are coming into one of our units within the hospital any or one of our clinics where patient care is provided, we want our healthcare workers to use standard PPE. That is the PPE that we know is effective in helping to protect them as they are caring for our patients. If our employees are in non-patient care areas, nonclinical areas, that is fine. They can use their own cloth mask. And in fact, we've had even donations from some organizations within our community with cloth masks. And we also have seen stories where one of our trauma surgeons at Harborview is, is sewing masks. I think those are appropriate in those situations and the nonclinical space where you cannot keep the six foot distance. We just had a discussion earlier this week with researchers in the lab and in those settings. Also the challenges of how do you maintain that physical distance of six feet and the use of masks because often you can't do that. And so again, we've tried to make that distinction between the patient care and the nonclinical areas.

Patricia Kritek: Thank you. And we'll keep talking about masks. I know it's a source of anxiety and we've evolved and we're going to keep learning and talking about it. The other thing that we've talked about before, what I'm going to bring up again is working from home. Cause there were a bunch of questions about working from home. So I'm going to actually look first to Tom: there's questions about the UW

Neighborhood clinics and, and efforts and people being able to work from home. Oh Tim, do you want to make that comment?

Tim Dellit: Yeah, there's going to be messaging that I'm going to be sharing with Tom and Rick shortly to send out. I think the question has been for instance, if I'm performing telemedicine visits, do I have to be in clinic or can I just stay home and do those. The challenges is that, you know, we are keeping our clinics open. We still need to see those patients who need to be seen in person. We need to see those individuals with urgent visits. And there's also a certain amount of equity between ensuring that our staff who are there to support the clinics and our providers are there as needed as well. What we are asking is that it really is the role of the clinic medical director working with the clinic manager to determine based on the patient population and the care they are providing, what their staffing needs are both from a nursing side as well as a physician side. And so what I would say is that really check, providers anyways, should be checking with their clinic medical director to determine what those needs are within the clinic and ensuring that we have adequate staffing, both our staff and our providers to ensure that we can continue to deliver the care needed. And again, this is really during this period of time until May 4th, while we're in that stay at home period of time. And again, I apologize because I think there was some misunderstandings that technically, yes, you can perform telemedicine visits outside of the clinic, but there are a lot of other reasons why we need providers actually in the clinic. And so it really is at the discretion of the clinic medical director from the provider standpoint and in collaboration with the clinic manager. Absolutely.

Patricia Kritek: Yeah. And I'll just look to our nursing leaders and see if there's anything you want to add to that. Keri looks like she might be unmuting herself.

Keri Nasenbeny: Yeah, no, I think what Tim said is exactly right and I think it for nonclinical positions that really needs to be in coordination with your manager decide if work can effectively be done at home. So again, I think back to that, you know, working with your direct manager to think about what that work is and if it can be effectively done at home or not.

Patricia Kritek: Okay. So we're trying to relate to our microcosm at every clinic is different and that we need to have a local response there though we're obviously all still part of one big community cause I think sometimes folks out in the clinic don't feel like they are as much a part of things. We're trying to respond to the unique needs of that clinic.

Tim Dellit: And I think the key is the clinic leadership together has to determine what those needs are as opposed to individual providers or staff making that decision on their own. It has to be coordinated so that we continue to meet the needs of the clinic and the population served.

Patricia Kritek: Okay. I'm going to sneak in one last question and that one is about testing of all patients. So where do we stand about testing of all patients? John, do you want to comment on that?

John Lynch: Yeah, so absolutely. So we made a decision over the last weekend that we wanted to do universal testing of all admissions at Northwest, Valley, Harborview and Montlake campuses. We started this last week working with the incident command planning and operations teams to get that. We've

made incredible progress and I think we're going to actually be able to launch it in the next few days. This process will have a combination of using a rapid test that we've used for some of our pre-op cases and the standard tests through our UW clinical virology lab. And I think the part we're just finishing off is how to make sure the orders for what we're calling a surveillance testing clear for all people involved compared to our symptomatic testing.

Patricia Kritek: Thank you. And I heard Santiago state, to me, it's probably going to go live Monday.

Santiago Neme: We're hoping that. We're working on ordering details.

Tim Dellit: And keep in mind, you know, this is really a huge benefit that we have because of our internal testing capabilities thanks to our lab and we already have been testing surgical patients prior to going to the ORs so that we can safely and appropriately care for them in that context, especially if they're undergoing aerosol generating procedures. We've been testing patients on our labor and delivery, ensuring that we can safely care for them. And I actually think this testing of all the patients who are going to be admitted to our facilities can also be part of the recovery plan as we think about how do we ensure a safe environment for patients coming back to the hospital. **Because one of the questions is even when we get to a point where we start doing those elective and non-urgent cases, will the community feel safe coming back into the healthcare sector?** And I think this is one of the ways we can actually help provide a safe environment for them to reengage in care.

Patricia Kritek: I think that's awesome. Thank you for updating that. That's definitely a question that came up in multiple spots. I also know that there are lots of questions I didn't answer. I'm going to say there was a basic science town hall, so for the questions about research, **I strongly encourage you to go to the UW Medicine huddle, the COVID19 page and there's a recording of two basic science town halls that have answers to the questions you asked about research and starting,** I hope tomorrow, but if not Monday, the medicine department is doing twice a week rounds and talk about the clinical care of patients with COVID. **I also encourage you to go to that site to see information. I know there were questions about ibuprofen and ACE inhibitors.** I think that's a good place to go for that and we can touch on it next week. I can't get to all of it in one week, but I think that's a good resource. Even before that, I'm going to close again by saying thank you. Thank you to our entire community. Thank you to the folks in this room who come together. I think we noted, this is our sixth week that we've been doing this. It's a little bit amazing to me that that's the case and we're in this for the long haul. We're going to keep coming to you as long as there's stuff that we need to answer. So I encourage you to keep sending us your questions, know that we will keep working to answer them for you, and I'm going to ask you all to take care. Have a good weekend, and we'll see you next week. Bye bye. Thank you.