UW Medicine Town Hall Transcript: April 17, 2020

Trish Kritek, MD, EdM, associate dean for Faculty Affairs and Pulmonary Critical Care doctor at UW Medical Center Montlake: So welcome to this week's UW Medicine town hall. It's a pleasure to be back with you again. I'm Trish Kritek Associate Dean for Faculty Affairs and Pulmonary Critical Care doctor at UW Medical Center Montlake. I'm letting people keep coming in, but I want to get us started so we can take advantage of all our time.

I want to thank everybody again for all the outstanding care that you're delivering. Thanks for everyone who's supporting the folks to take care of our patients. I want to call out a few new groups today. The first is the folks from advancement who have changed their, their lens and have been getting us food from variety of really generous folks across the city and getting into all types of different groups of people who are part of our team. A huge thanks to them for being "repurposed" in a variety of different ways. And they've been working on lots of things that support our team, including all the donations that are coming in about with PPE and, and other stuff that we need. So thanks to those folks. And, and thanks for the communications team for really coordinating so that we can highlight all the great stuff that's happening across UW Medicine. I personally have watched a variety of videos including the Today Show and various other TV shows, read about all the great stuff and I just want to thank the communications team for doing a good job of getting the word out. So, thanks to those folks in addition to everybody else.

And I'm going to thank all the people who are with us again today. I, a couple of people who are maybe new Seth Cohen is back, he did a cameo appearance early in our town halls. He's the head an Infection Prevention at the Northwest campus of UWMC and Paula Houston who I promised you would be here today, is joining us and she's the director of Healthcare Equity for UW Medicine. So, thanks for those folks and everybody else is some of the same cast of characters that we've had.

With no further ado, I'm going to get us going. Thank you for all people who submitted questions. Again, we had hundreds of questions. We'll get through as many of them as we can. I appreciate those of you say to me, I keep asking the same question and I hear you and we'll do our best to get to those through the day today. So, I'm going to turn to Tim Dellit CMO of UW Medicine and ask him to tell us a little bit about, kind of overall where we are, and I think there were a bunch of questions around where we stand in terms of clinic and surgery rolling out. Maybe you could touch on that to start with in this. Where do we stand and kind of reopening?

Tim Dellit, MD, CMO of UW Medicine: Thanks Trish. Again this remains a very interesting time I would say this week on one hand we're cautiously optimistic as we look at, for instance, IHME that continue to suggest that we're not going to see that initial rise and surge on patients that we had originally anticipated a few weeks ago. If folks recall original estimates where we may have upwards of over 960 additional patients, those numbers continue to come down and it looks like we've been at our plateau now around 115 to 120 patients across our four campuses. One of the challenges is that we have been at that level really since April 1st so although we seem to have plateaued at a lower level, it is sustained and continues to be more prolonged than perhaps we had initially anticipated. Some of this, I think is driven by the longer length of stay, particularly in those patients within the ICU. As those numbers continue today, for instance, we're at 110. The ICU numbers are staying pretty flat. We've seen a little bit of reduction on the acute care. We've also shifted from, initially we saw that insurgence at Northwest campus because of the long-term care facilities in that neighborhood that they serve and the older population. More recently we've seen the influx in South King County, particularly from Valley

Medical Center. And I think one of the things that concerns us, although we're not seeing that increase in patients within our hospitals, we also still have yet to see a real consistent decline. And we really want to see that decline continue here and we're not yet there.

One of the other challenges is we want to make sure that we are really understanding what's happening in different populations. And so, when we look at our long-term care facilities, we are still seeing a lot of activity in some of those facilities. Often when our teams are going in to do testing, they're finding upwards of half of the residents maybe positive and many of those are positive without symptoms. And so there's still ongoing activity there. We also know both in our experience, for instance, looking at patients admitted to Harborview or our work with marginalized communities that we really have concerns that we haven't had adequate testing access in certain populations. And I know Paula, will talk about that more later during the hour.

And so there are still some areas that we have concerns about, about ongoing activity. At the same time, we are trying to think about, well what could that recovery look like and what will that future state look like here over the next weeks to months. And I think there's some criteria that we're really looking at it as are everyone, whether it be public health or nationally. So some of the things that we need to look for to guide the recovery are, are we seeing a sustained decline in both new cases, deaths, which we seem to be starting to see when you look at Washington state, but also hospitalizations. And we're really, again, not seeing a dramatic drop in the number of patients within our hospitals. We need to have expansion of testing and our lab has done a wonderful job scaling that, but we need to be able to get testing out further in the community. That's going to be very important to identify those individuals who may be infected and then in partnership with public health do contact tracing, the contact tracing public health has not been able to do over the last month simply because the numbers have been too large.

And so we need to get the numbers down to a manageable level so that they can do contact tracing to both avoid new exposures and really help this continue to go down. So those are a few of the things that we're looking at. The final thing that we really need to look at as we start to think about what that reopen will be is PPE supply. We need to ensure that we continue to have adequate supply to care for those patients with COVID 19 as we think about expansion. When I think of expansion, we're thinking of three different phases right now. And again, this is very gradual because we have not yet seen that decline in hospitalized patients. What we are starting to do is look at those urgent cases and is there an opportunity to potentially expand the number of urgent cases that we're doing still in alignment with the governor's order, which really looks at those individuals who may suffer harm if they don't have the procedure within the next three months.

We started out using a more conservative marker of four weeks, and so when we look at that, the first piece of this however, is just identifying the list of potential patients. We need to know what that volume is so that we can adequately plan. So we're still in that planning phase for that. The next phase really would be in alignment with the governor's stay at home order, which is set to expire May 4th. If that date continues, then looking at how do we begin to bring back patients into the clinics at that time. But again, it depends on if that date stays the same. But that is our plan right now as of May 4th. The final phase would be really looking at those elective surgery and procedure volumes and the governor's order currently goes through May 18th and so that would be another phase of work. So, we're in this precarious situation where we absolutely have to focus on the care of the patients, which we still have the large volume of, while we need to look forward and think about that next future states as we try to recover.

Trish Kritek: Thanks for going through all that. You actually answered a bunch of the questions that have come in as you did that. I'm going to follow up one more question for you cause I think you alluded to it, but one theme that I heard with are we partnering with the state to try to figure these out and I thought maybe you could talk about our communications with the Governor, the Department of Health and how we're partnering there.

Tim Dellit: Yeah. So I think there's a lot of communication both with Public Health, Department of Health, certainly IHME has been talking both with the Governors, with the White House, with Governors around the country as a modeled many States. You know, the Washington State Hospital Association also is, there trying to have alignment with our healthcare facilities. I would say there are some differences of opinion in terms of how quickly we can do this. And quite frankly, it's easier to ramp up. And as challenging as this has been for all of us over these last six to eight weeks, that it's easier to go a hundred miles an hour in some ways than to, as we start to go back down the curve, that it may ways it's going to be more challenging. And some of those triggers are not yet known. We're still trying to figure this out. And so I think people have different views, different thoughts that we're trying to reconcile. And I think caution is a key word as we move forward here.

Trish Kritek: Thank you. I'm actually going to dig in a little bit more on this; so, what I heard was the tentative date of reopening clinics around May 4th depending on what happens with Stay Home, Stay Safe. So I want to turn to our, our medical directors and our chief nursing officers to ask a little bit more. So I'm going to look at you, Tom Steger Medical Director at UWMC and Rick Goss, Medical Director of Harborview. There's a bunch of questions about how we're going to open up our clinics and make sure that folks are safe as we start doing that and what our process will be around that. Now I'll start with you and then if Cindy or Jerome want to weigh in as well, you want to start at the Tom?

Tom Staiger, MD, medical director at UW Medical Center: So, as Tim said, we are in a plateau phase, which we've been at for the last two and a half weeks or so. We're just got a slight downward trend that we're anticipating being in this plateau for at least the coming weeks, possibly longer. In the ambulatory clinics we're operating under the Governor's Stay Home, Stay Safe, order which currently runs through May 4th that could be changed. And so we will continue to observe the Governor's direction in this and take that into account for ambulatory visits. The other thing that we're doing is, is doing a risk benefit analysis at a patient by patient, really clinic by clinic level to identify those patients for whom the benefits of coming in for face to face visit outweigh any risks of them being exposed to others in the course of a clinic visit or potentially exposing others in the course of a clinic visit. Um and so our clinics are, know their population of their patients and are doing that assessment for patients converting visits to telehealth visits or phone medicine visits as needed. And bringing in only those patients for whom the benefits outweigh the risk and that are consistent with the Governor's Stay home, stay safe order. As time goes on, we'll be able to bring in some more of those patients. We're also able to schedule increasing number of telehealth visits because we've amped up the telehealth visit capacity. So we're moving through this, but as Tim said, there's a lot of uncertainty depending on the pace of how these actions unfold.

Trish Kritek: Okay. Thank you. I'm going, Rick, I'm going to hold, I'm going to actually pivot to, to, to Jerome and Cindy because maybe the two of you can help with some specifics. I think people are worried about being safe when patients start coming back to clinic. And I'm wondering, there are people

asking questions about how we might do things with keeping people six feet apart and physical distancing in clinic, whether or not we're going to do any testing around people coming to clinic. So I'm going to start with just the physical plant of clinics and I'm wondering if either of you can comment on that aspect. Jerome?

Jerome Dayao, RN, chief nursing officer, Harborview Medical Center: Thank you Trish. There's a lot of discussion currently about the reopening or, or us starting to see the patients that we have normally seen before this crisis and that is currently being discussed in key places right now at the system level, which is in the operation of the surge planning because not only the opening we're looking at is the other important thing that we're discussing is staffing I was fortunate to have had the chance to speak with a lot of individuals that were re-deployed into the inpatient areas last Wednesday I was in the COVID units shadowing the nurses on the floors getting trained as a trained observer and I was able to speak with some people from the clinics that were deployed in that area as well. And the, they do have some, some questions and fears that I was able to answer. But really the bottom line here is as Tim eloquently discussed that as we go through the reopening and planning for that a lot of things are changing as we go because we're also getting new guidelines and new directives as to how to do this. Keep in mind that we're thinking really of the safety of our staff when all of the patients start showing up in the clinics. And that's why, you know, in addition with the physical distancing is having also processes and standards as to how we're going to operationalize that. And, and I'd like everyone to know and be assured that all of these are being discussed at the system level, at the local entities as well.

Trish Kritek: So thank you to Jerome. I think --

Tim Dellit: Can I kind of put it in context a little bit? I think we've talked about this a little bit with our infection prevention teams is that it's going to take a package of activities to create a safe environment, whether it be in the clinics or in the hospital, right? Some of those basic activities such as distancing. How do we keep people six feet or more apart? How do we ensure adequate hand hygiene? How do we clean the environment? I think we've talked about masks here in terms of, you know, people patients as they're coming in potentially wearing cloth masks, especially if there's risks that they're going to be within six feet of other, how do we still keep people who have respiratory symptoms separate from those who don't and get them quickly into the back? And so there's a lot of this that I would say all has to be done as a package. On the inpatient side A lot of those same activities, the additional pieces that this week we started testing all the patients admitted to our hospital, we're doing that so that we can use appropriate precautions for all those patients. I personally don't envision, although things change, I don't envision right now testing people who would be coming into clinic, right? Cause they're coming in for a limited period of time. And I think that's where potential mask use as we continue thoughtfully through that process and all those other measures. On the inpatient side, more universal testing along with all those other measures. And so to me that's going to be a huge piece of the messaging as we begin to see more patients, we have to ensure the patients feel safe coming back in for their healthcare. And so it really has to be a package of activities to keep everyone safe.

Trish Kritek: I thank you, and I think what I heard is that people are working on that package. I will echo what I read in the questions, which is I think people want to know what those details are and we might not be ready to share those details. We're still working on it, but I think particularly around the physical

distancing in clinic spaces that don't feel like it's easy to stay six feet apart, there's a fair amount of concern where you go.

Cindy Sayre, RN, chief nursing officer for UW Medical Center: Just going to say, I think that we actually have put, and I'm Cindy Sayre, Chief Nursing Officer for UWMC. I think we've actually put some environmental controls in place on the inpatient side in response to this crisis that we can then import over to the ambulatory side. For example, the screener has made a great improvement when they put a big X six feet away from them on the, on the ground and have patients down there are people that were coming into the building stand there. So I do think that we've learned a lot over the last six weeks and some of that we can import that to everyone else's point where we were going to have to build this together and it's going to take the creative thinking of the team to figure it all out.

Trish Kritek: So, thank you. I think we're hearing that we're working on it and what I would suggest is through this whole experience, the people who are doing the work have come up with some of the best solutions. So I'm going to invite all of you to share some ideas on those solutions. That doesn't mean every idea is going to be implemented. Let's be clear about that. But I think that it's still a work in progress, but we're going to be thinking through these things and some of the stuff I heard with potentially masking a patients, potentially marking spaces for people to stand so that we maintain physical distancing, figuring out how we're going to structure spaces so that people aren't too close to each other while in waiting rooms and things like that. So more to come on that, questions heard, work in progress. Jerome, I'm going to come back to you. There were questions, you alluded to this a little bit before, but there were questions about when the folks who've been repurposed to other areas are redeployed, when would they be returning to their old job, their usual job? Do you have insight into that right now?

Jerome Dayao: Well, that would be contingent Trish, with are we opening? Meaning to say as, as we start scheduling the cases or are we start having clinic visits those will run out. But as of now, we still continue to have them be deployed in areas where they can be trained as extenders of care. So that is what we know for now.

Trish Kritek: Okay. So I think for the folks who asked that question, once we know that we're going live, then there will be some returning to those places. And so we're holding steady and I think I want to just echo the message that I heard from Tim, which is we need to start seeing things coming down before we make these rock solid plans and we're not quite there yet. One last question and I'm going to kind of push this one to you Rick and, and you may decide to bump into somebody else. That's okay. So there was some questions about worrying about medications. Like if we start doing surgeries, are we going to have the, the neuromuscular blockade agent or the pain medicines or the sedating medicines that we need to do surgeries. And I wondered if you could comment on efforts around making sure we have those things that we might need.

Rick Goss, MD, medical director, Harborview Medical Center: sure. Good afternoon everyone. Yeah, it's a great question. I think though that does fit into the broader set of conditions that we've been talking about. And I would say that for me the unifying, unifying theory that we're working with as has been expressed is that as we begin to sort of expand, reopen those kinds of terms that we do, it matched with the other activities that still are very much focused on COVID treatment, COVID deployment of

personnel and space. And so I would think, and we can talk about specific medications of course, but as we move into procedures anesthesia, clinics based work, I would think all of those are in balance. So I think that's the premise. That's what I'm trying to really help lead here on site at Harborview as well as in conjunction with the rest of the plan. That wasn't an answer specifically about the medications, but I think it fits with the overall thinking that, that you're here. Free to ask us specific though.

Trish Kritek: Well, I think, I think that we're trying to keep tabs on where we stand with some medications that we need for these types of surgeries.

Tim Dellit: Um I mean we do that all the time through P&T --our pharmacy and therapeutics committee and Steve Fialka and Shabir Somani who really need a lot of those efforts across the system. We're constantly monitoring for drug shortages because this happens all the time, not just during the pandemic. And so they are constantly tracking this just like our PPE supply chain, same thing on the medication side. And so they are really watching that and then obviously as we look at what our needs are going to be if we start to open more or looks that we have to factor that in as well.

Trish Kritek: Yeah. And I think just to say it, we're strategizing and forecasting what we would need and looking at what we have. Um and there are shortages of things, there are going to be shortages of things that we have to keep patients comfortable in the ICU particularly. And I think the fact that our ICU population hasn't gone down means we're still using those medications in the ICU, which is part of the challenge here. Okay. I'm going to switch gears. And there were a whole series of questions that people asked about some of the healthcare workers who tested positive for COVID at Northwest Hospital. And there was an email about this to the community earlier. And I think a fair amount of concern in the questions about what happened, how did we deal with it and what are our next steps? So I'm going to let Tim just give us a few words and I'm going to actually look to folks over at Northwest and Santiago Neme here next to me who's the Medical Director at Northwest. But let's start with Tim.

Tim Dellit: You know, I think anytime we hear of healthcare workers that have been infected, we all have concerns, right? I mean, we absolutely want to ensure that we have the safest environment we can for all of our staff. We also recognize that as long as there's transmission, the community, all of us are at potential risk of exposure both at home in addition to ensuring that we have a safe place at work. I want to turn this to Seth to hear more details about this, but I think as we listen to this, I want to highlight a couple of things. When we've seen clusters of healthcare workers who have acquired COVID 19, one, it is often a reminder that we really, as healthcare workers again, cannot come to work when we are sick again, we all have unfortunately that commitment sometimes that we will come to work even with mild illness or maybe we think we just have a cold, it's not a big deal, but right now this is a huge deal and we all have to follow that. And when we all do this, attest at a station, when we come to work, we really have to take that pause and say, do we have any symptoms? Because often when we see these clusters, unfortunately it is a situation where we have that risk of one of our staff transmitting to another. And so we have to think about am I safe coming to work to protect my patients but also my colleagues. And so that I think is one of the key things. The other piece that I think whenever these happen and particularly this Northwest example is a great example of our team being extremely proactive and both understanding what happened, how do we prevent it and how do we keep all of our patients and staff safe as we identify these clusters. So Seth, why don't you give us a little bit more detail of what happened.

Seth Cohen, MD, clinic chief of the Travel Medicine Clinic: Yeah, thanks Tim for framing that. I, you know, what happened was we initially identified about three patients, sorry, three employees who tested positive in early April. And that led us to really open up a unit wide investigation where we did a lot of testing and a lot of tracing of contacts. We ended up identifying about seven unit-based staff who were positive. And then we also identified several staff were not based on that unit who also tested positive. And thinking back it's, you know, it's very hard to determine the, you know, the modes of transmission definitively. But what I would say is, you know, the staff who initially tested positive actually did not care for COVID patients but they actually worked very, very closely together over a period of a weekend in late March. So we're sort of hypothesizing that some of this you know, may have been due to lack of social distancing and other things that, you know, Tim was talking about. And I think has really led us to try to think about how to improve our social distancing in the workplace in addition to other measures like cleaning the surfaces and thinking about wearing masks in those situations. So lots of work being done on this. I just would also say that, you know, I, I know it's unsettling to see the email. We also want to be really transparent about our rates of staff illness. And after sending that out there's, you know, an understandable range of emotions, all of which are very appropriate. But the staff here has been really amazing and you know, both Keri and I received many, many emails immediately just saying, how can we help? And since then, I think Marcos, the unit manager, and everybody else has really done a fantastic job supporting the staff.

Trish Kritek: Thank you, Seth. I'm going to come back to you in a second, but first I'm going to ask Keri a question. Keri, can you talk a little bit about how you might've improved the physical distancing aspect of things?

Keri Nasenbeny, RN, associate chief nursing officer, UW Medical Center: Yeah, I think it's a great question. And I think, you know, it's interesting in talking to staff, they're here, I think that there's some challenges, right with physical distancing. Some of it's the layout of our nurses stations. Some of it is just old habits. You know, and, and, and some of the challenges with our geography and landscape of our units. And so, we've done some things around signage in particular and occupancy limits. So putting some strict limits in our break rooms around number of staff allowed those generally that's around three to make sure that staff have adequate space. We've closed some workstations so that staff are sitting every other workstation now or ever possible and brought out wows and or chairs for wall-mounted computer stations and then really just really tried to get this into people's mindset. I think a lot of it is habit and so just improving that awareness and making sure that staff, you know, we're, that we're all actively thinking, right. I mean for myself included, I think this is something we have to actively think about. You know, as I say, that's the same, same steps, just backed up, right. So that we're not close to each other. So the, all of you are sitting far apart. I think we have to role models this is leaders and we have to help each other remember to do this. So, some of its been around signage, some of it's been around reminders, some of this has been around, you know, actually physically moving some things around to create solutions.

Tim Dellit: Yeah. Yeah. Thank you. I just want to highlight a couple of things as Seth mentioned here. You know, one these individuals, they weren't caring for COVID 19 patients, so that we don't think that this was acquired from patient care and we really haven't seen a lot of evidence of that within our healthcare workers. And the other very important piece is that we don't have evidence of transmission from those staff who may have been infected to other patients as we tested other patients on that unit.

And so that was again, a very, very important part of that proactive approach to see not only which staff may be involved in to help ensure that they get the care that they need and also to help protect other staff, but also to ensure the patients were safe. And again, that I think is very important in terms of how they did that outbreak investigation.

Trish Kritek: So, I'm going to come back to a question with you, Tim. But first I just want to clarify one thing with Seth. So thank you both. Seth I think what you described is that you did contact tracing related to this exposure and you tested the healthcare workers in that setting as opposed to us universally testing healthcare workers when someone is positive. Could you make that distinction for us?

Seth Cohen: Yeah, absolutely. I think, you know, we're still learning more about what the role is of testing asymptomatic folks but in, in the context of an outbreak investigation, we looked at people who are at the highest risk who could have had possible exposure really because there was some evidence of ongoing transmission on that unit and we really wanted to try to clamp down on that, but we are not doing asymptomatic testing routinely in other situations.

Trish Kritek: Okay. Thank you for clarifying. There's a bunch of questions about whether or not we should test everybody and I think that that keeps coming up and people are curious about that. I think Santiago wants to weigh in and then I have two follow this and I'm going to move us to the next topic. So Santiago

Santiago Neme, MD, medical director, UW Medical Center – Northwest: I'm Santiago, I'm the Medical Director for the Northwest campus. I wanted to say. Well, number one, I'm very proud of the proactive approach to the Northwest team had which is the norm. It's, it's how they, they always work. But I also wanted to address a concern that was raised by several people that email me. The perception was because of the sequence of emails that most folks received UW Medicine email from John and me and they felt that we were playing catch up with that email. And what happened is that actually the email from Keri and Seth to the whole Northwest staff came first. That was the regional email. Then this was leaked to the media somehow. And then the media then interviewed Seth. Then there was a story that a lot of people saw and then the UW Medicine message. So it wasn't like, we weren't being transparent, we actually were transparent. And from the very beginning, it's just that the media kind of expedited our flow of communication because we typically let our staff know first and then we amplify it to the whole UW Medicine community. So just wanted to clarify that.

Trish Kritek: Thank you for clarifying that. I appreciate that. And I think we are trying to be transparent. That's why we do Town halls. And that's why I ask questions that sometimes there's no answers to. So that is our goal and we're imperfect at it, but we will keep working at it. One last question on this topic before I move on. Cause I do have a bunch of other things we need to get to today. And Tim, you can imagine that when the question came up about transmission between healthcare workers, a lot of people said, well, why don't we just say that everybody should be wearing a mask all the time. So I'm going to ask you that question again because it is a question we keep hearing and I think I'll let you answer. I don't know if John wants to weigh into, but I'm going to start with you.

Tim Dellit: He'll probably defer to me. You know, I think this is a topic that we have been continuing to evaluate and I think ongoing discussions new things this week, again, not based on necessarily new evidence, but the CDC has now recommended individuals within the healthcare environment wear a mask in alignment with what they've recommended in the public sector. There was a recent study coming out, again, as we've talked about before this concern about people potentially being able to transmit virus up to a couple of days prior to having symptoms. Again, the level of amount of transmission that that contributes certainly in, in close quarters for prolonged periods of time versus in the healthcare system It's not totally understood, but it's certainly a concern of ours. Our bigger concern as we think about that bundle of safety aspects is as we start to see more people within our facilities and we start to reopen so to speak.

I think this is something that you do have to think about. Of right now we have an optional approach where people certainly can wear masks. And I think we are actively evaluating should we make that more of a stronger recommendation to in particular in the anticipation of more people coming in. So it's very much on our mind. It's almost a daily conversation. As we review the evidence, it's also something that is going to take some time if we move in that direction to actually operationalize it is not the easiest thing to do to switch on the, even though it sounds simple, it's not. And so I think we're working through the evaluation process of what it would take to move us in that direction. Thinking of that as part of our recovery plan as we create that safe environment as well.

Trish Kritek: Okay. So thanks for talking to that. And I think just to echo it, continuing to think about it and talk about it and that doesn't mean that people aren't saying that, that they're not hearing the desire to go to that, but perhaps moving that in a very structured and thoughtful way.

Tim Dellit: Yeah, we very much hear and we have the same concerns that everyone is raised.

Trish Kritek: Okay. Thank you. All, John, this is the longest I've gone without calling on you in any town hall. So I'm wondering if A) hello John Lynch infection prevention leader at Harborview Medical Center. Could you give us numbers cause we haven't even done numbers yet today and tell us where we stand and then I have a couple follow up questions.

John Lynch, MD, medical director of Harborview's Infection Control, Antibiotic Stewardship and Employee Health programs: Okay. Yes, of course. Happy to share numbers from just this morning. UW Medicine hospitals are currently have 110 people who are hospitalized with COVID 19. 67 of those individuals are on acute care floors and 43 of those individuals are in the ICU. As I think mentioned before, a lot of these folks are staying in the hospital for quite a long time, but especially those ICU patients that we see those numbers sort of continue to increase over time. Valley Medical Center currently has 33 people in house. Northwest has 31 people in house. Montlake has 13 people in house and Harborview has 33. And most of them are acute care patients with the exception of Harborview, which actually has 19 ICU patients versus 14 critical care patients. Some really good news though in the last 48 hours between Harborview and Northwest seven, people were discharged, which is just a tremendous. And UW Medicine continues to do just a great deal of testing every day which helps really inform all of our practices.

Trish Kritek: Yeah. And that's exactly what I want to follow up on is the testing. There are a bunch of people saying, I heard that the lab has the ability to do up to 5,000 tests. Are we helping other people

with these tests? Is there some way we could facilitate more testing? Because it seems like we're rich in terms of testing and other parts of the local area and the country are not. So, could you comment on that for a minute?

John Lynch: Yeah, sure. Um as with many of my answers, I want to keep it not too complicated because it is a complex challenge and that's that when we think about a lab test, you're absolutely right. UW Medicine, we are so fortunate to have amazing colleagues and incredible department at UW clinical virology. It has allowed us to really do the work that we've been doing and keep our hospitals functioning at the level where you have and obviously take care of patients. You're right. So they can do about 5,000 tests per day and they're right now they're not at that capacity. I would say that the, when you think about a test, there's a bunch of pieces. There's what happens in the machine. There's the swab that goes in the person's nose. There's the transport media that it goes in, in the bag and so forth, and some other pieces along the way. And as we recognize it's not just that final product and putting the sample in the machine in running the test, it's actually all those little pieces have been challenges at times having enough swabs, the right types of swabs, having the transport media that, so it's sort of the idea of a kit. Sometimes even the materials, the chemicals you have to add to get the genetic material out that then goes into the test was a shortage at one point or the little tips to going into the machines that take out some of the fluid they called pipette tips were short. So over time we've kept running into these things that haven't allowed us to fully access the complete capacity. I would say that's one part that continues to be work. The other part is that lab tests are still embedded in what is sort of traditional clinical process, right?

A provider sees a patient, orders the test and then gets the results and works with that patient. And what we really need is widespread, minimal, you know, minimal barriers to testing that don't require a doctor or an advanced practice person, like a nurse practitioner or PA to see someone. And UW Medicine's definitely doing that, right? They're doing widespread testing out in skilled nursing facilities. We're doing widespread testing out and partnering with public health in shelters and so forth. But that really needs to go beyond and we need to be, start using that capacity in a way that our public health colleagues actually drive access so that we can get to every community that hasn't historically had access over the last month and a half or that maybe the future state. And what I'd really argue is that we need to get our tests ahead of the curve to those places where we're not seeing the virus. We got to keep testing until we get to where it's not happening in order to be actually use the full capacity of the tests we have.

Trish Kritek: And we're working with folks to try to do that. Is that right?

John Lynch: Throughout the, throughout the state. We've had fantastic meetings with numerous groups, you know, the Department of Health, Public Health, City, County. Last week Dr. Ramsey and I met with the president of the Quinault nation on the Olympic peninsula around how they can get easier access to testing and with tribal leaders across the country. So I mean across the state, excuse me. And so we're really trying to make sure that everyone who needs this test gets access to it.

Trish Kritek: Thank you. And I think it's going to lead into my questions for Paula and a minute before that I'm going to divert to antibody testing. But before I do that, I'm going to say the other thing people would ask about is are we sending workers to other places? And I'm going to reiterate what I said last time, which is yes, there are physicians and other healthcare members, nurses, who have left the

greater Seattle area and gone to New York to New Orleans, to other parts of the country that are in need. So we are trying to share what we have riches of right now and we're continuing to strategize on those, both within our community and across the country. Now. Rapid fire a little bit. I always look to Santiago to give us an update on antibody testing. So I'm going to turn to Santiago. There were lots of questions about where antibody testing stood. So do you want to give us a quick update on antibody testing?

Santiago Neme: Yes. Happy to. So great news from our lab. As you all know from last week lab has been using a, an assay for serology and research. But lab has just acquired some Abbott technology and new IGG test that's going to work on the Abbott architect instrument that the lab has, and the plan is to launch that sometime next week. It's going to be something that you can order on, on our EMR. It's going to be a qualitative test, so it's going to be positive, negative but again, helpful. And the, the clinical indications are still somewhat limited because again we're going to continue to rely on our PCI for anything acute cause remember that it takes several days for you to have positive antibodies. But it might have a role, clinically, we recently Tom Steger and I had a conversation with Dr. Ragu and there might be a role in ILD in interstitial lung disease post-COVID. So there's, there's a, there's a potential place or role for that. There's also the, the studies around prevalence. So it could be a really cool tool for public health. We're still using the quantitative research assay for the plasma studies that we talked about last week. And so basically that's the quick, the quick version.

Tim Dellit: Yeah. Yeah. We also just launched a COVID19 labs strategy, a work group, recognizing that as new tests come online, like the serology, there are a lot of unknowns and, and we're gonna utilize that group to, to help guide how best to utilize those tests and make recommendations. And so I think that will be coming out very shortly.

Trish Kritek: So relevant to that. I think one of the questions that came up was not any of the groups that you just alluded to, but healthcare workers, so health care workers want to know if we're going to be using antibody tests for our healthcare workers?

Santiago Neme: Yeah, it's certainly a question that has been raised, but it hasn't been decided yet.

Trish Kritek: I think it's challenging because we're seeing stuff in the press about other institutions that are using it for healthcare workers. So that's where I think the questions are coming from.

Tim Dellit: We don't even know what those tests mean yet. We don't know if that means you have protective immunity, what level. So there's so many unknowns that we want to be thoughtful and also you know, one, ensure that we use a good test and two, that we actually understand and can interpret the results.

Santiago Neme: Yeah, there's a lot of hype around industries too, so, but that could be something that we talk about next time.

Trish Kritek: Okay. Yeah, we will keep talking about antibodies. There's lots of questions about antibodies. And I think just to say, again, not entirely clear what it means if you have antibodies and we have a group that's working on thinking of how we're going to roll out our test. There is a question that I should have asked and I'm going to look to John really quickly. This is a, this is a quick one maybe. How are we going with this screening of all patients who are being admitted specifically people are wanting to know how many positives we're finding when we're testing everybody coming into the hospital.

John Lynch: Yeah. You know, I can't answer anything quickly, but I'm going to do my best. At Harborview. None. So it has been actually quite remarkable. So, this screening of patients at Harborview has not found surprises. Again, so this is testing of people coming into our hospital who are admitted to ICU or acute care, who do not have symptoms of respiratory tract infection and getting tested.

Santiago Neme: Yeah. So Northwest--Keri, keep me honest but last time I talked to Seth there hadn't been any surprises and we've been doing it for almost three weeks, like two and a half weeks that we started a little early. And at Montlake there was a, there was a test that came back positive, but it wasn't really a true asymptomatic screening test. It was a test of a patient who had clinical evidence on CT. So it wasn't really truly an asymptomatic screening. But other than that, I'm not aware of any positive.

Trish Kritek: That's the same one that I heard about and I think that one felt like it was not in precaution. So it felt very much like a team and that felt like this was somebody we unearthed with this new process. But I think in retrospect people said, well there were reasons to have suspicion.

Santiago Neme: Cause remember its clinical symptoms and also radiology that could raise your suspicion.

Trish Kritek: So that's great. Thank you. There are a bunch of questions about that. I appreciate that. And John, that was quick-- round of applause.

John Lynch: I know, I know I'm bad, but not that bad. (Laughter)

Trish Kritek: Remember what I said many weeks ago. That laughter is important during all of us and so we do laugh and it's important to do. I'm going to now turn to Paula Houston who I introduced earlier as the Director of Healthcare Equity for UW Medicine. Paula, thank you for joining us. There were a number of questions a few last week and then more in this week asking about disparities in populations with COVID19 and so I think we've seen in the popular press that there are African American and Hispanic communities that are being hit harder by COVID19 across the country disparities in terms of infection rates as well as mortality. And so my first question is kind of just a broad strokes. Can you tell us a little bit about what we're seeing in the community, in our communities in terms of disparities?

Paula Houston, MD, director of Healthcare Equity for UW Medicine: Sure. So first I want to give a shout out to the whole group of us that are, have been working on this. A lot of folks at Harborview Martine Pierre-Louis Lisa Chu, Nancy Sugg, Naomi Schaick Gwen Barker Susan Coviales, Susan Onstad and Leo Morales, those three last three, giving the data. In a way we started looking at this here at UW Medicine

was really there was a group of folks who looked at Harborview and looking specifically at limited English proficient patients back at the end of March, noticing that of the positives, about 7% were English and about 21% were non English speaking. So then they looked at the hospitalizations and also saw a pretty big disparity there. Then a group decided that we would ask the two Susan's and Leo Morales got involved in that to pull the rest of the data on race, ethnicity, and language and started seeing some small disparities and disproportionality, nothing like that we're seeing in other parts of the country. But we decided that we would continue to track that. For instance, in back at the end of March when we first pulled the report for Latinos, the percent was about 15%. It's now as of the 13th the last report we pulled is about 17%. The original report showed about 7% positives for African Americans and now it's up to about 9.6%. So we're definitely seeing an uptick. The problem that we know is out there is that we haven't been testing in large ways in our communities of color, in our black communities. And so even the recent data from the state it shows that they only have about 50% of the data for race, ethnicity, and language on everyone that's been tested. So we really are concerned that the burden of disease in our communities of color is not being adequately represented.

Trish Kritek: So just to make sure I heard you correctly, it sounded like for sure in the Hispanic population, we're seeing a higher rate of positive test results.

Paula Houston: Absolutely. In this state, in this state.

Trish Kritek: Just to highlight that. And I think that issue around language potentially plays into it. And then the second thing I heard you say is, and we probably don't have a full picture because we don't know the race or ethnicity of a lot of the folks who've been tested. Is that correct?

Paula Houston: That is, that is correct.

Trish Kritek: I'm going to ask you a follow-up question, I'm looking at Santiago too, cause I know he's done some work to try to do some outreach, but I'm going to start with you Paula, and then I'm going to go to Santiago. What are we doing to try to address some of this? Clearly, one of it is trying to understand the numbers better and you've alluded to doing more testing. Do you want to talk a little bit more about, we're trying to do to, to address this?

Paual Houston: I would love to do that. Yes. So really at the, about the same time we were, we were deciding that we wanted to gather this data. Were working to get a grant to do just that, to look at vulnerable populations. And so we were very fortunate to have received a grant from the Paul Allen Foundation. They wanted that mostly focused on homeless populations. And so Nancy Sugg and Naomi were taking the lead on that. We then went back to our advancement folks and said, you know, we have vulnerable populations that are not necessarily homeless. There's a subset of those that may be housing insecure, but could we use some of that money to address the needs in our communities of color? And so we got permission to do that. That resulted in us now setting up a mobile testing site. So we will have two sites using that funding. One for homeless that's going to be stood up in Pioneer Square. And the other is a mobile van, which is the healthcare for the homeless mobile clinic that's now turned into a mobile testing site that is being launched actually today they are doing some testing of it. And the first roll out will be on Monday starting at Evergreen Treatment Services, a, a substance abuse treatment

service in downtown Seattle. And so with that we decided, well, we'll get two days a week at South Seattle where we know from looking at maps that the city has given us, there's just a dearth of testing that was going on. Certainly other organizations were doing testing but doing it for their own populations. And so we will be the first now to have an actual community public testing site that will be both walk up, drive up, no appointment necessary will be two days a week at the Atlantic City boat launch, which is in Rainier Beach across from Rainier Beach High School with that same van. So we're very excited about doing that. The first day will be next Wednesday, the 22nd, and then we'll be there Wednesdays and Fridays after that.

Trish Kritek: That's wonderful. I think that's great. There were lots of people who wanted to know kind of what outreach we were doing and it seems like a, that's a remarkable amount of outreach. I'm sure that there's always opportunities to do more, but that's a great, great dent into the issue and we're doing in collaboration with the city. It sounds like

Paula Houston: Right. So the City, Public Health, we've reached out to the FQHCs that are down there, NeighborCare and Health Point. FQHC is a Federally Qualified Health Center or the Community Health Center. The community health clinics that, that many of, you know, we are, we will be partnering with them both to get the word out. Also more importantly, we Martine and I just got off the phone with about 15 community based organizations, many of them serving the African American community or immigrant communities so that they understood what it was we were going to be coming into the community and doing and asking really for their support, getting the word out and, and wanting to understand what some of their concerns are. So that was a really important part of the outreach that we didn't, wouldn't have done without the city. The other point I wanna make and that that Rick had asked about if we were going to talk about is yes, we have another opportunity to expand that because realizing that only two days a week, and even in Rainier beach or other communities where we knew that the that there were people who were at higher risk was not going to be enough. So we made an appeal directly to Paul Ramsey and our advancement folks and were granted enough funding to have a second van that'll be able to be full time in our communities of color our black communities and other communities of color so that we can have a full time fan at the homeless in focusing on our homeless populations and another full time van that will be in our marginalized communities. So we are very thankful for that and we have a team working on getting that up and running hopefully in another week or so.

Trish Kritek: Paula, that's outstanding. Thank you for sharing that. I think not only answers the question but I think goes beyond the questions that were submitted. And I think it's inspirational to me and I'm sure to lots of other folks who are listening. I think that commitment to our community is exactly who we want to be. So thank you for all the work on that and thanks to your whole team, which you did an outstanding job of recognizing in a very quick sentence. Speaking of community. So I'm probably not going to get many more questions in, but there were some questions about when we might allow visitors back into the hospital. And I think for a lot of healthcare team members, the lack of family is particularly challenging and particularly different feeling in terms of how we take care of patients and their families. So Cindy, I'm going to look to you and ask you just to comment on that for a moment as well.

Cindy Sayre: I'm going to say I think this has been one of the more difficult aspects of this whole experience is our visitor limitations and having to make just sometimes heart-wrenching decisions about who we can let into the building during this public health crisis. I think in terms of trying to understand when we might be able to liberalize that policy, it goes back to things that we talked about earlier. I mean right now we still have a stay at home order from the Governor. We're not sure if that's going to be extended or not. I, I think what we can do is look for the markers that Tim was describing about seeing the disease decline, seeing wider spread testing and those kinds of things that show that the community is improving before we can really liberalize the visitation. And I just want to acknowledge that it is, it's one of the hardest things that we have to do. And, and I, I do think it is the right thing to do for our staff and for our patients when we look at the greater good.

Trish Kritek: Yeah, it's a hard one. And I appreciate you taking on that and, and if fits into the whole thing of we're still in the phase of kind of checking in, checking in, checking in and seeing where we are. I'm gonna ask one last question and I know that I didn't get to all the questions people have submitted. We'll be back next week, so don't worry. Tim, there are some brewing questions about our finances and I think it's hard to answer that in the last little bit, but maybe you could give a little bit of a sense of, of where we stand and what we're thinking about finances.

Tim Dellit: You know, I think this pandemic has been very challenging for healthcare systems not only in the response and we are absolutely doing everything we can for that response, but there is a significant financial impact and cost as we've transitioned. So if you just look at the reduction in elective surgeries as an example on the UWMC Montlake campus since March 16th, we've decreased surgical volumes by 65%. And so that does come at a cost. When we've done estimates over a six month period of time, we would anticipate a reduction in revenue of over $300 million for UW Medicine. When we look at our practice plan, so the professional billing side, it's about a $40 million deficit and that's on top of our investment. We've spent over $50 million just ramping up testing and doing all the other things that we absolutely needed to do. And again what I'm really proud of is that we did all of this activity first. We still are obviously focused on the finances, but that has not prevented us from doing what we needed to do and responding. There's a tremendous amount of work on the financial side from a financial stabilization. There was the CARES Act. And so Jackie Cave and her team are actively looking at every avenue in terms of some of that money's that we did receive some initial funding from that we were able to get some advancement from our Medicare billing. That also helps from a cashflow standpoint. That money also has to be paid back though but it helps in the interim. We've been working a lot with the Governor's office, with our congressional delegation back in DC, looking at all of these funding opportunities and keeping track of all of our expenses for potential FEMA reimbursement as well. And so the finance team and the operational team are very active on this. So it is a significant impact. And so I think all of us just, and I say that with full transparency, that this is the challenge here as we go through and why recovery is also important so that we are able to achieve that financial stabilization. Uh fortunately we have wonderful people working on this. But it is a lot of work and I think it's important for all of us to realize that, you know, these next really this next six months and a year is really going to be challenging.

Trish Kritek: Fair enough. This is, these are hard times and we're going to keep talking about these things. I think our time is up. I know that there were some questions about the details that Paula talked about, which I'm going to encourage Santiago and John to fit into one of the daily updates, like where those clinics are and if people want to volunteer to help. If we could put that information into an

update, I think it'd be great to get it out to the community. So we'll follow up that way. Thank you. I'm going to end by saying thanks like I do every time. I'm also going to say happy birthday to my dad who turns 80 today. I know he'll watch this and I am thinking of him and since I gave a call to my mom I've got to give a call out to my dad, we believe in equity in my family.

So thanks to everybody. This is, as we've said a long time ago, a marathon and we're here with you through that marathon. We're going to keep coming back to you and answering your questions and keep taking care of each other. So thank you for all the care you give to our patients, their families, and all members of the healthcare team. We'll see you next week. Bye.