UW Medicine Town Hall: September 4, 2020 Transcript

Trish Kritek: Welcome back to UW Medicine Town Hall. It's a pleasure to rejoin you. This is our first town hall of September, and it's actually the first town hall of the Seattle school year. I think classes started today. Welcome back. I have a variety of folks with us today, and we actually have a special guest. So I'm going to go through all of the people who are here with us today, and then we'll jump right in. So I'm Trish Kritek, a pulmonary critical care physician and associate dean for faculty affairs in the school of medicine, and joining us as we do most weeks includes Tim Dellit, a chief medical officer for UW Medicine, and UW deputy president, Santiago Neme, medical director, UWMC Northwest, Tom Staiger, medical director, UWMC, John Lynch, infection prevention and infection control, no, employee health, I totally messed that up, at Harborview and med tech leader for COVID response, Cindy Sayre, chief nursing officer at Montlake and Northwest UWMC, and Anne Browning, our assistant dean for wellbeing.

We have folks on vacation and have other commitments today, including Jerome Dayao, Rick Goss, and Keri Nasenbeny. So they're not with us today, unfortunately. We miss them. Then I'm lucky to have Jennifer Petritz joining us today. Folks asked if we could "have someone from HR come join us" multiple times in the chat and in Q&A, and Jennifer is nice enough to join us today to hopefully give more informed answers to your questions. So thank you so much for joining us, Jennifer. With no further ado, I'm going to jump right in, and we're going to lead off today with kind of getting a pulse on where we stand in terms of patients with COVID. So John, I'm going to look to you and ask about... Let's just start with, where do we stand with numbers of patients across UW Medicine, and then we'll build from there.

John Lynch: Sure. Thanks. Hi, everyone. I'm hoping everyone's getting ready for a beautiful weekend wherever you might be. So right now, the numbers are down a little bit since I last spoke with you. We have 26 patients in our hospitals with COVID-19, 17 in the acute care units, eight in the ICUs. Valley currently has eight patients. Northwest has two. Montlake has three, and Harborview has 13. Those numbers go up and down a little bit. I will point out that we still are seeing a fair number of ICU patients, and at both Montlake and at Harborview, we have patients on what's called ECLS or ECMO, this heart-lung bypass machine. So we're pretty ill and have been on that machine for a while.

Trish Kritek: Yeah. I think those folks that I know of who are critically ill have been in our hospitals for quite a while as well. How about across King County and the state? Do you have a sense of how we're doing in terms of numbers of patients and test positive?

John Lynch: Yeah. Definitely. So when you look at in King County, I would say they feel like over the last seven days, the number of new positive tests is in the low 100s.

Whereas earlier in August, we were probably in the high 100s, even up to about 200. So the numbers seem to have calmed down quite a bit. You always have to take those positive tests with a grain of salt because it also means, how many people are you testing, and where are you testing? But I would say as a trend, we're seeing it, the numbers go down gently, carefully. If you look at some of the other metrics for where we are, the other one I look at every week is the effective reproductive number, which we've talked about before. This is, how many people on average one infected person infects. In King County, we're right around one, we're hovering right around one. So every infected person on average infects one or fewer other people.

We're seeing basically the same thing over across the state. So Washington State's looking... There's been some big outbreaks, Pullman and some other places. But across the state, the number of new cases seems to be on a gentle trajectory down. The other thing I just want to quickly mention is one thing that hasn't changed really through August was the number of people in hospitals across the state. In the last week, we've also seen maybe a slight decrease in that patient population. So I would say some cautious optimism around the numbers we're seeing

Trish Kritek: As you know, that's where I operate from, cautious optimism. So that's great to hear, and I think resonates with what I've heard kind of in the news and whatnot. One nuanced question in response to that, that came in through the question box was, do we think that we're artificially lowering the numbers because we're testing all these people before procedures and when they get admitted to the hospital, and so it looks better than we really are because of all the folks that we're testing in that kind of approach?

John Lynch: Yes. So I think that's a really thoughtful question. I know for a fact there's some really skilled and experienced epidemiologists on this call somewhere in the audience who can answer this question much better than I can. But yes. When we preferentially increase the number of patients who are at low risk for having COVID-19, we're kind of increasing that denominator of people and not contributing to the numerator, right?

So we're making it look like maybe the number's a bit lower. What we hope is that, and this is why we have to be very careful about interpreting positive tests and rates and percentages is that we really have to look at the trend over time. We have to look at access to testing in communities that are being hit harder than others, right? That have there's higher risk and a lot of barriers to care and across regions across the state. So that's really why I don't look at just UW Medicine, our testing percent. I don't look at just the county. I don't look at just the state. I really look at all of that together because we have to recognize there's definite challenges in interpretation of those numbers.

Trish Kritek: Okay. So yes, it probably impacts it, and so we have to have a little bit of caution in how we look at the data.

John Lynch: Yep.

Trish Kritek: Thank you. A couple of things I think that are triggered by what people see in the news. So I'm going to ask a couple of followups to that. Are we using pool testing in any capacity across our system?

John Lynch: Yeah. So I saw this question-

Trish Kritek: Oh, you went mute. You went mute.

John Lynch: I'm sorry.

Trish Kritek: That's okay.

John Lynch: Am I back?

Trish Kritek: You are back.

John Lynch: So it's interesting. I had seen this question had come up. So I actually asked Dr. Alex Greninger, who is one of our lab medicine specialists, and I'm just going to tell you what he told me right now. So in the city, we are doing that. So there's two city sites that are in contract with UW that are doing pool testing. But within UW Medicine testing, we are not, and I'm not going to go into that. I don't really know all the technical reasons, but we are using it in some populations and maybe not in others. Those may be linked to the prevalence of positive tests within a population or sensitivity issues, particularly around the testing, as you mentioned. We're doing testing for pre-procedure, where we really want great sensitivity, and maybe pool testing isn't the best in that. So I think we are doing some of it, not uniformly. A question just came up quickly. What is a pool test? So I should answer that.

Trish Kritek: Go for it.

John Lynch: Sorry about that. Great question. I should have defined that at the beginning. So the idea here is, can you take 10 or 20 or three people's swabs, put them into solution and test all of that at one time, and if it's positive, then you go out and separate them out? The idea there is that if you don't have much COVID in your population and you combine 30 people at a time, right, if it's negative, then you've tested 30 people in one test. So you basically are able to increase your testing capacity by pooling together.

Often our lab, there's something like one to four or one to five. It all depends upon what your epidemiology is. But again, it's good for some populations, maybe not great for other populations, and we are doing some of it in [crosstalk].

Trish Kritek: Okay. So some in the city, not within UW Medicine. Thank you for explaining full testing again, which I won't re-summarize because you just explained it beautifully. Two more things before I move on to other folks, and I'll come back to you for some more questions in a little bit. People are curious if we're part of the contact tracing that's happening across the county, and if so, how we're involved in that.

John Lynch: Yeah. So I'd say there's really two parts, and others on this call may have more information. One is we have faculty members who are very active in that. So we have faculty members of the UW School of Medicine who are also working in public health. For instance, Dr. Matt Golden is an infectious disease faculty member. He's active in public health and runs their STD branch here but is now leading their contact tracing program. So he's been very active in that, and I think there's other members of the UW Medicine community who are working with public health on that.

The other parties that our lab is doing some of their testing. Public health, South King County worked with a number of healthcare facilities across County to make sure that patients who were exposed to where they're contacting would have access to testing. UW Medicine is one of those places where people who are exposed can get access to testing through our drive-through or other mechanisms. So those are two our big ways we're supporting the county.

Trish Kritek: Okay. So thank you. I lied. I have two more. One is something I've asked you before, but I'm going to ask it again because it comes up almost every time we do this. How do you determine if somebody who's an employee tests positive got that exposure within the walls of the institution versus a community exposure?

John Lynch: Sure. So when we have someone who's positive, so we do contact them to ask them about where they potentially got infected, whether it potentially was in the community, whether it's potentially at work, right? That's really important. That's one of our jobs is to see what that person potentially got infected at their work, right? That's our responsibility. So that's really important to us or whether we don't know, we can't figure it out, right? No exposure or no known exposure in the community, and we just don't know.

So we do that because it's really important to keep our healthcare workers, our colleagues as safe as possible. But I want to make sure that everyone understands is that regardless of the way we classify where someone got infected, it doesn't connect to their L&I administrative leave work. I'll leave the exact terms to Jennifer who's an expert on that.

Trish Kritek: To Jennifer. Yeah.

John Lynch: Because I'm not skilled in the terms. But all of those employees are treated from the HR perspective, I'm looking at Jennifer, as if they got infected at work.

Right? So to some extent. There are some very rare exceptions, but the idea here is we look at that because we need to know whether it was a risk at work that we need to fix. But from the leave part, that's still sort of as all one situation. Does that make sense? I'm sorry, Trish, but I want to make sure I didn't say something wrong.

Trish Kritek: Yeah. I'm going to let Jennifer chime in, and then I'll try to summarize this and clarify. So I think John was talking about clarifying the difference between looking at people at work and trying to sort out the exposure part of it versus if you're a positive, what does it mean in terms of the coverage in terms of being out of work? So if you want to comment on that, Jennifer?

Jennifer Petrit...: Sure. So generally what John was saying is true, right? If you have a positive test, we're going to make sure that you get paid admin leave. We're going to work with you really closely to get hooked up with L&I so that you'll get that L&I benefit. But if we do have people that have been under the work environment for quite some time, and they get COVID-19, and they're very, very, very clear that they didn't get it at work, we may be looking at that a little bit different. Those have been the rare cases, but it has happened, where a person literally has not been in the work environment and tested positive.

Trish Kritek: So if you test positive and you haven't been at work for a number of weeks, we're not going to say that's work-related. But in general, we're going to have latitude to say the presumption is it could have happened at work. As far as the contract racing part, John, you're very specific about trying to figure out really, where could this exposure have happened so that we can figure out, how do we keep everybody safe within the institution? Is that correct?

John Lynch: That's correct. So sometimes, as part of that, we try to figure out, have you traveled anywhere? Have you been out? We definitely are not looking to be punitive or to accuse anyone of anything like that. We're just trying to learn where that infection came from. So if we need to take action on the campus, we're taking those actions as soon as possible.

Trish Kritek: Okay. I think people wonder if we're trying to minimize whether or not people got infected within our institutions. I think you bring the same rigor to wanting to know if it happened within the institution.

John Lynch: Absolutely. Again, regardless of how we classify it with Jennifer's exceptions, it doesn't matter where you get infected in the community by our evaluation. You'll still be on admin leave.

Trish Kritek: Yeah. We're not trying-

John Lynch: We're not trying to escape that.

Trish Kritek: I appreciate it. Okay. You got one more. This one is definitely driven by the news. When do you think there might be a vaccine available?

John Lynch: Not very soon. How about that? I think that there's been a huge amount going on. The vaccine research community is moving at a pace that we have never seen before. I am hopeful that there'll be a vaccine that works at some level in the near future. But if I had to put a nickel down, I'm looking at best the end of the year and maybe a little bit after that. But there's so much dependent upon this. It has to do with how effective the studies are, recruitment, how much COVID is circulating, where those populations are being vaccinated. But I would say that the thing that I would take away from this is that doing the entire phase I, phase II, phase III, all the studies that we traditionally do to test whether our vaccine is effective and safe need to be done now more than ever. Getting to a vaccine before all those studies are done and completed, we know what's going on, have extremely high risk of causing more harm than good.

So I'm really looking forward to robust studies that will take some time, doing everything that we're doing right now to keep everyone as safe as possible and have my fingers crossed for a really great vaccine, maybe around the turn of the year.

Trish Kritek: Okay. So need to do all the steps that we always do. It's even more important than ever. Your rough estimate is around the new year. Santiago or Tim, I look at the two of you to see if you've had any... Santiago is giving a thumbs up. It seems like a similar estimate. Tim's giving a subtle nod of the head to say the same. Okay. Thank you.

John Lynch: That's good you're asking from Tim.

Trish Kritek: Oh, yeah. You're right. Speaking of Tim, I'm going to shift gears, and I'm going to talk a little bit... There were some questions. I'm going to shift to kind of the finance stuff. I'm going to start with a question for you, Tim. A couple of people commented, I think mostly from the Northwest campus that they're seeing construction going on, and I think there's some dissonance between seeing construction and feeling like we're financially constrained. I wonder if you have any insights into that, and I should have asked you too Santiago, but I put Tim on this one.

Tim Dellit: Yeah. I think what they're referring to as a child birthing center. Keep in mind that as part of our strategic refresh, way before COVID-19 began, as part of our planning, we were focused on the women and children's service line. Part of that that had already been approved by the board of regions and funded. Well, before the pandemic to really upgrade the birthing center on the Northwest campus, there was a reevaluation, should we proceed or not? But because that was already funded and because other costs such as construction engagement had already occurred, it was decided it actually costs more if we delayed that project, as opposed to going forward.

In addition, if we don't go forward, we would have essentially a nonfunctional wing of the childbirth center on the Northwest campus. So it actually financially makes more sense to proceed. Again, I would think of that as a project pre-COVID already funded, already under development, as opposed to new capital projects where we are not moving forward with those. So I think that's the distinction.

Trish Kritek: Okay. So I'm going to highlight the last part, new capital projects not moving forward, established projects that are already funded, birthing center moving forward, so we can use that space and take advantage of where we already are and not slow things down.

Tim Dellit: Correct.

Trish Kritek: Okay. Thank you. I'm going to come back to you in a bit, but I'm going to stay with the theme of finances. Cindy, I'm going to look at you for this question. There are a bunch of questions actually about people being concerned that there might be more furloughs before November. I'm wondering if you can comment on that. I know this is a tough one.

Cindy Sayre: Yeah. Well, I'll start, and then Jennifer might have more information. What I understand right now is that any future furloughs would be based on volume types of issues. When I look across UWMC and Harborview and Montlake, our volumes are strong right now across the three medical centers. I personally don't know of any reason to suspect that that's going to change between now and November. If we were to see a resurgence in the COVID numbers and we had to dial back somehow on our procedures, then that might be a possibility going forward. But it's not something that I think we can predict at this point, either to others-

Trish Kritek: Yeah. I'll let Jennifer comment too. So what I heard you say was not something that is as planned right now and the current volumes make you think that that's not likely, but things could change. Jennifer, do you want to add to that?

Jennifer Petrit...: Sure. Yeah. We're actually sitting down with our labor unions right now just to discuss what furlough 2.0 might look like if we would need to implement it. But it would be based on some pretty significant triggers if the governor had another order canceling elective surgeries, right, or a significant drop in volumes or revenue. So again, I think right now, the outlook looks really not good because our volumes have come back. So hopefully, we'll be able to avoid that. But we do want to have a process in place. So it's more organized than it was in the spring if we need to utilize that.

Trish Kritek: [crosstalk] lean in a little bit more as you talk.

Jennifer Petrit...: Pardon.

Trish Kritek: Come a little closer as you talk.

Jennifer Petrit...: Oh, sorry. I have such a loud voice. I can't believe someone can't hear me. The key piece with me too is that we'd always start again with volunteers, so if we were to implement something like that again. That was a pretty successful program [crosstalk].

Trish Kritek: Okay. So again, no plans in place. Having some conversations with unions. We'd start with volunteers if we'd had to do them, and it would be in the setting of something dramatic changing in terms of the numbers, which right now I think are reassuring as they were last time we talked. Thank you both for answering that, because I think it is a source of much concern from folks and understandably.

Relevant to furloughs and changes, Tom Staiger, I'm going to look to you, there were a bunch of questions about the limited lab hours at Roosevelt and how we're assessing the impacts of that because I think people are quite concerned about the limited lab hours there.

Tom Staiger: Sure. So as some or many of you may know, based on our financial challenges and the need to reduce our costs, a decision was made to scale back the Roosevelt clinic lab hours and to end lab draws at 3:00 PM from its prior 5:00 PM. A number of individuals brought concerns about the impact to patients forward about that change. Cindy Hecker, our executive director, Thomas Hei, our ambulatory associate medical director, and one of our ambulatory assistant directors and myself discussed this morning. Cindy asked Thomas Hei and me to work with our Roosevelt clinic medical and administrative leaders to evaluate the change and then to determine how to best mitigate the impacts on our patients. That work is starting shortly.

Trish Kritek: So we're going to look at it more and try to quantify the impact and then respond to that in someway.

Tom Staiger: Yeah. We're going to look carefully at how it's impacting our patients, how to reduce those impacts in so far as possible and what changes we might need to make going forward based on that evaluation.

Trish Kritek: Okay. So more to come, and I'm going to come back to that question for you, Tom, at a future time.

Tom Staiger: Fair enough.

Trish Kritek: Okay. I want to talk about childcare. But before we go to childcare, I meant to ask this before. So Santiago, I'm going to bounce over to you. Maybe one of the biggest themes is something that we talked about last time, but this time I'm going to ask you, do you know when flu shots are going to be available for people? People are worried about the flu.

Santiago Neme: Yeah. So flu vaccine is really important, a key prevention intervention. For our employees, flu vaccine at UWMC and Harborview, we're scheduled for September 28th. That's when our campaign will launch for patient care. Some clinics already have the vaccine for their patients, and that's going to be intensified in the coming weeks. Valley is also late September, but I do not have a set date.

Trish Kritek: But September 28th is when will we'll see stuff across most of our sites. Is there an optimal time for people to get a flu shot? Should they go on September 28th?

Santiago Neme: Honestly, for employees, we want them to get it as soon as possible because the minute the campaign starts, our goal is to have 100% compliance. It is one of the key interventions for the fall that we have, although the Southern hemisphere has seen a lower flu prevalence this past winter for them. We want to be ready. We want to have the vaccine in our systems.

Trish Kritek: Okay. I'm there on the 28th. I always like to get it the first day it's available personally because I don't want the flu.

Santiago Neme: Then get one.

Trish Kritek: All right. I started by saying, I'm pretty sure someone can correct me, but I think today is the first day of school for the Seattle public schools. I think as folks know, this has been going back to school, and it being not normal has been a great stressor on many, many, many members of our community. So I'm going to ask some questions of both Anne and Jennifer to start with, and John, actually, all three of you get to get into the resources around childcare and school-aged kids. So Anne, we said before that you're on a series of task force working on this. This is kind of a broad question, but people are like, what's going on? What are the updates on what's available to support our, our faculty and staff across UW Medicine?

Anne Browning: Sure. As is a bit of a broad update, the central UW task force asked for an extension until September 11th to push the recommendations forward to the president and provost office. But in real time, we've been trying to implement things as they come up, knowing folks kind of need to hit the ground running into the school year. So we have brought Komen in as a kind of cooperative app that will help you kind of connect to other folks who might want to pool care and share care across families. So that's been a big one.

Another partnership with the college of education. They've actually just launched a online job board posting. So they have a kind of college of education students who are willing to be tutors, provide childcare, learning supports. I'm going to meet with them next week to see if we can actually scale their job posting board to incorporate students from across campus and see if we can make that a more robust tutor pool. I hope that that will actually give us some

access into some supports that might be available for IEPs or folks who have an individual education plan for their children as well. So these are some of the kind of biggies on the-

Trish Kritek: Can I ask a followup question on that before you keep going? So how do people get access to that job board?

Anne Browning: Sure. I can put the link in the chat, but pretty much there's a central HR website for childcare resources, and everything that we launch in real time, that will go live on that website. So we're trying to point people towards our centralized HR website for childcare as much as possible. So you don't have to track it down through a bunch of different links. So that's there.

Trish Kritek: And that's UW?

Anne Browning: Yes, the UW central HR website. I'll put that link in the chat as well.

Trish Kritek: Okay. So we'll go through that.

Jennifer Petrit...: Trish, can I just say that I did work with leadership in the medical centers to get a link on the UWMC and HMC intranet? It's titled child care and at-home learning resources. But you can link directly from the entering out sites to that UW HR website.

Trish Kritek: Wonderful. So there's an icon on the desktop now that you can just-

Jennifer Petrit...: There isn't an icon, but it's on the side, and it's [crosstalk]-

Trish Kritek: On the side. Oh, on the side on the intranet homepage. Got it. Okay. So you can go to the intranet homepage on the side, a direct link to that UW HR website that is a kind of clearing house for all resources. So we're going to keep pointing people to that, and we're trying to get people there from a variety of different ways. Yes?

Jennifer Petrit...: Right.

Trish Kritek: Okay. Great. I had some follow up questions. One was IEPs. So it sounds like you're thinking that maybe there'll be a way to leverage the job board for that individual education plan?

Anne Browning: Yeah. Potentially, and we're also in conversation with the hearing center, which is actually located next to kind of UWMC Montlake. They do kind of special education resources. So I think between them and looking at college of ed as potential resources. But I'm sure we're going to have to connect back in with individual schools and school boards to kind of get a sense of how to best serve individual students.

Trish Kritek: Okay. I'm going to talk more about childcare. But before I leave you, I know the other thing that you had said you were starting to think about and work on is elder care. So I'm wondering if there's any resources that we have available for elder care that came up and really just one question. But I think it's something that I've heard from other folks.

Anne Browning: Yeah. It certainly has come back as a feedback from our kind of childcare and care provider kind of surveys. Next week there'll be coming online a virtual brain health center, and we know that we've lost a lot of opportunities to have kind of elder care kind of day centers open and available. So some of these virtual settings, they'll be posting and sharing out with folks are really looking at trying to kind of increase social connection, look at cognitive engagement and trying to kind of promote some physical movements.

I know that a lot of folks are kind of juggling both young childcare and adult care. So I think we'll look to try and link up some virtual resources for families who are supporting eldercare right now.

Trish Kritek: Okay. So virtual resources to do the committee cognitive stuff that we think is so important about some of the daycare programs that folks engage in for elder care. Great. I may come back to you, but I'm going to transition to Jennifer. Jennifer, one of the questions that I asked everybody on this panel that none of us could answer even remotely adequately a few weeks ago was this question that a lot of people asked, which is earlier in the pandemic, they were able to take leave to do childcare. Now, with needing to do schooling of children at home, they were asking, why can't we still do that? So maybe you could respond and talk about that a little bit.

Jennifer Petrit...: Yeah. Well, I hope I can talk about it a little bit more holistically because I really do think it's really important that employees and managers know that we're really encouraging them to be as creative to do their best to support maximum flexibility, while at the same time recognizing the unique needs of our patient care environment. The first thing I would really encourage employees to do is to look at that website because there are so many awesome resources that are available on that site.

Then based on that kind of research think about what your needs are, and then employees really need to talk with their managers directly, and outline your needs. What do you need? We may be able to come up with a mutually agreeable solution. We can do things like temporary schedule changes or potential shift changes, temporary reductions and FTE. Some people may even choose to request a leave of absence.

I think the key in our environment with our patient care focus is that we have to be able to plan. So if we can do that pre-planning with our staff and our managers, we're going to be able to meet the needs of our patients. As a part of that planning, I think every employee and faculty don't have lead bounces. But every employee has lead bounces. What you can utilize for childcare or remote

learning is vacation time. You can use comp time. Use of sick leave has now been extended as was in the spring for childcare needs due to school closures.

So you can tap into any of your sick leave, and we can authorize some use of leave without pay. But it's not just a endless bucket, right? Again, I really would want to encourage people to create a plan. It's not only going to help reduce the employee's stress, but it's going to also allow our managers and our leaders to cover the business needs of the department.

So HR consultants on my team are available to answer policy and childcare. We've used questions, both managers and employees, and leave without pay can be used, but we need to have some guard rails around some of this use. So hopefully that answers your question.

Trish Kritek: Yes. I think it does. Let me try to do a synopsis though. Leave without pay is an option, and you're saying, let's think about all the ways we could support you and try to be holistic in that approach. So individual conversations to be creative and encouraging flexibility is a starting point. I think I heard you say earlier in the pandemic, you can use your sick leave to do emergency childcare or child schooling. Folks can talk with people in your office to try to walk through all these different options as well as fall back on this idea of you can take leave, but we're trying to also make sure that we can take care of all the patients and families that we have as part of our community. Is that right?

Jennifer Petrit...: Right on point. Yeah.

Trish Kritek: People do ask about how they would apply for FMLA. Is the best thing for them to do to reach out to someone in your office. What would your answer to that be?

Jennifer Petrit...: Sure. But I did want to confirm that the Family Medical Leave Act is really for employees with a serious health condition or to care for a family member with a serious health condition. FMLA would not be accrued for homeschooling or online learning or childcare emergency. But if you just go onto the UW website and type in request FMLA leave, it'll take you to the forms. But if you have questions, you can call the main HR operations number in medical centers human resources for faculty. All FMLA lately is processed through academic HR on campus. Then for the school of medicine, the main campus HR processes all of the leaves of absence.

Trish Kritek: Thank you for clarifying that. Just to say it out loud, I think humidity seems to be in FMLA or when somebody is sick or has a sick family member and leave without pay, which is what we were talking about earlier. Is that right?

Jennifer Petrit...: Yeah. They're different programs, and FMLA is really around needing to take time off to care for a family member with a serious health condition or your own serious health condition, or if you're sick. Correct.

Trish Kritek: Right. Okay. I have two last followup questions for you. The first one is related to what's come in, and that is, have we ever had pooled access to shared leads so that people can basically share? Is that something we do?

Jennifer Petrit...: Yeah. So we do have a shared lead program that's run by the state. I actually thank you for bringing that up because that is another thing that you can use for childcare and homeschooling is shared lead donations. Right now, the way the program works is that I can donate to you. Right? So if I have a lot of people that support me and understand my situation, I may get quite a few shared lead donations.

Right now, the way the program is set up by the state, there isn't a way to create a pool, but it is something that we've been discussing if it's something that might be available in the future, but it's not available now.

Trish Kritek: Okay. So you can donate. There's not a pooling, but you're in conversations and maybe something we hear more about in the future.

Jennifer Petrit...: Maybe. But you can donate to individuals that you know have a need currently.

Trish Kritek: Okay. Last question for you before I give you a break, because you've been on the hot seat for a bit. I think there have been many, many questions along the way about people wanting to continue to work from home. That's been a very hot topic, and I'm curious where we stand with policies or how we're going to move forward with people continuing to work from home.

Jennifer Petrit...: Sure. So I'm not aware of any existing plans for the near future to ask any groups of employees who are currently working from home to return to the physical work environment. UW is updating our telework policy to support continued telework and as long as that telework is effectively some pretty business operations. The policy will be relaxed a little bit to assist working parents to be able to better balance the work family needs, but with continued expectations that employees can effectively complete their assigned job duties.

The one thing we just wanted to stress is that each of you have your own challenges and needs. Each individual department has operational needs that need to be covered. So it's really hard to provide individual guidance in a large forum like this. But I just really want to encourage employees to engage with their leaders and start a dialogue so that we can start doing that individual problem-solving.

Trish Kritek: Okay. So I heard no plans to change people who aren't coming in physically to come and physically in the near future, talk to the folks with whom you work or for whom you work and navigate those waters based on the individual space and that we're trying to encourage the ability to work from home when it makes sense, and it is appropriate to allow people to do that where we can. So that's okay.

All right. Last thing on childcare, John, I think I just read this in an email that came out from you, but I'm going to ask you because it came up a bunch of times. Where do we stand with family member testing prioritization? You're muted. But I'm sure it was brilliant.

John Lynch: Okay. I'm all done now. Yes. No. Yeah. So yeah. Great news and actually thanks to many other people who really did a bunch of work on this and the last couple of weeks. Basically, what we were looking at is, how can we get healthcare workers, household members who may have symptoms of COVID or something like that to testing as fast as possible so that it helps the household members, but also it helps the healthcare worker get back to work as soon as possible?

What Jasmine and the rest of the group really did was to figure out a way for household members to be able to have a dedicated phone line that they can call and get prioritization for access to testing through the drive-throughs. Right? So the basic idea here is someone calls. If there's not one that could be scheduled, then they get a warm handoff to the site, Northwest, Harborview, and they can make sure they get you in that day or the next day.

I just send out a message around this. We're going to have to send a little bit of an update. Sounds like not all the information was perfectly correct. But we're going to send out an update. But the message I want everyone to take home is that your household members will be able to get priority access to testing.

Trish Kritek: Okay. I'm going to ask a followup question. First of all, thank you. Thank you for the work on that. I think that's a big step forward I heard, and I just want to clarify, priority access. Do they get priority results too?

John Lynch: Also, you got to remember, all of our testing is in UW Medicine. If you're at UW Medicine, patient employee, right, that's kind of our highest priority group of tests. So all of those tests get put to the system as fast as possible. So if you get tested today, whether you're an employee or a patient or household member, you're going to get basically put to the top of the pile to get tested.

Trish Kritek: Okay. So priority access and priority results so that we hope that we can get people back to work and get their kids back into their childcare or daycare or where they're going. Thank you.

John Lynch: That's the idea. Yep.

Trish Kritek: That's wonderful. We'll look for the update and the clarification, but that's great.

John Lynch: Yep. That's but the system is working. It's up and running. We're going to give you a quick update on how the slight tweaks that we need to fix.

Trish Kritek: Okay. Thank you. That's great news. I think it's great for everybody.

John Lynch: Sure.

Trish Kritek: Relevant to that kind of thing, there were a couple of questions about, what do I need to do to come back to work? Do I need to be cleared by employee health to come back to work?

John Lynch: So specifically with someone who has COVID-19 or anything?

Trish Kritek: Yeah, I had COVID-19. When can I come back to work?

John Lynch: Yeah. So this is another update that came out today. So let's just go briefly through a couple of scenarios.

Trish Kritek: Please.

John Lynch: One is you have symptoms, and you get tested for COVID-19, and you are at home, and you recover hopefully very soon. We need you to stay at home for a minimum of 10 days, plus at least 24 hours with no fever. No fever means no Tylenol or anything else. So you have to be feeling better and have no fever for 24 hours. You can come back to work after 10 days with no... You don't have to check in with employee health. You can if you're worried. If you have questions, feel free to reach out to your employee health team and ask, does this count? Does this feel right to you? But you don't have to.

If you are tested, for some reason, you're exposed, and you have no symptoms, you follow the same thing. If you're positive 10 days out from your time you retest, you can come back. You don't have to check anything. The last situation is if you don't get tested, say you have symptoms that are consistent with COVID, right. It looked like the flu or other things, and you choose not to get tested, for whatever reason, you still have to be out for the 10 days, as if you tested positive. This is an update that just came out today, and that's different from before.

The basic idea here is that's what's circulating out there. If you have a headache and a fever and a cough, COVID is more likely than anything else. If you don't get tested, we're going to treat you as if you have COVID. Now, there's some ramifications of little things, but in terms of your specific question, Trish, you don't have to check with employee health in any of those scenarios unless you have a question.

Trish Kritek: You can always check with employee health because-

John Lynch: Absolutely.

Trish Kritek: ... they're there for you. But you don't need to have them bless you before you come back to work. Just to highlight that one thing that you said at the end, if

you have never been tested for whatever that syndrome is, we're treating it that you're positive for COVID, and the rules for being positive exist for that. Right?

John Lynch: Right. That's correct. That's a new update as of this week.

Trish Kritek: Thank you for clarifying that. No town hall would be complete if I didn't ask a couple of questions about that. So it's time for some ask questions.

John Lynch: Bring it on.

Trish Kritek: There's still a lot of concern about whether you need a mask and six feet or if one or the other is sufficient. Please clarify.

John Lynch: Yeah. I think I should have done a better job of it's the very beginning. So I apologize.

Trish Kritek: No apologies.

John Lynch: Thank you, Trish. That's very nice of you. But the most important thing we can do to prevent COVID-19 transmission is distance, right? The farther away you are, the less risk you have from getting COVID-19. But we recognize through life, work, other things that we have to be closer to people both intentionally and sometimes unintentionally, and the way we are mitigating, right, reducing the risk of closing that distance is wearing masks. For our healthcare workers working with patients, masks and eye protection all the time.

So the idea is that the mask and the eye protection allow us to come close to each other within six feet, like lots of patient care activities, like lots of other activities in our daily lives. So masks allows us to come closer than six feet. We are learning a lot about that six foot rule, but the basic idea here is once you're a certain distance away, masks don't play much of a role, and we think it's probably a little bit greater than six feet.

So if you're across the street, one person's on one side, and one person's on the other side, masks don't help. But if you cross that street, decide to say hello to that person, that's where masks really play a role. It's where you're coming close to someone.

Trish Kritek: I appreciate that. So someone's sitting in my office way over there. Can they take their mask off?

John Lynch: I think they were trying to get people... If we get the six foot... I can't tell with your office, if that's more than six feet. Probably okay. Right? We want to err towards the side of caution. Right? I don't know about the airflow in your room and the ventilation and all that other stuff. I don't know if that person has symptoms or not. So we're going to err on the side of caution, wearing masks when in doubt.

But technically, if you had two people working in an office, they're both facing away, you have great air flow, and you're more than six feet away, those people don't need to have masks on.

Trish Kritek: Okay. So the absolute rule is okay, but let's be cautious. So you would still suggest to me, maybe keep the mask on.

Tim Dellit: I just want to clarify a little bit because we've gone back and forth on this. Upper campus, in particular, what they're looking at in nonclinical areas, yeah, they're really looking at, are you in the same space? If you are, even if you're more than six feet, they would encourage using a mask in that setting. Totally appreciate what John's saying, that you're further away. But because of those variables, you can't control. The air exchange often isn't as good as in the healthcare setting. It's in an enclosed space. So in general, we're saying even if you're, say in an area where there's cubbies, and you're more than six feet away, but if you're in that same general space to wear a mask.

Trish Kritek: Okay. So I'm going to highlight the clarification, which I think is what John really was saying, was trying to be nice to me, to let somebody take a mask off in my office, which is, if you're in a closed space, even if you're six feet apart, keep your mask on. When you're in office by yourself, you can take off your mask if you have it on.

John Lynch: Yes. Definitely. Yeah.

Trish Kritek: Okay. Relevant to that, I think, kind of, is there anything that any... We've talked about this one before too, but I'm going to ask it again. I think people are feeling that what you just described where people have to come close together and trainees particularly on teams are all near each other. I'm living this right now in the surgical ICU. I'm on service. When we're around, trying to stay six feet apart is hard because there's only so much space. I'm wondering if you have any guidance for teams as they're going around and doing their thing about how to keep distance.

John Lynch: I really wish I did Trish. I had some really great answers for this. I have to see what Tom has to say and Santiago's medical directors. But my perspective is someone who doesn't have to make the hard decisions around space and teams but give recommendations is that we really need to think about doing things differently. We're doing so many other things differently in our lives. I think we're going to need to think about how we thin teams, spread teams out, pace when teams are in a room and shared spaces, how rounds work, using spaces that are being underused right now, like conference rooms and other places where we generally have groups meeting together.

I recognize these are hard, but we've really made huge transitions and changes in our communities around how we live and work, and I think we're going to have to think really hard about how we do this and provide the appropriate

training for residents and fellows and students of all different disciplines and take care of patients in a realistic way.

So I don't have awesome answers beyond that. I think we're going to all have to engage in finding new ways. To be honest, a lot of times we see the best interest come from the people engaged in the work, right? Having a resident or a student or fellow or an attending tell me what they need is probably much more powerful and more effective and probably more useful than me telling you what they need, what you need.

Trish Kritek: Okay. So listen to the folks who were in the spaces and try to strategize. Tim, I see you're unmuted.

Tim Dellit: Yeah. I was just going to add this is why we tried to think of this. What does that bundle of activity? Right? Because it's not just one thing. John talked about the mask helping to mitigate. But there are other things, right? It's the hand hygiene that people are doing. It's at a situation that you don't have symptoms when you come to work. It's our EBS folks really doing an outstanding job cleaning environment for us.

It's all of those activities that help to decrease that risk, recognizing that it's impossible to stay six feet away or more all the time. So again, it's that focus of bundle of elements that are trying to help and keep our healthcare workers safe.

Trish Kritek: Okay. I appreciate that. I think it's good to just keep talking about it because it's the reality of what we're dealing with every day in our clinical spaces and our other spaces. So trying to figure here different strategies on this is helpful. Santiago or Tom, did you want to add to that? You don't have to, but I heard John refer to you. You're both okay.

Okay. I'm going to ask John two more questions before I hand it over to Anne. Last time we talked about, do I need to cover my hair? I said, "Oh, I kind of wondered about that." Somebody asked a followup question to that. They said, "Well, if it doesn't matter, if I touch my hair, then why does it matter if I touch my mask?" Because we always do hand hygiene every time we touch our masks. What's different?

John Lynch: Good question. Let me try to answer that. So I think there's a couple of things. One is, surprise-

Trish Kritek: It's a hard one. It's hard.

John Lynch: It's hard. Yeah, is that-

Trish Kritek: It's [crosstalk]-

John Lynch: So we're breathing through our mask, right? We are facing a person who may be breathing or coughing. So when we do that, our mask is probably forward facing. That's why we're wearing eye protection as well. These are the things that are most likely going to get impacted by someone coughing, breathing hard, laughing right in front of us, and those droplets or aerosols are going to hit us and hit our mask. So they're most likely the most contaminated parts of our faces, our heads, compared to the top of heads and the back of our heads.

In addition, we touch our face a lot, and we don't touch our hair as much. Some of us for different reasons, but most of us we touch your hair a little bit, but we're not touching our mouth, our hair like we're touching our mouths, our nose, and our eyes all the time. So in addition, when we touch her eyes, nose, and mouth, that's when we're infecting ourselves. So when we take off a mask, we're touching and we rub our nose, we're going directly from the mask to our nose, as opposed to, I think what people maybe touch their head or scratch their head and then rubbed your nose that may happen.

I think the idea is that these are the four facing. This is where we're inhaling, and those particles may be sticking and are the highest scripts for transmission.

Trish Kritek: Okay. So this is forward facing has the place where you're basically going to get most exposed. So if you touch it, hand hygiene. [crosstalk]-

John Lynch: I mean, I'll be clear. If you run your hands through your hair, feel free to wash your hands. I think that's a great idea there too. So-

Trish Kritek: Unlike you, I touch my hair way too much to do that every time. But anyway, last question for you before I transition. The last bit today, I've got a bunch of questions about isolation carts being removed from locations within the hospitals and people being concerned about that. Do you know anything about that?

John Lynch: No. This is actually the first I've heard of it. We've used isolation carts, and we have for many years. It's really a workhorse and commonly seen on inpatient units and sometimes in outpatient sites. If you are missing an isolation cart where you expect one to be and it's not clear to you for your unit or your clinic what happened, please call your infection prevention team who's at your site because there's a problem here. We want to fix it. We have made no decisions across UW Medicine around changing any of our carts, what's in them and so forth.

So this may be happening in some one unit that we just don't know about. So please reach out, let your infection prevention team know, and we're happy to help with work [crosstalk].

Trish Kritek: Okay. So don't know of any.

John Lynch: No changes we've done.

Trish Kritek: No strategy on that. Might be happening in random places. Please let us know specifically, and we want to help, but [crosstalk]-

John Lynch: Absolutely.

Trish Kritek: Okay. End of the session. The Baton is going to be passed to Anne, and I believe we're now calling this ask your friendly infectious disease doctor. Is that correct?

Anne Browning: That's correct. We're so lucky that our team here has three infectious disease doctors. So thanks to John and Santiago, and today, Tim, we're going to put on the hot seat. We realized we started doing this segment at the beginning of the summer, and we've had some evolution of the way we are cleaning things, the way we're moving through the world. So we know a little bit more about COVID-19. So I'll go back and even ask some of the first questions we asked John to Tim today as well, and thank you so much for the folks who've been sending in questions. So we'll start with the theme of travel, Tim. Tim, would you fly in an airplane right now?

Tim Dellit: I would with [crosstalk].

Anne Browning: What are your best practices for flying?

Tim Dellit: Well, it's certainly wearing a mask, making sure that it's an airline where they are not putting someone in the middle seat so that there's better spacing. I would recommend wearing goggles or eye protection as well. Make sure that you have some small container of hand sanitizer with you. If you can bring wipes to wipe down the environment when you get on there, even better. I would probably look for an early morning flight first thing so that you know that that plane hasn't been flying all day. I worry a little bit about the turnaround in between flights. But if you start first thing in the morning, I think better chance of that plane also being cleaned. So again, I think there are things that you can do. But I would feel comfortable doing that.

Anne Browning: Would you feel like you had to quarantine after a flight?

Tim Dellit: Different states have different requirements? So if you go to New York, for instance, they have a list of states. If you come from one of those states, you have to quarantine for 14 days. Washington State does not have that in place right now. I think you always want to be particularly diligent about watching for any symptoms or signs of symptoms. But you aren't required to quarantine if you had traveled on a plane, at least in Washington State.

Anne Browning: Would you let your parents, say 70-plus years old travel from out of state to stay with you for a week?

Tim Dellit: No.

Anne Browning: No.

Tim Dellit: What I would say though is if I have, and I do have parents over 70 at another state, it depends on the circumstances. If they had medical conditions or needed help or you had someone who was really sick, and this is your chance to see them, I would travel there. I would be mindful about how I may visit them in that scenario. But I wouldn't have them just come for a regular visit and stay with me.

Anne Browning: Okay. Thank you. Would you stay in an Airbnb or a hotel right now?

Tim Dellit: I would. Again, I would prefer if I were renting a house. As an example, I prefer that over a hotel just because I think it's a little bit more isolated. You can also check, how are they cleaning if you're renting an Airbnb or a house? When was the last time a resident was in there? Do they have 24-hour period of time or more in between guests? So there's some things that you can check on there. But in general, I would. I just want to know a little bit about their cleaning.

Anne Browning: Yeah. Thank you. This will be on the theme of kiddos. Would you let your kid have a sleep over at a friend's house?

Tim Dellit: No. Again, maybe if you're really in a tight bubble family, but in general, no, I wouldn't.

Anne Browning: Would you let your kid go to college right now?

Tim Dellit: Yes. I'll confess I actually have a daughter and stepdaughter that just went back to New York City for college. In fact, my daughter said, "Dad, I don't care if they're online. I am not staying here." So they're 21. They're adults. But they did go back, and they moved back safely.

Anne Browning: Was there any consideration of if they're staying in the dorms or if they're in the Greek system or an apartment with roommates?

Tim Dellit: They're both in apartments. One is in a studio. One has roommates. I do worry about congregate living, be it in Greek housing or the dorms. Certainly, when you look across, it seems like every college or university that has tried this has had challenges with increased number of cases. So I'm conscious of that. I did let them do that. Again, they're adults, so I'm not sure how much I could prevent them, and I supported their doing that. But people have to recognize, and you have to be smart when you're there. Right? You can't go to college parties like you used to that. You really have to maintain that physical distancing, which is really challenging at that age.

Anne Browning: Yeah. Heck I mean, it's challenging for all ages, but I think that the college setting, we're certainly seeing that as being a tough, tough spot. Thank you. Next set of themes will be life around here, and we'll go kind of rapid fire. Would you go to the mall?

Tim Dellit: No. Not just to hangout. If I had to go find something in a specific store, I would be very targeted. Go there, get it, and then leave, but not to hang out or wander around. If you do have to go to outdoor mall, better than an indoor mall in my mind.

Anne Browning: Not hanging out at the Cinnabon anytime soon.

Tim Dellit: Online ordering.

Anne Browning: Would you get a growler filled?

Tim Dellit: Yes.

Anne Browning: Would you keep up with recommended preventative medical screenings?

Tim Dellit: Yes, absolutely. In fact, I think the hospitals and clinics are the safest places to be right now. Everyone's mask. Everyone's using hand hygiene. That's the safest environment.

Anne Browning: We asked at the very beginning in this summer these questions of John I want to ask you now. Would you eat inside at a restaurant?

Tim Dellit: No.

Anne Browning: Would you eat outside in a patio?

Tim Dellit: Potentially. Although I have not since February.

Anne Browning: Okay. Would you have very close friends over for an indoor dinner at this point?

Tim Dellit: No.

Anne Browning: Okay. Last question, do you wear a mask when you're walking your dog at this point?

Tim Dellit: I don't. I carry one with me so that if I am in a situation where... Let's say I'm on a sidewalk, and I can't cross over, then I will put the mask on if I see people coming. I really try to just... If I see people even a block away, I'll move to the other side of the street. So I try as much as possible to maintain very wide distance, which I usually can do, but I carry a mask with me for those situations where I can't.

Anne Browning: Good. Tim, thank you for being on the hot seat as our friendly infectious disease doc for today. I'll hand it back to Trish.

Trish Kritek: I've never been happier to not be an infectious disease doctor so that I know I'll never be on the hot seat. Thank you so much, Tim. I really appreciate those perspectives. There's other reasons I'm happy I'm not an infectious disease doctor for you three too. It's always really generous of you to share your individual perspectives, and I think we've learned from all three of you, and thanks Anne for bringing up the stuff that people are really wondering about.

With that, I think we're out of time, and it's time for me to say what I say at the end of each town hall, which is a huge thank you to everybody in our community. This is a new hard time as we think about schools and start in the fall and worries about a second surgeon, all of those things, and yet, we're still getting through this because you take care of our patients, their families, and really so importantly each other. So please, keep doing that. We'll see you back in two weeks and take care.

Santiago Neme: Thank you.

Trish Kritek: Bye, everybody.

Anne Browning: Bye, y'all.