Trish Kritek: So welcome back to UW Medicine Town Hall. It's a pleasure to join you all again this Friday afternoon. My name is Trish Kritek. I'm the associate dean for faculty affairs in the school of medicine, and we have most of our usual panel here to join us today. So I have with me Tim Dellit, our chief medical officer for UW Medicine, Santiago Neme, the medical director at UWMC Northwest, Keri Nasenbeny, the associate chief nursing officer at Northwest campus, Anne Browning, our assistant dean for wellbeing, John Lynch, head of infection prevention and infection control and the medical response for COVID out of Harborview, Cindy Sayre, chief nursing officer of UWC.

I think I actually put everyone's title pretty close to right today, which is a miracle. We have some folks from Harborview, Rick Goss and Jerome Dayao who are finishing up with the joint commission who was visiting there the last few days, and Tom Staiger's away today. I think he was trying to be in the Olympics, but I suspect that's not what he ended up doing on his day off. So welcome back to town hall. It's a pleasure to be with you, and I'm going to actually start off right away by handing off to Anne Browning for our wellbeing message.

Anne Browning: Sure. The wellbeing message will be pretty short and sweet today. Essentially, I just wanted to take a moment to acknowledge just how tough the last 10 plus days have been. Of course, this has been a challenging time in last six-plus months. But man, just having kind of the smoke in our environment and suddenly being kind of stuck indoors, especially when we're already kind of working from home, and we have kids around at home more often as well, it has just been a really, really challenging time, and I recognize that's disrupted a lot of their wellbeing routines, and many of us have talked about how we try and get outdoors as part of our wellbeing.

So I would just say especially as the air starts to clear, try and give yourself the chance to kind of reset and get outdoors when you feel like you can, and also, just watch for your own kind of reactivity. I feel like we've all had kind of shorter fuses, and especially once we get into that more constrained environments. If you notice that in yourself or in the people you're around, just trying to give kind of yourself and the folks around you as much grace as possible. Hopefully, the rain and the winds will help clear some of this out. But man, this has been a tough week. So good job just hanging in there and making it through.

Trish Kritek: Thank you. I echo how challenging the smoke has been. I've never been happier for it to start raining like it is right now. So fingers crossed. I'm going to give Dr. Lynch a little bit of a break from leading off today. I'm going to turn to Tim Dellit. Tim, you can give us a kind of a rough sense of where UW Medicine is. I might ask some followup questions with John. But a theme of questions that came in was, where are we now, and what's going to be the impact of students coming back to school? Because I think we've been watching the and hearing about outbreaks in universities, and now, we're about to welcome students back to UW. I wondered if you could talk about that a little bit.

Tim Dellit: Yeah. No. Thanks, Trish, and again, welcome, everyone. Thank you for joining us here today. I think when you look overall where we're at with COVID-19 within our local region, we're actually in a positive state, meaning that we're seeing a reduction in the number of cases. Now, across the state, if you think back collectively since this all began, we were over 80,000 cases, just over 2,000 deaths. But those numbers have been coming down both across the state and here locally in King County.

In fact, that reproductive number, which we've talked about before, meaning if I'm infected how many people will I infect is estimated to be around 0.6. So again, when it's less than one, we typically see fewer cases, and that's what we're experiencing right now. We're also about two weeks out from Labor Day. So one of the questions was, would we see increased number of cases after labor day. So far, we haven't yet seen that. We're not quite through that period of time, but that's encouraging.

You raise a great question. When you look around the country and trust many of us who have. College-aged students have been very focused on this. But most universities that have welcomed students back have seen an increased number of cases. Our students return next week. So that's just something that we're going to watch very closely. We're actively coordinating with upper campus, and I want to just share a little bit of the plan that they have in place as they welcome back students.

They are doing some similar things, such as at a station. So all the students are going to be getting a text message every day. Do you have symptoms? Have you been exposed to someone with symptoms? If so, arranging to be tested. They'll be tested through a scan, which is the coronavirus version of the Seattle Flu Study who will be performing that testing.

We also are doing testing as students move in to campus next week. So UW Medicine is helping to support, and we anticipate we'll probably test about 3,500 students. These are individuals who are going to be living in on-campus housing. Now, the Seattle Flu Study is doing ongoing testing right now, and we'll continue next week for those students moving into the Greek housing as well.

Going forward, the Seattle Flu Study will continue to do testing as part of the Husky Testing Program that people may have seen a message from the university this past week. Again, that's a program through the Seattle Flu Study especially geared towards those individuals returning to campus. Their real focus, although they're offering it to students, faculty, staff, particularly in the nonclinical areas, they are offering but really focused in those individuals living in congregate residents.

They've actually developed a risk stratification methods. So they will be doing roughly a thousand tests a week, ongoing, focused in those high-risk areas. The students living in the dorms, in Greek housing, in other congregate settings. So again, people may have seen that. The nonclinical folks within UW Medicine are

welcome to enroll the students, trainees, staff nonclinical faculty, welcomed to enroll in that.

Within our healthcare system, in the clinical environment, we've had a very good testing program, where we test and offer testing to any of our employees who have symptoms, anyone who has been exposed to someone with COVID-19. We want to keep that process up. So for those people in the clinical arena, we ask that you continue to follow our clinical protocols. So that's one of the distinctions there. Now, we'll have to see what happens.

I will also say we have areas, dorms set aside to be able to quarantine students if we do identify students that are positive as well. So they've done a lot of preparation. I fully anticipate we will see some students that are positive, and then we just have to see how many and really identify them, get them isolated and prevent spread as quickly as possible.

Trish Kritek: So Tim, thank you so much. I think you answered some of my followup questions already. So I want to just ask a couple of clarifying. So a lot of testing for particularly people coming into dorms into Greek row, broader offering, but really focusing on those folks who are going to be living in places with other people as a priority and then continuing to test, particularly those that are at high risk. I think you've implicitly answered this, but someone asked, are we quarantining students when they come into school? I think the answer to that is no.

Tim Dellit: No. No. Our state does not have that in place. Now, some states like New York will keep track. I think Massachusetts, that's another state, keep track of States with higher rates of COVID-19, and if you travel there you have to self-isolate for 14 days. Washington State does not have that. So we're not doing that for the students, but we are trying to test, and it's volunteer testing. So we're offering testing to all the students who are moving on campus or living in the neighborhoods around campus as a baseline and then through the Seattle Flu Study, doing ongoing sampling really throughout this entire academic year.

Trish Kritek: Okay. So I just want to highlight, you said it's volunteer. We're not making anyone get tested, but we're offering it to everybody and then ongoing offer it. The second thing I wanted to clarify was this concept of if I'm a UW Medicine employee, which bucket do I fit into. I think what I heard you say was, if you are a clinical employee, you follow what's been happening for the clinical folks. If you're a nonclinical person, you can engage in the Husky Testing Program. Is that correct?

Tim Dellit: Yeah. We just would like everyone who's, again, within that clinical setting, following the same protocols we've been having in place and have been working. I think we really have done a good job with that. I would focus this really in the nonclinical folks who are interested. If they want, they can sign up to participate in the Husky Testing Program.

Trish Kritek: Okay. The last question I'll ask you about this before I pivot to John is some people have repeatedly asked, "Shouldn't we just test everyone in UW Medicine on a regular basis, random, serial testing of clinicians?" What is your thought on that?

Tim Dellit: Well, my own personal view is not to do that. Again, I think we've been successful not doing that. Keep in mind right now when people are tested, because we're testing if they have symptoms or if they've had exposure, they're not coming to work while they're waiting for the result of that test. I worry about a scenario where we start having random individuals being tested within the clinical environment when we don't know that they've been tested, and then they're still coming to work while they're waiting that test result.

I think all the other protective measures, this is where I really believe that clinics and the hospitals are the safest places to be right now because of all the measures that we have in place, the universal masking, the hand hygiene, the eye protection, the masking of visitors, masking of patients, the cleaning of the environment. We have done a tremendous job, all of us, keeping our environment safe for our healthcare workers. I think we need to continue what we've been doing.

Trish Kritek: Okay. I heard we're not moving to routine testing of employees and for a lot of good reasons about why we feel like the space is safe, and we don't want to make some more gray spaces. There was one followup question. I was thrilled to hear that there's quarantine housing that's being planned. Folks, well, someone reached out and asked, "Is that true for students who live off campus too? Or is that just for students who are on campus housing?" Do you know?

Tim Dellit: My suspicion, and again I'd [crosstalk]-

Trish Kritek: [crosstalk].

Tim Dellit: ... affairs, but I think it's for those students who would be in student housing on the dorms, because it's just separate dorms that allow that separation. That's my impression. But again, I would want to check with student life.

Trish Kritek: Fair enough. I think that's probably right too, but we can double-check that for whoever sent in that question. Thank you so much. I'm going to transition to you, John. Tim gave us a general sense, fewer cases, lower reproduction rate. Can you just give us the actual numbers across UW Medicine for the group, to start with?

John Lynch: Sure. I think the number we have right now is 15 people. So less than 20 patients in our four hospitals right now with COVID-19. So that number has kind of trended down very nicely over the last week or so.

Trish Kritek: That's super exciting to hear. Relevant to testing, there's still people asking about, are we close to having saliva testing? Are we considering saliva testing? And then I have a second.

John Lynch: Yeah. So the last time I spoke with the lab medicine folks, they definitely have trialed it and tested it to try to validate it, and the results that they were getting weren't great. So there may be a role in it for some sort of surveillance testing or group testing. But for the purposes of diagnostics, right now, it doesn't seem to be there. Even when you look in the literature, some of the studies, even from the same university will say, "This looks great." The other studies from that group will say, "This doesn't really work well for us." So still a lot of unknowns.

Trish Kritek: So okay. So not on the horizon for us to be using a lot of saliva testing, just to say that clearly?

John Lynch: That's correct.

Trish Kritek: But anterior nares, the folks who are being part of the Husky testing and things like that, is that an anterior nares test, or what type of swab is that? It is, right?

Tim Dellit: Yeah. They're doing anterior nares, self-collection. Again, they observed if they're doing it in person, but keep in mind Seattle Flu Study also, as they've done testing in the community, where they sent kits out and collect by self-administration of the anterior there.

Trish Kritek: I know that someone's going to say, "What the heck is anterior nares?" But that's just the-

Tim Dellit: Going up.

Trish Kritek: ... swab that straw that goes straight up that you swab in your nose as opposed to one that goes back and is more invasive.

John Lynch: Yeah. Then importantly, so the nasal swab is already being used it at Hall Health. So the upper campus clinical folks have been doing this for quite a while. Just to emphasize what Tim said is that the observed collection to be done next week, where we're watching students do it and other folks in UW. Seattle Flu Study, as the Husky Testing Program will be sending the swabs to people in their homes, in their dorms to do the swabs themselves. So they'll be doing both.

Trish Kritek: Okay. So both. Someone's swabbing you and swabbing yourself, both options, all. Great. I want to clarify something we've talked about before because I got a question about it, and I just want to speak to it. We had talked about household members being able to be tested, UW Medicine employees, household. Is that true for children less than 14 because there was some confusion in some sites. Could you clarify that for us?

John Lynch: Me?

Trish Kritek: Yes, John.

John Lynch: Okay. Just double-checking. Yes.

Trish Kritek: Sorry. My bad.

John Lynch: No, no, it's totally fine. Yes. So Harborview can do folks or kids who are under 14, and the testers are trained for that. Northwest, I think their threshold and looking at Santiago is still 14 years of age. So if you have little ones, we want you to go to Harborview. I've walked up, all that sort of stuff.

Trish Kritek: That's really-

Santiago Neme: We're working on expanding. We're working on expanding at Northwest. Yeah.

Trish Kritek: Okay. So just to clarify, if you have little ones that need to be tested, you need to go to Harborview right now, and they're still prioritized. We're working on trying to expand to smaller ones at Northwest as well. Thank you both. We're working on this. So keep giving us your feedback on that. I appreciate somebody put in a question about that. One more kind of question about testing or screening, John, for you before I ask about the flu vaccine because there's a lot of questions about that. This is something that's come up over and over again, and I'm going to ask it again because things change. People are noticing that wherever they go, they get their temperature checked and that we don't check temperatures when people come into our institutions, for the most part. I just went to the dentist two days ago, and they took my temperature when I walked in.

So the question is, why don't we check temperatures? That's the question. I was going to like say some statement, but that's the question.

John Lynch: Just cough it out. I'm ready. Yeah. No. It's a good question, and I'm glad people are still asking it because we want to stay up to date and let people know what's going on. So you're right. So within UW Medicine facilities, we don't check temperatures when people come to the hospitals or the clinics. So why is that? Well, there's lots of different machines out there for checking temperatures. We don't know how any of them work. We don't know how good they are at picking up temperatures. The SCCA actually did this for a little bit, and they missed people who had fevers, who got upstairs to the clinic, got their temperatures checked in a more conventional setting by a healthcare worker, were found to have a fever, brought them back down, tested them again, and it still wasn't working.

So in our own sort of world here, we've recognized that they don't work great. We don't have any data on how good any of these machines are that are out

there, either the big thermal scanners that look at across populations or the ones that you aim from a distance. If we were to use those, we don't know the healthcare worker... The folks who are screening aren't healthcare workers, right? They're often folks without any clinical background. If you were to use it, it brings that person closer to every person you're screening and probably creates lines and slows things down a little bit as well.

The other part of this is that we know that COVID-19 presents with lots of symptoms or no symptoms. Fever is actually pretty uncommon and when you look at the grand scheme of things. So when you think about the prevalence of COVID-19 out in the population, the chance of one of those people coming with symptoms, the chance of one of those people, students having a fever coming to your door, who shouldn't be there, right? Well, you're going to turn away from care? You're going to capture with a machine that we don't really know works. It doesn't make a lot of sense to us.

So we've looked at risk analysis. We've looked through all the literature. We can find actually no data supporting the practice. We've actually found lots of data in those big thermal deep screening programs, like at airports and others, where they show these captured no one. In fact, your capture a lot of people falsely, right? So they say they have a fever, they don't and having to divert that person off to some other process.

Now, I'll just call out that the CDC does recommend this right now. But we disagree. Again, we put a risk assessment together within UW Medicine. We're talking to lots of folks about it if they ask us, just like today. Yeah. So I think that that's... I had another point, and I totally spaced on what it was going to be. But-

Trish Kritek: Well, let me summarize. Let me try to summarize, and then... Let me summarize, and then I'll... So don't know the quality of the testing, i.e., the thermometers. Potentially some downside to people being closer to each other, whether in line or doing the testing and some risks there, and no evidence that it really makes a difference in terms of finding people because it's one smaller symptom and the myriad of symptoms or lack thereof of patients. So we've made a decision not to do that to date. Is that accurate?

John Lynch: Yeah. I remembered what it is now, too.

Trish Kritek: Okay. I knew that my summary would help you.

John Lynch: Yes. Actually, it was Chloe Bryson-Cahn who was reminding me via text is my-

John Lynch: If you actually go look at the media, there's a lot of media out in the past couple of weeks actually saying that this doesn't make sense for a lot of reasons. The reasons I just explained, also a lot of experts, including Dr. Tony Fauci, who I think we all look to as really important expert in all this is on record saying that they don't do this at the NIH because it just doesn't work very well. Working

with the basic attestations, asking the questions is far more important. A lot of times, we use these technological interventions. People lean on them and then don't ask the really important questions. Do you [crosstalk]-

Trish Kritek: Right.

John Lynch: Do you not feel well? The things that people often present with COVID-19 with. Thanks, Chloe.

Trish Kritek: Thank you, Chloe, for me as well. Prioritizing the attestation because we think that that helps more. I'm going to come back to some more questions on that maybe if I have time later on. I do want to talk about one more thing with you, John, before I pivot to other folks. I think you announced this earlier today in announcement in your email. But lots of people will want to know when they're going to be able to get their flu shots at UW Medicine.

John Lynch: Monday, September 28th. So it's a week and a half.

Trish Kritek: So a week from Monday.

John Lynch: A week from Monday. We are going to kick off on September 28th. We're going to be doing all the normal processes that you guys are all used to, right, with the kiosks, with the rovers, with all the other processes and practice we've always had in place. UW Medicine has been enormously successful. So thank you to everyone on this call and to your colleagues because we've done great when it comes to influencing the vaccination of health care workers. I'd say we're one of the best before in places anywhere. So what I really want to see this year is more of the same. We did a great job last year, and I fully expect that to happen this year, and our expectation, this is all done by the beginning of November.

Trish Kritek: So we start a week from Monday, basically have all of October to get everyone vaccinated.

John Lynch: Yep.

Trish Kritek: Try to come early if you can to get your vaccine because we think it's important.

John Lynch: I think anytime in that month, I think that there's a lot of discussion now around the duration and the timing. I think that the key... It'd be perfect if we knew when flu is going to happen, and we all got vaccinated two weeks before that. But that's not what really happens, and it takes time to vaccinate 25,000 people. So what we're going to do is take the month to do it. I think that will give us ample time based on all of our other experience with influenza to get everyone vaccinated, safe, and immune, right? It takes a couple weeks for that vaccine to work before we see any flu cases.

We're going to be paying very, very close attention to all surveillance mechanisms for influenza this year. Really, every day, our infection control team, Santiago, myself, and many others will be looking at these data on a daily basis with Seattle Flu and Seattle Children's and SCCA and many others so that we have very clear knowledge and insight as to when that's actually happening.

Trish Kritek: So we're watching to see it start to tick up.

John Lynch: Exactly.

Trish Kritek: One last question about flu vaccines, and that is, do we offer something special for our employees over 65?

John Lynch: So just to be clear, there are no recommendations from the Advisory Council on Immunization Practice with the CDC on actually preferentially giving people over age 65 the high dose influenza vaccine. I just checked with Dr. Seth Cohen is an employee health medical for Northwest and Montlake. I think we're in agreement here is that if that's something you really want to have as someone who's over 65 in the healthcare workforce, I think that we're up for doing that. I think there are some good data supporting it. It's not great data, and it's not really good randomized controlled outcome data. But there's a lot of good signals out there. If that's something that you want to do, I think going through the employee health teams and asking them, and we'll figure out a way.

Trish Kritek: Okay. So that's really important, that it might not be overwhelming, and yet we're going to offer it to people. So they should talk to the folks at employee health if they're over 65. Yes?

John Lynch: Yup.

Trish Kritek: Okay. Great. Thank you. I think someone asked a followup question about when, which I think we talked about. They asked where, and I think there's lots of different places where people will be able to get them. I think that's what you were speaking to. Do you want to highlight?

John Lynch: Yup. Just last year. So every campus is going to have them. There's going to be rovers. I think over the last probably three years or so, we've really made an effort to distribute access. So out into the floors, out in the clinics with rovers and so forth, and we're going to stay the course on that. Right? We don't want anyone clustering up. We want big, long lines. So look to your hospital or clinic intranet, the things you typically go to look for those calendars and access points. So maybe I would say one thing to think about is, where were you last year when you got it and probably think about, that's a good place to get it this year.

Trish Kritek: We have sites for folks who are nonclinical as well. Correct?

John Lynch: So all of you UW Medicine, all employees have access to this. I want to be clear that if you're off campus, if you're working at home, you are going to have to come onto campus. We do also know that the University of Washington also has vendors come onsite to provide vaccinations, influenza vaccinations. I just want to be very clear because we have UW Medicine personnel who are clinical and those who are not clinical and also University of Washington folks who are kind of mixed in places like the tower in South Lake Union. There will be vendors at South Lake Union. There will be vendors of the tower and also as 1616, and I think those are probably our three biggest places for UW Medicine, kind of nonclinical research personnel.

So there will definitely be the vendors there, and on the clinical spaces, we'll have our typical program.

Trish Kritek: Thank you [crosstalk]-

John Lynch: We're encouraging, if you're not sure, just go one of them and get vaccinated. We're not going to sit here if you're supposed to get at the vendor and you show up in employee health. We're going to vaccinate you this year. We're not going to be pushing back. We really want to make this as easy as possible. Thank you.

Trish Kritek: So great description of lots of places to get flu vaccine. If you're struggling, reach out to us, but there's lots of different places, and we just want you to get vaccinated over the next month or so.

John Lynch: Yep. In the link, for all those other sites is on my email from yesterday, the coronavirus email.

Trish Kritek: Thank you. Excellent. Okay. I'm going to shift gears. I'm going to come back to vaccines later probably, but different vaccines. I'm going to pivot to you, and there's been ongoing questions about childcare. So one thing that has come up a bunch is, do you have any updates on resources for work with special needs children? That's folks with an IEP or other needs.

Anne Browning: We've been trying to figure out if there's something that we can do within house. I know that the school districts are kind of struggling. It sounds like, given the IEPs are mostly about, how do they support students within the workspace, but since that space is changing and the ways in which instruction is being given is still being set, I think there's some real struggle still with trying to even have the schools figure out how to support students.

One thing that we've been thinking about leveraging is the college of education has a job posting board where any of us so families who have a student who needs or has an IEP can post and say, "Hey, I've got a second grader with an IEP that needs some extra help." Post it on the college of education job board and then basically kind of the students and alums within the college of ed who might

have some understanding of supporting students with IEPs can respond to those posts. Right now, I think that's probably our best kind of direct line into support.

Trish Kritek: Okay. So still working on it, but right now, partnership with the job board in the school of ed?

Anne Browning: Mm-hmm (affirmative).

Trish Kritek: One of the other questions I saw was wondering if in the various taskforces you've been on, there's been any discussion of partnering with or purchasing or somehow using a homeschooling platform. I guess there's a variety of them. Has that been part of any of your discussions?

Anne Browning: We definitely have been reached out to from various kind of platforms that are emerging? I would say right now, we've kind of decided to go with not even really a partnership. There's no purchasing piece, but just kind of a collaboration with Komae as a kind of resource to help with that collaborative learning experience and helping with pod formation. I would say the second piece, and this is all kind of at no cost to the university, which is a concern right now.

We are about to launch, again, this childcare connections, resource where I'll be sending out a message to kind of all undergraduates on Monday, trying to get them to sign up and offer times that they can help support either within home care or learning support, and/or both throughout kind of that K-12 experience. So we're trying to kind of build out more internal resources rather than buying something as an outside platform.

Trish Kritek: So it sounds like another partnership with undergrads broadly across the university who might want to be helping with childcare or teaching or tutoring. Is that right?

Anne Browning: Yes.

Trish Kritek: More to come on that. When will people in our community hear about that resource, do you think?

Anne Browning: I'm guessing since we'll start kind of reposting, and this is something we had started back in March, we're going to repost it to students starting again on Monday. Then once we have it populated with students, we'll also be posting and probably sharing out middle of next week maybe with folks across the university as employees, faculty, and staff and students with childcare needs to be able to kind of leverage that platform as well. So hopefully, within the next week, we'll have that fairly up and running.

Trish Kritek: Okay. So folks, so I'm going to be looking out in the next week or two for resources for K through 12 kids. The last question I'm going to ask you is I think

people are still concerned about resources for smaller folks. So I'm wondering if there's anything in your conversations about support of preschool age kids.

Anne Browning: So good clarification. I was thinking kind of in that childcare's connections piece of thinking about kind of in-home learning support or virtual learning support for K-12, but that group is also able to offer kind of zero to five. Then it's mostly like in-home actually, babysitting care. Certainly, with our population, we're concerned about making sure you get some support early mornings and late evenings if you have a long day in a clinical setting.

Trish Kritek: So trying to get them at the extremes of the day, that's a possibility, and we'll be asking about that specifically and then for younger kids as well.

Anne Browning: All right.

Trish Kritek: So thank you very much. Anything else you want to share about updates around childcare? Because I think it is a hot topic.

Anne Browning: I think that was most of what I wanted to make sure I shared today. As just a general update, we've submitted our kind of UW wide taskforce kind of recommendations, and that should be going to the president and provost more formally within the week. For UW Medicine group, we are kind of finalizing that taskforce recommendations. That's kind of working in partnership with the bigger UW wide taskforce, and that'll be kind of finalized this week as well. We just had our final meeting this afternoon. So lots of moving pieces, but we're getting a little more clarity on next steps and how we're hoping to kind of work with leadership and hopefully have some real impact on people's lived experience.

Trish Kritek: Great. So we'll check back in with you next town hall, and maybe we'll hear more about what those recommendations ended up being and what the next steps are.

Anne Browning: Sure.

Trish Kritek: Thank you. Cindy and Keri, I'm going to shift back to patient care a little bit. Cindy, I'm going to ask you this question. I'm not sure it's really directed at UWMC, but there were some questions about what the visitation rules are for ICU specifically. I think that they're probably close to the same rules for the rest of the house, but maybe you could comment on that.

Cindy Sayre: Right. No, we do, and I did confirm this with Jerome this morning. We have the same visitation rules for patients in the ICU, which is basically one visitor. Again, we're making exceptions for patients that are at the end of life, which is where some people might get confused if they see more than one person at the bedside. We're allowing for two people to come in if a patient's at the end of their life.

Trish Kritek: So one of the things I asked, and this is why I wasn't sure if it was really directly UWMC. What about if that's a minor? Are the rules the same?

Cindy Sayre: Right. Well, I did reach out to Jerome. From the beginning, the minors were allowed to have visitors even when nobody else was, way back when. What Jerome said to me in response was that they are making exceptions for pediatric patients. I'm not sure if that's a blanket exception for every pediatric patient or they're doing that on a case by case basis. I will say just that we all want as much clarity as we can get around the visitation policy. But the truth of the matter is there's so many nuances. We can't write one policy that covers every eventuality. So it does require our critical thinking and collaboration with the team on a case by case basis for some of these situations.

Trish Kritek: I appreciate that and have lived it while I've been in the surgical ICU, that there are times when we do want to facilitate particularly at the end of life, people being together. So one visitor per day, and children can have visitors, and maybe we're having some more latitude around parents depending on the situation. Is that accurate?

Cindy Sayre: That's what I understand. Yeah.

Trish Kritek: Okay. The other thing that I was going to ask you about is there are some questions about seeing more and more people in waiting rooms and whether or not we're talking about having limits on the number of people in waiting rooms as people worry about six feet and safety.

Cindy Sayre: Right? Well, I can tell you for the Montlake campus, what we are doing is we're hearing about areas that are becoming crowded. For example, we were hearing about the phlebotomy waiting area at the Montlake campus being more crowded than usual. Then we're doing a facility walkthrough and trying to identify, are there any overflow places where we might be able to put a few chairs, and I've seen in some areas there's kind of a chair around the corner. That has its own issues, right? In terms of eat grass, and there's regulations around it. So what I would say is we're working really hard to balance these needs that sometimes are competing. People need to have their labs drawn. They need a place to wait, and sometimes there's more people than we want to be that close together.

We are seeing, and when I'm walking through the medical center, it's universal masking for the patients and the visitors, which I do think helps mitigate some of that risk.

Trish Kritek: So masking is important, being in tune to the fact that there's some stressors on spaces and trying to be creative about it and continuing to monitor those spaces.

Cindy Sayre: Right. Yep.

Trish Kritek: Keri, is that similar on the Northwest campus?

Keri Nasenbeny: Yeah. In fact, I just did a walkthrough of the surgical waiting room today, looking with that same eye of, what else can we do? It really depends on the day for some of these areas. But I think it's a concern that we all share and are trying to mitigate.

Trish Kritek: Okay. Neither of you said this, and you're going to mock me, but I want to say, and maybe we want people to speak up if they feel like there's areas that are becoming too congested.

Keri Nasenbeny: Yeah. Absolutely. Because we don't see everything, right?

Trish Kritek: Indeed. Since Keri, you've now taken over the hot seat, there's a bunch of questions about having more space for eating. I think people are worried that they're seeing more people close together, and I'm looking at all the infectious disease doctors do. They can weigh in in a minute, but questions about, what are we doing to try to make it so that people have space to eat, whether that's in the cafeteria or in break rooms.

Keri Nasenbeny: Yeah. I mean, I can speak to what Northwest is doing, and then I'll turn it over to Cindy for what Montlake is doing. Here at Northwest, and I think this has been similar across all the campuses, we've asked the managers to look at their break spaces and really identify what's that capacity limit. Where can you sit? How many people can sit and eat and be safe and posting those and then holding staff to those limits? Because I think what we see is drift away from that. So doing some regular check-ins and really enforcing those.

In our inpatient areas, we've been able to close waiting rooms because what we've said for visitors is when you're done visiting, and you need to leave. So really, they shouldn't be visitors in our inpatient waiting rooms. So that's been really helpful as far as having some extra eating spaces. We're also blessed with a big campus here that people can eat outside now. It's raining now, thankfully.

So as we move into fall and winter, that option's going to go away. So I think we're going to... We've already talked that we need to rewalk spaces and look at it. I think the other thing that we've been doing informally, and I think we'll maybe need to look at doing this more formally is turning some of our conference rooms into eating spaces and really looking at, what are alternative spaces? Our staff and providers have to have a place to go to eat, and they need to do that safely.

Trish Kritek: Yeah. I saw a patient waiting room that had been converted into a break room when I was just on service a week ago. So I know that's happening. Cindy, do you want to add to that?

Cindy Sayre: No. It's exactly the same strategy here at the Montlake campus. Just looking for any area and then just empowering staff. I mean, we're sending the message. Any place you could find is not occupied, it's fair game. So yeah.

Trish Kritek: The other question is really relevant to maybe the Plaza Cafe or the cafeterias. People are asking like, are those spaces supposed to be restaurants in terms of the space and the number of people and the cleaning? I'm not sure if either of you can speak to that.

Keri Nasenbeny: I talked to Polly Poole who's head of our food and nutrition services here, and I am not an expert. But what I learned today, actually, asking this question is that we're held at higher standards actually. They have a 13-page document that they're held to through, let's see, environmental health and safety through the UW. So they they've done a lot of work in making sure that our tables are spaced out appropriately, that we're cleaning, monitoring, et cetera. So we're held to even higher standards, both from a food safety perspective, obviously, because we have patients, but also from the occupancy perspective. Nothing like town halls, if you wanted something new.

Trish Kritek: I know that. Me too. I think if people are seeing stuff that doesn't feel like that, they should also speak up. Santiago, I'm going to pivot to you. I don't know if you have anything you want to add about eating spaces and concerns about eating space since I have other other questions for you. You are the lucky recipient of some questions about masks and face shields today. So the first question that came up repeatedly was, is a face shield alone enough. Because there are people that are having face shields alone. So I think the question is, why might that be the case, and is it what we want to be doing?

Santiago Neme: Yeah. The answer is that no, we see face shields as accommodations for folks who have real allergies, who have real differences in facial anatomy and disability. That's the only place for a face shield. We have tons of evidence that masks really work. So a face shield is not equal, but I would say it's better than nothing. So that's why it's part of our policy around accommodations.

Trish Kritek: For an accommodation face shield and otherwise, face shield alone is not what we're talking about. Masks plus. Then the next question is, which is better. I feel like John might've answered this before, but we'll do it again. Which is better? Goggles or face shield. Or you could talk about the side of the glasses shields too.

Santiago Neme: Right? Honestly, we know that goggles are really good, and we know that in glasses provided that they're big enough and you're wearing those side protectors are good. I'm not aware of research that has compared face shield or goggles. I would say they're probably equal. John is an expert on PPE, so he might have a different opinion. But I would say they're probably equal.

I think that the nice thing that the facial gives you is that if you are wearing a mask, which you should, that facial does protect your mask, right? So if you're way in both, then I would say that facial does that. But John, any addition to that?

John Lynch: No. I thought you said it perfectly. I don't think there's any transmission data out there that prioritizes one over the other. It's just that with a plastic shield in front of your face, if you do get exposed to a cough or sneeze, blood and body fluids, right, you just have that much more material protection in front of you.

Trish Kritek: So there's a separate advantage potentially to a face shield. So the eye protection, we're thinking they're similar.

Santiago Neme: But I wanted to emphasize that goggles, we believe in them. They're adequate. We feel comfortable with goggles, and yeah.

Trish Kritek: Yeah. The side glasses shield too?

Santiago Neme: Yeah. Provided that your glasses are not tiny. Right? Because it's all about surface.

Trish Kritek: How about mine?

Santiago Neme: They look fine to me.

Trish Kritek: Okay, good. I was using [crosstalk]-

Santiago Neme: Maybe Tim's are reading glasses. So maybe those, not so much.

Trish Kritek: Okay. So Tim, you're out. Put on your other glasses. They would count.

John Lynch: Yeah. But for someone like Tim, that's where a face shield would be really nice because it could be-

Santiago Neme: [crosstalk]-

John Lynch: ... those reading glasses. You can have his near vision and as far vision and a face shield that he won't have to touch anything.

Trish Kritek: Awesome. I appreciate all of that. I have I think two more questions about mastery of Santiago. The first one is there was someone who said, if you've already had COVID, do you need to do all these things because you've already had COVID? Do you want to answer that?

Santiago Neme: The answer is yes. The answer is yes. Although getting COVID twice is rare, it has been documented. We don't believe that you have 100% protection for future

infections. So I would say in terms of PPE, my response is that we all need to do the same.

Trish Kritek: Excellent. How would we know that you had COVID when we interact with you? Right? So the last one is the most challenging one I'm going to ask you, which is someone appropriately based on the weather today said, what's going to happen when our masks all get wet in the rain? Are they less effective in that setting?

Santiago Neme: Well, that's a good one. I think that typically you're going to be wearing the mask, let's say your cloth mask when you're outside of the hospital, the clinical setting. Now, we've always said that if your mask gets compromised, and that includes wetness, moisture, things like that, you might want to replace that. We want the mask to be dry, to retain its efficacy. Right? I'm not a physicist, but I would like folks to have a dry mask when they're working.

So between my car and the hospital, again, I shouldn't be wearing a cloth mask. But let's just say I'm wearing my procedure mask from my car to the hospital and it gets wet, I would replace it. We have plenty of procedure masks for folks to use, and we want them to use a dry one.

Trish Kritek: So dry is better. When I read this question, I was going to say, maybe it's time for Seattleites to use umbrellas. We don't have any verdict.

Santiago Neme: That too.

Tim Dellit: No.

Trish Kritek: Everybody's shaking their head at me. Okay. So I guess umbrellas are still not in. But it would keep your, it would keep your mass dry. Thank you for answering all of those questions. Actually, Santiago, I did have one other followup. This is a little bit different, and I'm not sure if you or John can weigh in. We say that if you have a mask and eye protection on, that's a lower risk interaction if there ends up being somebody with COVID with whom you're interacting. We say that in the clinical setting.

Someone asked, "Can we extrapolate from that to the classroom or for other nonclinical settings, i.e., if I'm exposed to somebody with COVID outside of the hospital, but I had a mask on and eye protection, is that [crosstalk]?"

John Lynch: Can we jump in here, Santiago?

Santiago Neme: Yes, please.

John Lynch: Santiago is fully capable, but I just got off a conversation about this.

Trish Kritek: Okay. Great.

John Lynch: So what distinguishes what happens in healthcare situations where there's an exposure to healthcare worker from being outside of healthcare is that we have two things going for us, a supply of medical masks, right? The surgical masks that we use are great. They're really effective for prevention of transmission. They are usually to some extent, water resistant or fluid resistant and have electrostatic properties, multiple layers and stuff like that.

Second, our healthcare workers are trained, right? We spent a lot of time practicing and using these things. So within healthcare environments, we look at your PPE, particularly your mask and your eye protection, which we know are both very effective within our settings. We know that equipment. So use that in our risk assessment for exposures.

When you're out in the world, when you're a student in a school, they have neckers and cloth masks and handkerchiefs, and who knows what types of eye protection, if any? So when you look at the public health exposure processes, they do not look at whether you're wearing a mask or not. It is exposed or not exposed. That's because they don't have the same equipment that we do, and they don't have the same training.

Just to be clear, within the greater University of Washington, we're using these procedures for healthcare workers within UW Medicine, but also within the school of dentistry, school of nursing, the folks who are working with animals, where they're all trained and supplied with these higher sort of levels of protection. Again, so that's different than, for instance, a university student who's going to class that may be exposed, where he or she or they may be wearing a neckerchief for something different.

Trish Kritek: I think I call that a handkerchief, but okay.

John Lynch: A handkerchief. So-

Trish Kritek: Or maybe I call it [crosstalk]-

John Lynch: ... word escaped me at the moment there.

Trish Kritek: That's okay.

John Lynch: I see you laughing, Anne.

Trish Kritek: I think the take-home there is we are different and probably higher quality PPE in the setting of the clinical environment and training about using that PPE. Thus, we think of it differently in the clinical settings than we do in all other settings. So I really appreciate that. That was a good thing to clarify for folks because I can understand that question completely.

All right. I'm going to pivot back to Tim/Keri, Cindy. There were a series of questions about furloughs again, and there was concern that there is a second set of furloughs that are planned at this point in time. I asked this last time. Think of the continuing sources of a fair amount of distress. So I'm going to start with Tim and ask him, do you know of any furloughs that are planned right now?

Tim Dellit: No. There are no plans for furloughs at this time. Keep in mind, our hospitals are really busy. I think we're over 95%. I think that would only come up really as if we could match where we saw decreased bias. But there are no plans right now, and the hospitals are really busy.

Trish Kritek: Okay. Thank you. I'm looking at Cindy and Keri. Keri, you might want to-

Cindy Sayre: Yeah. I think people might be hearing... There's some conversations with the union to talk about a potential future state. If we got back to where we were in March, again, to Tim's point, there's no risk of that right now, where we're very, very busy. But they are having some conversations. I think that's what people might be hearing from their unions. There's nothing planned right now.

Trish Kritek: Okay. So there's some conversations going on with unions? Thinking about if things got back to the state we were in March, but nothing on the table right now.

Cindy Sayre: Correct.

Keri Nasenbeny: Again.

Cindy Sayre: Yeah. I think we have so many more things going for us now than we did in March. We have a much better understanding of this. So feeling like the census is going to hold, but [crosstalk]-

Trish Kritek: You're feeling optimistic about that.

Cindy Sayre: I am very optimistic.

Keri Nasenbeny: Well, and we're doing everything we can to retain those volumes and build those volumes, actively building surgical volumes and doing work in our ED. I think to Cindy's point, we are in a much better place, and our goal really is to maintain this volume that we're seeing. So this is I think more of just sort of what if and making sure that we're prepared.

Trish Kritek: So good volumes, working efforts to maintain volumes, no threat right now. I know that people are worried about it. So I very much appreciate that we feel like it looks good right now. I heard that before. As a matter of fact, speaking of good, John, how was the end meeting of the joint commission? How did that go? Oh, you're muted, but I'm sure-

John Lynch: Well, thank you for asking. We just finished our closing session just before this. I wasn't there for the whole thing. But my understanding from Glen Allen, who runs it for Harborview and Paul Hayes and Rick Goss and Jerome is that this was actually one of our best joint commission visits ever. They were very, very happy with UW Medicine COVID-19 response and Harborview mission and how we do things in terms of policies and procedures. So I'm sure more to come, more to learn, but a wonderful four days with the joint commission.

Trish Kritek: Thank you. Congratulations. That's great, and I think it is a reflection of all the wonderful teamwork. I have one last question for Tim before I hand it over to Anne for her questions to an ID expert. Tim, there were a bunch of questions because it's so much in the press right now about whether or not we have a plan to administer the coronavirus vaccine when it becomes available. So could you just tell us where we stand with that idea?

Tim Dellit: Yeah. There's a lot of discussion obviously in the media, and certainly, we all saw the letter to prepare for potential distribution by November 1. I think most of us think that's highly unlikely. In fact, if you listen to Dr. Fauci or the head of the CDC, they've been very clear. We may have some results preliminary out of the current phase III studies towards the end of the year, November, December. But then, to mobilize and get everyone vaccinated, it's going to take a prolonged period of time.

We also have been really advocating that we need to finish those phase III studies. We need to ensure that the vaccine is safe, that it's efficacious, that we maintain the trust of the public in our vaccine process. So this cannot be rushed. All national organizations have really responded to that. John outlined our vaccine approach for influenza. I would anticipate, again, it's still in the planning process, we would do something very similar. We are actually pretty good at rolling out vaccine within our system, and we would use those same tools and processes that we do for influence of vaccine, but we're not there yet.

Again, I think this is something we do not want to rush. We all want a vaccine as soon as possible, but we absolutely have to make sure that we finish the studies and that it's a safe and effective product.

Trish Kritek: So I think we've heard that from a lot of people. We want to let the process play out, know that we're doing something safe and we have a good system to use when we're ready to give it. All right. Anne, I think it's John who's your question, answerer today. The floor is yours.

Anne Browning: Yes. Thank you, and welcome back to ask a friendly infectious disease doc. We have Dr. John Lynch on the hot seat today. Thank you. We got a bunch of questions, and we'll see how many we can get through before I have to hand it back to Trish.

John Lynch: I feel like I need a buzzer.

Anne Browning: You almost do. We've got some big themes. We'll start with basic sanitation. So John, do you still wipe down your phone every time you get home?

John Lynch: I wipe down my phone every time I come to work.

Anne Browning: Okay. For household items, things like keys, pens, et cetera, what do you think about using a UV light box to sanitize them?

John Lynch: If you have one, fine. I don't do that.

Anne Browning: Could you use a UV light box to do that with a cloth mask, or should we just be washing them?

John Lynch: So UV is a nice second step. What you really want to do is use soap and water or bleach. CDC has a great website on how to wash your mask and think of it like your underwear or your socks. You wouldn't just use a UV for either those, go through the wash machine.

Anne Browning: Thank you. The air quality is sucked this week, and a couple of folks have been wondering around kind of at work and home air filtration. Somebody asked, would you recommend an H13 HVAC for the home or office? I have no idea what that means, but I figured you might.

John Lynch: Yeah. So it's actually a very high-level HEPA filter. It's kind of almost hospital grade. So I'll say just two things. One is the public health insider, that's the King County Public Health blog. Go to that. Early September, they have a whole long list of ways to deal with smoke in your home. If you have air conditioning, which very few houses actually do in Seattle, sure. Go ahead and use one of these high-level filters, a HEPA filter, a high-level murder filter or something similar. But most of us don't have access to it. That blog post actually does have a bunch of other things we can do around closing windows, using box fans and putting some of those or normal heating elements sort of filters against those box fans, making rooms, decreasing frying, decreasing vacuuming, decreasing candle use.

There's lots of other things before we start going to a big tech change. If you have it, great. Go for it. But there's lots of other things people can do.

Anne Browning: Cool. Thank you. Next theme, transportation. Several weeks back, Santiago mentioned that he supports public transit. He uses the bus. How do you feel about bus riding and taking the train these days?

John Lynch: Yep. I agree with Santiago. If you look at the Metro, they have great... I mean, I go by buses every day. I mean, literally every day, and they've got every other seat blocked off. They have masks required to get entry. Now, I know that that hasn't always worked for every driver, and there's been some unfortunate events out there. But in general, the practices are sound, smart, and I think work and keep it safe.

Anne Browning: What a question from somebody asking if they could carpool in with one or two other workers, if everybody was matched up. What do you think?

John Lynch: Yes. Roll down your windows if at all possible, if it's not too smokey. But great airflow. If smoky, keep windows up, and use lots of AC. But yes, I think that's okay. Tons of our healthcare workers do that.

Anne Browning: Question around communal eating. We've been told don't-

John Lynch: No.

Anne Browning: ... don't take anything from the buffet. But question. Somebody brings in a box of Krispy Kremes and leaves them out in a break room. Do you take one?

John Lynch: No. No communal food.

Anne Browning: Would you recommend if somebody wanted to bring something in, should it be individually wrapped? Is it a best practice?

John Lynch: Yes. I mean, that's what we're doing in our cafeterias. But remember, hand hygiene, before you touch anything in that box and hand hygiene immediately after. Not a great practice. We really don't want people bringing in food from home or from a store into the hospitals or clinics or any other places. So do I think it's dangerous? Not terribly if people do the right thing. But we really don't want that happening in our healthcare facilities.

Anne Browning: Cool. Thank you. Next set of questions is on kiddos. You have a family member who's willing to help out with babysitting, but that person tends to go out to restaurants, even if they wear a mask or social gatherings and whatnot. You let that kid watch your kids or that family member?

John Lynch: No. Sorry. Sorry. I'm pretty clear about that. Yeah. So I mean, when I talk about pods and other people have talked about it, I want people who share my level of risk-taking, and that's not my level of risk-taking. I'm sure they're a great babysitter but not in this situation.

Anne Browning: I liked your idea of having a shared mental model and making sure that there-

John Lynch: I think you wrote that.

Anne Browning: I thought that was yours. I thought that was so good, I stole it. Okay. Halloween is coming. Are you going to hand out candy if you wear a mask?

John Lynch: I would love everyone else's advice on this. I can see Halloween happening really the way we think about it. This for me is the first holiday in COVID time. I'm sure there's other religious holidays and other ones that I don't know about. But this is the first sort of secular one that I would engage in, and it's one our

family loves so, so much, and I can't see it happening in the way that we remotely think of it.

Anne Browning: Yeah. So you wouldn't even recommend having your-

John Lynch: [crosstalk] somebody put a candy zip line, but then someone told us to touch it, and then it touches someone else, and I don't know.

Anne Browning: So you would not recommend letting your kids wander around, even if they have masks on?

Trish Kritek: Those are a lot of [crosstalk]-

John Lynch: I think walking around outside, kind of a distance parade, but not going to anyone's house. Say you would just get in our costumes, and we go out in the streets and do that, I think outside, people in costumes wearing their masks, I actually think that's probably very safe, but not going to people's homes. So maybe what it is is like a Halloween parade that lasts several hours outdoors.

Anne Browning: Thank you. I think it's helpful to hear, and I share this idea, like, as we hit these holiday traditions that are going to be disrupted, trying to get creative and kind of roll with it. So thank you. Maybe we need some Halloween parades, but no neutral candy bowls at the front door. Next set of questions out in the world. Would you attend a religious service or an indoor gathering of masks and physical distancing were required?

John Lynch: I personally am not ready to attend large group indoor events of any type.

Anne Browning: With the smoke this week, a lot of the patios were closed for restaurants. How are you feeling about eating indoors in a restaurant right now? I saw the eyes get big.

John Lynch: I'm personally not ready for it. I think that there are some variations. We know what our city and state are recommending, but I'm not ready to eat indoors with people with no masks.

Anne Browning: Yeah. How about on the patio? Would you go back to the patio at this point?

John Lynch: I haven't done that myself. So my honest practice is I just haven't done it. I think Santiago's saying maybe.

Santiago Neme: I haven't done it, but I can see it happening.

John Lynch: I could see you with a lot of distance outdoors. I think biologically being outdoors is actually pretty low risk if you're distanced. So I could see it being okay. I wouldn't flag anyone down big time. But it just hasn't occurred to us to even try yet.

Anne Browning: Okay. Thank you very, very much. With that, I'll hand it back to Trish since we were at 3:59.

Trish Kritek: Woo, perfect timing, Anne, as always.

John Lynch: Rosh Hashanah starts today.

Trish Kritek: That is true. Happy New Year.

John Lynch: I'm going to mispronounce this, but l'shana tova. Right?

Trish Kritek: Yeah. There are-

I would just say, if there will still be Halloween, there just won't maybe be trick-or-treating. But the holiday will still exist, and we can still celebrate in a myriad of different ways that don't include the trick-or-treating part, for those of you who like to get dressed up. You could have a popery of Zoom encounters in your costume. I'm serious. I celebrated my 50th birthday by Zoom.

With that, now that I've shared all of that with you, I want to say thank you to everybody for answering the questions as I do every week. I really appreciate it so much. I want to thank all the people who keep sending in questions. They really help us think, and they change what we do. So please keep sending them in. We still appreciate it.

I'll say that we are back to having transcripts. Last town hall is transcribed. We will transcribe this one. It will be posted. I'll end this week like I do every week by saying thank you to all of you so much for all that you do for taking care of, I'm going to broaden it, our learners, our patients, their families, and each other. So thank you all so much, and we'll see you back in two weeks. Bye-bye.