

Trish Kritek:

Welcome to UW Medicine, Town Hall, I'm Trish Kritek, associate dean for faculty affairs. And it's a pleasure to come back and meet with you again at Town Hall. I'm going to tell you who the folks are, who are a part of our panel today, and then we'll jump right in.

Trish Kritek:

As we do most weeks, I have Tim Dellit, our chief medical officer for UW Medicine. Anne Browning, our assistant dean for Well-Being, Santiago Neme, medical director at UWMC Northwest, Tom Staiger, medical director at UWMC, Cindy Sayre, chief nursing officer UWMC, Keri Nasenbeny, associate chief nursing officer, UWMC at Northwest, sorry about that. Jerome Dayao, chief nursing officer at Harborview, John Lynch, infection prevention and head of our medical response team for COVID, at Harborview and UW Medicine. And then we have a guest this week, Todd Burstain, who is our new chief medical informatics officer for UW Medicine. He's joining us because there were more questions about D1 and we all thought it would be good to have an expert around D1 to join us.

Trish Kritek:

Thank you all for coming back together, for Town Hall. I'll begin by saying thanks to everybody who sent in questions, it is clear to me, in many ways, that the level of anxiety and stress about a second surge is palpable across our community. We had more questions this week, I think we had 124 questions than we've had in a while. And we appreciate that, and I'm going to say this at the beginning, I'm going to say it again at the end, we're going to come back together next week and we'll try to figure out the tempo of our Town Halls, as we see the situation with COVID evolve over the next several weeks.

Trish Kritek:

I also want to acknowledge a question that somebody said, which is, "Why don't you just read the questions verbatim instead of summarizing them?" And I totally get that, that you want to hear exactly what people are asking. And I will just say, I do that because there's so many questions and I'm trying to get to the themes. And since we'll be meeting more frequently, I will do my best to get as many questions in as possible. With that preamble, I'm actually going to start with, Tim, and say, Tim, as I just said, there were many questions, concerns about an impending second surge. I think it's in the news, across the country, we're hearing about folks in other states and hearing about more cases in Washington. And I think what people would like to hear about, at least to start with, is what our plans are for a second surge and how we're getting ready for that.

Tim Dellit:

Great. Thanks, Trish, and again, thank you everyone for joining us here this afternoon and, really, thank you for your continued work as we respond to this ongoing pandemic. Certainly, I appreciate the fact that there are a lot of challenges right now and everyone is feeling fatigued from this, and particularly as we look towards this next phase. As Trish mentioned, if you look around the country, we've seen many states rising, I think now 46 states are having increased numbers of cases and over 10 million cases, unfortunately, now in this country and over 240,000 deaths as well.

Tim Dellit:

John's going to go over more specific numbers but what we have seen here locally, in Washington state, is that although we have been lagging the rest of the country in many respects, with this, we've really seen a significant change over this last week. Beginning last weekend, we started to see an increase,

escalation of cases across the state and in all age groups. In fact, at that point, we had seen a 30% increase in hospitalized patients across our state, we started to see a reduction in available ICU beds and, compared to when we did not see an increase in our hospitalized patients within our system, in July and August, when it was really affecting a younger population, right now, we are seeing an increase within our system as well.

Tim Dellit:

And we went up to 55 cases on Sunday and even this past week, we got as high as 60, although now we've leveled out right in those mid-50s. And so this is a significant change from when we were with you, two weeks ago. With that in context, I want to just describe a little bit about what we're doing with our EOC, our Emergency Operations Center. Now, keep in mind, this EOC has been in operation since it opened, on February 29th, we never stopped. It has continued to be the vehicle through which we have coordinated and aligned our activities, across the system, even when we did not have as many cases during some of the earlier summer months.

Tim Dellit:

Now that we are seeing this increase, we have increased our frequency of meeting, we are meeting both in the mornings and evenings, each day, to continue to align and coordinate our activities. Keep in mind that we are in a much better shape now than we were last March, right? We have the infrastructure in place, we have learned a lot through this pandemic, we've incorporated those lessons learned, whether it be in our policies, our practices. And so we are in a much better shape in terms of just where we are in our preparation right now.

Tim Dellit:

The things that we are really focusing on right now, our space, do we have adequate bed capacity? Staffing? Do we have enough people? And then our supplies. And our supply chain has done a phenomenal job, in ensuring that our healthcare workers have had access to the appropriate Personal Protective Equipment, to safely care for these patients. And although we, like most hospitals, are in contingency phase with our PPE, simply because of the unknown certainty of future supply, we feel pretty good about where we are now and we're in a better position actually, I think, than we were even last February or March.

Tim Dellit:

From a capacity standpoint, what we're really looking at, and this is different than last April, I want to spend a little time with this, much to Trish's chagrin. In April, when we tried to build capacity and preserve PPE, we turned off our elective and non-urgent surgeries and procedures like a switch. It was an all-or-none, we did that on March 16th, the Governor's proclamation came a few days later. That dropped our OR volumes by 65%, it built bed capacity, it freed up personnel and actually we had probably more bed capacity than we even needed, during that initial surge, but we just didn't know at the time.

Tim Dellit:

What we are trying to do right now is, really, think of this more as a dial. Meaning that as we see increased COVID activity within our region and certainly within our system, starting to look at how do we, from a data-driven way, decreased activity in order to free up the necessary capacity and personnel. With our surgeries, we have put together a group that is looking at really guidance around surgical

triage. Using the ACS model and tiering around elective surgeries, how do we start to look at these and say, "If we decrease certain activities, what does that give us in terms of beds, in terms of personnel, in terms of PPE?"

Tim Dellit:

And so doing this in a very thoughtful manner to ensure that we can continue to provide the essential care our community needs, while also responding to COVID-19. Now, this could change in the future, if we saw dramatic increases, but we really are trying to be thoughtful in that balance of the care that we provide. And I would say, just to be clear right now, this is in planning because we've held in this mid-50s. We haven't actually scaled back those procedures yet, but we're getting prepared and having those conversations so that when we do see that increase in cases, we'll be able to move quickly.

Tim Dellit:

The last thing I'll say before you ask questions is, we're also working with our ambulatory leadership, starting to think about what do we do from a tele-health, in-person visit. Now, tele-health, as people recall, expanded dramatically, upwards of 30,000 telemedicine visits in April and May, and we're still doing over 21,000 a month. It never has gone away and is a critical part of our practice right now but the question is, how much should be in tele-health? How much should be in-person, right now? As we see increased activity in the community and we're, again, through our EOC structure, doing the planning with the ambulatory leadership, to think about how do we do that to continue to provide care in a safe way for our patients, a safe way for our healthcare workers, but ensure that we meet those care needs for our patients.

Trish Kritek:

Okay. Thank you. You have, with your thorough answer, mitigated me asking you more follow-up questions, here's what I heard.

Tim Dellit:

That's the goal.

Trish Kritek:

One, that we are meeting now morning and evening to have our emergency preparedness group come together. Two, that right now, we haven't changed anything with elective surgeries but we're thinking, we're working now on plans for basically dialing them down as needed and not just shutting them off, though, we might go to that if things got really crazy. And then I think I heard we're good in terms of PPE, albeit it a contingencies phase. And we've been strategic about it the whole time because people ask, do we have enough PPE? I think the answer we would say right now is, yes. Are we stopping elective surgeries right now? The answer is, no, and that we're thinking about and strategizing about that. And then, what about more telemedicine? And it sounds like, also working on that and maybe I didn't hear it entirely, a clear answer, it was like, is it okay to flex up with telemedicine now or is that something we're waiting to do more of?

Tim Dellit:

I think that the trick there is, our ambulatory areas are in different spaces, right? Our hospital-based clinics such as Harborview, I think, are feeling more crowded than, say, the neighborhood clinics or some of our freestanding clinics. It may not be a one-size-fits-all in terms of how we do that, but we also see

that the neighborhood clinics are still doing 20% telemedicine, in general. Other areas are not quite doing that much, so should we start to increase that there? I think, again, a lot of planning right now, we are not... We want to be cautious, last time we immediately switched to, essentially, canceling a lot of our in-person and trying to get them over to telemedicine.

Tim Dellit:

We have the telemedicine structure so we can do that pretty seamlessly, right now, compared to even the first time, when we did it quickly. But we want to still maintain that access to care that patients need so, again, there's a balance here a little bit. But if things continue to escalate, I would anticipate that we will be shifting more to telemedicine, but it's a little bit of a day by day, right now, while we're doing the legwork of planning, behind the scenes.

Trish Kritek:

Okay. A lot of planning, plans evolving, sounds like more telemedicine if and maybe when we see more cases. I have two last quick follow-up questions for you. One is, what about research? Are we continuing to do our research? Particularly, clinical research was the question that came up.

Tim Dellit:

We have not made any changes, at this stage, to what we're doing from a research standpoint.

Trish Kritek:

Great. And then the other question I had was, are we supporting departments and divisions and coming up with plans for like backup call or backup plans?

Tim Dellit:

Yeah. The departments are very much working on this in coordination with our medical directors, and starting to think about how do we expand that search capability, to be able to meet that need. Now, I'm just going to be honest, it is harder to do it as a dial, as opposed to when it was an all-or-none, you had a lot more immediately-free personnel, especially, right? It's a little more complicated as you're trying to still maintain OR activity, right? Then those individuals, if they're in the OR, they're not available out, for the floor. It's a much more challenging balance but absolutely all the departments are working on this and thinking about this. I also just had conversations with GME earlier today, the residency programs are starting to think about this as well.

Trish Kritek:

Okay. We're working with departments and divisions and training programs, to come up with strategies for backup, for folks who get sick or maybe when we actually need additional workforce, more challenging in the setting of continuing other business is what I hear. Okay, thank you so much, I'm going to pivot to John Lynch and, John, I have a bunch of questions for you, I'm going to start with just some first pass numbers across UW Medicine, in terms of what we see at each institution, ICU and acute care because I think people are concerned as they hear more patients.

John Lynch:

Sure thing. I'm happy to share this with you. As of today, we are at 51, total inpatients at our four hospitals. Just to give people a sense of where we're going and referencing what Tim said, we got up to

actually 60 patients on Wednesday, in-house, and then 54 yesterday, 51 today. And Valley has 21 patients, there were a few higher than that earlier in the week. Most of their patients are in acute care, they do have folks in labor and delivery, on acute care, and they do have ICU patients.

John Lynch:

Northwest is up at seven, as of early this morning. Again, most of them are acute care but they do have some ICU patients. Montlake has six patients, most of their patients are in the ICU, with two people in acute care, four in the ICU. And Harborview's at 17 as of early this morning, with nine people in acute care, eight in the ICU. And I believe three of those people are on that heart-lung bypass, ECMO, or ECLS. 51, total, 37, acute care, 14 in the ICU.

Trish Kritek:

And I'm actually the medical ICU attending right now, at Montlake. Thank you to Kevin Patel for covering my service, while I'm here at Town Hall. And we have no patients with COVID on ECMO right now but, as you said, multiple in the ICU, thank you. And people are asking and I asked this before but I'm going to ask it again, where do you think are the best places for people to get a sense of numbers, in terms of our numbers but also numbers across King County and the state. I think people are worrying about Washington hospitals becoming overloaded like we're hearing about in Wisconsin and other states.

John Lynch:

There's a variety of places to go, one is, the Washington State Department of Health. You put in Washington, DOH, COVID, it'll bring you to a website that has a dashboard and you can click on that. And I really do recommend people go into that dashboard and click around, the thing that I look at the quickest is the epidemiological trends, because it gives you those lines, those graphs that I think people are used to seeing, and in terms of surges and so forth. You can look for how many people have a positive test? How many tests, total? How many people are hospitalized and how many people have died, at Washington state? And you can look per county, which I hope to touch on here in a minute.

John Lynch:

I also look at the King County dashboard so, again, you can do the same thing, public health, King County, COVID, they have a fantastic dashboard which has a huge amount of information. Like the Washington state dashboard, you can look at demographics, which I also think is really important to mention, age, communities, ethnic demographics and so forth. And then for our own stuff, the message we sent out today will be coming out right after this, that has all of our data on it as well, there's a whole host of places to definitely look.

Trish Kritek:

Yeah. And I think on the internal side that you can get to from The Huddle, you can click on that and on the right-hand column, those daily reports are available to people, with their login and they have the numbers by hospital. Thank you, I have two more questions for you now, I will come back to you in a little bit as well but one is, do you have a sense of what percentage of our hospital beds have patients with COVID, right now?

John Lynch:

Actually, off the top of my head, I don't know. I'm not sure if Tim or Santiago or any of the CMOs know.

Tim Dellit:

It's about 5%.

John Lynch:

Yeah, I think it's just hovering just around 5% or just under 5%.

Trish Kritek:

Okay. I think that's reassuring to people because they're wondering if it's super high but it's 5% of the beds across our system.

John Lynch:

Yeah. And do you mind if I just make a quick comment, I'll be really fast? Is that we are paying very close attention to how many patients we have in our system, but also how many patients there are in King County to Snohomish, Pierce. We are seeing surges in Pierce, Snohomish, Clark, Benton, Spokane, counties across the state. And as Tim was speaking to, the hospitals are pretty full, everywhere, and so as we see these new cases everywhere in the state, that is, again, a very different scenario that we had in the spring.

John Lynch:

The age distribution is different but also just the widespread nature of COVID, across the state. And so we're paying attention with the Washington Medical Coordinating Committee led by Mark Taylor and Steve Mitchell, two of our UW folks. Working across the state, great visibility into the state EOC, around capacity. Particularly around critical care, which is where we're really stretched the thinnest, across Washington. Thank you.

Trish Kritek:

Okay. Unlike before, when it was a lot in King County and then later we saw it in different parts of the state, right now, we're seeing it across the state and that's putting, potentially, a greater strain on hospital beds across the state, particularly in critical care. Thank you, thank you for that clarification. We're going to do something slightly different today, I'm going to bring Anne in, to do her, Ask an ID doc, and actually ask three ID docs a series of questions. Because there were so many questions that came in about Thanksgiving and about folks traveling around the holidays, and I think it is a source of growing anxiety and angst. And I'm going to hand it over to Anne, to talk with Tim, John and Santiago and prioritize this because of the sense of concern, that we got in our questions. Anne, the floor is yours.

Anne Browning:

Sure. Thank you. Diwali, which is the Hindu festival of lights, starts tomorrow and runs for five days. And as of yesterday, we are two weeks out from Thanksgiving or American Thanksgiving. And these are holiday traditions that are marked by families gathering and eating together, but it's situated in this context of increasing COVID numbers and increased community spread, so even the recommendations that we might have now will still be evolving as well.

Anne Browning:

We've been lucky to have Santiago and Tim and John, over the last several months, share what they're doing and their own thoughts on best practices. Based on a lot of the questions that you've asked, we

also will speak to some ways to potentially mitigate risk, if folks are trying to gather, over the coming days. And also, I think, folks will weigh in on Jay Inslee, Governor Inslee's messaging around travel and on trying to limit gatherings to immediate family. But I'll start by asking each of these ID docs, what are they planning to do for their own holidays? I'll start with Santiago, what are you planning to do for Thanksgiving?

Santiago Neme:

We're planning on just limiting to our household, which is my husband and me, this year. We've been tempted to go to Florida, which is where we go to the beach every year, but not this year, that's our plan.

Anne Browning:

Thank you. Tim, how about you?

Tim Dellit:

I will be rounding at Harborview, earlier, because I'll be on the ID service, and we will have a very small... Essentially my wife, myself, our dog. I have a stepson who has been part of our bubble but we've also been clear to him, he lives in a separate apartment, that he needs to really not engage with others over these two weeks, prior to that, if he's going to join us.

Anne Browning:

Thank you. John, how about you? What are you planning?

John Lynch:

It's going to be a massive, massive buffet for myself, my wife and my two middle school age children. And some climbing in our backyard and our wall that we built this summer.

Anne Browning:

Awesome, that sounds pretty good. I'll get into some of the questions around risk mitigation, Santiago, we're about two weeks out from Thanksgiving, as of yesterday. A lot of folks are wondering, almost as Tim was mentioning with his stepson, can folks self-quarantine and then try to gather, what are your thoughts there?

Santiago Neme:

I think it's a strategy that probably works well. For me, it's too complicated, to be honest. I'm a control freak too so it's like, "How are they doing that? Is that going to be 14-day? And how are they accomplishing that? And is there going to be any break in doing that?" I would say it's a strategy, is one of the things that you can do, which is isolation, I think it would work, it's just not my preference for my situation.

Anne Browning:

Understood. And we've had some folks wondering, would you be... If folks were able to quarantine, do you think it would be potentially okay for them to gather at an Airbnb, if it was two families or two pods coming together?

Santiago Neme:

I'm less worried about the space, meaning the Airbnb, the fomites. I think we've learned that it's less of an issue in transmission, I'm mainly concerned about people, droplets, sharing a space indoors, that's my main focus.

Tim Dellit:

And can I just add, I think the reason the Governor and his wife, last evening, really emphasized the need to keep gatherings to your household. And the part of it is, where are we seeing the transmission right now? A lot of the transmission we're seeing is in small gatherings, as people move indoors with the colder weather and the rain. And even when you think that you're expanding your pod, so to speak, that because 40% of people may not have symptoms, you just can't tell. And so I think it is those small game night gatherings, dinner parties, that's where the transmission is happening right now. And so I think that's why you're hearing all of us being very wary, of really expanding and interacting with others or other pods. And I think that's what was really behind the Governor's message, because it's based on what we're seeing in the community.

Anne Browning:

And, Tim, I'll stick with you on that point. It seems like a lot of folks have kids, potentially, coming home from college, maybe from out-of-state. Now there seems like there might be some restrictions there, maybe just coming home from in-state. And some parents who have expressed worry about having a kiddo, potentially, bringing COVID into the household. Are there any recommendations there? I mean, it's family so it's hard.

Tim Dellit:

Yeah, that's really tough. I can tell you, I have a daughter and stepdaughter in New York, they're both staying in New York. And I think now with the Governor's travel advisory, that if they were to come home, then they really have to self-quarantine within the house, right? They're not going to be able to go out and go see their friends or they shouldn't, even if they came back. And I think the other thing is, many universities are now saying, "You know what? If you go home, don't come back, just spend the rest of the semester there, at home, because if you come back here, you're going to have to isolate for 14 days." I think it's getting really, really complicated for those kids who are away, and they're going to have to either decide how they want to spend the rest of that semester. They either come home and stay or they stay at school, until the end of the semester.

Anne Browning:

Interesting. I would say, as a quick follow-up, it seems like the Governor's travel restriction, it could even affect employees who might be traveling out and coming back. Do we have any plan around students returning or employees returning, after being out-of-state?

Tim Dellit:

I didn't speak to the upper campus but I think this advisory, literally, just came out today. I think we're still all processing in terms of what we have to do, from a planning, with our employees. The plan, prior to this, if you look at the University of Washington, through the Husky Testing, they were encouraging, if you are going to travel, you can get tested through the Husky Testing program before you go and then, if you come back, to get tested before returning back on campus. There is a website for the university

students, looking at that, it's not clear, with this new travel advisory, how that will get incorporated because it literally just came out a few hours ago.

Anne Browning:

Thank you. And actually that piece on testing, we had some questions around. And, Santiago, I was going to ask you, can folks get tested prior to trying to gather for the holidays, as a way of knowing that they're okay?

Santiago Neme:

My view on testing is that, it's one of the imperfect measures that we have and I think we may get overconfident with a test result, that is just a snapshot of today. We've seen, even at the White House level, that a lot of these people were tested but yet the transmission was pretty rampant. If it's testing while observing the other measures, I think it makes sense and we have to do it thoughtfully. I think it may give you some information but my concern is that, people feel like the testing means that you're clear and then you go, and so that's my concern. But I don't know what Tim or John feel, around that.

John Lynch:

I agree.

Tim Dellit:

Me too.

Anne Browning:

John, I have one more for you. We've heard a lot about well-ventilated spaces, and I think a lot of folks are trying to mitigate risk and asking about opening windows, doors, spacing things. What do you think about, if it's as cold and wet as we predict, is there a way to vent a house enough that it feels like a decent space to gather?

John Lynch:

Right now, I'd say, if the people in your house are miserably cold, yes, probably, but then it doesn't make much fun... It's not very fun to have around. I would say that, no, in general it'll be so uncomfortable, given the temperatures and the wetness out now, that you probably couldn't achieve the amount of ventilation that we're really looking at. And the issue and I think these are really good questions, Anne, because the 14-day quarantine, the testing, the ventilation, are all things that people are trying to wrestle through, to make this happen, to be normal, right?

John Lynch:

And what I think, my message, I'm not going to speak for anyone else, my messages, it's not. And my rec is to stop thinking that way, we have to think about this year as different. And I would really ask, being with a lot of my Department of Health and Public Health jurisdiction colleagues on Tuesday, at a press conference's topic, the ask is, make this year different. And I think that we, as much as we want it to be the same, this is not that time. And so finding these different things to get around it, I would say, let's just put that aside, that would be my rec.

Anne Browning:

I think, John, you and I have landed in the same place. And I feel like out of even a sense of well-being, 2020 is just a different year to try and make our holidays look the same, in a year that has just been wildly different. I felt that it's like trying to share pecan pie with my parents, over Zoom, that does not sound like fun right now. And so I feel like letting go of trying to force tradition and maybe trying to do a hike, maybe cooking totally different foods than we would typically have. But trying to come up with a different way to mark this holiday season, rather than force old traditions, and mark it as unique as it really is. With that, I want to say happy Diwali to folks who are celebrating, starting tomorrow, and I'll pass it back to Trish. Gentlemen, thank you for sharing your thoughts.

Trish Kritek:

Thanks to Anne and all three of you, I appreciate it. I also am having a 15 pound turkey for two people, which is staying with some traditions but smaller than usual, and I hope Andy likes turkey. I'm going to build on that theme of eating, because there are a bunch of questions about eating in the hospitals. And so I'm going to look to our three chief nursing officers, Jerome, Cindy, and Keri. And I'm going to start by saying, we've talked about this before and I wondered if there were some updates on what we've done, for finding spaces for people to eat and maintain distance. Since we know we have to take off masks, people have... There were actually a couple of questions about cafeterias feeling quite crowded. Cindy, do you want to comment on that?

Cindy Sayre:

Yeah, I can get started and then look to my colleagues. I would say we continue to look for any space that we can, for staff to physically distance during their breaks. I think, as we've talked about, it's really challenging on all three campuses because we have very constrained, just spaces, in general. I will tell you, for example, this week, at Montlake, we have been going back and forth about whether we should open a certain space up and now we've decided, "Yes, we need to open it." It's a challenge and I look to my other colleagues to say, "Yeah."

Trish Kritek:

Just to clarify, Cindy, you said you are going to open up a new space?

Cindy Sayre:

Well, it's been on and off the list, I can say. At the Montlake campus, the Health Information Resource Center, that is right next to our gift shop, was open for a while. And then we thought, "Well, maybe we could do some other functions in there," but now, again, open just to provide as much space as we can, for staff.

Trish Kritek:

Okay. Jerome, do you want to add to that?

Jerome Dayao:

Yeah. We're doing the same thing here, at Harborview. In fact, we have converted our spaces that were once visitor areas to, now, lunch and break rooms, so that we can ensure that there are socially... I mean the people that do go on break are socially distant from one another, because we do recognize this would be very challenging.

Trish Kritek:

Use of waiting rooms and family spaces but fewer visitors around, Keri?

Keri Nasenbeny:

Yeah. We've done the same thing where waiting rooms and most of our units, and we've bought those old TV tables, I don't know if any of you remember, so that staff have a place to sit and eat on the chairs. And then converted some conference rooms over in our E-wing and a variety of other areas, really trying to, I think, get ahead of this and open up enough spaces. Now, some of them might be a little bit of a walk, which I appreciate is a challenge. Though, I think we're trying to accommodate that extra time and breaks wherever we can, so people can eat safely and have that space that they need.

Trish Kritek:

Relevant to what Anne and John talked about, some folks asked about, what about outdoor tents? Could we have outdoor tents for people to eat? Keri, I'm going to bump it back to you because I know you were engaged in thinking about that.

Keri Nasenbeny:

Yeah. Pam Renna, who's head of our facilities and all those operations here, she and I looked and investigated that pretty extensively here, for Northwest. And I think, really, it comes down to the fact that when we thought back to the tents that we had for the ED last year, they were exceedingly hard to keep warm, to keep the wind out, to be hospitable. And at the end of the day, we just didn't feel like it was a space where people would want to go and take a break. There'd be cold, it's just hard to keep the elements out, they can blow over. And so really trying, I think, to find any space we can in indoor facilities, instead of pursuing that option.

Trish Kritek:

Okay. Is that true, as well, at Harborview, Jerome? No plans for outdoor eating tents?

Jerome Dayao:

Right. But we did replace picnic tables and all that but, to Keri's point, I mean, right now is not the season that people would really want to eat outside because of the elements.

Trish Kritek:

Okay. Multiple efforts to find spaces where people can physically distance in repurposed spaces. The other thing that... Couple of other things I want to talk with the three of you about is, the big one was visiting hours, and where we're going with visiting hours. Because people said, when this first surge happened, we went to no visitors and we're still doing visitors but we're doing it in reduced hours. I think the real question is, are we planning to go back to a no visitors policy? Keri, I see you un-muted, I don't know if that means you want to answer.

Keri Nasenbeny:

Yes. In fact, and Cindy and Jerome, chime in here. We are looking at next week, in implementing that same policy that we had previously, where we would return to no visitors with certain exceptions. Laboring moms, for example, patients who need a caregiver because of a developmental disability, caregiver trainings. I'm trying to think of the other exceptions here but-

Trish Kritek:

How about end-of-life?

Keri Nasenbeny:

... The plan is to roll that out mid-next week, but there's a lot of communication that has to happen before we can do that, signage, policy updates, et cetera. And Jerome, I think you said this nicely when we met about this, but just feeling like now is a time early, we need to protect our staff, our patients. And with that widespread community transmission, feeling like this is the right thing to do.

Jerome Dayao:

Yeah. That is absolutely correct, there's a lot of work happening right now, into this one of the revision of our current policy. I'm putting together, I was just in a meeting earlier with comms, of putting the standardized scripting that we are going to be telling patients, family and everyone, out in the community. All of these are being orchestrated in a very standardized approach and process, we are all saying the same thing. And this really comes from hearing what the community is saying, what the staff is saying and what our experts are saying, with regard to community traffic within our entities.

Jerome Dayao:

And that is with regard to protecting our patients and protecting our staff, from being infected or getting infection out from the community. Because, despite the fact that we do have a very robust screening process of checking symptoms, we still do see certain individuals come into the hospital and not say that they're experiencing symptoms, only to find out later that indeed they are. This is really where it's all going from and we have the support from all of our teams here, in making this happen.

Trish Kritek:

It sounds like what I'm hearing is a uniform policy across all sites, that would be no visitors and anticipating rolling that out next week, mid-Week and that there would be some exceptions... I'm frozen, I froze, that never happens, I never freeze. Exceptions would be laboring moms and, Cindy, I wanted to ask, what about end-of-life care? Is that something that's an exception as well?

Cindy Sayre:

Yes, that'll continue to be an exception and two visitors will be permitted, for patients at end-of-life. And I did want to add to Keri's and Jerome's comments, when we went to the less restrictive visitor policy, we promised to keep monitoring the situation. And so I think this is a result of that monitoring and just seeing the transmission rate go up, for the community, "Okay, we need to be more restrictive," as we see that transmission rate go back down, then we can adapt again.

Trish Kritek:

What I heard, there was, and I heard from Jerome as well, that this is a response to the increasing numbers of cases in the community, it's an attempt to keep our patients and our staff safe. And then Cindy added that, in the future, we will continue to reassess this just like we've been reassessing it as the months have gone by. I appreciate that and I think that answers a lot of the questions I saw, about this, I also appreciate the exceptions as needed. I've two more questions for the three of you, excuse me. Actually, Jerome, this one's specifically for you and maybe it will be mitigated by this change, but

there was a question about the long lines for people who are waiting to be screened, coming in the main... Patients coming into Harborview.

Jerome Dayao:

Right. I mean, before this proposed policy change that's happening next week, which is going to significantly reduce foot traffic within Harborview, from the community. We have been talking about, how can we have some shelter? Meaning to say, the people that are lining outside, because we are really concerned that people are getting wet from the rain and in the long lines. And what we've seen is that, when we open visitation here at Harborview, with the current process of 2:00 PM to 6:00 PM, that the start... That the lines, rather, start forming at about 2:00 PM and then it quickly dissipates, it doesn't stay for a long period of time.

Jerome Dayao:

But we are concerned about the line and people getting wet, there had been discussion trends as to how can we mitigate this by putting awnings, for instance, or coverings in those areas, but that plan might be changing as the entity-wide policy in visitation changes.

Trish Kritek:

That's a problem. Okay, it might not be a problem with the change of the visitation, otherwise, working on coverage for folks. Last question for the three chief nursing officers and that is, last time we talked about the fact that there are staffing shortages and you were doing a lot to try to mitigate that. I personally, have felt it as I've been working in the ICU over the last two weeks, it's really clear to me that it's still an issue. I'm curious if there's any updates on staffing shortages?

Cindy Sayre:

I can speak for Montlake and I think this is probably true across the other campuses. We are continuing to bring as many staff as we can, into the building, to address the current shortages, the number of employees we're going to need to support training for D1 and then now looking for staff for a potential surge. We really are working at all levels to bring people in, and just as an example, a very close alignment with some of our traveler agencies. And the reason is, we're not going to need these positions forever, right? Some of these positions are truly to help us get our staff trained, get us through the D1 implementation. We don't want to add hundreds of classified positions because, eventually, we'll be overstaffed. We're trying to titrate the number of just routine positions that we're bringing in, and then augment that with travelers to make sure that we can support all the work that's happening right now.

Jerome Dayao:

Yeah, that is very true and if I may just add, Trish, on that one. For instance, at Harborview, we currently have about 180 travelers here. And this is the highest number that we've ever had because, not only are we needing travelers to fill the needs we currently have with staffing, we are also needing them for the significant increase in sick calls that we're experiencing, in the past few months. For instance, last month, here at Harborview, our average sick call was 18, for the month of November, it is 28, daily.

Jerome Dayao:

We are beset with this kinds of issues and in addition with that, at the national level, I serve at the national board for the American Organization for Nurse leaders. And yesterday we were discussing, at the board meeting, how other states even have resulted into forcing their own staff to work, even they

have been positive with COVID. We are not yet in that situation but it goes to tell you, the national picture for nursing workforce is really a very challenging one. And we are, Cindy, Keri and Lisa, all of us are working together with our agency partners, so that we can bring in staff here so we can continue to staff to volume, we can continue to staff the matrix but that is without any challenge.

Trish Kritek:

Okay. Thank you all, for answering. Keri, did you feel like you wanted to add something?

Keri Nasenbeny:

I'm just going to add one sentence in that, we're also really working closely with our recruitment partners to improve our recruitment. I think that's just the only other piece that I would add, I think we're all really trying to address this. And it's not just nursing, it's CNAs, I think it's the whole care team that were experiencing some of these shortages. We're working on all fronts, really, to try to address this.

Trish Kritek:

I heard the same about respiratory therapist and the same needs. It sounds like, working a lot with travelers to fill the immediate need. And I think, in the chat, there has been explanation of what a traveler is. And then, at the same time, doing some recruiting to fill the spaces of places where we know we're going to have durable needs, across all sites. And I think that's helpful and I think it's still a area of stress for a lot of people, because it came up a lot in the question. All right, you gave me an entree to D1, I'm going to introduce, again, Todd Burstain. He is, as I said, the new chief medical informatics officer and he is helping with the roll out of D1. Todd, welcome to Town Hall, thank you for joining us today.

Todd Burstain:

Thank you.

Trish Kritek:

You don't know this about me but I try to get as many questions in as possible, into this hour. And so I'm going to focus my questions to you and it's a little heads up. I have three specific questions that came up a couple of times over.

Todd Burstain:

Sure.

Trish Kritek:

The first one was a lot of comments about feeling some frustration around registration? And the question was, how is registration being improved for folks, as we move forward?

Todd Burstain:

Yeah. First of all, apologies to everybody about the registration process. We know that it was not at the par level that we would want it to be, in retrospect. It is making some improvements, we have hired additional training coordinators to get folks registered. And as of now, we're about 80% of both all users as well as 80% of physicians, are registered for their classes. We're making progress on it, it's a lot better

than what we were, three weeks ago or four weeks ago, we were at about 7%. But we know that the process, which has been compounded by COVID, has not been as seamless as we would have liked to have it been.

Trish Kritek:

I appreciate the acknowledgement of the challenges and that we're almost done with people being registered, which is a great thing. The second one is a question I actually asked last week and then people said, "You should invite Todd." And that was the decision-making around virtual and in-person training, and I'll just say there were several questions with a great amount of anxiety around needing to do in-person training and the setting of trying to minimize people being in spaces with other folks.

Todd Burstain:

We share the anxiety and the COVID picture changes this all the time, and we actually just got off our executive steering committee for D1, where we had this exact discussion about this. And so there is in-person training that's centered around devices, for example, if somebody needs to learn how to use Epic with a barcode scanner or the anesthesiologists that need to know how to use Epic, in combinations with the anesthesia machines and the touch screens, that are going to still need to be somewhat in-person, but we are making a vast shift of a lot of the training to be remote. There's some staffing needs that we have to account for, because the staffing ratios for training for pure remote sessions are increased, but I think you're going to see, next week, a formal transition to more of those classes that are currently in-person, going to be remote.

Trish Kritek:

Okay. I'm going to take the last part as the take-home, which is, this is evolving and we're transitioning to more remote as feasible, in response to people's concerns about that.

Todd Burstain:

Correct.

Trish Kritek:

Thank you, again. And then my last question which is maybe the hardest one, and I know it's something that you've heard and that is, is there some threshold of a COVID surge where we're going to say, "We shouldn't roll out Epic, right now?"

Todd Burstain:

It's a complicated question, as Tim said, it's not on or off, from an operation standpoint. And as the COVID epidemic ramp up, we do see increased demands on the system but those demands shift in certain areas as well, so you have less elective surgeries, more ICU care, and so it's trying to figure out all that balance. We're working in close conjunction with the EOC with this, and I will say that there is some threshold to be determined, where that would be a possibility. But it is significant, not only from the cost of what that would end up running and the downstream effects of those costs, as well as the fact that it will require rescheduling of a lot of the training resources, the outside contracting resources that we've hired for support. And so it's a very complicated decision to try and make but it's not off the books that, that couldn't happen.

Trish Kritek:

Okay. I told you it was hard, I'll begin by saying thank you for coming and answering questions to our community, which we really appreciate. And I think what I heard you say is, there's lots of moving pieces, there could be that threshold where there's lots of implications of not rolling it out. And so all of those things are being balanced in collaboration with our emergency planning group.

Todd Burstain:

Correct.

Trish Kritek:

Is that fair?

Todd Burstain:

That's totally fair.

Trish Kritek:

Thank you so much for joining. I suspect, now that you came, if there's more D1... We will see more D1 questions and so you can expect to be invited back to Town Hall, in the future. Thank you, Todd.

Todd Burstain:

Absolutely. Happy to come.

Trish Kritek:

Thanks. Tom Staiger, I haven't asked you any questions today so I'm going to ask you a quick one, because then I have a bunch of questions for John Lynch, who has had only a cameo so far, today. Tom, I've asked you many times about the clinic, at Roosevelt, and I think you told me you were going to have an update. I think folks would like to hear what's going to happen with the clinic, the lab at Roosevelt, the lab at Roosevelt.

Tom Staiger:

Well, I'm happy to be able to report back that, after looking at the impact and mitigation options of scaling back the Roosevelt lab hours, that our lab leadership was able to come up with some efficiencies in their staffing at Montlake. And are going to be able to redeploy a couple of individuals back over to Roosevelt, that will allow the lab hours to return to the 7:30 to 5:30, effective January 4th. That is-

Trish Kritek:

I think that's great news for people, thank you very much about that. And it sounds like going back to normal as of January or old hours as of January 4th, thanks to the folks who are working on that process, I appreciate it and I'm sure others do as well. I'm definitely not going to get to all the questions we have so I'm going to prioritize some of them, for John. And, Santiago, you may want to weigh in on some of these as well, maybe Tim, but I'm going to start with John. John, There are lots of questions and I've asked it before but I'm going to ask it again, about use of N95s for all interactions with patients who are COVID positive. I guess the question really is, are we going to transition to using N95s for all patients who are COVID positive?

John Lynch:

We are talking about this specific question, pretty much every single day. In our infection prevention team, our med tech team, that's part of the Emergency Operation Center, talks about this pretty much every single day. We are talking to our colleagues locally, in the state and across the country, and reviewing the evidence as well as keeping a close eye on our exposures and healthcare worker infections, every day.

John Lynch:

And I'll just let people know that, I think, for those of us in the med tech team and probably others, this is the last thing I think about, not just me but our whole team thinks about, before we close our eyes at night. It is probably the first thing that we think about when we wake up in the morning. And so it is an ongoing conversation, changes are always possible and they are linked to the evidence that's available. Again, the data that we have now accumulated over 10 months and our supply chain, right? And what's possible. Again, those are all really important conversations that are, again, every day we're engaged in.

Trish Kritek:

Okay. I think I'm hearing you say it is something that is ongoing discussion with lots of people and a top priority and, right now, we're not transitioning to that being our policy.

John Lynch:

Not today, not Friday.

Trish Kritek:

Okay. I probably will keep asking.

John Lynch:

Please do.

Trish Kritek:

Because it sounds like it keeps being a subject of discussion, so I'm going to keep coming back to it so we can say if things evolve, I suspect we'll know, before Town Hall, if things evolve. The other one that comes up a lot is, are we going to transition to asymptomatic testing of healthcare workers, with questions about the fact that they're doing it at other academic medical centers in the country?

John Lynch:

I think this is... I don't know where this is coming from, I did get a question from the internal medicine residents about this specific topic, saying that this is happening at the Brigham. I actually contacted a colleague in that system and they're not screening healthcare workers, in a way that maybe they're hearing. If anyone knows where that's happening, please let me know, because I haven't been able to find a place where that it's happening. But it is happening-

Trish Kritek:

Okay. Yeah.

John Lynch:

What?

Trish Kritek:

The question was that, it was happening at the Brigham as well, when it came out-

John Lynch:

I called Erica Shenoy, who runs infection prevention at Mass General and they all have a line program, she said that's not what's happening.

Trish Kritek:

Okay. I actually thought about calling someone I knew there too, because I was curious as well. Thank you for investigating that and it sounds like we aren't seeing it at other places and, right now, we do not have the plan to start doing asymptomatic testing of our health care team.

John Lynch:

That's correct. Right now, no. I could answer a lot more to that but I know you don't want me to.

Trish Kritek:

I do. Do you want to say something else about it? It's okay.

John Lynch:

I'll just say, really fast, the cheap, fast tests, these antigen tests, right? Those are good for people with symptoms, not very good for surveillance. People who have no symptoms, lots of false positives, lots of false negatives. Just imagine if we have people show up and we're talking 15,000 people show up every day, and 5% of them have a positive test and don't actually have COVID, real challenging. Plus, we don't have them, we just don't have the machines, we don't have the antigen tests, the federal government's allocating those.

John Lynch:

The PCR test, which takes a longer time, you'd have to do sampling, who do you sample? What's the right... If I sample nurses, do I sample residents? Do I sample the lab people? And if it's positive, what does it tell us about what we would change? Well, if it's maybe positive sampling once a month in the lab versus, well, what does that mean for nurses or for docs? And so sampling, like we're doing in the upper campus, which is really one big, homogeneous population, honestly, in terms of what they're doing, very different for a healthcare worker population, it doesn't really fit into either of those scenarios right now. Again, if there's new technology, I mean, nothing is off the table.

Trish Kritek:

It sounds like resources, timing and logistics make it not feasible right now.

John Lynch:

That's right.

Trish Kritek:

And we'll keep assessing that one just like we keep assessing a lot of things and things change over time, as they have.

John Lynch:

Yep.

Trish Kritek:

Okay. I do want to get one last bucket of questions then too, because this is the last thing that was a theme, which is vaccines. Obviously people heard about Pfizer and this potential vaccine, I have three questions about it. The first is, are we making a plan around how we would vaccinate our healthcare teams, if and when a vaccine is available for COVID, not flu?

John Lynch:

Yes. There's a lot of work going on around this topic, with our pharmacy colleagues or the infectious disease colleagues and many other people throughout UW Medicine, working with the Department of Health, around what that would look. These vaccines will probably come through the Department of Health and be distributed to hospitals and hospital systems. They've got the capacity to maintain the storage, probably the first one that comes through maybe a -70° F requirement, which is a very cold freezer, and also probably require more than one dose, that's what it looks like. We don't have that yet, nothing has been approved.

John Lynch:

There is also a national framework for who gets vaccinated first and I'll just let everyone know that, healthcare workers are really in that top of that framework. But threaded through that framework is an important and critical attention to equity, right? We need to pay attention to that and those discussions are going on at the state, through a variety of systems and committees that have been in place for many years, to deal with disaster response. And I would say we have, here in Washington state, a fantastic, collaborative environment for healthcare systems, the Department of Health and dealing with questions just like this. Those conversations are going on, on a daily basis, I think we're in a good spot and more to come.

Trish Kritek:

Great. Department of Health will coordinate, we have statewide strategies. And healthcare workers are prioritized but we're also emphasizing equity, as we think about what the strategy would be to roll this out. I think the second question is, people are a little bit worried because there's all these different types of vaccines out there, or being tested. I wonder how we're going to know that it's an okay vaccine, when it's available?

John Lynch:

This is why, for everyone that I know of who has any expertise in vaccine design and testing, we've really demanded that all of these vaccine candidates go through the entire process for research. And when we do the phase one, phase two, phase three, what we learn is, what's the upsides? What's the potentially adverse effects? And what's the efficacy? Which is what happens if you get vaccinated and it's a perfect vaccine, what is its ability to prevent you from getting infected?

John Lynch:

And that's why we needed all those studies, those studies are built to learn about that. Now, we also recognize that we're moving pretty fast, even with all of those data in place and demonstrations that,

this is a useful vaccine, that it's meaningful and it has a very good safety profile. There will still be a huge amount of work that needs to be done in, "Post-marketing," surveillance, that phase four, where we keep track of all of that, right? All vaccines, all drugs, where we do close reporting, keep part of this-

Trish Kritek:

Or in post. And I think I'm going to say this for you, and we'll communicate with everyone as we move into those phases so folks understand, more about those vaccines as they become available.

John Lynch:

Absolutely.

Trish Kritek:

The last question is maybe the hardest one, and I'm going to ask it and then we're going to wrap up. And that is people ask, "Will we have to get vaccinated?"

John Lynch:

No. UW Medicine, right? And healthcare facilities have no authority to require someone to get vaccinated, right? We don't do that. We have had an incredibly successful program for influenza vaccination. You, everyone in this call and many others, have stepped up and gotten vaccinated at rates that are incredible around influenza, over the years. And that's because we've had a transparent, cooperative teamwork-based approach, aimed at keeping health workers safe and our patients safe.

John Lynch:

And that's what our same framework would be, I have not checked with Tim or Lisa Brandenburg, but I think that's what our MO would be. We're going to follow the exact same framework that we've always used, we're going to share everything we know, we're going to ask you to use that information to make good decisions. And we're going to try to make it as available as possible for everyone in the system, so that you can make that good, informed choice to keep themselves safe, their family safe, the community safe and our patients safe, ultimately.

Trish Kritek:

John, thank you. It sounds like we're going to use the same process that we do for flu vaccination and nothing like Town Hall, for new policies being rolled out. Thank you for-

John Lynch:

I got that from Tim.

Trish Kritek:

I saw Tim, he gave it a thumbs up so it sounds like we're on board with, no, it's not going to be required. And we will partner with our healthcare team to understand the benefits of it and prioritize the safety of our staff, as well as our patients, as we move forward. With that, I think that we've run out of time, for Town Hall. My apologies to all the folks who wrote other questions that I didn't get to, as always, it's a challenge to fit them all in. And I so appreciate all that you send so please keep sending them.

Trish Kritek:

As I said, at the beginning, we'll come back again next week. We won't be here the day after Thanksgiving but we'll be here next week, and we'll keep deciding on the tempo of Town Halls based on the needs of the community, that's how we've done it all along and that's what we'll continue to do. I want to answer one last question and that was, someone asked if they could share these videos of Town Hall with their family and friends. And the answer is a resounding, yes, we post it live on The Huddle, I send it to my family, every Town Hall.

Trish Kritek:

I think they think it's a way to know that I'm doing okay, despite the fact that I'm wearing scrubs and running around in the MICU this week. Please share it with your family and friends, we wholeheartedly endorsed that. And with that, I'm going to say thank you to all of our panelists, thanks for our guests, Todd, this week. And most importantly, thanks to all of you for taking care of our patients and their families, and most importantly, continuing to take care of each other. We'll see you back next Friday. Thanks so much. Bye.