Trish Kritek:

So, welcome back to UW Medicine Town Hall. I'm Trish Kritek, Associate Dean for Faculty Affairs. It's my pleasure to welcome you back. I'll quickly introduce who's here with us today. Got a lot of folks. Santiago Neme, Medical Director for UWMC Northwest. Anne Browning, Assistant Dean for Well-Being. Cindy Sayre, Chief Nursing Officer at UWMC. John Lynch, Head of Infection Prevention and Employee Health at Harborview. Rick Goss, Medical Director at Harborview. Jerome Dayao, Chief Nursing Officer at Harborview. Tim Dellit, Chief Medical Officer for UW Medicine. And Keri Nasenbeny, Chief Nursing Officer at UWMC Northwest.

Trish Kritek:

And we have another special guest this week, it's my pleasure to introduce Dr. Alisa Kachikis, probably close, probably imperfect, who is faculty in the Department of OBGYN and in the Division of Maternal Fetal Medicine. She is actually a really informed voice that we're super excited to have join us today to answer questions about pregnancy and vaccines. She has been on the WHO Advisory Committee around the ethics of vaccinations of pregnant people, and she's actually the lead investigator of our UW Long Term Registry Assessment of folks who are pregnant or lactating who have been vaccinated, so I think she's the perfect expert to answer your questions, and we're really excited to have her join us today. All right, so, with that in mind, I'm actually going to hand off, right away, to Anne, for our well-being message.

Anne Browning:

Sure. Hey, everyone. I want to start thinking about our reactions at this one-year mark. We're merging from winter, my crocuses are starting to come up in my garden, and it feels like we're arriving back where this all started a year ago, and I want to start thinking about how do we make sense of the anniversary of the felt start for the pandemic for us. I found myself reliving these moments of disruption from the past year. One year ago today, I was actually on a flight back from a work trip from Dublin, Ireland, and it was my first memory of wiping down everything with antibacterial wipes.

Anne Browning:

And I've been having these reflections all week, just about earlier this week, a year ago, my family had been in Lisbon, and we were in Lisbon when the first three cases were announced in Italy. We understood that spread was happening, we remember doing the mental math of thinking, "Okay, we have 36 more hours here before we get back to Dublin, then we have 48 hours before we jump on a plane and head home," here, to what was already becoming an emergent hot spot.

Anne Browning:

Last year at this time, I was also traveling back and forth to UCSF each week, as I had some shared work there, and my last flight home was March 3rd. I'd canceled all of the flights after that that I had, and I rebooked one for a time I thought was so far in the future that we couldn't possibly still be dealing with this, and I rebooked my flight for April 20th. I was wildly naïve about what we were in for, and I'm actually really, really thankful that I was as naïve as I was because it's taken some time to really process the duration of what we've been in for and its impact.

Anne Browning:

And even though I'm feeling hopeful and feeling like I'm living well day-to-day, I anticipate reliving some of the grief, the sadness, at the things, the experiences, the people we've lost this year, as we roll

through the anniversaries of events and trips that didn't happen, and we relive some of the traumas of events that did happen. So, in the coming weeks, you might find yourself reflecting on and reacting to some of your own experiences of your one-year anniversaries, and I want to give several of us a chance to reflect on our own year in this town hall and the next couple. So, I'm going to start by inviting in Cindy to share some of her reflections on this year.

Cindy Sayre:

Yes. Well, with all of you, I am wondering what the heck happened. I mean it has been really an incredible year. When I use the word "incredible," I'm using the definition of difficult to believe or impossible to believe what we've all been through in the last year. And, like Anne, I remember those early days of COVID and not fully understanding what a global pandemic really meant. I feel a little foolish now, not having understood that. But I share that with Anne that it took me a while to fully grasp the significance of what was happening and the fact that our world was literally being turned upside down.

Cindy Sayre:

I think the other piece was it's the first time in my career where I've had fear at every level. So, at the community level, at our hospitals level, for our staff and providers, for my family, and for my own health, it just hit every single one of those levels and really knocked me off my feet for a little while. And what I do when I'm faced with something like this, although this is the worst example, just this global pandemic is, I immediately begin looking for hope, that's just who I am, I'm always trying to find the hope in a situation.

Cindy Sayre:

And I think about Mr. Rogers' mom telling him, when he was scared, "Look for the helpers." I'm so incredibly grateful to be surrounded by helpers, everywhere. I think about our Infection Prevention team that literally was working around-the-clock, I think John Lynch might have slept one or two hours a night during those first several weeks. I think about the care teams that were going into the rooms when they didn't know really what this was and how we could, thus, protect ourselves from it. People that were working with policies that were changing every single day.

Cindy Sayre:

And so it's been an incredible year of inspiration at the same time that it's been so disruptive. I'm proud we've flattened the curve in Seattle and Washington state. We gave the first vaccines in UW Medicine, offering hope to our community. And I've never been more grateful to work for UW Medicine and with each of you.

Anne Browning:

Cindy, thank you so much. I'm going to give Tim a chance to share a couple thoughts as well.

Tim Dellit:

Yeah, it's really hard to imagine that it's been a year already, and almost to the day. February 28th, last year, we were in the Leadership Development Institute. I remember giving a brief overview of, "Here's what we may expect." Of course, I was quite wrong probably on most of the fronts. But I also remember learning, during that meeting, about the community transmission involving high school students in Snohomish, and just having some inkling of what we maybe anticipated for, but I never would have

imagined that, a year later, we'd be at over 500,000 individuals in this country who have died, and none of us could have predicted everything that we've gone through.

Tim Dellit:

And what really comes to me when I think about this is what a privilege we have, as part of the healthcare team, to have this window into this unprecedented event that has just been horrific, tragic, exhausting; at times, joyous, as we see people recover, the news of the vaccine. But that window and that lens and that pure exhaustion that all of our team members have felt responding to this, even though this has absolutely impacted all of our community, the larger community outside of healthcare, when you try to talk to your neighbors or what experienced, if they aren't in healthcare, it's a very different experience. And seeing that human tragedy and the impact that it's had on our patients and the families and our staff has really been just an amazing window into humanity.

Tim Dellit:

And it also, again, is so inspiring to see how our system has responded. And if anyone has ever doubted the role that we play within our community and serving our community, I mean this pandemic has just highlighted what an amazing organization we have, and it's because of the people and how committed they've been throughout this period of time. But it is really hard to imagine everything that we've gone through, and it's hard to process that at times. I think you're absolutely right, Anne, I mean you have to process in bits, as you remember different aspects as we've gone through this past year, and knowing that we still have a long way to go.

Anne Browning:

Good. Thank you, Tim, and we'll hear from some more folks in two weeks time, but thank you for your reflections. Trish.

Trish Kritek:

Anne, and Cindy and Tim, thank you all for sharing those thoughts. I think there are parts of everything that each of you said that resonated very strongly with me, and I suspect with lots of other folks who are listening right now, so thank you. Okay, John, I'm going to turn to you, my friend, and ask, as we think about this moment, where we stand in terms of numbers across our system?

John Lynch:

Sure. So, as of this morning, we have 25 patients with COVID-19 in our hospitals, 15 of those patients are in acute care, and 10 people are in the ICU. Again, as of around 8:00 this morning, three of those people in the ICU were on ECMO, the heart lung bypass machine that I always talk about, two of them at Harborview and one at Montlake. I would also like just to highlight, just quickly, that national numbers, like I just talked about here in UW, generally have been headed in the right direction, Washington state numbers, King County numbers, and our own inpatients.

John Lynch:

But I also want to just ... I'm very happy about that, but we're starting to see a slight uptick in cases across the country right now. When you're looking at national numbers, going from the 40,000 to now around 70,000 mark, in potential role of these new variants that we've been talking about over the past few weeks, definitely has me and many others a little concerned. So, a lot of hope, a lot of good, but a little bit of caution, as well.

Trish Kritek:

So, 25 is a low number, and I think your comment about variants was reflected in the question. People want to know, and I think we've talked about this before, but I'll ask again, if we're testing for variants and what we're seeing in terms of variants in our community?

John Lynch:

Yeah, so we have an incredible clinical virology lab, I think we've talked about them many times. Just as a note, we had 100,000 vaccines today. We hit, I think, two million tests today, as well. Sorry, Trish, if you meant to announce that later.

Trish Kritek:

No, it's so exciting.

John Lynch:

It's great. I mean 100,000 vaccines, two million tests, a lot, in a year, just thinking about the reflections that were just made, a year into the CoC and all these great things that we've done. But in terms of this great clinical virology lab, when we do those tests, it doesn't tell us whether it's a variant or not. There's some signals in some machines that give you a hint, but don't tell you whether it's the UK variant or the South African variant or the variant from Brazil, and they have lots of numbers associated with them.

John Lynch:

But what the lab is doing and has been doing for weeks now is, when they get a positive test, they're sampling, somewhere around 200-300 per week, and they're communicating that and coordinating with public health at the state level and locally. And so you've seen some of that with the first B117, that's the UK one, in a UW student; 1351, described earlier this week, that's the one that comes from the Republic of South Africa. And they're working on dashboards with the state to make that data a little more accessible for everyone. And I'd also say that the Department of Health is also standing up their capacity to do what we call genetic surveillance, basically just being able to do more sequencing, looking at what variants are potentially out there.

Trish Kritek:

Okay, so we don't regularly test for it, and we don't actually always test for it, we sample, and so we have a sense of there's presence in our community, as opposed to there's this much presence in our community.

John Lynch:

That's right. The test for saying yes or no, the machines and the technology are different than the technology machines that are used to determine whether it's a specific variant or not.

Trish Kritek:

You just moved on my screen, so I have to readjust myself. So, the second question about these variants that we're hearing about, a lot of what we're hearing is "more transmissible," and I wondered if you could explain what that means?

John Lynch:

Yeah. So, broadly, what that means is that compared to, for lack of a better term, the other variants, the variants of less concern, the other types of SARS-CoV-2 that are circulating, is that these, the three that I just described, and probably others out there that we haven't described very well, appear to infect more people per person who's infected. So, what I mean by that is if I have B117, the strain from the United Kingdom, the probability is higher that I will infect more people than a non-UK strain or non-South African strain or non-Brazil strain.

John Lynch:

And so the concern is that, for instance, in Washington state, most people aren't vaccinated and most people have not had COVID, even though we've had 500,000 deaths in the United States and large numbers of cases here in Washington state, most people still have not been infected, and so those people are still susceptible. And so if you throw a variant that can infect more people with any given infected person, that's the real concern, that we're going to see more infections as a result. And that's the concern when I talked about the uptick in national numbers, that there may be some link to that.

Trish Kritek:

We may be seeing that these variants, when someone's infected with it or infecting more people and, thus, we're seeing that rise. Do we know why it's more transmissible?

John Lynch:

So, it's still not 100% clear. I just actually got off a call with Dr. Evgeni Sokurenko, who's a microbiologist at the University of Washington, he's published on this and some of our other great scientists here in the University of Washington. There appears to be, for some of these, and, remember, they're talking about different variants, some of them appear to bind to the receptor on us, the cells in our nose and our throat, where these viruses bind, they appear to bind better, stronger, so they stay on, and if they stay on and are more tightly bound, the likelihood of them making it into the cell, and then start replicating and leading to all of the subsequent responses and so forth, that's just much greater and more likely.

John Lynch:

The other part is the possibility of evading at least part of the immune system. And those are just two things. There may be other parts to it. Maybe they have more virus in people's upper respiratory track. Maybe they stay at higher viral loads, how much virus is there, for a little bit longer. And so we're still trying to figure out all those pieces. And it may be more than one answer to that question.

Trish Kritek:

Okay. So, there might be multiple reasons why they're more transmissible: stickier, more of them up here, coming up, maybe they evade our immune system. More to come, I'll ask you again, probably in the future.

John Lynch:

Absolutely.

Trish Kritek:

I'll ask you one more question before I give you a break, and it's related to that question, which is: obviously, the other concern is are the vaccines as effective against these variants? And I think we've

asked that multiple times, but we're gathering more data, so I'm wondering if you have anything new to reflect on that?

John Lynch:

Yeah, and we may talk more about vaccines during this session. But the first thing I want to say is these vaccines are proven to be remarkable. I mean the data we're getting is showing that they are better and better and better as time goes. So, the two big questions, really, that are out there is, one, the one you asked: how effective are they against the variants? So, against the one from the UK, the B117, they appear to be very effective, highly effective, and probably very similar to the non-variants of concern. There are some signals that they may be less effective for the one from South Africa and the one from Brazil. But, remember, most of the tests have been only with parts of the immune system, so looking at, for instance, antibodies, but we have other parts of the immune system that are also affected.

John Lynch:

What I would say is that in all of the studies that have been done so far, even with those variants from South Africa and Brazil, even if these vaccines work a little less well, they still work, and they still work remarkably well. And so if we had tons and tons of the 1351, from South Africa, I'd still want these vaccines that we're using because they are still remarkably effective. Going from 96 to even 74% effective is still knocking it out of the park. And so maybe when we come back later and talk a little bit more about some of the other things around asymptomatic transmission stuff, we can talk a little bit more about that.

Trish Kritek:

Okay. I definitely will come back to that because that's a question that keeps coming up, and we're learning more, so I will come back to that question. Thank you. I think take-home is: vaccine, really good against UK variant, and still very good against the other ones, as well.

John Lynch:

Yep.

Trish Kritek:

Okay. Tim, we've been talking vaccine, I'm looking at you. I was going to ask you to update us on how many vaccines we have administered, but you could update us on that.

Tim Dellit:

John stole the punchline, as always.

Trish Kritek:

I know.

Tim Dellit:

No, I mean it really is a milestone though. We administered our 100,000th dose today, at Harborview Medical Center, and that's such a huge accomplishment. At the same time, as John mentioned, we only have about 13% of individuals within King County who have actually been vaccinated, so we still have a long way to go, and still significant challenges from a supply chain standpoint.

Trish Kritek:

So, let's talk about supply chain. Two questions. One is, did we get more vaccine? And, two, are we in line to get Johnson & Johnson, if it starts coming.

Tim Dellit:

Yeah, a couple of comments, and people may have seen, last week, unfortunately, with all the weather, Moderna had shipping issues, and it affected everyone across the country, and so we ended up having to postpone about 4,000 individuals who were due their second shot. We got them rescheduled still within that 42-day window, and so they've all been reassigned, but there was a significant impact last week. This week, we did not have to postpone or cancel any appointments, we got all of our second doses, we got a good chunk for the first doses. We're still not in a position where we know far enough ahead, in terms of predictability, to be able to start rescheduling first doses yet, so it's still week-by-week, knowing what we will potentially get.

Tim Dellit:

You mentioned the Johnson & Johnson, great news. The Advisory Committee for the FDA, today, this afternoon, did recommend approval, so I would anticipate that the FDA, probably tomorrow, will issue that emergency use authorization, as well. I don't have a good sense of when we potentially may see Johnson & Johnson in this state, and I also suspect, again, it's a single dose, easier to manage, it probably won't go directly to the health systems who can handle the more complicated Pfizer and Moderna, it'll probably go to other areas to be able to get the vaccine out into the community. But it's extremely good news that that's moving forward.

Trish Kritek:

Okay, so had to cancel some folks, particularly who were getting second dose of Moderna, those all have been rescheduled. Continuing to vaccinate, but not yet opening up first vaccine appointments yet, and that waits on us, week to week, knowing how much vaccine we'll get.

Tim Dellit:

Correct.

Trish Kritek:

Okay, so we'll keep coming back to that because, obviously, lots of people, which I love, want to be vaccinated. And I think, just to finish off, that Johnson & Johnson is much easier, so it can be distributed to places that don't need the special freezers that we have.

Tim Dellit:

And I want to emphasize one more thing, John alluded to this, as well, but the Johnson & Johnson, people will see while its efficacy may be lower than those first two mRNA vaccines, but that's in terms of preventing all symptomatic disease. When you look at the ability to prevent severe disease, death, hospitalization, all of a sudden, that goes way up. And if you think of the normal flu vaccine is, at best, 60% effective, but the whole idea is to decrease severe disease and risk of hospitalization and death. And so the Johnson & Johnson's going to be very effective and a great tool, so I really want to emphasize that. That's the critical component, does it prevent severe disease and bad outcome?

Trish Kritek:

Okay. And we feel good about Johnson & Johnson doing that?

Tim Dellit:

Yes.

Trish Kritek:

I, personally, support that because that means that you don't end up in the intensive care unit, as of patient of me, which is really what we want to avoid the most, not being a patient of me, but you know what I mean. Couple categories of people that people were asking about. Are we moving towards vaccinating inpatient any more than we have been in the past, which is very occasionally?

Tim Dellit:

Not yet. We've used, sometimes, inpatients as part of our waste mitigation strategy, but we haven't pivoted there yet. The biggest push, quite frankly, as we partner with the county and the city right now is how do we reach vulnerable populations who are eligible, how do we get out into BIPOC communities, limited-English proficiency, and we're doing a lot of work in that area. We just launched our mobile vaccination team yesterday, in coordination with the Housing Authority, and so that was a huge win, and that effort will continue.

Tim Dellit:

We got additional doses from the county that we are going to have a pop-up clinic this weekend for about 500 doses, down in Kent-Des Moines, really, again, targeting BIPOC community. And we're also identifying people who maybe aren't using e-care, maybe aren't as online-savvy, but still eligible, and having direct outreach to those individuals to try to get them in to be vaccinated, as well. Now, I feel like we're pivoting. We went through the healthcare workers, we went, initially, with a lot of people who had online-savvy capabilities, but we've really got to go after the vulnerable population, and that's the focus and partnership, again, with the city and the county.

Trish Kritek:

Okay. So, partnerships to reach BIPOC communities, folks who are more vulnerable, and people who maybe aren't going to engage in e-care and technology, really doing some outreach there. That's great. There was a question about hearing that undergraduates were getting vaccinated, and I don't know if that's the case, have you heard anything about that?

Tim Dellit:

They're not eligible. Again, where we're at is at 1B Tier 1, which is 65 years of age and older, or 50 years of age and older who are in multigenerational household. So, they shouldn't be. Now, I'm not saying the system is perfect, and, again, there's a bit of a honor system in terms of attesting to when you meet that qualification. But unless they're in a research setting where they're handling SARS-CoV-2 samples or are a member of a healthcare worker, the younger population should not be eligible yet for vaccination.

Trish Kritek:

Okay. So, that's a rumor, if that's going on out there, that's not who we're vaccinating. And the last question before I pivot and switch gears a little bit, and we'll come back to vaccines later, is folks who

might have declined the vaccine before, but would like to get the vaccine, and they are eligible, what should they do if they want to now change their mind and get vaccinated?

Tim Dellit:

Yeah, we just launched, actually, an electronic tool for members of that 1A group, the healthcare workers, where they can online register, and they are at least, now, in a list for end-of-day, if there are leftover doses, where they will get text messaging, potentially, to come to receive some of those end-of-day doses. So, we're trying to get them in where we can, and we've always said that you can change your mind later. The challenge, right now, is just the limitation of the vaccine supply. So, as that increases, we absolutely want to get all of those individuals who have changed their mind vaccinated, as well.

Trish Kritek:

Okay. New tool, and come and get vaccinated as soon as we know we have more vaccines. Great. Thank you. Rick, I'm going to come to you. John told us our numbers are way down. I know you're mostly focused on Harborview, but have our COVID services been decommissioned, or do we still have COVID services that are caring for patients in our hospitals?

Rick Goss:

Sure. Good afternoon, everyone. Yeah, and I think I can speak to our general conversations about this issue. I think people are aware that we've really been using the concept of scaling up and then scaling down to match the degree of our COVID patient care needs. And so having been in the 120s at our peak of this most recent surge, now more into the 20s, we really are seeing a dramatically lower volume.

Rick Goss:

Here, at Harborview, that has allowed us to scale back and, in the ICU environment, we still have two teams that are in place, partially because we're also very busy with other ICU care, so we're just keeping those two teams there. The acute care side is generally able to manage through the four or five patients, I think that's comparable at our other sites. And, again, we anticipate that we're still going to be seeing COVID patients for some time to come, hopefully there's no further surge activity, and, ideally, that continues to diminish.

Trish Kritek:

So, strategies to keep taking care of folks as they come in, but mostly back to our normal services, with the exception of the two ICU services because there's other ICU stuff that's keeping them busy, as well. And just to follow up on that, are surgeries "back to normal" across the hospital and our other institution?

Rick Goss:

Yeah, surgeries, again, we're on pretty much a similar plan regarding surgeries, and surgeries are open, we're scheduling, we have no restrictions there. I think February, for our site, was a little bit of a transition, we're having scaled back a little bit for a month or two, and now people are rescheduling, we're ramping back up, so it's a little less than maybe expected, but I believe we're fully anticipating, into March, we're really see our baseline levels of surgery.

Trish Kritek:

Okay. So, ramping up, not back to totally normal numbers, but getting closer. Is that true, Santiago, at Northwest, as well, in terms of surgeries and census?

Santiago Neme:

Absolutely. I think the thing that we're noticing is that our patients are still reluctant to come to the hospital, and I think, as providers and healthcare workers, we need to remind folks that this is the time where they probably are the safest, most of the staff are vaccinated, but I think people are just waiting for their own vaccination to be able to come. But I'm seeing my own patients really delaying care that they need. It's not urgent care, but it's care that's been delayed already for months. So, we're seeing that across the system, so I would encourage folks to have that conversation with your patients.

Trish Kritek:

Okay. So, some slow uptake, but we're really saying, "This is a safe place to get stuff done, now's the time to come in." Okay, thank you. I'm going to go come back to you, Santiago, with some more questions about vaccines and stuff, but I'm going to go to Alisa for a little bit. So, Alisa, lots of questions about vaccines and pregnant people, and whether or not they should get vaccinated, and then the second question is when should they get vaccinated? Is there a right trimester or timing for that vaccination, if they decide to do so?

Alisa Kachikis:

So, the question about vaccines and pregnancy, this is a hot topic right now, nationally, and, obviously, here at University of Washington. When we talk about the COVID-19 vaccine and pregnancy, the difficulty is, kind of like what the steam point is, is that we really don't have any data on pregnancy, and that is the problem right now. So, back in the summer and the fall, when the COVID-19 vaccine clinical trials were ongoing, the pregnant population was excluded, and so here we are now.

Alisa Kachikis:

In terms of the vaccine, there's really no reason to think that pregnant people would have any increase of adverse events with the vaccine and that they wouldn't respond well to the vaccine. There is also some thought, just from our knowledge of other vaccines and pregnancy, that there may be a benefit, both for the fetus and the placenta, for someone to not get infected with COVID-19, and then also for the neonate, both through the transplacental antibody transfer, and then also potentially through breast milk.

Alisa Kachikis:

So, there may be benefit, we just don't have any data. So, what we're recommending right now is that the pregnant patient or pregnant individual talk to their provider about their own risk factors for adverse events with COVID-19 infection and what they feel like their risk is to be infected with COVID-19, and then decide on vaccination.

Trish Kritek:

And how are you counseling your own individual patient?

Alisa Kachikis:

Kind of like that. I think most patients come in with an idea of what they're thinking, but if they're healthcare providers, then I think they are at higher risk for having COVID-19 infection, and we talk about the risks involved or how they perceive their own risk. But, again, we know that the pregnant population have a higher risk for adverse events in pregnancy.

Alisa Kachikis:

Now, in general, COVID-19 and pregnancy, most people do fine, but based on our national data and based on some data that's come out of Washington state through the Washington State COVID-19 and Pregnancy Collaborative that was headed up here at UW, we do know that pregnant individuals are at higher risk for hospitalization, ICU admission, mechanical ventilation, ECMO, and even death, with COVID-19. It's one of those high-risk medical condition category from the CDC, so there is reason to think that a vaccine and pregnancy could be beneficial.

Trish Kritek:

So, we know that folks generally do well, but can have really severe outcomes, including lots of stuff in the ICU, and even death. We just don't know for sure, and so it's going to be an individual conversation about risk/benefit between the doctor and the patient. If they decided to get vaccinated, is there a trimester that's best to do that? What would be your guidance there?

Alisa Kachikis:

Well, there's no recommendation, there's no data, there's no recommendation for a specific trimester, but I would put this in the same category of the influenza vaccine that we give routinely during pregnancy, and the reason we give the influenza vaccine is to protect the pregnant individual from getting influenza, and we think that that benefits the individual, the pregnant person, the fetus, the placenta, the neonate, eventually. So, I would put that in the same category as influenza, and we give influenza in any trimester, to protect the pregnant patient, so any trimester would be fine.

Alisa Kachikis:

Now, there have been questions about people who have a history, for example, of recurrent pregnancy loss or miscarriages. So, for example, if it would give you peace-of-mind to wait until the second trimester in that case, then I think that's totally fine. If it would give you peace-of-mind to get vaccinated in the first trimester because you don't want to get COVID-19, I think that would also be totally fine. There's just no guidance on that.

Trish Kritek:

There's no guidance at all. It's going to be who you are and how you're going to feel about the risks and potential benefits of getting vaccinated. So, it could be any trimester, maybe first trimester, if that feels good to you, but if you want to wait a little later, that might make sense, too. Fair enough. Two more, I think, that I saw a bunch of. There's concerns about fertility, and if people are trying to conceive, should they avoid being vaccinated? And I think it's at least partially linked to people talking about having an immune response in the setting of getting vaccinated, and I suspect you're going to tell me there's no data to tell us what to do, but I'm wondering if you have any guidance in this space?

Alisa Kachikis:

Yes, there is no data. This is the recurring message here. There is DART data, which is our Development and Reproductive Toxicology data for all of the vaccines that are available and also coming out, even for

the Johnson & Johnson, for the Janssen vaccine. And the DART data, which is data that we collect on non-human mammals, do not have any safety signals for developmental or infertility effects. But, again, it's very limited and it's not on humans. I have heard from colleagues of mine who work in infertility that sometimes the thought is, especially with infertility treatment, to wait two weeks or two months, but, again, there's no guideline for that. So, if you're attempting to become pregnant, COVID-19 infection, in any case, would likely have more adverse events than the vaccine.

Trish Kritek:

No clear evidence that it's a bad thing to do, no data to tell us what the right thing to do is, and maybe, the same thing that you said, which is it's not good to get COVID, and there could be significant downsides to that. And it's hard, I'm asking you hard questions, and I'm asking you to give us answers in a data-free zone, which is super hard, so thank you for continuing to do your best to do that. The last question I'll ask you is, is there a vaccine that's best for pregnant women? I guess there's been some discussion about Moderna, but I don't know why, so I'm curious about that.

Alisa Kachikis:

There's no specific recommendation for which vaccine to get. In fact, guidance is to get whatever vaccine is available at the time. I think that's going to be the same guidance, also, for the Johnson & Johnson vaccine coming out. But as far as I understand ... well, there is no data, so I don't think there's a recommendation for either Pfizer or Moderna, if those are the options. There is DART data available that you can read up on for both of those vaccines, and there's also DART data available for the Johnson & Johnson vaccine.

Trish Kritek:

Okay, so there's data from animals about whether or not there's impacting fetuses for all of them, we can look at it, but no clear recommendation. I lied, I always do this, I have one more question for you. I know you're gathering data about folks who are getting vaccinated, I suspect we're still pretty early in that data collection, but is there anything that we know from looking at people who are getting vaccinated?

Alisa Kachikis:

There's nothing published yet. There is a little bit of veris data out, I think I saw an article. I think Dr. Fauci went on, nationally, and said that there were no safety signals, so that's veris data, and there are no big safety signals for our concerns for pregnant people. But there should be data coming out soon. We have our registry here, and then the CDC also has a survey lung study, so I'm really hopeful that between all the groups around the U.S. that are doing studies, we'll get some data out pretty soon.

Trish Kritek:

That's exciting. Maybe when those data are available, maybe you can come back and join us and talk us through what you've learned, if that sounds okay to you.

Alisa Kachikis:

Sounds great.

Trish Kritek:

Thank you so much for answering all of those questions. Santiago, I'm going to come back to you. I know you've done a lot of work with the various languages sessions about the vaccine, so I'm going to ask, are we also doing a one-pager in different languages that we're getting out to the community? Are we doing other strategies to get the word out?

Santiago Neme:

Yeah, so that's a great question. The problem with all the vaccine information, when it gets a little bit more detail, it's just the rapid evolution of the data and the information and a new vaccine, so when you're trying to control 18 different versions, version control becomes an issue. So, we are working on coming up with information sheets for patients, and I can also share, there's a really good link where you actually can find general information on vaccines in multiple languages. But the version control is something that, every day, you need to update it, and it's just very labor-intensive. But it is a goal to have something at least that's pretty basic, where patients can get the information they need.

Trish Kritek:

Okay. So, continuing to work on that;, challenging when there's still evolution all the time.

Santiago Neme:

Right.

Trish Kritek:

I think since we talked about your side effects, I'll ask you this question: have we heard anything in the signal, maybe from V-safe or anything else, that there's more likely side effects with one vaccine than the other, more with Moderna than Pfizer? Do you know anything about that?

Santiago Neme:

I talk with Dr. Shireeshy Dhanireddy, who leads our vaccination efforts from a med tech perspective, and she actually shared with me that, overall, the rates are pretty similar, except for the delayed skin reactions that appear to be more prevalent, more frequent in the Moderna cohort. I received Moderna, I didn't have the skin issue. These reactions tend to happen seven days after the shot, and they go away, and, definitely, if you take an antihistamine, they go away. And there seems to be an increase for the Moderna, and they haven't been reported as much in the Pfizer group, but in terms of fever, myalgias, and other things, she seemed to think, just in reviewing the latest data from CDC, that they're pretty equivalent, at least not significantly different.

Trish Kritek:

Okay. Pretty much the same, except for the skin rash.

Santiago Neme:

Exactly. That's been described, and it's still very rare, by the way, and it goes away with antihistamines.

Trish Kritek:

Okay. Two mask questions for you. Evidently, the CDC, and we've talked about this before, talked about maybe double-masking, and the specific question we got is, "Should I wear a cloth mask over an N95?" Is that something that people should be doing?

Santiago Neme:

Yeah, I would like to distinguish, again, what we do in the hospital as healthcare workers, and then what we do in the community, very different. In the hospital, we do not recommend double-masking. There is one exception in the hospital. If you're using an extended-use N95, let's say, in the ER, and you want to put on a surgical mask, not a cloth mask, a surgical mask on top of that N95 that's with you all day or most of the day, because, remember, every time you remove your N95, it needs to be thrown out because there's no reuse. There is extended-use, but no reuse. So, in that situation, yes, you may don a surgical mask on top of your N95. It's not necessarily for extra protection for you, it's just to protect the mask itself.

Santiago Neme:

Now, outside the hospital, CDC really recommends using two to three layers. How you accomplish that is different. If you have an N95, you are covered. If you have a surgical mask, remember that medical-grade surgical mask have three layers, although they don't look like they do, but they do. If you have a cloth mask, then you add another cloth mask, and then that's two layers. So, again, it's not about the double-masking, it's about the number of layers and, more importantly, it's the fit, it's how tightly it sits on your face. So, that's my point, it's not necessarily the double-masking, it's about the layers and the fit.

Trish Kritek:

Okay. That's great. That's a really excellent answer. So, multiple layers in both places, but multiple layers outside of the hospital might be achieved with two cloth masks. In the hospital, one mask, with the exception of the N95 with the surgical mask over it if you're using extended-use for your N95. Thank you.

Santiago Neme:

Of course.

Trish Kritek:

Cindy, Keri, and Jerome, I haven't talked to you much today, so I apologize. Keri, I'm going to start with you. Questions, again, about visitor policy, and if we're thinking about changing our visitor policy as we hear about fewer cases?

Keri Nasenbeny:

Yeah, I think that that conversation has started. I got an ask to bring some nursing leaders forward to a committee to start talking about that. I think we have to think about staff safety, the variants out there in the community, and the needs of our patients. I think our patients suffer, I mean there's challenges for our patients when they don't see their family members, both for our COVID patients and for our non-COVID patients, and so I think we are going to start to look at that, how would we want to go about that, and what does that mean, and pushing that we need to continue to keep our patients and our staff safe. So, nothing yet, but I think that that conversation will be starting very soon.

Trish Kritek:

Okay. So, no evolution yet, more discussion, doing that risk/benefit patient and safety of staff. Jerome, how about at Harborview?

Jerome Dayao:

That's true with Harborview, Trish.

Trish Kritek:

The same? Nothing has changed. Are you starting a conversation about that as well, at Harborview?

Jerome Dayao:

Yeah, I think it's front-of-mind for all of us because our patients do need to see their families and friends or whomever, but it's a delicate balance. Until we have full certainty on what the next approach is, based from the science and evidence that we have, then that's going to be it, and, of course, based from John Lynch's recommendations.

John Lynch:

And, Trish, just to say, it's a UW Medicine-wide committee that we're bringing together to look at what would be the threshold so that we can actually make an informed choice. And, also, importantly, we don't want to make a chance, and then, three weeks from now, have to reverse it, and if we did have to do so, we want to give people a clear heads-up, "Here's where the numbers are going, and so, hey, it looks like we might be there next week, so prepare your families, your patients, yourselves for having to go back." And so we want to give people information and a clear metric that we're going to be using, rather than just, "It feels okay now."

Trish Kritek:

Okay. I appreciate that. And I just want to highlight what you said, which is it's going to be a UW Medicine approach, not one-institution approach, I appreciate you saying that, which is why Jerome said it's the same at Harborview. Cindy, there has been some discussion about incentive pay for nurses. Is that something that is happening?

Cindy Sayre:

Yeah. Well, it's been happening at the Northwest campus for a while now. We just signed an MOU for the Montlake campus, a couple of weeks ago, and we're starting that program here. And then I'll let Jerome answer for the Northwest campus. We have different unions between Montlake and Harborview.

Keri Nasenbeny:

Just to say though, for the Northwest campus, that's a practice that's been going on for years, it had nothing to do with COVID, it's built into our contract, so I just want to make sure that people understand that.

Trish Kritek:

Baseline incentive pay at Northwest, talking about it at Montlake. Jerome?

Jerome Dayao:

It is under discussion, as what Cindy's saying. We have different unions. At Harborview, we have SEIU representing our nurses, so it is still an ongoing discussion, no finality yet on that one.

Trish Kritek:

Okay. So, conversations ongoing. And that's for nurses, is it for other members of the healthcare team, like PCTs and others?

Cindy Sayre:

At this point, at Montlake, this is for nurses.

Trish Kritek:

Nurses, okay. Is that true for you, Jerome, as well? Okay. Thank you for clarifying that. The last question for the three of you is: are we doing anything with additional staff resourcing as we get ready to go live with D1? So, I see Keri nodding, so I'll start with you, Keri.

Keri Nasenbeny:

Yeah, I mean we've been in the process for the last ... well, we did it, thinking we were going to go live in January with adding staff, and now we're doing it again for the go-live in December, bringing in additional staff so that we're able to both free up superusers, and also make sure that we're staffing appropriately so that we're not short at the time of go-live. So, both hiring, if that's the need on a long-term permanent basis, and also bringing in temporary travelers to help augment our staff through that go-live. So, yes, and I think that's the case across the board. Most of our units will have two superusers around-the-clock, providing support for the inpatient units, some of our smaller units will just be one, so it just depends on the size of that unit.

Trish Kritek:

Okay. So, travelers and potentially hiring to make sure that we're supporting folks as we plan for, about a month from now, when we go live, right? Okay. Thank you, all, very much. I promised that I would come back and ask some more questions about vaccines, so I am going to ask a few more questions about vaccines, John. The first one that I wanted to ask you is, we've talked about this before, but I'm wondering if there's any new data about whether or not you can be infectious after you've been vaccinated?

John Lynch:

Yeah, so there's actually some really exciting data that came out this week. One is from the J&J vaccine, the one that Tim mentioned, was approved just this afternoon, or I shouldn't say "approved," but went through this one committee, and it'll likely be approved tomorrow by the FDA. In one study looking at that vaccine, after about 70 days, asymptomatic infection in vaccinated people, one vaccine, went down by 74%, so that is tremendous, excellent news. We were all thinking this is what we're going to be seeing, but this is nice confirmation.

John Lynch:

Quickly, just two other data points from Israel, and both of these are the Pfizer vaccine. In one unpublished study, this is just data that's available, asymptomatic cases went down by 90%, so, very, very good data. Symptomatic cases, like we know before went down by 94%. This isn't trial data, this is experience in Israel in rolling this out, and we all know they've been very successful in this.

John Lynch:

In a second study of Israeli healthcare workers, about 7200 healthcare workers, all infections, including asymptomatic infections, went down by 75%. So, really, really good news. We were expecting to see stuff like this. It's not 100%, but it's still remarkably good data, demonstrating that these vaccines probably prevent most asymptomatic infection, what we call carriage of the virus, which means the vaccination of a person protects not only that person, but those around them. That's a key thing that we've been waiting to hear.

Trish Kritek:

Yeah, you have said that that was biologically plausible multiple times, and I think now we have some data to support it's unlikely, if you're vaccinated, though not zero, that you are infecting other people, that you would be asymptomatically infected and infecting other people, which begs the question that came up multiple times, which is: if there were two couples, and both members of both couples were vaccinated, can they have dinner together, indoors, without their masks?

John Lynch:

I'm going to tell you what I think, and this isn't work, going back to Santiago's framing, I'm talking about out in your life, away from work. So, the idea here, let's just take two couples who don't live with anyone else, they just live two people and two people, living together. So, what is the likelihood of one of those, let's say, four people is asymptomatically infected, one of these minority of people who get a J&J or a Pfizer vaccine, and probably Moderna, and the chance that they give it to one of the other people, and then that person gets asymptomatically infected to the extent that they now infect an unvaccinated susceptible person. We don't have data, it is unlikely we'll get data on that, but it is very, very, very unlikely, biologically, that that would ever happen.

John Lynch:

So, the issue, I think, that people are still ... if you have two people, two people, no one else in the household, that seems like a rational, biologically appropriate opportunity. Now, we have no guidance out in the world, no CDC guidance, although I bet you we will be seeing some of this in the near future, but I think that that's rational. Where things get complicated and why we haven't written a policy is when a lot of people live with other people, and many of us live with people, maybe even those partners, who aren't vaccinated, or there's kids or vulnerable adults who haven't been vaccinated yet in their homes, and that's where things become a little bit higher risk. Was that clear?

Trish Kritek:

I think what you did was give a very nuanced, thoughtful answer to the question, which I'm going to distill down to if it's really just the two of you in the household and the other two of you in a household, and everybody is vaccinated, it's reasonable to have dinner.

John Lynch:

I think so.

Trish Kritek:

And I live in a household with one of those types of people, so I hope he watches this town hall. Okay.

John Lynch:

So, just to be clear, I live in a household, my wife's a nurse, we're both fully vaccinated, but I have two children, and so I'm not going to probably do that yet.

Trish Kritek:

Fair enough. It's either that or get rid of the children, which you're probably not going to do either.

John Lynch:

They're teenagers. If anybody wants them, they're available.

Trish Kritek:

Awesome. Thank you. I mean it's what we're talking about, it's what we're thinking about, so I appreciate you thinking it through with us. Santiago, can I ask you another vaccine question?

Santiago Neme:

Yeah.

Trish Kritek:

If I've had COVID, do I really have to wait 90 days to get vaccinated? People have asked that question repeatedly.

Santiago Neme:

There's no biological reason to wait, but in terms of priority, when we have limited supply, we know that those folks really are protected for several months, there's more and more studies looking beyond antibodies, looking at the cellular response of those T cells that are continuing to work, and the same goes for the variants, like the T cells are proving to be really, really strong at protecting us. So, I would say in terms of priority, I would say that person wouldn't be a top priority for me, but is there any biological reason why they couldn't get vaccinated? No. So, that's why we have the 90 day.

Trish Kritek:

Okay. Not unsafe, but you're protected-

Santiago Neme:

Not unsafe, it's just risk and priorities.

Trish Kritek:

What if you got COVID between doses? We've talked about there have been a few people who got their first dose, then they got COVID, what should they do about their second dose?

Santiago Neme:

And we had that happen in a couple of cases, at least I know one case, outside of UW. But this person got COVID, basically, around the time he was getting the first dose. And what we typically recommend is to get the second dose as soon as they recovered, but not sooner than the four weeks. So, typically, you would get it at four weeks, you want that person to have recovered before they get that.

Trish Kritek:

So, recover, but get the second dose.

Santiago Neme:

Exactly.

Trish Kritek:

Okay. Tim, can I ask you a question? We've talked about people and clinically-working folks getting vaccinated. There are some people who, very episodically, come into the clinical setting, but mostly work from home. Are those people who should also be getting vaccinated as that first tier, or not?

Tim Dellit:

Yeah, I think, again, that 1A, where people who work within that clinical environment, so we really have to look at these on an individual basis. Are they working within the hospitals or clinics? It's not just coming into work in a non-clinical environment, and sometimes that gets confusing because, early on, the state defined essential workers, back in the spring, of those people who could still come into work, but that's not the definition they're using for vaccination, so it really is people who are actually working within the hospitals or clinics on that 1A.

Trish Kritek:

If you're working within the hospital and clinics, then you should get vaccinated, even if it's not all the time, but if you're coming in, that's the case. If you're not working in those spaces, then you're not in that group, if you will.

Tim Dellit:

Correct.

Trish Kritek:

Okay. John, can I ask you one more question about vaccines, as well?

John Lynch:

Sure.

Trish Kritek:

Any word on booster shots? As people were worrying about variants, I didn't ask you this earlier, have you heard anything, read anything, know anything?

John Lynch:

I think I've heard what most people have is that companies like Moderna and Pfizer are looking at how to build booster shots and thinking about making them available. This is one of the great things about these mRNA vaccines, these new technologies, is you can potentially change the genetic material around pretty quickly, and that's great news. But I just want to go back to emphasize that all the data right now indicates that the vaccines that we have in hand are still highly effective, and so it's not abundantly clear to me whether we need booster shots, either for the variants. I think probably the

larger open question to me is how long does immunity last? This goes back to the questions we had, months ago, about is this going to be an annual shot? Is this going to be a twice-a-year shot? That still is unknown. So, I'd say, for both reasons, the idea of booster shots are definitely a possibility, and the companies are working on them, but I have no visibility into when we would need them or even if we would need them.

Trish Kritek:

Okay. So, working on them, but no obvious need for them in the near future.

John Lynch:

Yep.

Trish Kritek:

My last question for the day shows us how compassionate our audience is. And I'm going to ask you, John, but maybe someone else knows, I'm not sure you'll know. There is concern that we're going to hurt birds with all the discarded masks and the ties are something that they'll get caught in. Yes?

John Lynch:

Yeah. There's actually articles out there, numerous articles, that these kill birds, and probably kill turtles and lots of other animals. These things get wrapped around beaks, get wrapped around bird legs, just like other plastic material. This is plastic, petroleum-based, and these things get wrapped around animal appendages, and they suffer, and they die. And this is what we know, straws in turtles' noses and all the other things, Save the Turtles. And so don't throw your mask on the ground. Don't leave them in the parking garage, don't leave them in the stairwell. Don't leave this stuff out in the world. The last thing we need is more garbage floating in the world. We're not going to stop animals from getting hurt by these things by just putting these things in the garbage, but, for the time being, we can't stop using them, we can't use them less. These work great against the variants, just like Santiago said, and every other Coronavirus out there, and flu, just for a little building up for next year, they work great for flu, that we can help prevent these getting to the environment by putting them in the garbage can when we're done with them.

Trish Kritek:

Okay. So, put them in the garbage. Still a problem, even in the garbage, but better in the garbage than on the street. And someone was like, "Should you cut the ear loops?" I've heard people doing that, I think it's logistically challenging to do it in real time.

John Lynch:

It's like the plastic things on a six pack of pop or something. Yeah, go for it.

Trish Kritek:

Yeah, if you can, sure. Go ahead, sorry.

John Lynch:

Be conscientious.

Trish Kritek:

Be conscientious and save the turtles is, I think, what I heard Dr. Lynch say.

John Lynch:

And the albatrosses.

Trish Kritek:

And the albatrosses. And we'll end on that note. I want to close by, first of all, thanking the folks who shared their personal reflections on this year. I think they resonated with a lot of people, I know they resonated with me, and I look forward to hearing about other people's reflections on this. Maybe that's something that you do with the people on your team, in your community, in the spaces where you work, that you take a moment to reflect on the impact of this on all of us and what it means to reflect on that year, together. So, I appreciate Anne modeling that for all of us and bringing those voices to the table.

Trish Kritek:

I want to give a thanks, as always, to all members of the panel, a special thanks to Alisa for joining us today and answering questions, sans data, which is always difficult to do, I really appreciate that so much. I want to give a special shout-out to all the residents and all the fellows within our community, as this is Thank a Resident/Fellow Day. Truthfully, every day is Thank a Resident/Fellow Day, it should be at least, because they are essential to all that we do across our institution, and they're really the thing that inspires me to come to work. The only comparator to that is the medical students who inspire me to come to work. So, I really want to say a big thank-you, and they've been a huge, huge force as we've taken care of patients with COVID. So, a huge thank-you to all of you.

Trish Kritek:

And I'll end by saying a thanks to our whole community. It's a year, holy cow. It is because of all that you do to take care of our patients, their families, and each other, that we've gotten to where we are and done so well, so thank you all very much. We'll see you back in two weeks. Stay safe. Bye-bye.