

Trish Kritek:

All right. Welcome back to UW Medicine town hall. I'm Trish Kritek and it's my pleasure to welcome you back. With us today are Tim Dellit, our chief medical officer for UW Medicine, John Lynch, head of infection prevention and employee health at Harborview Medical Center, Keri Nasenbeny, CNO at UWMC Northwest, Jerome Dayao, CNO at Harborview, Anne Browning, assistant dean for wellbeing, Santiago Neme, medical director at UWMC Northwest, Tom Staiger, medical director at UWMC, Rick Goss, medical director at Harborview and Cindy Sayre, chief nursing officer at UWMC. I was doing so well and then last one didn't really go perfectly. Anyway, it's the whole crew from town hall. We have no guests today. I am appreciative of everyone being here and I'm going to jump right into having Anne give us some comments from home.

Anne Browning:

Yes. Greetings from my kitchen. Last week I talked about celebrating my milestone of sending our kiddo off to kindergarten and no kidding, less than one week later, we got news that there was an exposure in our classroom, and we are currently quarantining her and doing remote learning with a five year old from home until September 20th. There's a couple thoughts that I've had running from my mind one of which, so far the kiddo seems to be doing just fine, but I worry about the kids' family. There's so much frustration around kind of these exposures and I recognize that it could just as easily could have been us and who knows next time, maybe it will be. And I certainly hope there is no next time, but this certainly is highlighted just kind of how fragile those classroom systems can be.

Anne Browning:

And thinking about fragile systems, I think it also highlights just how hard it is with two-parent working family and little kids in childcare and family care responsibilities, a disruption like this it feels like it sinks our battleship and it is something that we have to try and figure out on the fly. We recognize this is going to happen to folks across our community over this year, so we've been brainstorming what are we going to do to support folks and get some resources in place? But just to recognize that this is going to be really hard as we're bringing kids back into classrooms even with all the best protection mechanisms in place that we have.

Anne Browning:

The second piece I want to bring up is a couple folks have mentioned in the questions to us for town hall, just kind of dealing with this concern around finding themselves kind of slipping into frustration and anger at unvaccinated folks whether they're patients and families in our spaces, or just kind of in the broader community. I just want to highlight we're going to work with the chair of bioethics Denise Dudzinski and on October 8th, we're going to turn over our town hall time to really having kind of a conversation around some of that kind of what could even feel like moral outrage at folks who are choosing to be unvaccinated and helping us recognize that there are lots of reason that folks are unvaccinated, even though it's putting some strain on our systems. It's something that we want to create some space to kind of navigate. So know that that's coming and mark your calendars for October 8th. With that, Trish?

Trish Kritek:

Anne, thank you for sharing something that I think has been personally very challenging and is very personal. And I think is something that's happening to lots of folks already as the school year kicks off. So as Anne said, we're going to be coming back to you with more thoughts on that because we know

that that's a very real thing. And I appreciate the other part, which is us continuing to feel like vaccination is the way that we can keep ourselves safe and our community safe. And that folks who unvaccinated are folks who are members of our community too, they're individuals and we want to treat them as such and so there's a tension there that we need to talk more about. So thank you.

Trish Kritek:

John, I'm going to pivot to you right away and talk about what Anne is experiencing before we even do numbers, which is walk through what an employee is supposed to do if their child is exposed at school and is quarantining. And then my second question will be, what do they do if that child actually ends up testing positive for COVID?

John Lynch:

Yeah, sure. All sympathies Anne. I think this just points to the complexity that we've talked about before is school's getting underway and this situation occurs. It creates an enormous amount of challenges. And so yeah, definitely sympathy for you and your family as you work through this. I think this is going to be happening a lot and it's going to be impacting all healthcare workers and really everyone in our communities. So what do you do? So if you have a child who's exposed, obviously there's remote learning those kids, because they don't have any immunity, right? They don't have access for under 12s to vaccination, especially even those above, most school systems are asking those kids to quarantine. That means you're not infected. It just means for 14 days from the day of your exposure, you can't be in those public settings or school settings. So I'm assuming that Anne's child is being asked to stay home for about 14 days.

John Lynch:

During that time, Anne, as someone who lives with that child can continue to work regardless of their vaccine status, right? That child, her child is not infected. So that child's in quarantine. So people can continue to work as a parent or a caregiver or a guardian. Now, if aunt's child develops signs or symptoms of COVID-19, regardless of testing, but if the test is positive as well, then that child is now moved from quarantine waiting to see if they have an infection to isolation. Isolation means now you need to stay home because you're a potentially contagious person. And what that means is, especially when we live with that person, regardless of things we do like masking or staying in different rooms. We know that homes don't allow us to really separate, isolate from other people.

John Lynch:

And so then Anne is exposed and during that exposure time, she needs to stay home. She now is a quarantine person and she needs... And depending upon the situation we may be able to get her back to work sooner, but what we really ask in that situation is you do stay home and regardless whether it's just symptoms or positive tests so we know it's not COVID, we ask for that now exposed person to quarantine, stay home and call employee health and we'll walk you through those steps. We might able to get you back to work a little bit sooner based on testing, based on your vaccination status or similar. So we want to help you with that. It gets complicated, requires some details. And again, we're here to help you out. Does that make sense, Trish?

Trish Kritek:

Yeah, that was awesome. And I'm just going to summarize it really quickly. If your child is quarantining, asymptomatic, but got exposed at school, then you can work.

John Lynch:

Yep.

Trish Kritek:

If your child develops symptoms, now they're going to need to be tested, so now they're isolating. And if they test positive, they're definitely isolating. When your child is isolating, you don't come to work and to get the details about when you can come back to work, you need to talk to employee health because there's some nuances to that. Thank you. I think-

Santiago Neme:

May I add something, Trish, also? Let's remember to leverage our technology too. So for instance, I had an exposure and I had to get tested, but then I was able to switch my patients to a telehealth med visit or a phone visit like preemptively, so then the patients could get that visit in a modified way. So there are ways to do these things and just ask. Thanks.

Trish Kritek:

Thank you, Santiago. So less about the rules, but more about let's be creative to kind of keep working. So I appreciate that very much. All right. I thought you were going to correct me. I was like, "I thought I got it right." All right. I do want to go now with John on current numbers, where we stand at... Let's start with UW Medicine and then actually we'll talk about the state and maybe even kind of pushing over to Idaho.

John Lynch:

Yeah. So right now we're kind of stable. We're on 91 patients as of six, seven o'clock this morning. 51 of them are in acute care, 40 in the ICU. Much smaller numbers of COVID positive people in isolation, that term we just heard where we have to take special precautions who are on that ECLS, ECMO, the heart lung bypass, but still a lot of people requiring the machines. Most of these folks are at Valley Medical Center, 38 people there followed by Harborview at 22 and both Northwest Montlake are in the mid teens. So still we're kind of about the same overall within the UW Medicine system.

Trish Kritek:

Steady high and steady, but not escalating right now. How about the state?

John Lynch:

Yeah, the state, I think is looking in much rougher shape. We can look at a couple different things. I think one is looking at the overall number of folks who are acquiring hospitalization. That remains extremely high. And over the last... I reported out in the last couple weeks and this continues is the trend around critical care patients, ICU patients is still faster than the acute care patients who need hospitalization. And that has a huge impact because we only have so many acute care beds in the hospitals. In Washington state, we have even fewer ICU beds and many hospitals really don't have that capacity at all, so that means moving people around the state.

John Lynch:

The other part, I think we really need to pay attention to is how is that distributed? Yeah. We have 1,600 plus patients in the hospitals in Washington state. We have a whole bunch here, but in some parts of

our state, it is overwhelming. There are way more patients particularly in Eastern Washington. As you mentioned we'll talk about it in Idaho the overflow from either Oregon and in from Idaho over to Spokane. Right now, the situation in Spokane and some of the other major healthcare facilities regions in Eastern Washington are under great deal of strain that is very concerning.

Trish Kritek:

Yeah. So while our numbers are high and stable, the state is really still at a pretty critical level and particularly in those critically ill patients. Do you want to just comment about Idaho?

John Lynch:

Yeah.

Trish Kritek:

Because I think it's been in the news about kind of crisis standards of care in Northern Idaho.

John Lynch:

Yeah. Just so everyone understands, when we talk to this term crisis standards of care really briefly, there's basically three levels, there's conventional. It means just routine everyday care. Conventional status, that's kind of the middle tier, means that we're doing all of the normal care, but we may be doing it in a slightly different way, but everyone's getting what they're supposed to happen. I would say that's where most of Washington's right now is contingency, right? We're doing something slightly differently, but we're doing it all. The most concerning level is crisis standard and crisis standard of care is when we know longer are doing standard of care, we are providing patient care, but we're doing it in a different way. And when that happens, that's the declaration that's made by state leadership or public health leadership. It is not an individual. I don't declare crisis standards of care, Tim doesn't declare that. That is a state public health situation where say our system, our state, our region, can't do this.

John Lynch:

And what's happening in Northern Idaho right now and is definitely a deep concern in parts of Oregon is that they've moved to crisis standards of care, their public health authorities and the government authorities have said, we cannot take care of all these patients, we have to now step into a different level of standard of care and expectations. And there are very discreet guidelines on how this approach is. This is a situation we never want to occur, that many folks are working very hard to ever let happen, but is happening. And what that means is that you know who gets access to care and the order in which that access happens is dramatically different than what we want and what we typically see. I can't really describe how terrible the situation is in that area. Our own system in Washington state are trying to support, but given what I just described in Washington state, particularly in that Spokane area, the critical access hospitals along that border that are already extremely stressed how much help can be given is really an hour by hour and day by day thing.

Trish Kritek:

Yeah, it's a big deal to go to crisis standards of care. And so it's sobering for all of us that that's happened in Idaho and we're doing what we tend to keep supporting them. I will say that Eastern Washington folks do that all the time in collaboration with Idaho and I know they're continuing to do that as much as possible. Thank you. Relative to numbers, there were some questions about people looking actually at the King County COVID dashboard, where there now are things that give you kind of

vaccinated and unvaccinated percentages. And there was some question about the percentage of deaths that are happening in unvaccinated folks versus percentage of deaths that are happening in vaccinated folks. And I don't know if you can give some clarity on that.

John Lynch:

Yeah, sure. So thanks for that. You had sent me a message around this and so I did go back and check and I looked at both our public health King County data, and also looked at a new publication that came out in the CDC's MMWR, which is free to everyone on this call. So right now, just to be clear, if you are vaccinated, you are seven times less likely to have a positive COVID test. This is in the last 30 days. So full on Delta, which is where we've been. You are 50 times less likely to end up in the hospital if you are vaccinated and you are 30 times less likely to die from COVID in the last 30 days. So when you break that down in percentages, of the people who have died vaccinated versus unvaccinated, 70% were not fully vaccinated and 30% were fully vaccinated.

John Lynch:

Now, remember why people die. If you get hospitalized unvaccinated with COVID, COVID is probably a big contributor to your situation. For vaccinated folks, it may not play a discreet role, right? They don't go through every single person and say, this person had a heart attack and a terrible heart attack and died from a heart attack and had COVID. So we have to be thoughtful about it, but it's very clear, the vast majority of people who are dying with a positive COVID test are unvaccinated, three quarters and it is the 34 rule. When we look nationally, it's very similar. Looking at just in the Delta phase, it's about seven times more likely if you're unvaccinated you have positive test and greater than, at least greater than 10 times more likely if you're vaccinated to not be hospitalized and at least 10 times more likely not to die if you're vaccinated.

Trish Kritek:

I think if you're going through those numbers, the King County site has them. It's much, much, much more likely that if someone dies from COVID it's said that they were unvaccinated. It doesn't mean that people who are vaccinated never die from COVID, which I think is something that people are curious about when they look at that website, but I think that the odds are much different and I think that you went through those numbers nicely.

John Lynch:

Can you say one really quick thing? I mean, what you just said, Trish, is really, really important. If you are vaccinated, this does not mean that you are a hundred percent immune, that you will never get sick with COVID or that you won't die from COVID, but the risk of that happening is decreased dramatically. It's the exact same thing with lots of other things we do. Seat belts. People die in car accidents who have a seat belt on, but your risk of dying drops so dramatically that wearing a seat belt universally makes great sense. And this is true for many, many other things that we do in society.

Trish Kritek:

I think it's a really good analogy and I appreciate that. And it's why I think... I know that people feel like there's some moral imperative on this. It's really that honestly, we don't want people to get sick and we don't want people to be in our ICUs. One of the questions someone asked was, what's the percentage of people who get intubated with COVID, what of those patients die from their disease?

John Lynch:

Trish, I'm going to actually throw that back to you, as an ICU doctor who's done this work, do you... I mean, you can-

Trish Kritek:

Yeah.

John Lynch:

Speak more skillfully on this than-

Trish Kritek:

That's fair. That can happen once every three months, I can get a question thrown back to me. What I would say is the numbers are very similar to other patients who develop acute respiratory distress syndrome or ARDS. So the data that we have probably most recently, I think the paper I looked at most recently was in June, so a few months ago is about 40% of patients who are intubated will die from their COVID. So it's high. It's similar to what we see when other diseases cause people to have respiratory failure and be on a ventilator with ARDS, but that's not good and something that we want to avoid at all costs. Two more questions, John, before I go to Tim, are we seeing much  $\mu$  here in Seattle and or in King County or in this area?

John Lynch:

Yeah. So I'm actually going to tackle that for both  $\mu$  and  $\lambda$  because-

Trish Kritek:

Thank you.

John Lynch:

... those are the ones I get asked about. So  $\mu$  is the B.1.621, and  $\lambda$  is the C.37. These are two variants that may have some potential resistance to preexisting immunity getting by our vaccines, right? So that's the big concern. These are circulating in South America and the question is, are we seeing them here? I looked at the UW clinical virology surveillance data, which it takes a little bit of time, so it's about five to seven days out. I also looked at the Washington state database and neither database did I find any representation of either  $\mu$  or  $\lambda$ . Now, though it's a subset of all positive tests, it's possible there's a  $\mu$  or  $\lambda$  out there. There are cases in other states in the United States, including California.

John Lynch:

What I would say just for folks to understand right now is looking at where this better surveillance is done in the UK and where we're seeing in the US is these don't appear to be able to compete against Delta. Delta really seems to be the big dog in this fight, and  $\mu$  and  $\lambda$  just don't seem to be able to get past how great Delta transmits to other people. Doesn't mean it's not a future issue, doesn't mean people aren't paying attention. We're not seeing it here, which is great, but it also doesn't seem to be a big variant of concern in the US right now, based on the inability to penetrate past Delta. I see Dr. Mathias is also texting. I'll look at that online here in a second. He's the pro on all this.

Trish Kritek:

Okay. Thank you for live updates from our lab folks. We appreciate it. And what I heard was none really here and could be some because we don't test everyone for those phenotypes. Up-

John Lynch:

So a live update from Dr. Mathias. About a hundred new variants total up to date, but a very small fraction of the percent. So I searched from them the percentage, but I think it's so small that I couldn't see it. So I just want to be very clear. I was wrong. There's about a hundred, but it's super tiny.

Trish Kritek:

Thanks Patrick. I appreciate the update. So very small number. Doesn't seem like it's impacting us right now. We'll keep an eye on it and we'll keep coming back and talking about it. So I appreciate it. Last question for you, John for now. I'm going to hope to get back to you. Flu shots, when will we start getting flu shots?

John Lynch:

October 4th.

Trish Kritek:

And should we get it right away?

John Lynch:

Yes. There's no reason not to get a... If you haven't been vaccinated against COVID there's no reason not to get vaccinated against COVID in one arm and flu shot in the other or both or whatever you want. Both vaccines can be given at the exact same time. All that concern earlier in the years, when we knew a little bit less, now we know more. Giving those vaccines concurrently or flu vaccine within whatever time is completely appropriate. So October 4th, get in line.

Trish Kritek:

Okay. October 4th, get your flu vaccine, get your SARS-CoV-2 vaccine at the same time if you haven't been vaccinated and more to come on that as we roll that out. I can't wait for my flu vaccine. I want to get it right away.

Trish Kritek:

Tim, speaking of the winter, people are... or for the flu, people are worried out flu in the winter with the kids getting infected, but they're also worried about, are we going to get another surge or is it going to get worse during the winter? So do we have plans to deal with a worsening surge in the winter?

Tim Dellit:

Yeah. So a couple of comments as John mentioned earlier, we're plateaued kind of at that 90 within our healthcare system now. We still have that potential that we could continue to go up, especially if you look at the return to school, you look at some of the Labor Day events that occurred. And so we don't know which direction we're necessarily going right now. If you look at some of the IHME projections, and again, that's a model but they look at us continuing to go up through middle of October. So I don't think we're done yet with this wave. Even if we do start to go back down, there's always that potential

just as we saw last year, that we could start to go back up. Recall last year towards the second half of November into December, we started to go back up again. So I think we have to anticipate that that's likely.

Tim Dellit:

Keep in mind from surge planning, our hospitals and system have done a tremendous amount of work from the very beginning of this pandemic. We've maintained our EOC structure, so all of those surge plans are still there. We also recognize though that we have baseline staffing challenges, right? So we recognize that are we in a slightly different position now than perhaps when we were there? But we've already done somethings such as pulling back on those non-urgent surgeries that require hospitalization and there are other measures within our surge plan that we could implement if we needed to. So we have those plans in place around how do we build capacity, both from a bed standpoint, staffing and equipment. Our real concern as John alluded to is watching what's happening in Idaho and the fact that our state is really at extreme capacity right now. And that is something that we're very concerned about. Keep in mind when we're at 1,700 for COVID-19 in the state now. Previously we topped out at about 1,100, 1,200. So we're well above that even with our current surge.

Trish Kritek:

Okay. So we don't know where we're going quite yet. We'll keep a watching it. We have a surge plan, we're ready to roll out extra elements of that as we go forward. So we'll keep asking about that as we move forward. I think the other big thing that I want to talk about for sure with you is an update on the medical and religious exemptions for vaccination and where we stand with that with our employees in UW Medicine.

Tim Dellit:

Yeah. There's been a tremendous amount of work on this. And just again, to reframe it's because of the significant capacity restraints and there's real strong desire not to have our healthcare systems overwhelmed that the governor went forth with a mandate around vaccination as a condition of employment for all healthcare workers as well as higher education. So that affects all of us. It's also worth noting that yesterday, President Biden also made an announcement regarding all healthcare workers as well. So there's now both federal and state requirements really surrounding the fact that we just can't have our healthcare systems get overwhelmed and especially again, as we look at what's happening in Idaho. So with that in mind we have been working very closely with colleagues across the university because our goal is to have a consistent, standardized approach for the evaluation of medical and religious exemption requests that we receive across the university.

Tim Dellit:

And I believe that we now have reached that agreement. Because we had to do some work to develop that consistent process we had to pause in responding to some of the exemption requests we received. Now that we've come to agreement, individuals if you have submitted a request, you will start to be notified whether that is approved or denied here going forward, hopefully over the next couple of days.

Trish Kritek:

Okay. So we came to a consensus on what a standardized process is, people are now being notified about the decision about what they've requested. And I think there's also primary care providers who



are being asked about giving medical exemptions for their patients and I'm wondering if that's standardized-

Tim Dellit:

Let me make that-

Trish Kritek:

-meaning it could be shared.

Tim Dellit:

Yeah, let me make a few comments. And so there are standard forms that we are requesting that be used. And so for a medical exemption, there's a standard form that should be used by your practitioner and that really outlines really what those primary contraindications are, and there are not very many of them. That form outlines, did you have a severe allergic reaction after your first dose or do you have a severe allergic reaction to one of the components of the vaccine? Those are really the only medical contraindications. And in fact, that form lists a whole number of other things that sometimes are raised such as autoimmune diseases or even pregnancy, but those are not Contraindications to being vaccinated. And so we strongly encourage people to use those forms and our primary care physicians should also use those.

Tim Dellit:

We anticipate quite frankly, the number of actually approved medical exemptions is going to be extremely small because it's really only based on those severe allergic reactions to a component of the vaccine. Now, that's the medical. I do want to make a couple of comments around the religious exemptions, because when you read the proclamation from the governor it not only states, is this a firmly held religious belief? And none of us are ever going to question whether your belief is sincere or is that a real... We totally appreciate and respect how you may feel and your belief if you say that I have a firmly held religious belief. The component, and the governor also has stated this is that then the next thing that we evaluate is what an accommodation cause an undue burden on the organization, meaning what we would have to do to make that accommodation, is that even feasible in a healthcare setting? And the governor also said that many such exemptions or requests may well be denied.

Tim Dellit:

And so I think the reason I want to say that is it's important for people to understand that just because you have submitted a request for an exemption doesn't mean that that will necessarily be granted. Each of those is reviewed on an individual basis through a group of individuals to provide a consistent approach, but some of those will be denied and if they are denied, then we strongly encourage you to be vaccinated and fully vaccinated prior to that October 18th date.

Trish Kritek:

Okay. So I'm going to try to summarize. For medical exemptions, very few things are going to count and really it's severe allergic to the vaccine when you got it the first time or stuff in the vaccine and that's a standard our primary care providers could use as well. And the second thing that I think I heard is not... it's hard. People can share with us their religious reasons why they don't want to be vaccinated and we're going to respect those and there needs to be a way to accommodate them and that if we can't accommodate them, then that would be something that would potentially leads to termination.

Tim Dellit:

Yeah. And let me explain some of those accommodations and obviously I would look to John as well and why those are difficult to accommodate in a clinical setting. It's not only the consistent mask use, which all of us are doing now. It's additional eye protection when caring for any patient, but more challenging is those individuals wouldn't be able to care for patients with COVID-19 or patients who are immunocompromised or patients in congregate settings, such as our psychiatric units. And so when you start to look at those clinical environments it would become extremely difficult to provide some of those accommodations. Again, those are things that we have to look at on an individual basis as we review those.

Tim Dellit:

The other piece that would be required would be twice weekly testing. And that also becomes really challenging to navigate and so the... And that's where, again, as per the governor's proclamation, if that accommodation becomes an undue burden for the organization, they are able to deny that exemption and just say, they can't make that accommodation, but they have to go through that review process, which we're doing.

Trish Kritek:

Okay. So go through the review process. There's many reasons that make accommodations challenging, including the testing and the places and spaces where people can work. This is stressful to a lot of people, so I think it's worth us taking the time to talk about it. I will ask one more question in Tim and then I'm going to pivot to the CNOs, because I think this has implications for staffing that people are asking about. But before I do that, one question was, what about if we just had people test regularly, as opposed to saying that they have to be vaccinated, like you just alluded to as what could be part of an accommodation?

Tim Dellit:

Yeah. The governor also made it clear when he made this proclamation that he did not accept that as an alternative to vaccination. And his rationale is because he highlighted examples where individuals were undergoing weekly testing and they still got infected and led to exposures. So the proclamation does not allow that as an alternative to vaccination. And so when I mentioned that twice weekly testing, that is in the context of a consideration of an accommodation, not an alternative because someone chooses not to be vaccinated.

Tim Dellit:

I also want to really emphasize our whole goal with this is to really help protect our patients, to protect all of our staff to create a safe environment and keep our hospitals and healthcare system from getting overwhelmed. We don't want anyone to lose their job. I just really want to make that clear. And we are reaching out to everyone from whom we know, or we don't have confirmed vaccination. We want to give everyone every opportunity to be in compliance with the governor's mandate. We're required to follow it. We want all of our staff and we're trying to help support them as we go through this. Ultimately people will have to make a personal decision, but we're doing everything possible to ensure that they have the right information, the right understanding to help inform them as they make that decision.

Trish Kritek:

Okay. I really appreciate that because I think throughout this pandemic, one of the things that has been a guiding light is taking care of the folks who work here and then obviously taking care of our patients and their families. And so we want to work with people. We want them to be a part of our community, and we want to understand how we kind of help folks navigate forward through this. So thank you for that sentiment.

Trish Kritek:

Cindy, Jerome, and Keri, I'm going to jump to you. There were a bunch of questions that said we're taxed on staffing. We've been talking about that, and now we're worried that we're going to lose staff over this. What are we doing to try to mitigate that? And Tim kind of alluded to some of that already. I wonder if you want to add to that. So Keri, I see you're unmuted so I'll go with you first.

Keri Nasenbeny:

Yeah. So first and foremost, I think all of our managers are reaching out to anybody who's on that list, so has not been vaccinated and, or non-compliant right now with the mandate and helping them try to get vaccinated if that's... Or pursue exemption. And for those folks who have questions, connecting them with resources. For example, Dr. Neme, Dr. Cohen have offered so generously to spend time with folks so I know for some of our folks who are really trying to work through that process, get them the support and resources they need. And so that's really been our first strategy is to support our staff and help them understand and to get them any information resources. For some employees that we know are firmly rooted and not wanting to get vaccinated and we don't believe that they will have an exemption, we're actually going ahead and trying to replace those positions because we need to be... And those are, I would say the one offset right now.

Keri Nasenbeny:

I think most of our staff, the vast majority of them are pursuing vaccination, which is great and I think what we're hopeful for, but if... And some of our staffs have said, "Well, I'm going to resign." And so again, we're going ahead and replacing those proactively and we're pursuing travelers, if that's what we need to do. So our managers have a really good sense of this and the numbers of the staff that they're worried that they might lose, that's not our goal. Our goal is for folks to get mandates or vaccinated. So that's really where we're going to first is trying to give them that support, give them information and help them become compliant with this mandate.

Trish Kritek:

Thank you. Jerome?

Jerome Dayao:

Yeah. We're doing exactly the same interventions of what Keri said. In addition with that, we're monitoring closely our progress on compliance and reviewing them. I mean, from my review last week to beginning of this week where we are on the compliance, I'm pretty optimistic for the numbers that I'm seeing that people are getting vaccinated or are submitting for exemptions, and we're getting those lists back from HR and all of that. But as what Keri said, I mean, the last thing we want is to replace our employees, but if we have to we are also looking into being ready to do that.

Trish Kritek:

Okay. So we're contingency planning, and we're supporting folks to get them opportunities to talk to people, to express their concerns and have a conversation with folks like Santiago and Seth and John probably too and all the folks in our infectious prevention teams. I appreciate that. And this will be a challenge as we move forward. Cindy, one of the other questions that I wanted to ask all our CNOs is people are worried about the fact that similar to what Anne was talking about, that if they need to quarantine and stay home, that they're going to be out of sick time and how we're going to address that. And I'd say, we talked about this before, and I feel like it's really present for people now as school starts again.

Cindy Sayre:

Right. Thank you, Trish. And I think the rules are largely the same as they have been throughout the pandemic and that is if we have a high risk exposure in the workplace, which we have had some of those, and we need to remind people to make sure they're six feet apart when they're eating their meals. If you have a high risk exposure in the workplace, then you are eligible for administrative leave, which is paid time for the quarantine that you need to do. If it's a community exposure, which has been the vast majority of what we've seen in our workforce, then you need to use your sick time and your vacation time to cover that loss. Those employees are eligible to ask for shared leave donations if they're really out of time, but they have to spend down their balances of their vacation and sick time. But then if they really don't have any time, they're eligible to request shared leave donation.

Jerome Dayao:

And I'd just like to add also, in addition with what Cindy mentioned is that they also can contact their HR leave specialist let's say for instance, should they have used all of their accrued time if they have other questions as to what other options are available, but for the meantime, all of their accrued time they can utilize, be it PTO, the sick time and the pump time, if they have those.

Trish Kritek:

Okay. And I think it's going to feel hard to people to give up to use their vacation time. I just wanted to acknowledge that, but what I heard was using your sick time and PTO and things like that, as well as your vacation time, maybe shared pulled sick time and talk to your HR specialist. And I think it's probably something we're going to have to keep revisiting as we see how many people have to stay home because their kids are being quarantined with schools being open. I'm just going to say that out loud, just feeling the community right now. Okay. Last question for the three of you. I ask all the time about visitor policy and I guess I'm going to ask it slightly differently and that is, have we established a threshold of anything in particular that would have us go back to no visitors? And that would be like the number of patients we have in house or the level of community transmission. Where do we stand with that? And maybe Cindy, do you want to take that one?

Cindy Sayre:

I'll start, but I know that Jerome, and maybe even John wants to weigh in on this as well. So this continues to be a really dynamic situation as everybody knows and what we're really looking at now is that we have different physical plans just to say across the medical centers. So we're looking at the risk for each medical center and even within the medical center for each area of visitation. At this point for the Montlake campus, we're not going to restrict further, but we are exploring requiring vaccination from visitors. Exploring can take us time to think all the way through and operationalize, but that's

where I would say we are at the Montlake campus. And I think hearing from Keri earlier today, I think there's an area at Northwest where they have restricted visiting because of the physical location.

Trish Kritek:

Okay. So we'll go through everybody. So at Montlake, no changes right now, considering vaccination status for visitation, but that's not where we are yet. Keri, for Northwest and I'll go Jerome.

Keri Nasenbeny:

Yeah. So at Northwest, I think similar to other campuses where we have shared spaces, we have limited that to one visitor. So sometimes when we get in high census, we definitely limit visitors there to one. I think, like Cindy said, this is something that we're keeping a very close eye on and have to keep in the balance. I don't know that there's a particular threshold. And then that said, I would say in our psych unit because it's a congregate living area where our patients really aren't able to mask or are challenged to mask at all times, I'll just say, and also, it interacts with the therapeutic milieu we have there. It's an older population of patients. We are limiting... We don't have visitors there at the moment just because of the risk of transmission and we do have some unvaccinated patients. We try to vaccinate all of our patients on that unit if they come in and vaccinate, but some have declined. So that is the one space for the safety of those patients and because of the history of having some outbreaks there.

Trish Kritek:

Okay. So on the psychiatric ward at Northwest, no visitors, but otherwise the same policy as Northwest. And then Jerome, it sounds like it's evolving at Harborview.

Jerome Dayao:

Right. It is evolving at Harborview and we're probably at the very high likelihood that are considering some measures including pausing visitation, but we are at the final stages of this decision making because the impact of this to our community and to our Harborview community as well is going to be pervasive. But because of the cases that we're seeing, because of, we want to ensure the safety of everyone that works at Harborview, including everyone who comes is that, that's being considered very high likelihood of doing that.

Trish Kritek:

Okay. So high likelihood of going to no visitors. We'll know more, it sounds like in the near future, and we'll come back to this next week, for sure. It's plausible to me that people will hear something before then, but we'll re-discuss it next week. So thank you Jerome for that. And I think that'll be interesting to see how that evolves across different sites. And I appreciate you saying there's differences in patient population spaces, risks to folks, et cetera.

Trish Kritek:

I'm going to pivot to thinking about how we treat folks with COVID for a little bit. Rick and Tom, I was wondering if one of you, or maybe both could talk about how we're doing... What our processes for referring patients who we want to treat with monoclonal antibodies. There are a bunch of providers who asked about that. Rick, I'll go with you.

Rick Goss:

Sure. I can briefly talk about that. I had a chance to review that process today and visit the clinic. Harborview has been operational now for about a week with the monoclonal antibodies Regeneron and the process here, I think the overall process is pretty similar. When a patient is identified as COVID positive, really two things happen, the team that ordered the test will be notified, but there will also be a centralized list of those newly diagnosed patients. I'm aware that on a more centralized level, those lists are being reviewed and there is patient outreach. In addition, for example, if I were in clinic and a patient of mine was diagnosed, I then too could activate the process. There's a list of high risk qualifications. And then I would use the REDCap tool to notify our central coordination of that test and the likely candidacy for this treatment. Similarly, this is happening at the central level.

Rick Goss:

Then the sites on our system get notified as to the best fit. Harborview we are using a subcutaneous injection approach. There's also an IB infusion approach. We're now doing about four per day and after that process further is developed possibly we will be able to go higher than that. So I'll pause there and turn it over to Tom.

Trish Kritek:

That was great, Rick. Thank you. Tom. Do you want to add to that?

Tom Staiger:

Yeah, it's very similar at UWMC, we have capacity for about six patients a day across Northwest, Montlake in our two sites. We've got the centralized process and I have to call out Shireesha Dhanireddy and Santiago Neme for doing a lot of the work on that. And then there's a REDCap survey process that went out to all our medical staff earlier this week that people can make referrals if they feel like they've got an eligible patient.

Trish Kritek:

That's great. So there's a list of high risk criteria and a REDCap survey to use. And then we have access at all three sites to administer antibodies. And I'll echo the thanks to Santiago and Theresa for all their work plus the rest of that team that's worked on it. Santiago, did you want to add to that?

Santiago Neme:

Just quick addition, we're actually piloting through the emergency room. So those patients who are actually having an ER visit who are basically found or known to have COVID and they will be candidates for this, especially those folks that are very easy to track, someone who's homeless, someone who doesn't have a phone number. Because we struggle with those folks then when we have the result the next day and they were in our hospital or our EDs and then we can't track them anymore. So we're launching this very limited pilot now through the emergency room and I have to give kudos to our emergency room leadership, our chair, but really the whole team of all ERs and this has only been possible because of them. Thanks.

Trish Kritek:

Okay, great. Thank you. You can stay unmuted. I'm actually going to stick with you. I'm going to give Tom and Rick a break for a second. I think lots of questions about third doses. So do you know... is there any update on whether or not we're going to be giving third doses to folks? I'm not talking about immunocompromised folks. I'm talking about the rest of us. Start with that.

Santiago Neme:

Right. The actual boosters. Yeah. So the ACIP, the Advisory Committee for Immunization Practices is meeting, I believe on September 17th to discuss the Pfizer booster and then we are pretty much primed to start vaccinating on the 20th of September with two max sites at Shoreline and also Harborview. So we're prepping for that, but just like before we need to wait for that signal and approval really.

Trish Kritek:

Okay. So meeting on September 17th about Pfizer, ready to go when we get the go sign. Lots of people are asking, if I had Pfizer, do I have to get Pfizer? If I got Moderna, can I get Pfizer? If I got Pfizer can I get Moderna?

Santiago Neme:

Traditional CDC stays consistent with the recommendation and unless there's an exceptional need, but in this case I believe that we expect the Moderna approval to come a little bit later, just like we did initially, where we have first Pfizer then Moderna, we're kind of following that. The only thing... for Johnson & Johnson it's kind of an open question at this time. There's also issues with the supply of that vaccine. So we're anxiously kind of waiting to see what will happen in regards to Johnson & Johnson.

Trish Kritek:

Okay. So it sounds like in general the way that the recommendations we think will be, well, if you got Pfizer you'll get Pfizer and we have to wait to see what happens with Moderna and J & J. So more to come on that. And I think we won't do anything until we hear more from the CDC and the FDA.

Santiago Neme:

But our teams are ready.

Trish Kritek:

Yup. I got that. Thank you. Yeah. Ready to go. There are people who are worried about equity. They're like, there's lots of people in the world who need vaccines before potentially we need a booster. So two questions about that. One is, will boosters be required? And two, is there any discussion about like checking antibody levels to decide if somebody needs a booster?

Santiago Neme:

Yeah. In my mind, and I welcome Tim and John here, the utility of antibody testing is really not quite there. The thing that makes me feel much better around global equity is that our president, President Biden has really focused on donating massive amounts of vaccine across the world, including my home country, where I come from, Argentina. But we're talking about over 600 million doses. So there's an intentional effort to help. So I feel a little bit better about that. But yeah, there's a lot of questions and controversy around that because we focus a lot on those waning antibodies, but as we've said before, the T-cell immunity is so important at preventing me from getting sick and end up as one of your patients, Trish.

Trish Kritek:

Yeah. Thank you. And I appreciate what you said. So antibodies don't really tell the whole story, so we don't think that's what we should use. And then yeah, the equity thing's a real thing and we are as a

country trying to support other countries in a big way and it's also a tension for a lot of us. And I personally feel that tension as well. I just want to say. I heard of [inaudible] say it's an and, we're trying to do both, consider a booster and vaccinate the world. And it still has attention. One last question for you, Santiago. Do you have any updates on where we stand with vaccines for kids? Have you heard of any next steps-

Santiago Neme:

The latest I heard is that some documentation has been submitted and folks are talking about November, but I don't want to get people too excited because in the past we've said October, and now we're saying November. So I would say, stay tuned. I don't have any insight or information. It's just what I read.

Trish Kritek:

Okay. I'm going to ask a couple of quick questions before I hand it over earlier to Anne because I cut her short last time, my poor time management. John, I'm going to ask you a question. What do you think of home coronavirus tests? Are they something that we should be using?

John Lynch:

Yeah, so this is going to be a hot topic. It has been, but even more so in the coming days or weeks. The important thing to recognize about home test is that these are essentially what are called antigen tests. The tests we usually do at UW Medicine are called PCR tests or molecular tests. The molecular tests are super sensitive and they are wonderful tests. The issue with antigen tests is they tend to be less specific in the home ones, the ones you get at home, Costco do the swab in your nose are probably of the antigen tests are among the least sensitive. So the issue here and it'll be today's message, which may have come out even now a short explanation on it is that if you have symptoms of COVID and you swab your nose on a home antigen test and it's positive, you very likely have COVID. The issue is if it's negative, I can't be as sure about that. And if you don't have symptoms, I'm even less sure.

John Lynch:

And conversely, you may have no symptoms and swab yourself and it may be positive and it's wrong. This falls into this false negative, false positive area and I think that with the home test, there's still a lot of gray there. Since you have at home, you swab, is positive. I think has a great utility doing multiple tests over days, probably a great utility. And I think we're going to be seeing a lot more access with President Biden's new plan, but that still needs to be sort of flushed out. So there's some specific instance where they're great, a lot of instances where they're sort of iffy, and it also depends upon what your next step is, right? If it's Anne's child at home and has a fever and she swabs and it's positive. It's great. But if it's negative, it doesn't mean she gets to go out and play with their friends or something similar.

Trish Kritek:

Okay. I appreciate that. So some nuances to it. Good if it's positive. Not good, but it's positive, but it's more reliable if it's positive and repeated testing helps, but some challenges. Okay. We'll keep talking about that. Sounds like you're going to talk about it in the message. There's a bunch of questions that I'm not going to get to. I'm going to answer one that I was asked last week and this week, and I'm going to answer it myself really quickly. And John's going to correct me if I get it wrong. There was a question about clarifying the attestation rules for folks, not the people who are in clinical spaces. You need to



attest every day, but those of us who are either basic science faculty and staff working in health sciences, and never going into clinical spaces, or for some of us clinicians who are not going in those clinical spaces, the question is, do we need to do a test every day?

Trish Kritek:

And I think the answer is no, you need to attest if you're in clinical spaces or going to touch a clinical space that day, is that correct? Okay. Thank you for the thumbs up. I'm going to go with that as what it is. Someone's going to tell me the policy doesn't say that, we're working on it. Okay. As I said, mismanaged my time last time. I'm going to hand it over to Anne so she has more time to ask Tim and we invited him back because of my error. Thank you.

Anne Browning:

Thanks Trish. And Tim, welcome back. We're going to stick with the theme of kids for a little bit here. One person wrote in and just asked, would you get your 13 year-old vaccinated in middle school? I'll even answer this one and say, please do. If that kiddo is in a classroom that has an exposure if they're unvaccinated suddenly they have to be out for 14 days. That doesn't necessarily have to be the case if they're vaccinated and of course is their own risk mitigation. Tim's nodding. So I think we're going to go with that. Please, please get your kiddos vaccinated if they're eligible.

Tim Dellit:

This is great. I should ask Anne questions.

Anne Browning:

Good, good.

Trish Kritek:

This is definitely backwards today.

Anne Browning:

Q and A. It's kind of a hot mess, so thank you-

John Lynch:

We can go around and all get to ask her questions.

Anne Browning:

Second one, there's a parent who makes their kid wear a face shield in school and the parent is wondering if this is excessive.

Tim Dellit:

Yeah, the recommendations are the face mask, eye protection is not required. Again if a particular parent feels more comfortable having their child wear that, I certainly would not tell them that they can't do that. I probably wouldn't do that if it were my own child. I don't think it's necessary, but I also, again, wouldn't strongly argue if they really felt strongly about it.

Anne Browning:

Fair. This one, actually I think John may have just answered. Somebody was asking, should I have a bunch of home test kits around because kids are getting symptomatic with stuff all the time, not necessarily COVID, can I do a home test kit and potentially send them into school? Do you guys know do we need to do PCR tests if a kid is symptomatic?

Tim Dellit:

Yeah. A couple of comments, one, please look at your school's website because just in my perusal, every school is slightly different in terms of, some of the private schools relatively to the public schools in terms of what testing they may or may not require. And as John said, if you have a child who has symptoms, please don't send them to school. And even if you did a home test, if it were negative, we worry about that lower sensitivity that we would want to either follow that up with a PCR test while you continue to keep them out. So I think we have to be careful that we don't over rely on those home tests, especially if they're negative with symptoms. We have to go do that PCR test. Now, I don't know if a school will actually require a PCR test, for instance, towards the end or if they'll just go by the duration. But that's where you really got to look at your own local school guidance. The good thing is most of the schools I looked at, they have it easily available.

Anne Browning:

Cool. Thank you. First holiday question of the season, what do you think about Halloween and trick-or-treating? Do you think that's going to be possible this year?

Tim Dellit:

I actually think that we are more likely to be able to do it this year because of what we know and if everyone's masked. So if I had a young child and if I was masked and I'm taking my child and they have a mask on, I would feel comfortable doing that for that brief... If I'm setting out candy, I'd probably also would consider just setting it out so I'm not having to open the door to expose myself. Last year, people got really creative in how they did this. Sometimes they were lines that they would slide things down or setting it up, so I think there are ways to do it with minimizing exposure and then add on the mask. And I think that we can have Halloween. Again, it may look a little different than it did two or three years ago, but I think we can still do it.

Anne Browning:

Good. One more holiday question. Would you let an unvaccinated adult family member come over to your house for Thanksgiving?

Tim Dellit:

No.

Anne Browning:

I thought that might be a simple answer. Would you go car camping with another fully vaccinated family this weekend?

Tim Dellit:

I'm not a big camper but I'll try to answer as if I were. I'll try to funnel Trish in thinking about this. If it were another family with whom we've been having regular interactions, so kind of part of our pods, so

to speak or people that I know well, then I probably would feel comfortable doing that. If this were, let's say we just started the school year and it's a brand new family that I've never met and they wanted to go do that I probably wouldn't. So to me it depends on do I know the people and their kind of practices and behavior and is this someone that I've been in general in contact with?

Anne Browning:

Good. Thank you. One on travel. If you were flying on planes right now, would you try and do any extra prevention in terms of testing before you went or testing when you returned?

Tim Dellit:

I probably wouldn't. The recommendations for domestic travel if you've been vaccinated, so one make sure you're vaccinated if you're going to travel, but if you are vaccinated the recommendations are that you don't need testing before travel or return. Now, there are some states, I'll throw out Hawaii as an example, they've had a different approach, but for most of the rest of the United States the testing has not been required. International is a very different situation in terms of those requirements. And if you're unvaccinated and travel, then when you come back, you are supposed to get tested three to five days after and really keep yourself separated for that period of time. I think up to seven days. I'd have to go back and look at it, but I'm going to actually be traveling this weekend. I'm moving my daughter into college, which should be quite the adventure, but I'm not planning on getting tested before I go and I would get tested if I developed symptoms afterwards, or if I have a known exposure. So if I determined that I actually was exposed, then absolutely I would get tested.

Anne Browning:

Good. I've got one quick one and then one slightly nuanced one. Seahawks, folks want to go to the game. They're now requiring masks and vaccination. Would you go to a game under those circumstances?

Tim Dellit:

I still don't like the large crowds for myself. I am really glad to see though that they are going to require vaccination and masking, so I feel very positive about that and it's outside. So I think that's a great combination. I personally am still a little more hesitant about the really large crowds, but I think you could do that in a safer way now, especially with the vaccination and masking requirements.

Anne Browning:

Great. Thank you. Slightly nuanced one, as we ask you and all the ID docs these questions, folks are kind of wondering how you are responding, is it as an ID doc where you're saying I would never get on a cruise no matter what or is it kind of your own personal risk assessment level or is it kind of a little more conservative, concerned about community spread and public health? How do you think about answering?

Tim Dellit:

Yeah, I try to share my personal reflection. I really wouldn't go on a cruise. So that is my personal statement. But I think in general, because of what we're seeing and because we've been living this for so long, and I know all of us have been living this so long but we may air a little more on the conservative side just because as infectious disease and particularly infection prevention teams are the ones who are involved in all the exposure notifications, the contact tracing, and it's a big deal. And so I think that

causes us to be a little bit more conservative because we see the ramifications of these events. But in general, I think all of us have tried to answer as we personally would do it, recognizing that we tend to lean more conservative in this state... in this manner.

Anne Browning:

Good. Thank you, Tim. As always really appreciate it. Trish?

Trish Kritek:

Thanks Tim. And big take-homes. We won't have a no Halloween debacle of town hall this year. Thank you. Two, Tim doesn't like-

Tim Dellit:

John's anti Halloween not me.

Trish Kritek:

I know. It was John. Two, Tim doesn't like to rough it and three, the carnival cruise endorsement is out. So I want to say thank you to everyone. I know there were a lot of questions. I actually really want to call out that there's a bunch of questions about outpatient spaces that I will prioritize for next week and so I apologize for not getting to those. I appreciate all the questions and I ask you to keep sending them. I also want to say that I heard from people here and I want to say it myself. We appreciate all members of the community of UW Medicine. You are all really important to us. And I really do mean it when I say that I want us to keep taking care of each other. I'm going to come back to that in a second, because I want to do another shout out. And that is I shout out to our PCPs who are talking with folks about vaccination a lot.

Trish Kritek:

I shout out to our teams in the ED and in the hospitals who are taking care of more patients with COVID. And it does feel like Groundhog Day to some of those folks and I think we have to acknowledge that. And then I want to acknowledge the fact that we're part of WWAMI. And I have had conversations with colleagues in Eastern Washington and Idaho that are incredibly sobering over the last several weeks. It's not like it feels here. It feels different in those spaces and so I want to say a special thank you to all of our healthcare team members across those spaces where they're really feeling it in a different way. It is heartbreaking to hear some of the stories that you hear. So a deep felt thank you to all of those people. And a thanks to everybody who keep coming and tuning in and asking us the tough questions. I appreciate it. We all appreciate it.

Trish Kritek:

I'll say goodbye. I'll say we'll see you next week and say thank you again for taking care of our patients, their families, and really continuing to keep taking care of each other. We'll see you in a week. Bye-bye.