Trish Kritek:

Welcome back to UW Medicine Town Hall. I'm Trish Kritek, Vice Dean for Faculty Affairs. It's my pleasure to have with us today Anne Browning, our Assistant Dean for Well-Being; Keri Nasenbeny, CNO at UWMC Northwest; Santiago Neme, medical director, UWMC Northwest; John Lynch, Head of Infection Prevention and Employee Health at Harborview; Tim Dellit, our Chief Medical Officer for UW Medicine; Rick Goss, Medical Director for Harborview; and Jay Sandel, CNO at Harborview. A couple folks are away on vacation, which is great for them. We've got a good group here and lots and lots of questions to get through. So, with little further ado, I'm going to hand it over to Anne for her well-being message. Anne?

Anne Browning:

Thanks, Trish. We've gone to monthly, which means we haven't been together in a little while. A lot has happened. One of the hats I wear, I'm a Senior Fellow for Equity in Brain Health with the Atlantic Institute, which is housed at the Rhodes House in Oxford. For the first time in the pandemic, we finally had a global convening last week, which is very exciting. I flew out to London, acclimated for about 48 hours, started the convening, and, on the third morning of the convening, during our pre-meeting testing every day, I ended up coming up with positive test. So I end up shimmying off to isolation in a hotel room in Oxford, and I started Zooming into 10 to 12 hours of meetings per day from three blocks away, which was mind-numbing and hard. Overall, I was incredibly lucky. For me, having COVID was having a fairly mild cold with an annoying sore throat. So, in that sense, I was really, really, really lucky. But that first night I spent in isolation, I barely slept.

Anne Browning:

I had two goals in my mind around COVID over the last couple years, and it was, one, don't get COVID, which I managed to go about 26 months without getting. And, two, if I got COVID, do whatever I could to make sure I didn't pass it on to anyone else. I didn't sleep that night because I was so mortified that I was going to wake up, and all of my other colleagues from this convening, more and more people would test positive, and I would've been their point of contact. The next morning, nobody else tested positive. The morning after that, nobody else tested positive. For the duration of that convening, no one else tested positive. I am so grateful that I think I've managed to get through this, and, to my knowledge, I have not passed this on to anyone else. But that was not a very easy experience to go through. It was just really, really tough. It was tough for everybody else to be so worried that they might have had it and might have contracted it.

Anne Browning:

I'm lucky. I managed to come home without too much delay. I've managed through this pretty quick. Overall, my takeaway? Man, this BA.2 is tough. I was in the UK, I still masked indoors everywhere, and you know what? Somehow I got it. Vaccinated, boosted, somehow I still got it. So a takeaway I have is, man, it is not worth letting down your guard too much. We can do really minimal things to still protect ourselves and each other. I'm so glad that folks in the convening I was at, people were still masking indoors and taking precautions. It meant I didn't get anyone else sick. So, to the extent that we can, still be vigilant. This is still present and still moving about. We might not be able to keep ourselves from getting sick, but the best we can do is still try and take care of ourselves if it happens, and each other, by trying to make sure we don't pass it on. A bit of a heavy experience and a well-being message, but I'll leave it at that. Thank you, Trish.

Trish Kritek:

Anne, thank you. I'm going to thank you for two things. One is for sharing what's hard and super personal. I think it's the first of us at Town Hall who've had COVID and for you being willing to talk about it with people. So thank you for doing that. And then, secondly, thank you for not getting really sick because while you were losing sleep about getting other people sick, I was worrying about you back here. I'm so glad you're back and that you're doing okay. Maybe you have some uber immunity now. So I'm happy about that, too. I'm glad you're back and okay. Thank you again for sharing. I really appreciate it. With that story in mind, John, I'm going to start with you and have you tell us where we stand across UW Medicine and King County, because we had some questions about what's happening in the county.

John Lynch:

Yeah. Sure thing, Trish. As of this morning, UW Medicine Facilities are up to 15 patients in our hospitals with COVID-19. Four of those folks are in the ICU. 11 are in the acute care units. Valley is at three. Northwest at three. UWMC Montlake is at five, and Harborview is at four. I think Harborview is leading the way with ICU patients. We have three there. Importantly, Seattle Children's Hospital, thanks for giving those data. They continue to have about five patients pretty much every day for the last number of weeks. Fortunately, all are in acute care. No one in the ICU. But it's pretty steady throughout, for at least a few months now.

John Lynch:

When we think about the county, I'll just say those numbers in our hospitals are maybe creeping up ever so slowly. I think that's really a reflection of what's going on in the county. Public Health Seattle & King County, just looking at the dashboard yesterday, or actually this morning, we report out, it's actually increased about 36% in the last seven days. We've had about 2,700 cases in the last seven days compared to about 1,900 cases in the week before that. Just to give you a context, I think when we last talked, we were probably around 1,200 cases. So we've gone up about a hundred percent. We've basically doubled the number of cases in King County over the last just couple of weeks.

John Lynch:

After a long period of hospitalizations going down and down and down, it leveled out in the middle of the week. As of this morning, hospitalizations have actually increased. Now, it's going to sound like a big number, 52%, the percentage, but what it really is, is about 32 hospitalizations in the last seven days, versus 21 hospitalizations. Still low numbers, but a big shift, relatively. Again, fortunately, deaths continue to trend down quite steeply, 63%. About 17 people have passed away in the last two weeks, versus 46 people in the two weeks before that. When we think about those numbers, those transmission rates, again, when we last talked, we were getting right around down to around 50 cases per 100,000, which would've put us almost in what's called a moderate category. Remember those tiers that we talked about? We're right around 50-52, and we are now back up to ... I think it's 119 per 100K, which puts King county back up into the high transmission range right now.

John Lynch:

The last thing I say, because I do think it's important, and this probably is going to be part of your next question, UW Clinic of Virology and DOH are tracking the BA.2 variant, this type of Omicron. It's now the vast majority of all cases going on out there. Pretty much everyone who is getting infected now is getting infected with the BA.2 variant. The data only goes up through the end of March, but at that time, it was about 80% of all cases. You put a couple more weeks on that and how steep it was changing, it's pretty much all cases now.

Trish Kritek:

Okay. I think take-homes that I heard were numbers are still low, but as opposed to coming down, we're seeing things going up a little bit, both in terms of cases and hospitalizations, and that we think it is predominantly BA.2 that people are getting infected with. I think that was one of the questions people asked about. Do we think this is all BA.2? I think the other thing people asked is, do we think this is a reflection of not having a mask mandate anymore? Where do you think that plays into this?

John Lynch:

Yeah. I'll make one little course correction in your comments.

Trish Kritek:

Thanks.

John Lynch:

I would say transmission rates are actually pretty high. We're seeing a lot of cases out there. When we're at 110-120 per 100,000, that's actually a lot of transmission. I'll just say it's a really big underestimate, a gross underestimate, because a lot of people are getting tested only because they have symptoms, or there's some really serious exposure. A lot of people are doing home antigen tests. And, in those cases, people are not getting tested. So there's probably a lot more COVID transmission going on out there than we think.

Trish Kritek:

I appreciate that.

John Lynch:

That's one thing to take home. Lots out there. I think Anne's story is very ... I'm hearing, actually, every day. I have friends, colleagues, family members who are telling me the exact same thing. Lots more people getting infected, particularly this week. That's one part.

John Lynch:

As far as what's driving this, it's some fraction of the fact that we are engaged without masks in more public activities, that we're gathering together in more public activities. The other fraction is this BA.2, which is somewhere between 30% and 50% more transmissible than BA.1, which was way more transmissible than Delta. We have a very transmissible variant in a situation where we are close together much more often, and we're not wearing masks in the way that we did before.

Trish Kritek:

Yeah. It's a combination of those things, a much more transmissible virus, and we're not doing the stuff that we were doing earlier as we have pulled back from those things. One thing that came up as a multiple question is are we seeing people getting BA.2 after they had the earlier Omicron variant, so a second infection, both with Omicron?

John Lynch:

Yeah. It's a little hard to know that for sure. It's more of a research question because we don't know the sequence a person has when they get sick. We find that information out. The reason why some of that

sequencing data that I told you about is only up through the end of March is because it takes time to do that. It's more for public health awareness at the population level than how we think about each single person. That being said, the outside of BA.2 looks pretty much a lot like BA.1, the outside. There are a lot of differences, particularly on the inside, and some minor differences on the outside. But the outside, the part that our immune system sees, is pretty similar to BA.1. That's why it has that shared lineage, and it's called BA.1 versus BA.2. For instance, the infection-mediated immunity, if you had gotten infected with BA.1, the first Omicron, January, works against BA.2. And the vaccines work pretty similarly as well.

Trish Kritek:

Okay. It seems like the protection that we might have from having an infection or being vaccinated would apply to BA.2, but we don't know for sure. And it's hard to know on the individual basis, if people are getting infected and then infected again, what exact those were. So I think the take-home is there's a lot of it, it's more transmissible, and we're not wearing masks as much as we have been, for sure, in the past. Okay. I'm going to come back to this probably later, but I have to talk about the single-most common question that we received in the last few weeks. That is since we last came together, there was a recommendation from the CDC for certain populations to get another booster. So, really, the most common question was should I get a booster, another booster? Maybe you could reflect a little bit on that. I'm going to invite Santiago, and Tim, if you want to weigh in on this as well. It feels a little grayer than earlier times when we had this question.

John Lynch:

Yeah. I actually really look forward to hearing other people's opinions on this, anyone on this panel, to be honest, or in the Q&A. I would say that the way it's set up right now is that second booster shot for folks who are over 50 years of age is being posed as an option. It is not a requirement. It's not even a strong recommendation. It's a may. That word may is really important when you think about public health language. It's an optional booster. Now, why did it happen? I think it's a combination of things.

John Lynch:

We do have some data from groups, particularly in Israel, who have really been at the forefront of looking at vaccine effectiveness, mostly in health worker populations, but in other populations. There's some small studies. There's maybe one or two larger studies that maybe have a signal, I wouldn't say absolutely convincing, but a signal of reduced hospitalizations, particularly in older adults, for folks mostly over 65, potentially people who have other medical problems, particularly heart problems, lung problems, and things like diabetes. But I wouldn't say it's super compelling. It's really in those special, small age groups. Typically, we would look at multiple studies from around the world, looking at those same age groups.

John Lynch:

I'd say that the way the FDA looked at this is they had this signal, and these Israeli researchers, many of them have been right in the past, in retrospect, when we look at subsequent surges like Omicron. What we do know is that if you look at measures of immunity, things like antibodies, or neutralizing antibodies, particularly, they do tend to go down over time. What we know is that it's been a little while since a lot of people got that first booster.

John Lynch:

The flip side is, in those studies, we know that giving people a second booster is very, very safe. When you look at while we have these antibody data that are going down, some evidence of waning immunity, not maybe clinical, not looking at how many people get sick, how many people are in the hospital, but really look at just those numbers, and you look at how safe it is to give one, that was, I think, really drove the FDA's recommendation to do this. And then the director of the CDC signed off on it. Note it did not go through the advisory council on immunization practice. Sorry for my dog.

Trish Kritek:

That's okay.

John Lynch:

She has opinions about the booster as well.

Trish Kritek:

Evidently, she feels strongly.

John Lynch:

She feels very strongly. I think that's the part. We don't really have that ACIP sort of recommendation guidance on the second booster. I'm going to just put one little plug in here. We're kind of in this middle period where I think we have really awesome data on your base vaccinations, two mRNAs or a single J&J, and a booster. Those data are really profoundly good. We're still way behind on that at the US population. Of the people are even eligible for the first booster, only about 60% of people are boosted. So we have actually a lot more to go on getting people fully vaccinated and up to date.

John Lynch:

But for folks, I would say, my perspective, I'm in that age group who's eligible for the second booster, and I'm kind of like, "I'm lucky." Like Anne said, I'm pretty lucky. I'm healthy. I live with people who are healthy or vaccinated. I'm taking it slow, one step at a time here, thinking about what's coming up next, and I'm not necessarily rushing into that second booster. The part here that's in the middle is we may be looking at regular boosters. Think about influenza vaccination. We may be looking at variant specific, like we already do with influenza vaccination, where it changes every year. I'm going to just wait and see how things are going because I got that privilege of being fairly healthy and living with healthy people who don't have a compromised state, who aren't much older and similar. So that's my quick perspective, or maybe not so quick.

Trish Kritek:

Not so quick, but good, because I think we want the ... This is a nuanced space, and I appreciate that. I'm going to highlight what I heard, and then I'm going to invite Tim into the conversation. What I heard was we didn't do the same exact process with that committee that reviews it. But we did it based on data about antibodies waning. We don't have the same data about risk of getting hospitalized or dying from COVID for this second booster. But the feeling was there may be benefit, particularly for older folks or people with other medical problems, heart and lung disease. I heard you say, "I'm slowly walking towards getting this booster instead of running towards getting this booster, and have held off so far." How about you, Tim? What are your thoughts about it?

Tim Dellit:

Yeah. I thought John summarized it really well. The other piece that I wonder, as they were looking at this, is they were seeing pretty striking increases across Europe at the time as well. So I think some were thinking, "Well, do we want to try to mitigate potential additional increase here?" We are seeing some increase here. Hopefully, it won't be as significant as what we've seen before. I wonder if that played role. When I made my own personal decision, because I'm also just into that eligibility, and also, I think, would recognize that the data is pretty ... not quite there as strong.

Tim Dellit:

What tipped me a little bit is I also will be going to London for meetings here at the end of April. Watching what's happening over there, decided, you know what? Weighing the risk benefits. And I have a lot of confidence in the safety of these vaccines, that I went ahead and did that, and got the second booster this week, largely anticipating that I was going to be doing additional travel, and just watching what's happening in different parts of where I may be going. But I think it's an individual choice, given that data. I also fully anticipate that we'll likely see some sort of a recommendation again next fall. Whether you get boosted now versus, likely, I think many of us anticipate that we'll see some sort of an increase again next fall, if not before then.

Trish Kritek:

That's really helpful. Thank you for telling us what you did. I appreciate that. I'm going to ask two followups. People ask, "I'm also thinking about traveling overseas. Is there a right time to get the booster if you're going to get it?"

Tim Dellit:

Yeah. I mean, typically, when you get vaccinated, you need a couple of weeks before you think that you're going to have adequate response. For me, I'm going to be leaving April 30th. So this timing made sense for me, just given those anticipated plans.

Trish Kritek:

One more follow up. Did you mix and match, or did you stay with the same?

Tim Dellit:

I stayed with the same, largely just because I knew I tolerated the version of mRNA vaccine that I had gotten before. So I just stayed with that again. I'm not as convinced about that data, either, in terms of is there real value of going from one mRNA to another. Very much from a J&J to an mRNA. Absolutely. But I think, again, from one to another, again, I looked more in terms of what I knew that I tolerated well.

John Lynch:

I'll just point out there have been good studies on the mix and match. It's very safe, and, from a theoretical perspective, it's a pretty reasonable option. If people do choose to do it, totally reasonable. If people choose not to, also a very reasonable option, but safe.

Trish Kritek:

So safe. Safe. I'm going to say it again. Safe with mix and match and well-tolerated, so reasonable to do it, but also reasonable not to. I think, Tim, I heard you say you want to have two weeks before you travel. One last question, and then, Santiago, I'm going to pivot to you. But maybe, John, I'll ask you this.

There were some data that just came out that says, "Well, that boost you get from this booster doesn't last this long." You want to comment on those data? Then I'm going to pivot to Santiago.

John Lynch:

Yeah. Again, I'm not a laboratory immunologist. There's people on this call who are probably much more well-versed in this topic than I am. So I'll plead a little bit of grace here. Yes. I think this is one of the challenges. When we're starting to really make a lot of decisions based on laboratory data, without very clear clinical correlation, I worry we get into this, and we're sort of chasing our tail around, looking at neutralizing antibodies or other antibody measures as the temperature of whether a vaccine works well, or whether a booster is needed. We have to recognize there's a lot of other parts of our immune systems. They're amazing and critical for our vaccine-mediated immune responses to infection, T-cells, and other things. I think that's a part that remains fairly unmeasured when we make these discussions and make these decisions.

John Lynch:

I would say that I'm cautious about these interpretations, but I think that where I am taking some of the information and thinking about how it's going to impact our practice is that point I made. I would not be at all surprised, and I'm probably closer to, if I had to make a prediction, us moving towards some sort of annual vaccination campaign than I have in the past, based on some of those data. It makes sense immunologically, and I think it makes sense from just a process perspective.

Trish Kritek:

Okay. We've said this before. Antibodies aren't the whole story to your immune system and your immune response. It's looking more like we are going to have some kind of annual vaccine. I'd probably come back to that later because I think people are wondering about the fall. I'm going to table the fall for now. Santiago, I wanted to ask you a question about ... John was saying, "We don't have the same amount of data that we had before about boosters." Are we doing more to study the impact of another booster, or what booster, or when to do the booster?

Santiago Neme:

Yeah. Thank you. Trish. I actually talked to Doctor Anna Wall earlier today, and she told me about three studies where they're looking at healthy volunteers who have been vaccinated with one of the approved vaccines. They're looking to study the effect of the booster. The key studies are three. I'm going to put this in the chat so that people can see, and also the phone number, to be brief, because there's a lot of description. But for healthy volunteers, if you want to sign up for these studies and help the research, that would be awesome.

Trish Kritek:

Okay. So more studying going on. All right. One last question about boosters. I'm going to turn to you, Tim, for that. And then maybe I'll come back. We have a bunch of other questions, but this was by far the most common thing people asked about. I think I already know the answer, but I'm going to ask it because it was asked multiple times. Are we thinking about requiring a second booster for UW Medicine at this point in time?

Tim Dellit:

Not at this time, no.

Trish Kritek:

Okay. So this, again, I think, fits with we're trying to figure out where this fits in, and it's just somewhat individualized. I appreciate that. Actually, I lied. The other thing that people asked about was what are we going to do about giving boosters as we see vaccine clinics shutting down? Our vaccine clinics. I think that's specific focus people were thinking about is at Harborview. If the vaccine clinic closes there, how are we going to get boosters to our special populations and our staff?

Tim Dellit:

I don't know if someone from Harborview wants to answer that.

John Lynch:

Yeah. Sure.

Tim Dellit:

I would make one general comment, though. With our vaccine clinics, we've flexed in terms of what the need is going on at that time, in terms of if we see there's a push to vaccinate a large number, we'll expand. And then we may contract when there are periods of time when there are not that same need. It doesn't mean it's not available, but we have to be able to be flexible as we have throughout this pandemic. Sorry, John. Go ahead.

John Lynch:

No, I was just going to say, just think about it just like influenza vaccination. I think what we're increasingly thinking about is how do we think about COVID vaccination like we think about influenza vaccination, or other vaccines that need to be repeated over time? I think the employee health teams are working on how to make that part of our normal process.

Trish Kritek:

Okay. It's the time for boosters. We rev up. And then it's the time that we're not doing boosters, and we'll pivot down. Appreciate that. Tim, the other thing that people asked about relevant to what John was saying before is we're seeing numbers go up in King County, and John said, "We actually have high rates of infection right now." Are we thinking about changing any of our guidance across UW Medicine in terms of masking or physical distancing or any of those things right now, based on those numbers?

Tim Dellit:

Yeah. Again, I'll make sure that John corrects me. I think this is something that we're continuing to monitor very closely, both within our infection prevention teams within UW medicine, but across the university as well. Right now, we aren't making a change, but I think we have to continue to monitor the situation. We've always said that we have to be prepared, that we may have to, at some time, re-implement certain measures. But John, what are the discussions within Med Tech right now?

John Lynch:

I was doing the Q&A so I missed the question. I'm sorry.

Tim Dellit:

The question is whether we would go back in terms of some of our measures, particularly around masking, given some increase in the rate of transmission.

John Lynch:

Yep. Just think about it like a toolbox. We've talked about this the whole time. All of these pieces, respirators masks, distancing, are all parts, are all tools in the toolbox, and we may need to pull out some extra tools. The construction's a little bit more concerning or more challenging, and we would use those things. We've learned a lot over the last two years, each of us individually, and how to incorporate those tools, how we incorporate into our work flows and so forth. We would very quickly move to use any of them, should we need to keep the environment safe.

Trish Kritek:

I think it's the same message that we're hearing. We'll pivot it up and down as things change and become part of our culture. I also want to note that was the first time that somebody else summarized my question for me. Thank you, Tim. That was really affirming, and I very much appreciate it. Okay. I'm going to shift gears entirely for a little bit. We'll come back to more questions about COVID because there was another thread that came through about something totally different. Keri, I'm going to start with you on this. There was a verdict in the last couple of weeks ... I think it was maybe two weeks ago now ... about a nurse in Tennessee who was convicted after having made a medication error where a patient died. I think it's been very challenging to our community to see this happen. What, really, people asked was can our chief nursing officers comment on the impact of this verdict and what that means for us? So I'll ask you to weigh into that for a second.

Keri Nasenbeny:

Yeah. I would welcome Jay to weigh in here as well.

Trish Kritek:

Yeah. Jay's up next.

Keri Nasenbeny:

I can say here at Northwest that this verdict reverberated through the community. I had a lot of people reach out to me, distressed or stressed by it, and concerned by it and asking, "Are we going to be doing anything differently? How does this impact us?" I guess what I'd say is, first of all, I share that distress. I think for all of us in the nursing community, and I would offer healthcare community, this was a really distressing verdict. Just the fact that it went to trial, I think, was really distressing. I think we all support ... There are people out there who do bad things intentionally. That's a whole other bucket of ... That's entirely different, somebody who intentionally harms a patient. I think in that space though, of errors, all of us have made an error. If you haven't, you probably just don't know it. I certainly made mistakes when I was at the bedside. I can think of two medication errors that I made.

Keri Nasenbeny:

I think we all, despite doing our best, have made mistakes. And that's likely because of the systems issues at play. So what I have reaffirmed in my messaging out to our teams, and UW Medicine did a really good job, is that we're committed to just culture. We are committed to really focusing on those systems issues that play into these errors. It's not to say that in just culture, there isn't an accountability piece of it, because there is. But our first commitment is to our teams, to fostering psychological safety,

fostering transparency. I think now more than ever, with everything that our teams have been through, we really want to reaffirm that approach, and reaffirm our commitment to psychological safety, and to supporting our teams, and approaching errors from a just culture approach. So Jay, I would welcome you, but I think we all share that distress. So I've tried to message out to our teams, as broadly as we can, that message.

Trish Kritek:

Jay?

Jay Sandel:

Yeah. I think you said that great, Keri. I think it is something that has been brought forward here at Harborview as well. A lot of nurses and other ancillary staff are interested in it. Been trying to send out a lot of messaging for myself out to staff members, as well as talking to people when I'm making rounds throughout the units. I just pulled a team together to really put together some really good messaging in all of the ways that we message out. We're looking at our Rising Tide, which is our newsletter here for nursing, to really inform people of the structures that we have in place here, that will allow a just culture, as well as keep our patients, as well as our staff, safe on the things that we do here. So really just using every platform that I can to discuss this at every level of staff in here.

Trish Kritek:

I appreciate the messages from both of you. I think it's really important. I also appreciated the message to the whole community. It feels so contrary to like, to err is human, and the part where we started to say, "It's okay to talk about these things because that's how we get better." So I really appreciate both of you. I'll just add, I think it has deeply impacted our nursing community, but it's impossible, as any member of the healthcare team, not to be sobered by these events and that. I think doctors are in a different place, but it sure felt like it to me, like a sobering, sobering thing that feels unprecedented. I'll stay with the two of you and stick with support. I had an interesting question that came in from somebody about how are we supporting our managers? I think they were broad in the word manager, not just our nurse managers, but our managers across our healthcare teams. Keri, since you're unmuted, I'll ask you. What are you or we doing to support managers?

Keri Nasenbeny:

Yeah, I think this is a really important question. Our managers are super important, I think, in so many ways for our teams and leading our teams. They have had a really tough role through this pandemic, like all of our staff have. They're not exempt from that. They've carried. I think, often, what they do is they shoulder a lot out of the burden of our staff. They're there to absorb that pain. Sometimes I think what's really hard is they can't fix it. I think they are used to being able to fix things, and they have not been able to fix it.

Keri Nasenbeny:

I think we're doing a lot of the same things that we're doing for our staff. There's the Got Burnout sessions. There's things like shorts rounds. I emailed Sherry and Marie. They gave me a bunch of different things. There's All the Care for You. There's the peer support. There's those types of things. In addition, though, we are also coming to them and coming to their meetings and offering time to debrief, and talk about what their needs are, doing check-ins, purposeful check-ins, with them, whether that's with their leadership team or just them alone.

Keri Nasenbeny:

And then, I think, lastly, we're really looking at flexibility, and how do we incorporate more flexibility into their schedule? So things like nine nines or four tens, because time away is super important, as well as our managers get plagued with ... not plagued, but part of what they do is, also, they support the team 24/7. One manager said to me really poignantly, "When I get called Saturday morning because we don't have staffing, the rest of that day, I'm worried about my unit," which is absolutely true. So I think, "How do we create a structure that offloads them on the weekends so that they can have some time away and really get some rest and rejuvenation?" Really important question. I think this is top of mind for all of us. I'm sure, Jay, you're doing some amazing things at Harborview, and I'm sure I've forgotten some things. So I'd love to hear that as well.

Jay Sandel:

Yeah. I think flexibility is huge for the management group right now. They do carry a lot of the burden of their units 24 hours a day, even on the weekends. Because they're so great at what they do, their staff feels comfortable in reaching out to them and really asking them questions and engaging them when they need time to get away and try to gain some resiliency themselves. One of the creative things we are trying to institute here at Harborview is where, much like we have an AOC on call who takes all of the calls that are happening throughout the hospital, we're trying to do that for our management group as well.

Jay Sandel:

When our managers are away, there could maybe just be one person that's a touchpoint for all the management concerns that may come through, to really relieve those other guys of having to feel the need to be on call for their units. That's one creative thing we're doing. Also, just listening. I try to take a lot of the burden off the managers. If I start hearing some of those things that are keywords or phrases that they're using, I listen very well and just really try to take them to the side to take care of them, because I know that they have gone through mighty trials through the pandemic as well.

Trish Kritek:

I appreciate both of you. The care of the folks who are caring for others has been something that's been really important and hard through this pandemic. I heard using the structural supports that we have, creating spaces for people to talk, as well as listen to them, and then some structural stuff, increasing flexibility and ways to offload. I appreciate all of that. I appreciate all the work that you're doing on that. Thank you for sharing and for doing that support of managers. I mean, I think, also, always looking for ideas and how to do more, I know that's true for both of you. So if other people have ideas, we welcome them. Okay.

Trish Kritek:

I'm going to pivot to you, Santiago. I'm going to have you maybe wear your ID doctor hat for these questions to start with. One of the things that came up in, actually, multiple questions was how much protection is wearing a mask when everyone around you is no longer masked? Let me just start with that. What do you think about that as we go about? And now, I'll just say, when I go to the grocery store, most people are masked, but there are more places where there are fewer people masked. How much protection am I getting when I wear my mask?

Santiago Neme:

You're less protected if the people around you are not masked, but you can still have a decent amount of protection, especially if you're wearing something like a KN95 with several layers that's fitting snugly. You have less protection when people around you are not masked. But you can still be protected by wearing a mask of three or more layers that fits tightly and is comfortable, and you wear all the time as part of your normal routine.

Trish Kritek:

Okay. So less protected, but it's not futile to wear your mask.

Santiago Neme:

It's not, no.

Trish Kritek:

So still wear your mask because there's protection with it. The other thing that-

Santiago Neme:

Can I add something?

Trish Kritek:

Yeah.

Santiago Neme:

Typically, the better the mask I wear, the more the mask basically prevents me from getting other people sick. But the mask itself is a membrane that's protecting me, and depending on the quality, might protect others if I have COVID right.

Trish Kritek:

Okay. The quality of it helps for me getting other people sick, like Anne was talking about she was wearing about. But wearing a mask, in general, is protecting me from getting COVID. So thank you for that.

Santiago Neme:

Exactly.

Trish Kritek:

The other thing that came up was this question of what counts as a close contact now? If we're in this era of this more transmissible virus, how do we define close contact?

Santiago Neme:

Yeah. The CDC hasn't really changed the definition. You still see that the close contact is having contact less than six feet of distance with another individual for at least 15 minutes in the course of 24 hours, 48 hours before the individual became symptomatic or tested positive. Now, that being said, that's when the window starts. That being said, we've learned so much about COVID and these new variants. It is a highly airborne virus. Therefore, I would say I don't put as much emphasis on the distance. I put more

emphasis on being indoors and the prolonged time that I'm spending indoors. That's the key part for me.

Trish Kritek:

So the formal definition hasn't changed, but you think it makes sense to say, "Well, that six feet maybe isn't as protective as one might think." Being indoors is really a risk, and then the time that you're indoors with folks.

Santiago Neme:

It helps some, but it's not key, I think, because we've seen all the outbreaks of people not being really together, really close, and they still got the whole room infected, exposed.

Trish Kritek:

Yeah. I think people are just picking this up and worrying more. I think a little more worry is appropriate. I'm in a little bit of a potpourri of questions phase, so excuse me for jumping around. But I had two questions about long COVID. The first one is, can people present with long COVID weeks or even months after their infection? Or is it usually something that happens just after you've been infected, and you stay not feeling well?

Santiago Neme:

Yeah. With COVID, we have two types of syndromes. We have the acute COVID that tends to last until it's been four weeks, so from the onset and four weeks. And then long COVID is anything beyond that, that develops during COVID or after COVID. I would say, in most cases, the symptoms are present and persist rather than having something new. However, some of the things that we're seeing in long COVID are things like arrhythmias or having more cardiovascular issues, or maybe something that's psychological or in the nervous system, that may not be evident, and it might present a bit later.

Santiago Neme:

I do want to remind folks that we have an excellent post-COVID clinic at UW Medicine that is outstanding. Also, remember that we also need to ... The diagnosis is really about excluding other alternative causes because I might think it's COVID, but it might not be COVID after two months. So it's important to rule those out and work with your doctor, and potentially this clinic, to try to get to the bottom of what is really going on.

Trish Kritek:

Okay. What I heard was, usually, it's right after, or prolonged symptoms. But we do see some more distant, and if they're more distant, we want to have a higher threshold to say, "Are we sure it's not something else other than long COVID?"

Santiago Neme:

Right.

Trish Kritek:

I'm wondering if we could put the information about Janna Friedly's clinic or the resources towards what we have for long COVID in the chat, you or somebody, because ... Thanks, Anne. That'd be great. People ask about that. Okay. One last-

Santiago Neme:

One plug. If you really want to avoid long COVID, get vaccinated, get boosted, because that cuts your risk significantly, more than 50%.

Trish Kritek:

Okay. Boosting helps decrease the risk of long COVID.

Santiago Neme:

Yes.

Trish Kritek:

One last thing about side effects of vaccines, actually, not long COVID, was I've had this question before, and it came up again, this question about tinnitus, or ringing in the ears, with mRNA vaccines. Has there been more information about that?

Santiago Neme:

Yeah, there been a recent review where they found that the incidence is extremely low and extremely rare. I would say it's less than one percent. But it's there. It's something that we've been hearing people have, and it's well-documented. So it happens. But, typically, it's transient, and it gets better. If it's not transient, I would have a visit with ENT, because sometimes a short steroid taper might help.

Trish Kritek:

Oh. Okay. So it is a real thing, not super common, and usually gets better on its own. But, if not, then see one of our ear, nose, and throat doctors, or potentially have a course of steroids. Okay. That's super helpful. Thank you. Rick, I've left you silent for a really long time. I apologize. I'm wondering, there were some questions about what's going on with our census and what's happening with borders. Where do we stand right now? You can speak to Harborview. If you know about UWMC, that's great, but maybe to Harborview.

Rick Goss:

Sure. Well, thanks, Trish, and good afternoon, everyone. Sure. I know census is running high everywhere. I'll speak to Harborview just because it, I think, illustrates a lot going on in our community. And then what are some things we're really working on very specifically? By way of numbers, we have really been seeing this high 400s, today, 499. We have this sense that this threshold of 500 is really almost a tipping point to where we go higher. If we get higher and higher, we really see the entire organization truly pushed to its limits, to be able to manage patients in the best geographic areas and with the staffing. The 470s, we're pretty used to running our hospital at that level. So the high 400s, it's a stress, and it has really been that way now for a couple, three weeks. You really feel it when you're on rounds like today. Nursing teams, the medical teams, all really sense. There's that exhaustion that accompanies such a sustained high census.

Rick Goss:

One area that I've learned about recently is that of dialysis. I've learned that in the greater community, the dialysis needs are up about 40% than they were even a year ago. That's a tremendous increase in the number of patients that need dialysis on a regular basis. Our dialysis services are really working to create the staffing. Here at Harborview, just over the last couple years, I'm aware the number of monthly dialysis runs have gone from about 400 now to 600. That's an indicator of just the increased need and demand for inpatient care for acute care services. We asked ourselves, "What explains that?" I think the best that I can think of is that we know there's been delayed care over the couple years. Perhaps risk factors have increased because some of that delayed care. Clearly, the discharge options are under stress, staffing in our skilled facilities. All of that together is putting the census, which has been there throughout the pandemic, but now that we can focus on other things, we're really putting, again, a renewed focus on that very question.

Rick Goss:

Just a couple things here at Harborview. Jay's very involved with this. We're organizing our medical leadership, nursing leadership, our care management teams, and taking ... What I'm really looking at is a novel approach to the way we really ask the questions. What can we be doing to help patients move through? Just picture this, that we're really going, in a sense, patient by patient. Well, how do you do that at the whole hospital level? Basically, you just take one service, one team at a time, and you go to that team, and you just talk about every case.

Rick Goss:

You learn about who's really sick. You learn about who absolutely doesn't need to be here, and we can help with that. But you also learn about who's in that more transitional phase. What are some of the barriers? Is it deconditioning? Is it swallowing? Is it pain management? Those are maybe areas that we can work on medically to help. But it's also listening and supporting and just knowing we are all in it together. I think there's something energizing about that. At the same time, we also feel the exhaustion that people feel. So, Trish, that's an overview of how it feels to be working in such a high census situation.

Trish Kritek:

I appreciate the nuances of that. And, Rick, I appreciate the ... We're learning new reasons why we're still at this really high level. That's really straining us, whether it's all these increased patients in dialysis, or walking through it patient by patient to say, "Where are there opportunities? What do we need to learn about where this stands right now?" Jay, I don't know if you wanted to add something to that, or not.

Jay Sandel:

I don't have anything, necessarily, to add that Doctor Goss said. But it is very challenging. We do our thing every day to make our patients feel safe and at home. It is a challenge, but we are surviving for the moment.

Trish Kritek:

Yeah, I hear it. I don't want to minimize it because I think it is the fact that it's been day after day after day is what comes through in the questions. I appreciate the efforts that both of you and all of the

leadership team are doing to try to mitigate it. Thank you. John, I'm going to pivot to you for a couple quick ones before I hand off to Anne. The first one is any updates on vaccines for kids under five?

John Lynch:

Not a lot to report out. I know, at the end of March, I believe Merck submitted ... I wrote it down here ... did submit a ... Well, they said they're going to plan to submit an application to the FDA for under six-year-old kids. It's a lower dose, multiple doses, for kids. They said they were going to do it in the next few weeks. I have not heard any updates since then. I know the Pfizer trial's still ongoing.

Trish Kritek:

Okay. Pfizer's still going. Merck may be getting close to putting something in. So more to come in the future.

John Lynch:

Yep.

Trish Kritek:

Do you have guidance for folks who have kids in that age range, because I think they're feeling like, "Should we stay in our bubble because our kids still can't be vaccinated?" Or "Should we voyage out? It's been a long time." It's a really hard space.

John Lynch:

Yeah. I don't really have good news for those families. I'm sorry about that. I think someone recently gave me some ... It feels like I get bad news a lot. When we look at those case rates right now, they're going up pretty fast. Pretty transmissible. We know the first surge of the Omicron put a lot of kids in the hospital, a lot more than any other time we've had in our time here. So what I would say is, yes, these types of birthday parties, I think in the QA, and a pool party, if we can aim towards outdoors, maybe even incorporating things like testing, antigen testing and similar, into those. I think that there are ways to get our youth together in fairly safe ways. But we're not going to take the risk to zero if we get close together. It feels like we're stuck. We're actually moving backwards for these little ones. I think that we just got to use those tools that we talked about to the best effect, and try to get them together as much as we can in a safe way.

Trish Kritek:

Yeah. I appreciate that. I appreciate that it's a hard question. I think it's hard for-

John Lynch:

It's hard.

Trish Kritek:

... those parents. I think acknowledging that is part of it, but also, these kind of ... Be outdoors if possible. Try to mitigate the risk, but acknowledge that there's risk, for sure. I don't know that there's anything unique about this, but there was a question about masking requirements in clinical labs. Is it just surgical masks like we do in our other spaces in our clinical labs?

John Lynch:

Yep. Yep. It's just in our clinical labs, we want to be following the same thing. Think about the bedside person. Everywhere in those clinical footprints, that's where we want to continue to wear masking. The reason we kept things in place was because we saw what was coming down the road with those transmission rates and just trying to keep our facilities, like Jay said ... I loved how he put it, safe ... I don't know what you said. Safe and homey. Safe and comfortable. We want everyone to feel safe and comfortable at our hospitals and clinics.

Trish Kritek:

I do like the thought of safe and homey. That's an interesting-

John Lynch:

I forgot what he said, but it felt very positive.

Trish Kritek:

That felt nurturing. I think that's true. Thank you, Jay, for those words. Okay. I know there were a bunch of Ask an ID Doc questions, so I'm going to hand off to Anne. I think today she's talking with Santiago, so Anne and Santiago.

Anne Browning:

Yeah. First, I'll say ... I should've mentioned this earlier. Out of all my close buddies, Trish wakes up the first each morning. So, for the whole time I was in Oxford, I would always get a Trish text crazy early Seattle time, checking in on me and asking how I was doing. So thank you for that. It was really nice that you reached out. I really appreciated that, and I appreciate you broadly. So BA.2, not awesome. I got a be-more-conservative kick in the shins last week. So now I get to ask Santiago a couple questions around how are you feeling, given where we're at right now? A question that came in, a person who has a large memorial gathering to go to, it's at a restaurant. There'll be people eating and drinking. Would you go to a restaurant indoor gathering right now?

Santiago Neme:

Oh, it's a tough one. It just depends, in terms of what is the risk benefit for me? How much do I think I want to be part of that? If I really want to be part of that, I would probably be masked, and I would probably just try to be close to the door and minimize my risk through the measures that John just described. I probably would not miss it, but I would be well-equipped. We have our gear. I would probably test before going. I've actually been testing before traveling myself anywhere, or meeting with a couple friends, even. I'll just test before the event.

Anne Browning:

How are you feeling right now about restaurants in general? Would you go out to eat these days?

Santiago Neme:

I feel like we've only gone out indoors when we had no choice, and that tends to happen when we travel. There's been literally three episodes where we ended up inside a restaurant. It didn't feel great. But in Seattle, we have options. So I haven't in Seattle, to be frank.

Anne Browning:

A question came in. Would you have lunch with an unvaccinated friend?

Santiago Neme:

I think it's doable. I mean, I happen to have no unvaccinated friends, to be completely fair. We live in Seattle, so it's ... But I would say I think it's doable. I think you can do it outside. Definitely not inside. Again, it's just I think I value friendships that have the same principles, protecting the community and things like that. So I don't find myself in that situation as much.

Anne Browning:

Sure. A couple questions that came in around travel. Would you go to a national conference right now?

Santiago Neme:

I'm seeing a lot of people going to national conferences. They seem to be having a good time. It's really important for them. I typically just go to one national conference a year. It happens to be later in the year, close to November, and I haven't obviously gone. But, again, I think it just has to do, as John many times has said, it's just a risk assessment on the situation. How much do you need this? Are you going to end up at a big buffet with multiple people, all that? That wouldn't be my cup of tea, to be honest. It would be maybe grabbing a drink with someone, with one or two people that I really like and missed, et cetera, as opposed to the big party celebration. But, again, I don't want to judge people because I think that, in the right setting, if I really wanted to do it, I would do it. I would just be more prepared and probably not unmasked throughout the time. I mean, I'm at that place now.

Anne Browning:

I know several of us have traveled abroad or have plans to. How are you feeling about travel abroad this summer? Would you plan for any?

Santiago Neme:

I'm actually traveling abroad. I have a couple trips. They're short. They're to see a few friends that I haven't seen in a long time. It's really important for me to do this, so I'm going to do it. It's basically four days in Switzerland, and there's five of us that we're going to be meeting. I think I'm willing to take that risk. Again, I'm not concerned about the flight. I'm not concerned about my friends who are all going to be testing. It really depends on what you do there.

Santiago Neme:

I don't think it's time to go to Disneyland or Disney World right now. But it might be if it's outside and your kids really want it. It's a question of ... I'm sorry. I'm wishy washy on these things because I really think that it has to do on how much you want this, and are you comfortable with the risk of potentially being stuck in Switzerland or the UK or whatever country, because that's always a possibility. So I've been traveling with my laptop in my bag, just in case.

Anne Browning:

Yeah. John hit on a couple of the questions we had about kids. So I think probably-

Santiago Neme:

Thank God.

Anne Browning:

... good on that front. So I'll spare you. I know how much you love me asking you questions about kids. There were a couple that came in around dating. Do you think folks can start dating again? And then the big question somebody asked was, would you date an unvaccinated person? I think I can predict your answer there.

Santiago Neme:

Dating ... I think we have to continue to live our lives. I think there is a way to have a date outside, especially now the weather is getting really nice. I think it's really important to meet with other people. We're talking about one person. You want to be extra sure. You can test before you have the date. You can be outside. You get to know the person. Now you become part of their bubble. I think, for me, it would be a green light. If I really want to do it, I would go for it, again, taking the precautions that I know to take.

Santiago Neme:

Dating an unvaccinated person, I would say that, as an ID doc, it would be very strange for me to end up with someone who doesn't value vaccines. But we have family members who haven't been vaccinated, who fear vaccines, who have bought into the propaganda around vaccines are bad, and it's a political issue. I don't know that I would be dating that person, but we have situations that I've encountered where you have unvaccinated folks in your environment. They're still your family, et cetera. So I think we need to gain some flexibility in that, but obviously, understand that there's a higher risk from hanging out with that person.

Anne Browning:

Santiago, thank you very much for being on the hot seat yet again. Much appreciated.

Santiago Neme:

Thank you.

Anne Browning:

Trish?

Trish Kritek:

Thanks for always answering the dating questions. I'm pretty sure everybody else is very excited that you answer all the dating questions.

Santiago Neme:

I'm married. I'm married.

Trish Kritek:

I know. I know. I just want to acknowledge that you always get those. Anyway, I want to thank everybody, thank all the panel. There was a lot of disclosure today, which I think was intentional. I think it's a time when we're all trying to talk about how we're navigating this. I will disclose a couple things as

well. I did get a booster. I got it just the other day. I mix and matched. Like John and Tim, who were both like, "We're in that age group," I'm in that age group where I should consider getting a booster, too. And I did. That's partly because I am standing with a background that is not my usual background, because I'm at a national meeting right now. I'm in Tennessee. I'm in Nashville. For all you know, I'm wearing cowboy boots right now. I won't tell you one way or the other.

Trish Kritek:

I came here to the Society of Hospital Medicine to run a course that I was supposed to run two years ago, in 2019, and was canceled. It's a full-day course on critical care for hospitalists. I just want to say that this experience has made me exceedingly grateful. First of all, I heard a lot of stories, over a hundred hospitalists in this room. It was great to teach in person. I wore a mask. But they were intensivists for the last two years in a way that they never anticipated being intensivists. They did it with a ton less resources than we had at UW Medicine. It made me so grateful for the community that we're in and how we got through the pandemic when I heard the stories of the folks who I was teaching critical care to, but they had a crash course in critical care for the last two years.

Trish Kritek:

The second thing is it's super cool to be in another part of the country. There's hot chicken and cowboy boots and country music. There's almost no masks here. It is sobering and different to be in this space. I just want to say, I know we've been talking about how we're less masked in Seattle. It still feels palpably different. I'm exceedingly grateful for the community that I live in and all the people around me that have really prioritized taking care of each other.

Trish Kritek:

As we go into this next phase, and I don't know what it will be, and we've heard that there's some things that make us a little bit more concerned. I just want to stay the same thing that I've said for a long time. A big thank you to all the people on the screen, all of you who are out there in our community, for continuing to take care of our patients and their families. But, really, what I've felt so much is how we've taken care of each other. So please keep doing that. Let's all keep taking care of each other. As Anne said, we're going to be on a monthly strategy unless things change, in which case, we'll come back sooner. We'll see you back at Town Hall in about three to four weeks. Take care. Bye bye.