

## February 9, 2022, Briefing Transcript

Dr. Podolsky:

Good morning. I'm Dr. Daniel Podolsky, President of UT Southwestern Medical Center, and I welcome all of those who are joining me this morning for this campus briefing. I do hope all of you fared well in the winter storm last week, which thankfully was less severe than our experience last February, but I know still a challenge for so many. And I want to thank those of you who through personal sacrifice still were here to help our patients and support the overall institution, and realizing that that was at, for many of you, the cost of personal sacrifice, sleeping overnight in the hospital or at a hotel near the campus to ensure the campus and hospital continue to run so smoothly.

So thanks for all that each of you have done to ensure the work of our mission continues despite the challenging weather. And so then let me turn to an update on where we are in meeting the challenges now of the pandemic. I did have the opportunity to review the latest update from our multidisciplinary modeling group earlier this morning, and those will be posted later today for everyone to be able to review themselves. But I am pleased to say that all of the trends are certainly encouraging. As we look across the campus today, the census of patients, both at Clements University Hospital, Parkland, and Children's have declined significantly by more than 50% since my last briefing two weeks ago at Clements, and almost 70% at Parkland Hospital.

This is mirrored in the overall decline of census of patients hospitalized for COVID in the region more generally. And along with that, we see that the positivity rates are falling now approximately 10%. That's well off the 25 to 30%, but I do note is still significantly elevated relative to where we were prior to the Omicron-fueled surge. In the analysis of the modeling group, it was reassuring to see that the  $R_t$  in Dallas and Tarrant County is now well below 1.

And as we've all come to learn over the course of time, when an  $R_t$  is below 1, it means the number of people who are being newly infected is actually diminishing, and so we're at the declining slope of this surge clearly. And as I said, the update suggests that we will continue to see steady and really well-paced further declines in hospitalizations and newly acquired instances of COVID infection. That experience has also reflected in our own campus experience. So for the first time since the Omicron surge began, in these past five or six days we've not had any instances of on-campus transmission.

And also the number of colleagues who have needed to sit it out under quarantine or isolation is down more than 90% from its peak some number of weeks ago. So with all of that, it's a foundation for our EOC to have considered where do we go from here when they met yesterday? And I'm pleased this morning to share with you plans to move later in this month to restoration of near or essentially normal operations in many respects. Projecting the pace of the current declines, we aim to restore these many operations, which I'm going to summarize now very briefly beginning Feb. 21 with a couple of exceptions that I will note.

And beginning on Feb. 21, we will lift the limit on the number of people who may attend an in-person event on campus. So meetings and gatherings are permitted to be as large as the space will reasonably

allow with, again, encouraging that safe distancing be maintained and masks continue to be worn indoors irrespective of vaccination status of those attending. Also, on the 21st with those meetings, we are lifting our ban on food and drink for in-person meetings. I do ask you to follow the usual departmental procedures for approval of meetings, and that will be one of the ways in which we're going to return our campus to normal operations on the 21st.

Also, we are no longer going to restrict visitors to campus, including vendors to only those who are mission-critical, but rather those who would come to campus and the normal course of events of the work that goes on the campus. One change that we will make ahead of that Feb. 21 will be in our clinical operations and specifically in our hospital. Beginning this week, we will lift the restrictions limiting the number of visitors to two per patient at a time and go back to normal visiting guidelines.

Other changes that will be tagged to the Feb. 21 deadline, our shuttle occupancy; we will lift the requirement that shuttle occupancy is limit to only one person per bench. And finally, another exception to the Feb. 21 for our students, we are approving them to resume their in-person classes beginning Feb. 14. We know that the necessity of going to remote learning has had an impact; we learned that in the first year of the surge on all of our learners. And so with that under consideration, we will get a jump-start on that Feb. 21 by resuming in-person classes as I mentioned on Feb. 14.

I want to once more encourage everybody vaccinated or unvaccinated to wear a mask in any circumstance, other than being alone in an office or in a room. And finally, I want to extend my sincere thanks to all of you for enduring with patience and commitment to our mission of meeting all the challenges that we've once again faced in these last several weeks in the latest Omicron surge. So with that, I'm going to turn to other UT Southwestern community matters. I'll begin with one that I know has been on many people's minds – I'll begin by reminding all of us that before we had the specter of Omicron, we were moving toward the implementation of our future normal, the implementation of a flex work here on the campus, as I say, anticipated to have begun shortly after New Year's.

But as we all appreciated, it was entirely appropriate that we put those plans on hold to meet the surge in front of us. But as we now are seeing that surge declining, and hopefully soon in the rearview mirror, we do want to now once again lay the groundwork for proceeding to implement our flex work opportunities. After a lot of discussion with the Executive Vice Presidents, it's been our decision to aim for that in the first Monday of April, that's April 4. We're aiming for that. And so in that, it gives several weeks now for everyone to work through again those plans, and also out of consideration for those who may need to make arrangements for child care that would change by virtue of the implementation of flex work.

So more to follow. You will be hearing about that from managers over the weeks ahead, but that's certainly an important step toward a future new normal for UT Southwestern. Incorporating some of what we've learned can be accomplished through remote work, which was necessitated by the pandemic and at the same time, the true value of also being able to work together here on the campus. So, an important new threshold for UT Southwestern.

I want to remind you that we will be undertaking once again, the Values in Practice survey. That's the VIP survey, which is intended to really learn from you, all of our nonfaculty employees, your experience as someone who works at UT Southwestern. This engagement survey launches next Tuesday, Feb. 15,

and will remain open through Sunday, Feb. 27. And I really do hope that everybody will give us the benefit of your perspectives and your input. I would note that once again, this survey will be administered by a third-party vendor, GLINT. And this third-party vendor ensures that there is anonymity during the process so we hope you'll feel comfortable in really providing your candid feedback.

I can tell you that I personally, and I know the Executive Vice Presidents and other leaders here at University do place a lot of importance on what we learned through those surveys and use that to guide some of the expectations we set for our managers to do everything we can to make UT Southwestern as a good environment to work, for everybody to be fulfilled, and to maximally achieve our mission. So please answer honestly based on your personal experience. And if you're looking for more information ahead of that, you can email the Organizational Development and Training, or ODT team, at [EmployeeEngagement@utsouthwestern.edu](mailto:EmployeeEngagement@utsouthwestern.edu).

The last thing I'll mention before going on to speak to the questions that you've sent since the last briefing, is to let you know that planning has now really gone into high gear for the state psychiatric hospital, which will be constructed here on our campus. For those who may not recall, or were not aware the State Legislature last year appropriated funds initially for planning, but then for the full construction of the first state psychiatric hospital here in the Dallas-Fort Worth/North Texas area.

I don't think anybody can doubt how great the need is for access to psychiatric care, mental health services, behavioral health services in our community. And I am proud that UT Southwestern is going to step in as a partner with the state, and that is the Health and Human Services Commission, to take responsibility for the planning, oversight of construction, and the operations of the state psychiatric hospital. I want to thank the scores of people who have agreed to be part of that planning process. We are looking for your input just as we will also be soliciting extensive input from community stakeholders to be sure that this is psychiatric hospital really best meets the needs of our broad community for behavioral health services. And so I look forward to providing you updates as that project progresses.

I want to give a special thanks to Dr. Hicham Ibrahim and Ms. Becky McCulley, who are spearheading the planning process and oversight of that project. And so with that, I'm going to conclude my update and turn to Jenny Doren, who's going to pose the questions that you've forwarded since our last briefing.

Jenny Doren:

Well, good morning, Dr. Podolsky. There has been a lot of chatter about a new version of the Omicron variant, what some are calling a 'stealth variant.' What do we know about it?

Dr. Podolsky:

Well, this subvariant called BA.2 was first detected in other parts of the world where Omicron first appeared, but was first identified in North Texas by our own UT Southwestern sequencing team studying samples taken in early January. The variant was first detected in December in India and South Africa and has emerged in several European countries, most notably Denmark during its Omicron wave, which hit before ours here in North Texas. Two aspects of this particular subvariant have grabbed the attention of scientists first, and although commercial PCR tests can detect the BA.2 subvariant, it is more

difficult to distinguish from Delta or other variants by standard PCR testing than the original BA.1 subvariant.

This has led for it to be referred as, the questioner notes, as a stealth variant. Although this is a bit of a misnomer because the PCR can still detect it as COVID-19. However, it is a fact that it does require more advanced PCR or sequencing to distinguish it from other variants. Another reason why it grabbed attention is that in certain countries, this subvariant appears to be growing in prevalence faster than the original Omicron, BA.1 subvariant. That's true, for example, in both Denmark and in South Africa.

This has naturally raised a question of whether it was more transmissible or contagious, and really there's no firm evidence to that, but it may well be – at least studies in Denmark suggests it could be as much as 33% more contagious than the original subvariant of Omicron. The good news, and I say good in the relative sense, is though that it does not appear to be associated with more severe disease than BA.1, and the same treatments and prevention measures such as masks and vaccines will work, it appears equally against this new subvariant.

So far, the subvariant has been detected only at very low rates here in North Texas, but we are continuing to closely monitor case counts. And of course, as our sequencing team continues to sequence positive samples received at UT Southwestern and at some of our partners so that we are clearly monitoring closely for how much this BA.2 intrudes on North Texas. Let me just add one thing; right now with that understanding, which is incomplete, our best expectation or our best understanding of what impact it may have – given that it does not appear to cause more severe disease or evade our treatments – is that it may slow the rate of decline of the Omicron variant, and that's what we expect will be the overall impact. Jenny, your next question.

Jenny Doren:

Yeah, we received a number of questions about children. What are some of the impacts of Omicron on children? There have been reports suggesting increased hospitalizations. Is that true?

Dr. Podolsky:

That does appear to be the case. The recent data from the CDC revealed as many as 880 children were being hospitalized every day with COVID-19 in mid-January, which is certainly clearly the highest rates we've seen so far in the pandemic. Locally we've seen the highest census on our own Children's hospital, both here on the Dallas campus and out in Plano. And there are likely several explanations to begin with as we've all come to realize that Omicron is much more contagious or transmissible, driving a steep increase in cases amongst all age groups, including children.

And this means that, and this is sort of what we saw also in adult populations, that even if the percentage of individuals who require hospitalization is small, it's a small percentage of a very large number. And so the absolute number of children requiring hospitalizations increases as the denominator of total cases has increased so dramatically. Also without knowing exactly how it fits into this increase among the pediatric population precisely, Omicron does appear to be to preferentially infect the upper airways rather than the lower lungs, which was certainly the case for the original COVID-19 and the earlier variants like Delta.

This can lead to increased inflammation in the small airways, which may be more difficult for younger children, particularly those 2 years old and younger to handle; let me just clarify that, because the airways of children are so much smaller than adults. Even if Omicron targets the upper airway, the smaller airway of children can still lead to more important clinical consequences. Other respiratory viruses like RSV are common causes of bronchiolitis that can lead to hospitalization of young children.

So we appear to be seeing more of this with Omicron compared to prior variants. And finally hospitalization, excuse me, vaccination continues to be a key protective measure for children, but vaccination rates among eligible children, all those 5 and older, still lag significantly behind those seen in adults. And so the majority of those we have seen hospitalized in Children's and in the region are unvaccinated, and I take this opportunity to really encourage children if they've not ... excuse me ... parents, if they have not yet had their children vaccinated to strongly consider that for their welfare – and of course also the protection of those around them.

Jenny Doren:

There seems to be some conflicting information, conflicting dates out there. When can we expect COVID-19 vaccines to be available for children under age 5?

Dr. Podolsky:

Well, the FDA announced that next week, Feb. 15 to be precise, its Vaccine Advisory Committee will meet to discuss the request for EUA, emergency use authorization of the Pfizer COVID-19 vaccine for use in children 6 months through 4 years of age. In a news release, the agency said having a safe and effective vaccine available for children in this age group is a priority for the agency, and we're committed to a timely review of the data. As with all prior meetings of the FDA looking at potential EUAs for vaccines and other medications, there will be a robust analysis and presentation of available data on the efficacy and safety, in this instance of the vaccine in these younger children.

Following that review, the Advisory Committee will make a recommendation to the FDA as to whether to extend emergency use authorization to this younger demographic. Based on prior experiences, a formal decision will likely come in the days following the meetings. The CDC and its Advisory Committee on Immunization Practices, ACIP, will provide clinical recommendations and consideration for the use of these vaccines as well. So depending on the outcomes of these meetings and the recommendations given, it is possible that by the third week in February the vaccine will be available to those in that younger age group, from 6 months through 4 years of age.

Jenny Doren:

A related question: Does UT Southwestern plan on providing employees the opportunity to have their babies, toddlers and preschoolers vaccinated on our campus like what was offered for the 5- to 11-year-olds?

Dr. Podolsky:

Well, we certainly appreciate that our working parents in many instances may feel more comfortable having their young children vaccinated at UT Southwestern. And just to remind those who may not

recall or have been aware: back in November we offered two back-to-back Saturdays for employees to schedule vaccinations for their 5- to 11-year-olds at Clements University Hospital; and of course, opportunities to return the following month for the second dose of those children who were vaccinated on those two Saturdays.

The team is once again considering the possibility of offering a limited engagement vaccination effort for very young children of UT Southwestern employees. Our Pharmacy Services has proactively reached out to the state to express our interest in receiving vials of the vaccine once they are made available for use in those 6 months to 5 years of age. What's most important is making sure we have enough staff trained in providing vaccinations for these younger individuals.

Nurses require special certification for administering lifesaving treatments to infants and children, who due to their small size need to be treated differently from adults. So while I cannot guarantee yet that we'll be able to vaccinate these very young children, it's certainly a possibility, and we are actively looking for ways to help our campus community protect their children from COVID-19.

Jenny Doren:

Well, thank you for that. Our final question this week is about surgeries. The CDC recently reduced the duration of isolation for someone who tests positive for COVID-19 but remains asymptomatic and is fully vaccinated. Is additional wait time and/or a negative COVID-19 test required for a surgery or a procedure here at UT Southwestern?

Dr. Podolsky:

So let me first provide a clarification on the updated recommendations, which are for the general public and not specifically for patients. The CDC recommends a minimum of five days of isolation and then consider a rapid antigen test if available. If the person is asymptomatic or symptoms are resolving, they can consider coming out of isolation but are encouraged to wear a mask for the next five days any time they are in public, and to avoid situations where they might encounter others who might be at high risk, including living centers or health care settings.

The CDC explicitly states that shortened duration of isolation does not apply to patients or visitors in health care settings. This is because up to 30% of individuals could still be infectious at Day Five after isolation. At UT Southwestern, we are continuing to maintain our standard 14-day isolation period before patients are allowed to return for routine clinical visits or procedures. After that period, we have confidence that, based on recent data, including with the Omicron variant, individuals with a normal immune system are no longer infectious, even without requiring a negative test.

The decision to keep this 14-day isolation period is for two key reasons. First, while masks are required in our clinical environments, patients may need to remove them for their surgery procedure or visit; and therefore we want to ensure that they are no longer infectious before coming to campus to protect both our staff and other patients. And second, there is prior data from the pandemic demonstrating a higher risk of complications for certain types of elective procedures or surgeries when done during the acute phase of COVID-19. So we want to continue performing these procedures at the time when it is safest and most appropriate for the patient after they've recovered from their acute COVID-19 illness.

Jenny Doren:

Thank you, Dr. Podolsky.

Dr. Podolsky:

Thank you, Jenny.