Subject: Important COVID-19 Updates for March 23

Team –

We are facing what is very likely to be a challenging week ahead – but I believe we have the right team in place to face these challenges, and I am so glad YOU are a part of it. There are many things to share today, so I apologize in advance for the length of this note, but we also know that many of you have been asking for more information.

Last week, we had the first of what will be many members of our UC Davis Health family who test positive for COVID-19. That person, and a few others we've learned about since Friday, have all been very likely community-acquired infections, from family members or others living in close quarters to them. Moving forward, the overwhelming majority of infections will be community-acquired, because we are all members of the community, and while we practice contact/droplet precautions here at work, we simply can't be as protected outside of work.

This week, as our internal testing abilities increase and begin to deliver large numbers of test results each day, as our backlogged test results begin to come in, and as an increasing number of people in our community become infected – we are going to see a dramatic rise in the number of people testing positive. In the coming days and weeks, there will be literally dozens of our team members who will have to call in sick and stay at home to rest and get well. And when they do recover (and are symptom-free for more than 24-hours), they will return with an immunity to COVID-19 that will provide the foundation which will slow the spread of this disease.

We owe it to each other to not infect each other and to avoid others when any signs or symptoms of illness are present. We owe it to each other, from now forward, to be extremely aware of our bodies and potential signs of disease. While most of us will recover after catching the disease, our patients have a much higher risk. In the last few weeks, we have been worried about catching the disease from our patients. This week that will switch to us being worried about keeping our vulnerable patients safe from our workforce as well.

Against this backdrop, there has been much discussion about why we are continuing to perform surgeries at the UC Davis Medical Center. Let me share some stats with you: Today (Monday, March 23rd), these are the surgical cases we will be handling:

- 32% of today's cases are classified as urgent – related to trauma, injury, or physical repair 24% are oncology-related – including the removal of tumors and lymph nodes

- 15% are to relieve immediate pain – including kidney and gallstone removal

- The remaining 29% include bowel obstructions, fistula creation for dialysis access, insertion of surgical feeding tube, removal of dialysis catheter (infected or no longer needed after transplant), decompression of endolymphatic sac (inner ear surgery), and an esophagogastroduodenoscopy (related to either cancer, assess for pain (GERD) or injection for achalasia – we didn't open patient medical records for this review).

- When possible, surgical cases are performed with MAC anesthesia (i.e., conscious sedation, not intubated, not requiring full surgical PPE and usually completed in scrubs or scrubs and a gown).

This weekend, we performed two organ procurement and transplant operations. This deserves a special thanks to our amazing lab team, not only for developing our own much-needed testing, but for an extra five to six hours of weekend work to make sure the deceased donors were negative for COVID-19 prior to transplant. (Living donor transplants are on hold.) With donor organs being the limiting step in life affirming kidney transplant surgery, we cannot simply throw these organs out because we are concerned there may be a problem in the future. Essential surgery like this should be the last thing we give up as we prepare for COVID 19 patients. While we are waiting for COVID-19 patient who will need us, we are still the healthcare provider for all of the other patients who need us, too. We should not deny patients, some waiting years for a matched organ, the ability to disconnect from a dialysis machine that dominates their lives, and worsens outcomes compared to a transplant.

These are the kinds of surgeries we do at UC Davis every day. In my opinion, and in the opinions of the surgeons and patients involved in these procedures, these are cases that can't wait. When we further restrict essential surgeries, patients will have to wait at least two to three months for a procedure, and perhaps as long as six or eight months (given backlog, rescheduling and reprioritization of cases). Our cases moving forward now are, quite simply, patients who cannot wait that long. In every case, we involve the individual doctor and affected patients to inform decisions, as the physician - patient relationship is paramount in making medical decisions.

These are not the typical "elective" surgeries performed in other hospitals. That's not what we do at UC Davis Health. We are following national guidelines for essential surgeries – guidelines developed in part by our own experts. (Dr. Diana Farmer, Chief of Surgery, is a Regent of the American College of Surgeons (ACS) and helped to develop the guidelines ACS sent out a week ago – and which we have been following here. Dr. Greg Farwell, Chair

of Otolaryngology, is a leader of the American Head and Neck Society and is helping write national guidelines for head and neck procedures on patients who may have COVID-19).

Providing health care is about making tough decisions. Often, the choices in health care are not easy, and involve high levels of risk, no matter the option. Tomorrow, Tuesday, even more of our surgeries are cancer-related. Unfortunately, cancer doesn't wait. As you would expect, we are planning for a potential patient surge and we are working to manage our resources and supplies smartly ahead of that possible event. Similarly, we know some patients will have adverse outcomes if they are forced to wait six or eight months for surgery. What we can do today is be informed by science, smartly plan ahead, gather data, evaluate evidence, adapt and change daily to the changing circumstances, and be ready to think in new and different ways so we can best serve the needs of our patients.

I know people worry we won't have enough personal protective equipment (PPE) for if or when a surge comes. With a markedly increased UCDH COVID-19 testing capacity coming on-line this week, allowing us to test >200 patients with 1 hour turnaround, we will stop wasting PPE taking care of people without COVID-19. Fewer than 1 in 10 patients admitted to our hospitals who are considered at risk of having COVID-19 actually turn out to have it. If we use PPE according to appropriate guidelines, we will save even more PPE for future needs. We are utilizing other sources (like closed dental offices) to augment our supplies. Furthermore, based on extensive state and national discussions, the shortages seen elsewhere have spurred sufficient production to overcome some of the current deficits. All of this, combined with our current inventory, should keep us in good stead. There is no certainty in this, of course. But there is certainty that every day we are making the best possible decisions, for not only the patients with COVID-19 that will come, but the patients that currently count on us to take care of them.

We are making room in the hospital, in case there is a surge. Our daily hospital census continues to drop, and it will likely be below 500 in next day or two through natural attrition – that's about 125 people less than usual. We have open ICU beds and our Emergency Department volume remains low, running on average more than 100 people BELOW what we see on a normal day. This will change, and when it does, we will adapt and change as needed. We are ready as COVID-19 continues to grow in the coming weeks in our community. We serve our entire region by being the most advanced, and by far the largest, ICU provider. Even with our existing large size, we have plans to double our adult ICU capacity in the event of an overwhelming number of sick patients that might present here (and elsewhere), so we can play our part in the best way we know how.

I know everyone is inundated with information and trying to keep up is a concern. Over the last few weeks, the health system leadership team and I have tried to be mindful of how much we are sending to you, balancing it against how many other things you have to read and do each day. As we are listening to you, we are hearing that people want us to err on the side of more information, so we are moving in that direction.

The Insider and InsideOut will always be your home base for the latest information, and the Coronavirus Resource Center has up-to-date materials specific to how we are managing COVID-19. Other information being shared:

- Our Chief Medical Officer, Dr. J. Douglas Kirk, has shared a more detailed clinical note with physicians about surgeries and about how the proper use of PPE is critical. As he says, we have enough PPE for regular use, not enough for inappropriate use – so we must curb unnecessary uses that are more "feel good" than science.

- Chief Privacy Officer Shara Rasmussen is sharing a reminder later today about the critical nature of HIPAA and patient privacy, which is an especially good point right now, as the temptation may be greater to "check on" family, friends or colleagues in the EMR. This cannot be done, and we hope will not be done, at a time when we can least afford to terminate people for violations.

- School of Medicine Dean Allison Brashear has asked all Department Chairs to set up regular daily communication times for Faculty and staff to share information directly, and to make sure questions can be asked and answered in a timely manner.

- Chief of Infectious Diseases Dr. Stuart Cohen provides some in-depth answers to frequent questions in this 6-minute video, including ‘Does The Virus Live on Hard Surfaces?’ and ‘What Are Proper COVID Precautions?’

- In good news, we are seeing great strides made with moving patients to video visits. We’ve gone from about 20 video visits per day just three weeks ago to over 800 video visits on Friday alone – that’s nearly one-third of all outpatient encounters. A special shout-out goes to the Department of Psychiatry and Behavioral Sciences, which has moved 100% of appointments to video visits. Not only do video visits keep patients at home, reducing their risk of exposure, but they also reduce the need for protective supplies in the clinical setting.

Whatever may come in the coming week, please remember, we are here to take care of patients first and foremost. This is what we do. As Chancellor Gary May reminds us, this is who we are. This is why UC Davis Health is

here. Please be sure to take care of yourself, and if or when you aren't feeling well, stay home, rest and get well soon. In the coming weeks, we are going to need all available healthy people picking up extra shifts and working in new and different ways to meet the needs of patients and our community. I'm glad you will be part of how we meet the needs of Northern California together.

Yours in health,

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CEO, UC Davis Health