ERIN MCCLURE: Good morning and happy Thursday to each of you. My name is Erin McClure and I'm a medical education manager with 3M and I'd like to welcome you to today's webinar Continuing with Optimal Wound Care in United States Outpatient Settings during Uncertain Times. We're excited to bring this program to you. Our presenters will be sharing a lot of their day-to-day challenges in identifying solutions for the way that they manage their wound care patients and their practices.

I'm going to go over some important information with each of you. Any opinions, findings, and conclusions or recommendations expressed in this presentation are those of our faculty and not necessarily those of 3M and its affiliates. Also, any photographs in the slide deck are the presenters, unless otherwise indicated.

This presentation is also based on current United States federal requirements as of May 2020. US state or other country requirements may be different and always consult user instructions and follow local laws and regulations. This is some disclosures of our faculty and then we're going to move on really quick to some of the important housekeeping information which is vital.

As you note on your presentation, at the bottom there is a Q&A widget which you can go to type in questions throughout the program, which we highly encourage. At the end of our three faculty going over their presentations, we're going to have a virtual roundtable with them with questions and answers that come in from you all, which again, is very important. You will get some pop-up reminders to submit your questions. Again, you can never have too many and that's why we have this expert faculty here with us today.

We also have, if you scroll down to the bottom of your page, you will see a resource widget as well. In there, we'll have some upcoming medical education events for 3M, as well as some educational materials that you can utilize and implement in your practice. The last piece of information I want to share with you is that this program is going to be on demand and it will be available in the next few weeks. So utilize the link that you pre-registered with to access the webinar once it's available on demand.

I'd like to introduce each of our speakers at this time beginning, in the East part of our United States with Dr. Christopher Barrett in Springfield, Pennsylvania who is a DPM certified wound specialist and fellow of the American Professional Wound Care Association. He is the director at the Centers for Wound Healing at Crozier Keystone Health System.

We'll then we'll take a trip over to the West part of the United States, ending up in Oakland, California with Dr. Colin Traynor, DPM, who practices currently at Highland Hospital, a Level 1 trauma center in Oakland, California.

Our final destination will land us over to Louisiana-- Hammond, Louisiana that is-- with Amanda Estapa who is a board certified Acute Care Nurse Practitioner, Certified Wound Care Specialist, and Fellow at the American College of Certified Wound Specialists. And she is the vice president of clinical services for MedCentris.

So Dr. Barrett, Dr. Traynor, and Amanda, I'd like to take this time to welcome you to today's presentation. We're going to begin with Dr. Barrett, who I'm going to hand over at this time so he can begin. Thank you, Dr. Barrett.

CHRISTOPHER BARRETT: Thank you, Erin. I appreciate it. So first hello everyone and thank you and welcome to our presentation. I appreciate everyone taking time from their busy day to have this discussion. And I know with everything that's going on in this world right now, a lot of us aren't traveling. OK, so we have to-- if you're like me, you're getting inundated every day with requests, advertisements for webinars, so a lot of information being exchanged this way. We can't get out, unfortunately, and meet together.

So what know what I find interesting about our group today, my two colleagues, we each practice in a different care setting. OK, so I'll give you a little bit of background on my practice setting. So I work for a management company, RestorixHealth. I've been specializing in wound care for the last 18 years. So 18 years ago, I kind of jumped into this new concept of wound care and hyperbaric oxygen therapy.

And so I kind of have an interesting role, in that I'm an administrator. I'm a clinician. Some days I'm a front desk coordinator. Some days I'm a wound care nurse. So I kind of do it all in the center. And I charge entry and coding and billing, so I've kind of seen all aspects of wound care.

My situation here in Springfield, Pennsylvania-- and again this is kind of one of the interesting things about our panel-- some of my other two panelists, Amanda and Dr. Traynor, are in kind of busier, high-risk areas. Amanda is kind of seeing multiple care settings. I'm strictly in an outpatient wound center in a hospital that's now closed to inpatient care. And for the last month and a half, my wound care center-- we're in a basement just outside of pretty much an empty parking garage-- and so I kind of have a unique perspective in that I've been dealing with mainly a lower risk, lower volume population.

So I'll give you my perspective on my patients and how our hospital's dealing with the pandemic. And then you're going to kind of hear two different-- a couple of different perspectives-- on maybe a different type of practice, whether it's in inpatient side and outpatient, skilled nursing facilities, home care. So this is kind of one of the interesting aspects of this discussion is it's really going to cover really all the care settings that we have in wound care.

So at this time, I'm going to switch over to my deck. Let me share that. OK, and we will get started. OK. So again, just some housekeeping-- and I think we went over the disclosures-- so this global pandemic that we're dealing with right now, very, very-- it's a very, very difficult situation for everybody. These numbers change every day, so I think these numbers that I've put up-- and I've had to kind of chase this on a daily basis to keep the slide up to date-- but these are four days old. So what's amazing is the number of cases worldwide, the number of deaths growing. Here in the US, we know that this depends on what side of the political spectrum you're on. But the unemployed-- this number jumped from seven million to 23 million just in the last few days so pretty amazing. Very difficult time for everybody.

Certainly health care has been impacted dramatically. And it's not just finding physicians and health care providers to manage the volume of patients, ill patients. But how about shortages in PPE, shortages in space to treat patients? So a lot of things have happened to kind of accommodate this outbreak, this public health emergency, and I'll kind of talk about that, but wound care-- it hasn't escaped this.

Wound care has been impacted, but differently. Again, impacted differently in different parts of the country and different practices. So I'll talk about how I've been impacted, my wound care practice in my location here on the suburbs of Philadelphia, and then you'll hear our other two speakers, presenters, talk about how their health systems and their own practices have been impacted by the pandemic.

So this is a question that kind of popped up-- when? Probably late March and it really-- there was a discussion going on. Again, I look at the wound care family. OK, and this started to become a concern, because while it didn't impact me, what I was hearing is certainly from our management company was the hospitals, health systems, were they were mobilizing for the pandemic and trying to mobilize providers and also protect their patients so they started looking at non-essential service lines, and unfortunately, wound care came into the discussion.

So many health systems started to say, well, women care probably isn't that important. And we need the resources for other sick patients, more at-risk patients, so many wound centers started closing. OK, without really any discussion about the impact that it would have on our patient.

So what happened was, the Alliance of Wound Care Stakeholders kind of took the lead in this issue and put out a position statement. And I remember this discussion coming through, not only RestorixHealth, but the American Professional Wound Care Association and some of the other societies. We all kind of mobilized and we kind of follow this statement and what was great was, not only how quickly and effectively the Alliance worked, but it's how quickly CMS and the government responded to our need.

So the Alliance went out and first put out the position statement that wound care is essential, and while we're trying to protect our high-risk fragile patients the impact on some of our-- especially our diabetic patients-- would have foot ulcers or veinous leg ulcers, pressure ulcers, our patients with many co-morbidities. What the hospitals are trying to prevent may actually happen if we don't really continue care on this high-risk population.

And once the Alliance got out there with the physician statement, we started to see a lot of other key opinion leaders, other wound care professionals kind of stepping up and providing information for all of us that we could use, not only to support our position, but to help us in our practices and help us with our hospital administrators.

And one of the first guidance documents to emerge after the position statement was this-- and it was led by Dr. Lee Rogers and three other-- probably four, of the most influential DPM's in the world, I'll say. So we all know David Armstrong, Dr. Warren Joseph, who was one of my instructors in school, Dr. Lavery from Texas, and obviously Lee Rogers. And Lee Rogers has really kind of become the authority on developing systems of excellence for wound care. And they're being adopted by other health systems and other wound care centers.

This article that was put out in the Journal of the American Podiatric Medical Association, it was really geared towards podiatry, or at least it was meant for the podiatric crowd in dealing with the highest risk patient population we have-- and that's the diabetic with the foot ulcer-- but really, this pandemic triage system is not just meant for podiatry. It really crosses over to other care settings and other specialties.

And in fact, last night, I watched another webinar which was just published in "Wounds." There was an article led by Lee Rogers, Dr. Lee Rogers, in another group. In fact, our CMO from Restorix was also part of that article. And it was the Wound Care Center without walls. OK, and it's really taking this podiatric center, all-feet-on-deck triage system and really expanding it to all places of care.

And that the point of this triage system is to kind of address the Alliance's statement where certain patients of ours, depending on their co-morbidities and the urgency of their problem-- whether it's a diabetic foot ulcer, a venous leg ulcer, a pressure ulcer-- many of these patients are-- they need to be seen. They need to be treated for their wound care. We can't just kind of forget about them and close our center.

This is why we need to really be open and available for them, but we need to triage patients because the less critical patients really don't need to come into the Wound Center and be put at risk. So these triage systems, these guidelines, were really to shift less critical patients away from the hospital-- and whether that's, as you can see in Dr. Rogers in this model, whether it's the ambulatory surgery centers or office space laboratories. Maybe a vascular laboratory, a radiology laboratory, private practices, home health care.

OK, there are places that we can take care of our patients and not put them at risk and bringing them into the hospital, but there is that subset of patients who meet-- many patients are going to need to be admitted. They're going to have to have surgery if they're infected and they need to go into the hospital and those critical patients cannot be denied that service because the point of all this is obviously to prevent amputation. So this guideline, really the focus here is utilizing telehealth, telemedicine, remote patient monitoring. These are things that, prior to the pandemic, we really weren't focusing on.

But I think now-- I can tell you truthfully. I'm not using these tools, not yet. Actually I had my first telehealth visit with one of the home health nurses yesterday. But I think these are going to become more routine because this pandemic isn't going away. And this triage model is going to be with us for months and, potentially, years. So remote patient monitoring, there are devices and technologies that exist today that can be utilized to monitor your patients at home. And certainly using home health care.

But how do we do this? How were we able to start utilizing all these new technologies and these new ideas? Well, what happened was-- and this is where the Alliance really working with CMS, and really health care working with CMS, in saying we need to mobilize. OK and we need to be able to do that without barriers.

So CMS-- and kudos to the government-- we know sometimes it moves very slowly and the bureaucracy can be pretty frustrating, but you know it really stepped in and these waivers and flexibilities-- really they did two things. They ensured beneficiaries could get safe and effective care during this emergency, but they also kind of took away the impediments to make sure Medicare payments and coverage policies didn't interfere with these patients and the ability of health care clinicians to see patients.

OK, so it allowed us to see more patients and really use technologies and methods that we really weren't using prior to pandemic and, here's the other part, to get paid for them. OK. To be able to bill for services. So and we'll kind of if we go to the slide to the right, I can't spend too much time on this, but if you kind of look at these flexibilities and waivers, here's what it did.

Number one, telehealth. It expanded coverage. So now providers could use telehealth and telemedicine phone visits and get paid for it like they were using it like they were seeing the patients in the hospital or in the office and that didn't exist prior to the pandemic. Or I should say nobody was doing it. It was very difficult. There were a lot of barriers.

How about expanding the workforce? Patients had to be moved from other locations, sometimes to other states. Physicians needed to-- if they're working in Pennsylvania-- some of our physicians needed to go to New Jersey to be able to see patients, to be able to follow patients, because we needed health care physicians and clinicians to be able to see the volume of patients that were ill. And so these waivers and flexibilities took down those barriers. Clinicians now didn't have to get a new license to go to New Jersey. You know how long that would have taken?

So it took down the barrier to allow the health force, the workforce, to get out and see patients without barriers and address this pandemic. We have one here in Philadelphia, it allowed us to take a hotel and turn it into a COVID hospital. And not just turn it into a COVID hospital and not have to jump through a bunch of hoops to do that, but it allowed our physicians to go into that hotel, that motel, and get paid like they're working in the hospital. So they're still actually able to practice and there's no barriers. We don't have to jump through all those hoops.

Removing the waivers for reporting deadlines, for audits, for prior authorizations that are really just made it so difficult for us to respond to the volume of patients coming into-- whether it's our clinic, whether it's our hospital, or whether it's a convention center that we've now turned into a triage center. That's what the flexibilities and the waivers did and it allowed us to mobilize, to deal with this health care emergency that we're dealing with right now.

So now we know that a certain subset of our patients need to be seen in a clinic, OK Not everyone, but in my clinics-- I'll talk about my Wound Care Center-- we never close. OK, we have a physical therapy department working side-by-side with us and they shut their doors. OK, they were seen as nonessential. We've been seeing patients and we never slowed down-- OK, we had a slowdown and I'll talk a little bit about the impact of the pandemic-- but we've been treating patients so we know patients are going to come in and we know that my staff members and other staff members are going to be working with these patients, these at-risk patients.

So how do we protect ourselves-- my staff-- and our patients? OK, well number one, it really talked about probably the hottest topic. It's masks. OK, so you can't go anywhere. And this is now mandatory everywhere we go, OK. Whether it's in the hospital or outside in the public, we need to have a mask.

And there is a difference and I'm not going to-- we have experts from 3M here that can really dig down deeper into the technology, to different technologies with masks. So we have the N95 respirator-- very popular. We have surgical respirators and then we have surgical masks and I'm not going to belabor the point, but respirators are, in general, are to protect the wearer from the outside versus the surgical mask.

We know that as a surgeon this is what we wear in the operating room. It was to protect our patients. It was to protect the environment from us-- saliva, mucus-- and also protect us from any splashing that could potentially get into our nose and mouth. So there's an important difference to understand between masks and respirators, and depending on the rules in your hospital and what you're doing in your clinic, you may have a combination of both. Or in my situation, we primarily use surgical masks.

OK and again, because I'm a different patient population, we have really nobody in our environment other than us. We're in a basement and patients can walk right in the door and walk right out to a private car, so a little bit different in terms of risk. So this is an important topic and certainly ask questions later. We have experts who can talk to you about that, OK, so

--and that's what I just talked about. So let's talk about my clinic. So this is how my health system reacted. And this is a month old, so I can tell you there's been changes. So when I first got the email-- this is the phone triage for a new patient. Now I can tell you, number one, my patients, they're not flying to Luxembourg. OK. I can tell you nobody's flown to Luxembourg or Liechtenstein. So I don't ask my patients if they've gone to all these countries.

What I do, from day one, we ask them, have you traveled? OK, and I can tell you in the last month and a half, nobody's traveled, at least in my group. So we asked them if they've traveled and then we ask them if they had a fever, if they have a cough or shortness of breath, or if they have been exposed. OK, and then depending on the answers, if they've traveled and they have symptoms, we're not seeing them in the outpatient department.

OK, then we're going to make sure that-- and again this has already changed-- so now they're not calling the Pennsylvania Department of Health. We're going to get them if they're sick. We're either going to get them to the emergency department or they might want to see if they're stable enough to see their primary care physician and be evaluated. They might come into the ED. So things have changed.

OK, so we're going to guide them where we think or they get they might go and get a test. OK. And we have drive-through testing centers now and they can certainly get that as well. We document this in the EMR and we maintain a log. And then again if they travelled and have no symptoms, how about if they've traveled. They have no travel history and no symptoms, we're going to see these patients.

Back a month and a half ago, they didn't require a mask. Now everybody requires a mask. So that has changed because we certainly know now, we have better policies in place, and then we have phone reminders. Every patient-- even if we've seen them before-- if we're calling them up to remind them to book an appointment, we're going to ask them those questions.

So make sure we're monitoring our patients, So that anybody has potential symptoms, or maybe there's a potential that they're ill, we're going to direct these patients to the right location. We're taking temperatures now, which we didn't do a month and a half ago. Everybody's walking into the hospital getting their temperature taken.

In the office, if somebody comes in-- and this is a little-- Again, this is from the health system if they're sick and they're not COVID 19. Well that's pretty-- we're not going to know that. So if patients are sick, we're going to not see them, and we're going to have these patients directed to the emergency department or their primary care doctor and be evaluated, get a test.

We have posters and supplies up. We have gowns. For my physicians we have shields, we have masks, we have everything they need to be protected. Some of my physicians like to gown and mask, others just use a surgical mask, but these are-- we do have these stocked because of the requirement.

And then daily setups when patients walk in. Again now, they're getting them-- everybody gets a mask and pretty much everybody comes in now with the mask anyway, so it's pretty common. But then we added general precautions, so what happens is when you walk into any of the hospitals in our system-- we have four hospitals-- every employee, every physician gets their temperature taken and gets handed a mask if they don't have one.

Visitors-- and I think this is probably in every health system in the country for the most part or at least at the beginning. We don't allow any-- only one visitor per patient. OK, so we can't have a family coming in and sitting in the waiting room or going up into the emergency department. We also don't have our vendors. Our reps are not allowed. They haven't been here in a month and a half so unfortunately no free lunches, but these are the rules that the hospital put on.

And social distancing. We took half of our chairs out of our waiting rooms so we have everybody distanced. And we're modifying, in terms of the way we schedule and things like that, so we don't have a lot of people sitting in the waiting room. These are the things, the preventative measures.

Back before a month ago, a month and a half ago, if you were a health care system-- if you were an outpatient ambulatory center-- the CDC put out some guidelines, and very similar-- Again the goal being if you look at wanting to keep sick patients out of the clinic, and healthy patients, keep them safe, then utilize telemedicine. Utilize other methods of triaging patients.

If you think they're sick, OK, then get them to call 9-1-1 one or go to the emergency room with their primary care doctor. Have algorithms that you can screen patients so that they don't come to the clinic to be screened. OK, you want to screen them at home and direct them to the right care location to keep everyone safe.

Home health services. Engage other organizations, but certainly home health has been, for me, it's just been huge just to help us treat our wound care patients and get through this pandemic and still assist those who really need care, they've been invaluable. They're angels. They just do amazing work.

And also health care providers, OK. Take care of them. OK protect them. Be able to have-- Again, they recommend algorithms, so many health care providers are getting ill from COVID. They're on the front lines. Have backup plans for these down times when you're going to need physicians and have backup for your supply of PPE.

I'm fortunate that I haven't had a major problem with getting PPE, but I know this has been a problem, especially in those areas and those hospitals that have been overwhelmed-- New York, New Jersey-- just outside, you know, the state right next to me. One of the worst in the country certainly. Amanda dealing with that in Louisiana, Dr. Traynor out in San Francisco, so different for me than for them and they can kind of really speak to what they're seeing.

There's a website on the bottom. This is a wonderful website provided by 3M. If you can spend an hour going through all of the links and information on, not just PPE, but how to take care of yourself and how to deal with this pandemic. There's so many resources on that website. So certainly utilize that. It's wonderful, wonderful information.

So here's the last thing I'll talk about. Here's how the pandemic affected us. So again we never closed, but as this ramped up, as we saw this getting worse and worse, unfortunately my company had to-- like pretty much every business in the country-- we had to start furloughing some of our part time folks, salary reductions at the corporate level.

Unfortunately for my staff I've had to, when the clinic hours are over they go home. OK. Now the clinic doesn't close. I get to answer the phone the rest of the day, but we're trying to cut down because as a company we've suffered just like every business, so reduced staff hours. We saw about a 40% reduction in patient volume, which is down to about 25%. Now we're starting to ramp back up, thankfully.

Staff flexibility-- that's me. So I pretty much do every job here as needed. OK, and that's how we kind of fill in the gaps. We had a patient volume-to-hours-worked target of 2.0 for the staff, including myself so that was pretty challenging. And then now we close early if we have to and I keep my staff home. It keeps everybody safe, but it also reduces the volume.

So that's the impact that it's had on my program. Physical therapy has opened up here again. The hospital's starting to expand. Although two weeks ago my hospital closed in inpatients, so everybody is being funneled to a couple of the other hospitals in the health system and that's kind of how they're managing the volume, but we're seeing fewer COVID patients in the hospital.

So with that, I'm going to step back and pass on the baton to Dr. Traynor. So I want to say thank you very much for your attention.

COLIN TRAYNOR: Thank you Dr. Barrett, and hello out there, everybody. Thank you for joining us today. I'm a DPM out in Oakland, California as Dr. Barrett introduced me. System professor at the California School of Podiatric Medicine, and an attending at Highland Hospital in Oakland, California, where I practice 100% of the time.

And Highland Hospital is the Level 1 trauma center, not only for the city of Oakland, but also for the county of Alameda. And so of course, a little bit of a contrast to what Dr. Barrett's been dealing with at his wound care center at his clinic.

So I'm going to spend my portion today talking about my practice and how it's changed. In order to know how it's changed, you kind of have to know what it used to be like. As you can imagine, a Level 1 trauma center is a busy institution, especially out in California, in Oakland, California of all places.

So that busy institution typically had an emergency room that was standing room only from noon to 2:00 AM, seven days a week. My clinic, being the same way, we have clinic four days a week and our waiting room typically was always full. Not full with just patients, but of course full with vendors, family members, care providers, to the point where patients were in a crowded room and of course not able to socially distance at all.

And that same waiting room for us is the waiting room that services all the clinics, in addition to our clinic on that floor. When I say that floor-- and I talk about the differences between my practice at Highland and Dr. Barrett's is-- our clinic is on the seventh floor. So how do you get to our clinic on the seventh floor? Well, you have to enter the level of the emergency room, go up from level four to level five, where the OR suites are, up to level six where adult medicine is, and then up to level 7.

So we are in the hotbed as an outpatient clinic when it comes to being an at-risk location for our patients to come and be treated. So our clinic not only is a busy clinic and a busy hospital at a Level 1 trauma center, we are a teaching hospital. So running eight rooms at a time, seeing patients with three to four MAs staffed with an LVN. We also have anywhere from eight to 12 students with us at all times, two to three residents as part of our team, interns as part of our team, and as a attending for the hospital representing the residency program, we get visiting students from all over the country that wanted a sneak peek at what life would be like as a resident at our hospital.

And we'd have students visiting that would be interested in podiatry in undergrad coming to look at the hospital and to look to see what their education and their training would be like. As you can imagine this is an institution that was always buzzing, always busy, and of course my head sometimes spinning, being able to try to balance it all.

Well that's not the experience anymore. That's not the practice we have now obviously with COVID 19. Our hospital has had over 120 positive COVID 19 tests I think we currently have about 12 inpatients at our institution and we've had several employees test positive for COVID 19 so it's very serious and very real where we are in the hospital.

So as I suggested, what does my practice look like now? Well, the waiting room is empty. Waiting room has to be empty. We have to be able to socially distance our patients, decrease volume as Dr. Barrett was talking about, which also meant that we had to significantly reduce our staff to decrease their contact, decrease their risk, and so it does mean flexing individuals off, furloughing individuals.

We talked about using eight exam rooms in a typical clinic, sometimes even overflowing to add additional rooms-- stealing rooms-- from other clinics. Well now we only run four rooms. Three private rooms and one minor procedure room is always left available for us now at the clinic. The exam rooms selected are those rooms that are closest to the waiting room so we can decrease the traffic of patients going through our clinic.

Resident coverage has been minimized. Our team isn't always a full resident team, which of course, means that not only are we now losing some of those helpful hands, but residents are losing some of those experiences that are so important in their education. They have such a brief moment with us and the brief time of a residency and so education is getting affected on the resident level to the point where the national organizations have decreased the required numbers of contact hours required, numbers of cases, to make sure that these residents can actually qualify for graduation, which is coming up soon for senior residents.

Well we talked about education being affected for the residents, well all of our students have been dismissed. So students were dismissed nine weeks ago from rotation and haven't been back. And we don't know when we're going to allow students to come back. It was a mutual agreement between the hospital system and the University to not expose, unnecessarily, individuals. And so the students have been left at home and students now are getting a different type of education. They're doing Zoom meetings, similar to doing the webinar that we're doing today, and they're learning about that telemedicine. How to do Zoom visits and telephone visits in simulation labs, so the students get exposed to something that's obviously changing right before our eyes, as Dr. Barrett suggested. This is new to us, and of course some clinics have been doing this for some time, but not on this scale. And not with reimbursement, the way it's changed just over the last few weeks. And so they're getting a different type of education, but still getting that education, so they too can graduate and go on to residency. And of course, we have no recruits coming to look at our hospital. No recruits from undergrad and no recruits from other doctoral programs.

So it's difficult to give you the perfect algorithm to which patient needs to come into this setting-- this high-risk setting and be seen-- and this particular patient doesn't. It really truly comes down to the individual and we as providers make that decision.

So what types of dressings are we doing? It's important to think about. I have less staff available, vendors and reps aren't available to us in clinic, and skin substitutes are considered, by our hospital, as elective procedures. So the decision was made to finish out anyone that was being treated with a skin substitute in the first few weeks of shelter in place back in March. And then we did not elect to start any new wounds or new patients on skin substitutes and we have not, to this date, started the use of skin substitutes on new patients, on new wounds.

We're putting on dressings ourselves with the lack of MAs, the lack of interns, and the lack of resident coverage, so these dressings need to be cost-effective, available dressings that are on the shelf. And the dressings that either can be changed by the patient, the patient's family, or home health agencies, are dressings that are available and can be made available to them. And dressings that hopefully can stay on for a prolonged period of time and still manage the bioburdens of the wounds, still manage the drainage.

Total contact casts, I'm a big believer offloading is key. We are still doing total contact casts, so not only patients that were currently being treated with TCCs, but patients with new diabetic foot also is that need to be offloaded are being seen weekly with TCCs, because we can't heal these wounds without the help of that TCC. And again, these patients are at risk and I do not feel comfortable leaving a total contact cast on for greater than seven days. There's too many additional risks associated with that, so we're continuing to see those patients on a weekly basis.

As I mentioned as providers, we're responsible for putting on the dressings. We're responsible for taking off the dressings. We're doing the photo documentation. We're measuring wounds. We're doing it all, similar to what Dr. Barrett is having to do at his clinic, but we are a lot more involved with our patients as far as doing the actual dressing changes and the documentation for the patients.

Within the dictation room, we are making sure to socially distance ourselves. We leave a computer station open between every provider and we are responsible for cleaning each station before and after use at the beginning and the end of each clinic. Highland Hospital has been really good about making sure on the hour, every hour, they're cleaning all the high contact, high risk, surface areas-- doorknobs, door handles-- so everyone's being very responsible there. And it makes it feel like a safer environment than maybe it is.

As far as the PPE goes, we in the beginning had a little bit of a shortage that we don't see that anymore. Thank goodness. We are permitted as providers to wear N95 respirators in clinic if we elect to do so. We are mandated to wear a face covering or a surgical mask at all times. Everybody that comes into our facility gets screened-- staff and patients alike. You have to answer a short survey. You get a temperature scan and you are provided a mask if one is not already with the patient or with the staff member. And you're expected to leave that mask on at all times.

So what's happening with these patients? Are they doing well? Are they completely falling apart with some of the changes, some of these restrictions? Well now we've actually seen, especially with a diabetic foot ulcer, with a DFU, and improved compliance. It's much easier for patients in California that are sheltering in place now for nine weeks going on 10 weeks it's much easier to offload if you're not allowed out of the house. And so these patients actually are doing a much better job than the traditional patient had been doing prior to this at keeping off of these wounds.

Now it hasn't been on a long enough period of time to know how poor patients are doing with glycemic control. I think in a few more weeks we'll have a better picture of what's happening there. I know myself I'm not doing a great job at home with what I'm eating, so I'm sure that's true for a lot of my diabetic patients and other co-morbid patients that are stuck at home and probably not doing as good of a job and of course probably not exercising. But we are seeing an improvement in the offloading of these ones.

So when do we get back to normal? What is normal anymore? Will we ever truly go back to the way we were in December or January of this year? We don't know. It just got announced earlier this week that Los Angeles is extending their shelter in place by another three months.

We had word from Gavin Newsom, the governor in California, that we were going to start to be allowed to do elective procedures again. That's true more so at small facilities, smaller hospitals. That's a big revenue source and maybe hospitals that aren't currently treating COVID 19 patients, but as we are the hospital for the city of Oakland and Alameda County, I have the feeling that we're going to be one of the last to start opening up our operating rooms to all elective procedures.

So it's going to be some time and I think we're going to see some long term changes, as Dr. Barrett suggested. Some long term changes for the positive with the improvement in telemedicine and leaning on home health agencies. So thank you. And with that, I will send everybody to Louisiana to speak with Amanda. Hi Amanda.

AMANDA ESTAPA: Hi, everyone. Thank you for joining us. I'm going to talk to you a little bit about our practice. We are a company-- I'm a nurse practitioner first and foremost. I work for a company called MedCentris. We're a wound medicine company out of Louisiana-- based out of Hammond, Louisiana-- and we cover over 60 facilities in the states of Louisiana and Mississippi.

We provide services throughout the care continuum, so we are in the acute hospital all the way to the home. So I see patients and have tried to manage the challenges of COVID and all of the barriers we've had to seeing our patients in almost every care setting throughout all of this. So that's what I'm going to talk to you about today.

And we'll start with how do we empower our providers to continue providing quality wound medicine during this time? Like I said, I am a nurse practitioner, first and foremost. I'm also vice president of clinical services for MedCentris. I've been a nurse practitioner for 16 years. I'm acute care by training, but really narrowed my focus on medicine in 2010, about 10 years ago.

Our home office is in Hammond, Louisiana as I mentioned, and we service patients throughout the entire care continuum. So what are the preventative care measures that we are taking? Of course, protecting our patients, staff, and their families is of highest priority-- in all care settings-- whether it be in one of our private office clinics or sending our providers into a facility that we actually partner with.

We are following recommendations from each health care facility that we partnered with, whether it be an acute hospital, a long term acute care, skilled nursing facility, or rehab. We're seeing checkpoints at entrances of all locations. We, as a company, have mimicked the other care facilities that we work with and placed checkpoints at the entrance of every building to check temperatures, provide brief screening and questionnaire regarding symptoms, travel, and any recent exposure before anyone is allowed to enter the buildings.

All clinical staff are provided N95 respirators, as well as cloth masks, to cover those N95 respirators. In the beginning of all this, we had a lot of challenges getting our hands on the respirators for all of our providers and clinical staff. So we opted to start making cloth masks to cover those respirators, to prevent soiling throughout the day time, to limit replacing the mask throughout the day.

Of course, we followed standard PPE and infection control measures. As always-- in every location-- that's standard health care. And cloth mask are also provided to all administrative staff. Here in Hammond is our home office, so half of our building is administrative offices. We have coding, billing, denials, human resources, et cetera, and all of those departments for the staff that is actually physically coming to the office, we have them wear cloth masks.

So to talk a little bit about the difference. I know Dr. Barrett touched on this, the surgical mask versus the respirator-- and like I tell friends, family, neighbors, and co-workers-- the difference between the mask and the respirator is very simple. The mask protects you from me, whereas the respirator protects me from you.

The surgical masks prevent any bodily fluid or anything from exiting my mouth and going into the air or airborne particles. It is not fool proof. That surgical mask is really just to prevent transmission of fluids. And there's some data out there that suggests that it reduces transmission rate of 50% just wearing a mask in public, which is why most people are. The CDC has recommended wearing masks in public.

The respirators, on the other hand, really need to be fit-tested. Most hospitals fit-test medical personnel when they're hired and that fit-testing-- I'm not going to get in great detail, but essentially you would try the different size mask, though differentiating between COVID-19 guidelines. Being we are in all care settings, like I mentioned, we carefully monitor guidelines as directed by the CDC and the Louisiana Department of Health.

As individual facilities or institutions offer guidance daily, we follow those directions as well whether they have differences in their screening processes or their accessibility for our patients. Most of our hospital partners have been great about those daily updates and really sending out blasts on number of cases in each building and how many patients have been discharged-- of course we celebrate that-- how many patients have actually beat this virus and actually on the way home or just go outside the hospital.

Guidelines for private offices have also been modeled after the CDC and the Louisiana Department of Health and partnering institutional guidelines. These guidelines are reviewed daily and reported to what we have is a COVID-19 task force. That task force for our organization meets regularly and then reviews all the information, evaluates it, and disseminates it throughout the organization so that everyone is kept up to date on the latest guidelines and where we're moving, where and how we're moving, forward.

Again, in our hospital outpatient departments, we're following guidelines by institutional policy. So should these guidelines in the institution be less restrictive than our current practice in our private offices, then we adhere to the company practices of our private offices. Meaning if we have hospital partners that don't require an N95 respirators for our clinicians, we offer those respirators to our clinicians to ensure that they have the proper PPE to actually enter into facilities that may have clusters or high volume, high volume of infected patients.

As far as the Louisiana Department of Health, they update there COVID-19 statistics daily at noon every day. The most latest I've updated-- like I said it updates daily so I've got some new numbers here as of May 13. And as of now in Louisiana, there's over 32,662 cases. 2,315 of those have died from COVID related illness. 1,194 infected patients are actually hospitalized and less than 10% of those hospitalized are on ventilators.

And I think as the country has worked through this pandemic and really started to treat patients in all levels of care, especially the acute hospital, they're not as quick and apt to put those patients on the ventilators as they started to find that maybe early ventilation actually may-- or early intubation and ventilation actually may-- decrease positive outcomes.

The one thing that I love about the Louisiana Department of Health is now they are publishing the positive cases that have recovered, so I highlighted that in red, and that is that 22,608 of those patients have tested positive, have recovered. And I think that's really important to focus on, because in this time of mass hysteria and fear, we really need to focus on the positive outcomes.

And this is a virus that people can overcome and those at high risk should remain at high risk and protect themselves but the average healthy individual can recover. And I think it's really important that we focus on that.

As far as the impact of COVID 19 on my daily practice and my organization's daily practice, we've seen our daily in-person encounters were initially down about 20%. I think now it's a little higher. It's roughly about 20% with the addition of TeleWound, which is our version of telemedicine. Overall encounters are up 30% in comparison to the same time last year.

So even though we have lost 20% or 28% of our in-person encounters, like our patients coming to the clinics, we've actually seen an overall increase in the number of overall encounters across the care continuum in comparison to last year, which is quite pleasing to me because as a clinician, my number one concern is, how do we reach our patients during this time? How do we prevent our patients' wounds from deteriorating during this time?

We do have challenges, and have had challenges with limited resources, such as timely delivery of DME and dressings, but overall this has really improved. Even the access to N95 respirators, which was initially very difficult is actually-- we have an order en route now, a very large order, so we have accessibility to most supplies now.

There has continued to be difficulty arranging referrals to specialists, such as vascular surgery, especially for evaluation and possible intervention, more specifically because of transport issues. Patient transportation is not as readily available. So whether you're a traditional ambulance transport, you have family or caregiver transport, or public transportation, we're finding challenges.

Because I can tell you in the New Orleans area public transportation ceased for a period of time, especially for non-essential personnel, while most of our patients in the inner city in New Orleans and our clinic take public transportation, and if they don't take public transportation, they use Medicaid funded transportation, and Medicaid funded transportation was very limited to what they deemed as necessary services such as dialysis, but wound care was not one of those essential services. So we lost a lot of transportation access for our patients.

Luckily starting tomorrow, May 15 in Louisiana, we'll launch into phase 1 where some businesses will begin to open, public transportation will be available, and so that's-- on a positive note, I'll end that things are starting to turn around. We're starting to get back out there. Things are starting to open up again and I'm really looking forward to that.

Of course, we still have patients concerned about leaving their home. Even if they can, they transportation, they're afraid because of media that if they leave their home they're going to be infected. So we try to mitigate that with phone calls and doing daily checks and confirmation of appointments.

And then transitioning patients' care from in-person visits to TeleWound, especially when they're too afraid to come in or they can't come into the clinic, and how do we transition them to this telemedicine platform if they don't have an electronic device or media. There's a lot of patients out there that don't understand how to use FaceTime or Google Duo. We have a sophisticated telemedicine platform. We're not using that one right now. We're actually using FaceTime in Google Duo and other media references just because it's easier for the patients at this time.

But for those who can't participate in telemedicine, or TeleWound as we call it, we're really transitioning to a bucket of do we put them in our home to heal program, which is our home visit program. We work directly with home health to go see the patients in their home if they're unable to get to us. We also have TeleWound patients that if they're declining or their wounds are deteriorating, we're really concerned and they can't get to us, we will go to them.

So we're really trying to access our patients in any which way we can. The fear, at the beginning of all of this, was our patients weren't going to be seen and wounds were going to deteriorate and we were going to flood the health care system or the emergency rooms with all of these complications and wound infections and septic patients. And I'm sure that Dr. Barrett and Dr. Traynor especially, being in their fields, see a lot of patients that may need emergent surgeries or deep space abscess or just lots of things that you can't sit on and can't wait and can't be managed on an outpatient basis.

So with COVID-19, I think education is the key. We must mitigate the effects of this virus not only in our local community, but the community globally. We all have different challenges and we're all working through it together. And I think the health care community has really rallied together to try and figure out and navigate all the barriers. Education is key to prevent mass hysteria and continue the care for our patients while considering preventative measures. This includes educating our staff, educating our patients, educating the family members and caregivers. There's a lot of education going on in our telephonic visits or our phone call visits. There's a lot of education going on in our TeleWound visits.

And then of course in-person visits, we're big on education as most clinicians are. And as wound care clinicians, our greatest challenge is not treating our current patients but maintaining our pressure injury prevention programs in the hospitals. There's these infected patients and these COVID units where these patients are essentially isolated. They're not getting-- how do we mitigate the challenge of those patients not being turned, re-positioned, someone at the bedside as frequently as they would normally be.

And I think that hospitals have done their best to try and work with their staff from a quality perspective as well as we've tried to work with their quality department to prevent further pressure injury related wounds. And then also the facilities in the home patient's life, are they isolated and quarantined? And are they getting up and moving around?

I think overall we're probably-- and I think Dr. Traynor was going to allude to this-- we're seeing some better compliance because patients are limited on travel and mobility. So they don't have the access to be as mobile as they would like to be, and therefore the compliance with offloading is much better.

So resources from wound care companies, such as the iOn HEALING mobile app. Patients can order their supplies through these mobile apps, track orders, complete wound assessments. Something like this is vital during this time. We really have to help our patients remain educated and give them some control over driving their care as we intermittently check on them and guide them through this.

Also the iOn PROGRESS, which is remote therapy monitoring. If someone has a negative pressure unit or a vac that's turned off or they've unplugged it and the battery has died, an associate will call the patient and notify them, you need to call your unit, why did you turn your vac off and really walk them through any challenges. This also encourages compliance because I can tell you, with some of those non-compliant patients, they give us all a run for our money that tend to unplug and think that they can just choose not to pay attention to their device. When they get a phone call they realize that someone's out there monitoring as well. It really does give them, make them accountable for their care.

And then of course, the MyWoundHealing app, which is a patient-centric app, and it features educational content and wound healing progress tracker. All of these apps are great for patients to get interactive with their care. And I highly suggest that everyone look into them. I've done a deep dive since all of this quarantine and stay at home order has been launched and it's proving very beneficial for not only our staff to access educational videos, but also for patients and family members to look at videos and really get some education that they need that we can't provide in-person now.

So we've all been faced with multiple challenges due to COVID-19. The ability of our patients to follow-up in outpatient settings, the use of screening tools in all settings, challenges and limitations rounding in facilities across the care continuum, all facilities are now requiring clinical staff to wear N95 respirators. And the prejudice of medical personnel entering the home is also a challenge that I didn't really touch on, but I would like to elaborate, just for a second.

We have patients that don't want to come to the clinics because they're afraid to venture out. But then when we've tried to go into the home at times, there is some prejudice of patients in the home that don't want clinicians coming in. They feel that you're putting them at-risk in carrying the chance of exposure into their home or increasing the risk of exposure into their home. So that that's another challenge to navigate through. And obviously education and discussion helps us work through all that.

And then obtaining proper PPE, again, we had issues in the beginning. We're not seeing that as often now so I'll just kind of skim over that because those things have improved. And that's about all, as far as my presentation. I'd like to thank you all for having me and letting me participate in this roundtable. I think that it's a very interesting topic and we all have a different view and stance, but we're all working together and have similar outcomes and goals, so thank you.

CHRISTOPHER BARRETT: OK. First off, I'd like to thank my two colleagues. At this time, unfortunately we've got about-- well we've got 3 minutes. I think we're going to-- maybe we'll go over a little bit just so we can take some questions. So I'm going to kind of I want to get a couple of the questions that came from the audience, which I thought were really excellent questions. One was "I work as a physical therapist and a wound care specialist in a hospital-based outpatient department. They use MIST, ultrasound, pulse lavage, low frequency ultrasound, debridement. They've stopped doing it and there is a concern for aerosolization so the question is what are the risks related to COVID with these treatments and what PPE should be worn.

So first I'll tell you, we were going to bring this and plus lavage into our center and then we moved a couple of years ago and I'm kind of actually looking at that. I could tell you that we haven't been using it, but we still get good outcomes without it. And with the risk, I would probably say it's something, as you said, probably maybe not something you're going to use right now. What's the risk? I don't really want to make that comment because aerosol-- if the patient's wearing a mask, is there a concern working on the leg with ultrasonic debridement-- I don't know.

In terms of what to wear, that's probably something that the 3M experts could probably talk to you about. Since I don't use it, I don't want to make a comment on the risk, but certainly I would probably say being that it's not a mandatory intervention, a technology that you need in the center, probably a good idea to kind of hold off on it right now, as you did, and let's see where this goes. At the end of the day, it really comes down to the hospital and their policies and what they're comfortable with working with. The experts making the decisions on health care and dealing with COVID.

I'm going to pass this next question. I'll ask the question. I'll pass this to Amanda. "When you resume outpatient wound care, will you require patients be tested for COVID-19 prior to being seen or treated in clinic? How will you screen patients? Will you require staff and require full PPE?"

AMANDA ESTAPA: So we currently are seeing our patients and they are entering the wound center. We never limited access to the wound center. So right now what we're essentially doing, is just screening at the door, temperatures, and questionnaire. If they-- At this point in time, it remains the same answer as it did two months ago and that's if they have a temperature greater than 100.4 or if they have traveled outside of the United States, which most people have not. If they have symptoms or have had direct exposure, then we're sending them to be screened.

At some points we actually order the test. We have tested some of our patients ourselves with our own test kits, and then we've also referred them to their primary to order the testing. It really just kind of depends on the dynamic of the patient, where they're being seen, and what's available in the area. Being that we're all over the state of Louisiana and Mississippi, it tends to be a little bit of a challenge navigating that, getting testing, but we've kind of figured it out in every market.

So we're still open for business. We never turned patients away. We just do traditional screening just like about everybody else.

CHRISTOPHER BARRETT: Great. Thank you. We're going to do one last question. I'm going to get Dr. Traynor on this one. So Dr. Traynor, since you're in the hospital, you're in the outpatient department, have you found yourself adjusting your treatment approach-- what you do to the wounds-- to reduce visit frequency for high-risk patients and what specific types of products have you found successfully using certain combinations-- better fluid management and biofilm eradication technology stuff like that-- anything you've changed and maybe are going to keep and finding success with?

COLIN TRAYNOR: Yeah, I mean there's a few things that-- not just myself-- but the other providers in my practice have really transitioned to. And some of it will stick after everything calms down and we get our new normal back. Well I do the dressing changes now in my clinic. Myself or my residents are doing the dressing changes, similar to what you were talking about that you now have to wear multiple hats and so we have to have dressings that are simplified, but also we only see patients because we're in a hospital setting that need a debridement, or need to be monitored for infection, or treated for infection.

So we're no longer allowing just dressing change visits to occur, because of course, that's putting the patient at risk. So we're leaning on home health agencies and family members more so than we typically were previously. And I think the other providers especially, have seen how helpful leaning on the home health agency can be.

And it's something that I think that is where medicine is going to go-- that we're all going to start utilizing home health a lot more-- in the future and especially within wound care. Because those are the eyes and the ears for you that can treat those patients, go out to those patients, and keep those patients safe.

Dressings, as far as what we're doing in clinic, we have to put on dressings that are readily available to us in clinic. Cost-effective but dressings that can potentially stay on for up to seven days. So we're doing four layer compression dressings on patients that need compression. We're making sure that we're doing collagen dressings. Typically-- and you know this, Dr. Barrett. You and I have had this conversation in the past. I'm a big fan when you've got a patient that doesn't have a lot of access, even prior to this, doesn't have a lot of access to the hospital, access to you, with the triple dressing where you're controlling the bioburden with collagen. You've got a non adherent layer and then a calcium alginate for any excess drainage. If you put that under a two to four layer dressing, that's a dressing that can typically push out to seven days and I'm comfortable pushing that out seven days.

And more people in my practice have adopted that dressing. Dressing that-- I think back in January you and I were discussing-- that has become real popular now in our clinic because it's easy for us to access from the shelf. It's easy for us to put on. It's easy for us to teach patients and family members of patients how to repeat that dressing if it does need to be changed, and it's a dressing that can last a lot longer than some of the other options.

One of the things I was going to mention is that all patients that we're currently seeing, with the exception of those that were currently being treated with skin substitutes, are no longer getting skin substitutes in our clinic. As an elective procedure that complicates the dressing with lack of access to reps and vendors coming into the hospital to protect patients and to protect the vendors themselves.

We're going to these simplified dressings-- well not simple dressings, they're advanced wound care dressings-- BUT simplified dressings that can be repeated at home and repeated by a home health agency and a visiting RN. So that's been our go-to for the majority of problems, not all the problems, but the majority of problems.

CHRISTOPHER BARRETT: Great Yeah, and I agree. I mean I think using high capacity, super absorbent type dressings, and like you had mentioned, collagen. I'm using biofilm disruption plastics. I'm actually trialing it and I'm giving it to the home care nurses and my patients and they're taking it home, but we're trying to see if we can affect infection and inflammation, that part of it, using a topical, less debridement because they're not coming in as frequently, maybe drawing out the dressing two to three days.

It's combinations like that, but that's I think everybody's-- again different situations, different risk factors but we all kind of use those AWDs kind of in different ways to work for our situation. I apologize, we're five minutes over and I think we're not going to be able to do any more questions, but I want to thank the panel and thank the audience for joining us having this great discussion, and everyone be safe. Thank you.

ERIN MCCLURE: Thank you so much. On behalf of 3M, I'd like to thank the panel of clinicians for sharing your expertise with us today. And also thank you to the attendees for joining today's webinar. We hope you found it valuable and learned a little bit more about what's going on in these uncertain times and how these clinicians are treating their wound care patients on a daily basis.

And I do have an ask of you. At the bottom of your screen, there is a button to take an evaluation. That is very important. Your input is very vital because that's how we develop our innovative educational programs for each of you. Also if you would take a moment to look at the resource sections. We do have a few webinars coming up for post acute care settings.

One on June 17, at 1:00 PM, titled "Chronic Wounds Tips for Early Identifying Wounds the Impact of Silver-ORC and Treatment." Then one on June 25, which is titled, "Addressing Persistent Inflammation to Alleviate Microbial Growth with the Help of Silver Gelling Fiber Dressings" and that's with our own Dr. Barrett here as well. We also have multiple acute care offerings. There's a list with all of our-- KCIwebinars.com. website, which we encourage you to go to for on demand presentation. And that's where this will be showing up in the next few weeks. So just, if you can, complete the evaluation and on behalf of 3M, thank you so much for attending today's presentation. And stay healthy and be happy throughout the upcoming months. Thank you.