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AAWC® Association for the Advancement of Wound Care®

COVID-19 Summary Report Webinar Q&A
Answers provided by Dr. William Tettelbach

When do you see wound clinics getting back to normal?

Wound Clinics will most likely start reopening or ramping up operations in May and June. Observing a return to normalcy is a little harder to predict since if there is the expected spike in the COVID-19 positive cases during the period of restrictions easing we may see a return to some the previous restriction. Overall, we may see a return to the new normal sometime in July and August.

How long can some treatment be delayed? Will these patients need to be treated later?

In regard to wounds how long to delay treatment should be determined on case by case bases. If your hospital affiliated wound clinic has been temporarily closed due to redeployment of staff or deem not essential by administration, then attempts to arrange follow up through home care or private clinics that have remained open should be done. Telehealth visits can also be deployed to track progression of wounds and gauge the urgency of an in clinic visit.

Have any HIV positive patients with stable CD4 and viral load come down with C19?

For HIV positive individuals with stable CD4/viral loads and on effective treatment there's no evidence that they are at higher risk of developing serious COVID-19 symptoms.

After a person tests positive and recovers how do you know they are no longer contagious? Example: 13 days after symptoms first started but still has a cough and burning chest

A small study of recovered COVID-19 patients suggests patients may continue to shed the SARS-CoV-2 virus for up to six weeks after symptoms emerge.

How do you define elective vs non-elective?

An elective procedure is simply one that is planned in advance, rather than one that's done in an emergency situation. A wide range of surgical procedures can be considered elective. Cosmetic surgeries fall into this category, but so can things like ear tubes, tonsillectomies, and scoliosis surgery. Although these procedures may be done "electively," they can be significant and potentially life-changing operations. Non-elective procedures can include urgent procedures that usually must be done that day (for example, an appendectomy) and emergency procedures which must be done right away.

The American College of Surgeons put out a COVID 19: Elective Case Triage Guidelines for Surgical Care that can be found at

https://www.facs.org/-/media/files/covid19/guidance_for_triage_of_nonemergent_surgical_procedures.ashx

What is safety/recommended use of ibuprofen? Should APAP be primarily recommended for OTC analgesic?

There are physicians in the medical community advising against using ibuprofen for COVID-19 symptoms based on reports of otherwise healthy people with confirmed COVID-19 who were taking an NSAID for symptom relief and developed a severe illness, more specifically pneumonia. Be aware that these are only observations and not based on scientific studies.

The WHO initially recommended using acetaminophen instead of ibuprofen to help reduce fever and aches and pains related to this coronavirus infection, but now states that either acetaminophen or ibuprofen can be used. Rapid changes in recommendations create uncertainty. Since some doctors remain concerned about NSAIDs, it still seems prudent to choose acetaminophen first, with a total dose not exceeding 3,000 milligrams per day.

However, if you suspect or know you have COVID-19 and cannot take acetaminophen, or have taken the maximum dose and still need symptom relief, taking over-the-counter ibuprofen does not need to be specifically avoided.

Do you recommend we tell our patient to hold off on obtaining venous/arterial ultrasounds, vascular consultations, etc. needed to determine treatment to decrease their risk of exposure to virus?

A non-invasive procedure if available can still be performed in the outpatient setting if available. Obtaining a vascular consult that is not emergent is difficult to obtain at this time. Otherwise, if the patients wound are stable such a procedure could be delayed. Of course, these types of decisions need to be determined on a case by case basis.

Can you talk to the recent CMS guidance that hospital acquired conditions will not be tracked or reported from January until end of June this year? How might this set back facilities and patients?

For institutions with data submission deadlines in April and May 2020, submission of those data will be optional, based on the facility's choice to report. In addition, no data reflecting services provided January 1, 2020 through June 30, 2020 will be used in CMS's calculations for the Medicare quality reporting and value-based purchasing programs. This is being done to reduce the data collection and reporting burden on providers responding to the COVID-19 pandemic.

The lack of this data may unfavorably impact the data used to help continuous quality improvement measures, but CMS recognizes that quality measure data collection and reporting for services furnished during this time period may not be reflective of their true level of performance on measures such as cost, readmissions and patient experience during this time of emergency and seeks to hold organizations harmless for not submitting data during this period.

What do you see as a “normal” in the near future?

The new normal may include a continued increase in the utilization of telehealth, how we define patients that truly require weekly routine clinic visits, and consideration of delivery models that transition of site of service wound care to the home and unskilled facilities.

Do you see access to clinics from industry in the future changing?

We may see further increase in the utilization of video or streaming media platforms to convey information from industry to providers. However, the partnership between industry and healthcare for now will most likely remain intact.

Is telemedicine becoming more of the norm?

It will especially as Healthcare Institution invest more in what is being called virtual hospitals which is basically a building where all specialties reside, and patient visits are only done thru telehealth platforms.

Although primarily respiratory droplet and possible fecal transmission, any increased risk of aerosolized inoculation with cleansing wounds with wound spray, etc?

Use of spray cleansers should not be used as common source in any outpatient wound clinic since the spray bottles are a known source of nidus of spread infection be it multidrug resistant bacteria or SAR-Cov-2. SAR-Cov-2 can be spread through fomites therefore once the bottle becomes contaminated every pull of the trigger has the potential to infect. If you are working with actively infected patient the providers should be soaking the wounds not spraying which would potentially have the ability to aerosolize the virus.

Do you see home health being more involved in Advanced wound care? Evaluation of wound progress and less clinic visits? Possibly every other week visits instead of weekly due to the need?

Deploying telehealth in a coordinated effort with home care providers could definitely achieved the above stated goals of fewer in office clinic visits that are spaced farther apart.