Centers for Medicare & Medicaid Services
COVID-19 Call: Dialysis and Kidney Organizations and Providers
Moderator: Alina Czekai
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OPERATOR: This is Conference #: 3689246

Alina Czekai: Good afternoon. Thank you for joining our April 15th CMS COVID-19 Weekly Call with Dialysis and Kidney Organizations and Providers. We really appreciate you taking the time out of your busy schedules to join us today.

This is Alina Czekai, leading stakeholder engagement on COVID-19 in the office of CMS Administrator Seema Verma.

Today, we're joined by CMS experts, as well as some providers in the field who have offered to share their best practices. I'd now like to turn it over to my colleague, Jean Moody-Williams. Jean is the acting director at the Center for Clinical Standards and Quality here at CMS. Jean, turning it over to you.

Jean Moody-Williams: Thank you so much. Thank you all for joining us this afternoon. And as always we appreciate your efforts as you continue to compassionately care for those who rely on you. Not only those that are receiving dialysis – depending on you for kidney health – but their families and caregivers and all. So we appreciate that.

We understand the workload that you're under at this point, and many of you have reached out to us regarding some of the strain of reporting and survey, and all of those kinds of things. We hear that. We are looking for ways to reduce that burden, while at the same time offering protections, and being able to do what is expected of us from many. Trying to find the right balance towards that. And we'll be getting more information out to you on that shortly.

We are also aware of some of the shortages of supplies in certain settings. And I'm going to turn to Dr. Jesse Roach in just a few minutes to talk about that. And there – and I just wanted to take the opportunity as well to remind you about the waivers that we released a couple weeks ago. And I've walked through most of those with you at one point or another. I know we get different folks on the call.

But just as a reminder of a few of them. We waived the requirement to furnish dialysis services on the main premises for dialysis patients that reside in a nursing facility, or skilled nursing facility. So you can actually go into those facilities. I'd be curious to see how that's working.

We waived the requirement for monthly visits with the medical team for stable patients. And the – waived the dialysis patient care technician certification requirement, to allow technicians to continue the work until the public health emergency is over, and then at such time they'll be able to catch up on their requirements.

And also expanding the special purpose renal dialysis facilities, so that there can be a designation – so that there can be access for those who are – have a COVID positive status. And I have been getting reports on that, and understand that that's been working well.

So we look forward to continue collaborating with each of you as – and identifying different opportunities of how to address the COVID-19 situation. I still have to applaud you – because we do get daily updates, and you're really doing a fantastic job in the middle of this. I know there were tornadoes that closed down several facilities. But without missing a beat, the patients were able to get their treatments. And so all of those things continue to happen in the midst of this.

So before we get – we do have a treat, in that we have some guest speakers that will talk about some of the practices going on in the field. We'll be able to take your questions as well.

But before we move to our guest speakers, I want to turn to Dr. Jesse Roach, who of course is a nephrologist at CMS, and practicing. And I'll turn to Dr. Roach.

Jesse Roach: Thank you Jean. I just wanted to let you know. We've heard multiple reports – mostly in New York, but in some other places – of severe shortages of CRT fluids for acute – for patients with acute kidney injury with COVID. The increase in the ICU has led to an increase in the need for renal replacement therapy in the ICU. And so there's put a strain on some of these fluids.

So I just wanted to – one, let you know that we have been working on this diligently. We're working together with FEMA, our preparedness and response section of HHS, as well as the FDA in trying to come up with solutions for this.

But what I have to ask of you guys is if you are having shortages at your facilities, or at – if you could please let us know. We aren't always getting reports of this in real time, so that makes it harder for us to deploy resources.

And if you want to just reach out to me directly, you can. My name is Jesse Roach. Jesse – so jesse.roach@cms.hhs.gov. And we will compile a list of places, and hopefully use that to get these fluids and equipment where it needs to be.

So that's all I've got right now, so I'll just turn it back to Jean. Thank you.

Jean Moody-Williams: Great. Thanks – thank you for that. So before we go to our questions – as I mentioned, it's really my pleasure – I'd like to introduce Dan Weiner, who is the associate medical director at Dialysis Clinics Incorporated in Boston, and also associate professor at Tufts University School of Medicine. So I will turn to you.

Dan Weiner: Thank you so much, Jean. So my name is Dan Weiner. I'm a nephrologist at Tufts, and I'm one of the medical directors for DCI Boston. I've just got off of the inpatient consult service last week. I have this week to focus more on the

dialysis patients, and then go back on – back to the consult service again next week.

And as you guys know, I'm sure, Eastern Massachusetts has been getting rather busy with COVID. We have the wonderful honor of being number three in the country right now after New York and New Jersey. So we are making some inroads there. I think that goes to the fact that everybody is working hard.

So my major comments in terms of best practices, and then areas where I think we really need help. My first major comment is – just having spent time in the hospitals, spending time in the dialysis unit – is that people are amazing. And I think it's incredible how nurses, technicians, doctors, patients – everybody is really rising to what is a totally unique challenge that we haven't faced before.

I think the second thing is that the hospitals right now are very surreal and very sad places. And I've been doing this for 25 years now, and spending time in hospitals for that long. And I've never seen anything like this.

We're beginning to consider how to minimize utilization of certain things, such as CVVHD fluids, as Jesse used – as Jesse mentioned – so that we don't run out. So trying to use the minimum that we can in order to be able to maintain our supply in a time of uncertain resupply. We're gone into – we've developed a QPD protocol, so that we haven't had to use this yet. We're a few weeks behind New York, I think.

And then the thing that we've been dealing with the most – at least on the inpatient side – is how we can keep our inpatient hemodialysis capabilities sufficient to treat the number of dialysis patients that we have, both people with acute kidney injury, and dialysis patients who are admitted to the hospital. And this has become particularly challenging, because we're doing essentially almost all one to ones. Not really transporting dialysis patients within the hospital.

In our particular practice, we split our nursing staff between inpatients and outpatients. And we currently have two of our nurses – so about 15 percent of our nursing staff – out with COVID, and four patient care technicians out with COVID. So at a time when demand has gone up, we have actually had some decrease in our staffing capabilities.

So what this leads to is our – our critical need, which is being able to provide the right kidney replacement therapy to the right patient in the right place at the right time, in order to be able to best use our resources and provide care that's as safe as possible. And the thing that we've struggled with the most is how to get patients out of the hospital into outpatient dialysis facilities when they're ready to leave the hospital, or if they don't need to be admitted.

So in terms of our best practices, I think we've done well with home patients and telehealth, although we still have some uncertainty as to whether we need to bring otherwise stable patients into the clinic, or have them go to a nearby laboratory for monthly labs. And I'd make a push that hopefully we'd be able to use our clinical judgment here for those stable patients, that we won't need to have them leave their houses just to be able to get labs.

Moving to the hemo facility, which I think is much more challenging. We have about 110 patients in our facility, and right now we have 14 positive COVID patients. I think the most remarkable thing of that number is, of those 14 positives, we have five who either live in nursing homes – five of our nine patients who either live in a nursing home or a shelter are COVID positive.

So more than 50 percent of people who come from those congregate settings are COVID positive, while less than 10 percent or so are positive who live independently. We do think that number is going to be much higher, but testing certainly is not universal. And like I think you've heard from many others, our best practices involve cohorting COVID patients. So opening up evening shifts basically with only COVID patients. Or for a larger unit where you have all the COVID patients in one area, and you're dividing your staff in half.

So we're really doing our best to try to fight this disease. And where I think we need the most help right now is when it comes to transportation. This is a modifiable issue, and I think it can make a real difference. I've spent the bulk of the last two days just talking to our social worker here, who has spent the bulk of the last two days trying to get transportation for COVID positive patients. Either those who are patients who are ready to leave the hospital, or people who have tested positive in the outpatient setting who don't require hospitalization.

For Massachusetts – at least for our unit – we're an intercity unit, and most of our patients are dual eligibles. And for Massachusetts at least, Medicaid and the agencies that arrange Medicaid rides won't currently transport COVID positive patients or PUIs. And the policy for Medicaid and MART, which is the ride, states that these patients should be transferred by EMS.

In contrast – and I wrote this part down – the current CMS guidance states, "Due to the beneficiaries' condition, the use of any other method of" – I copied down incorrectly. But if the beneficiary essentially is ambulatory, your – any other method of transportation is contraindicated is how this is being interpreted.

So for people who are safe at home, they're able to walk, in theory they'd be able to get into a chair car, or something else like that – the ambulance services are interpreting these people as not – as being contraindicated for emergency transport.

So it's really a catch-22, in as much as we need to decompress our hospitals, and be able to get patients to outpatient dialysis facilities where we do have sufficient staffing. We need to make sure that these patients don't get admitted to hospitals in the first place, and use up valuable resources. This goes directly to the CVVHD fluids, because the more people we can treat with intermittent hemo – even if they're on a little bit of blood pressure medicine to raise their blood pressure – the fewer people we need to treat with CVVHD, then the less CVVHD fluids we need.

So this whole issue of getting people to the right place for their treatment, at the right time, is absolutely critical, and in the transportation infrastructure, something we really need help with.

So that's sort of my comment about best practices, and where we are desperately in need of help as well. So thank you very much for this opportunity.

Jean Moody-Williams: Thank you so much for – for sharing that, for the practices as well as the challenge. And we, I know, are again working with our partners that ask for FEMA on this issue of transportation. And hopefully some resolution we can find.

I'd like to turn to Dr. Mike Ross, who is the Chief Division – Chief of the Division of Nephrology, and Dr. Maureen Brogan, the Clinical Director, at Albert Einstein College of Medicine, Montefiore Medical Center.

Mike Ross: OK. So thank you for this opportunity. Now just so I know the format, I think I'm probably best off ceding most of my time to Maureen, since she's the clinical director, and has a – the better intimate knowledge of what's going on day by day in the patient care units.

But we have three main hospitals that we run. We have close to 1,000 outpatients – dialysis patients that we manage chronically in a large transplant center. So we sort of have an overwhelming patient load overall, spread through the hospitals. And essentially close to 100 percent of our medical center right now is COVID positive. And they've quadrupled the number of ICU beds through the hospital.

And, you know, providing renal replacement therapy to everybody on the inpatient side has been extremely, extremely difficult. And we've had to, unfortunately, ration a lot of the – not ration, but we've had to cut the number of treatments to twice weekly by default for people on chronic dialysis, and shorten the time. And really, we're basically just barely able to provide enough dialysis to keep people alive. But certainly not as much as we think that most of them should get.

On the outpatient side, I also totally agree – it is absolutely critical to manage patients, if at all possible, outside the hospital to offload the inpatient side. And we have – we have COVID positive patients in all of the outpatient dialysis – or people who have turned positive in all the outpatient dialysis units. And trying to manage them outside the hospital is really critical, and requires a lot of coordination with the units, and leadership with the large dialysis companies and our own staff.

And also creating robust plans for how to ease people out of the hospital back into dialysis units also requires a lot of coordination as well. And there are some dialysis companies that will only accept patients once they've tested COVID negative back into their home units. Others where we can use a little bit different criteria. So it's – that's sort of the general overview of what's happening at our institution.

I'll let Maureen get into the more specifics on the inpatient – especially on the inpatient side.

Maureen Brogan: Yes. This is Maureen Brogan. So the first thing we did when we had our first patient on March 10 come into the hospital was – Dr. Ross established a nephrology leadership task force, in which we meet every day at 4 o'clock on the phone. And this group does a lot of planning together.

It consists of nursing. Someone focuses on outpatient dialysis. I focus on the hospital dialysis. We have someone to focus on outpatient clinics, because a lot of these patients are getting discharged, and they need proper follow up. And one person focuses on infection control, and gives us ideas of what we need to do. So we all work together, and meet every day. So this has been really helpful on planning.

For the ICUs, for acute kidney injuries, the best way for clearance for our patients has been prolonged intermittent renal replacement therapy. We're doing six to 10 hours of the – you know, of therapies with effluent flow rates of 40 mls per kilogram an hour. We did not have enough nursing to take care of these patients, because they're on a four to one ratio right now.

So we – I got the perfusionists in the hospital involved, and they're helping run these circuits. And they are also able to maintain the circuit by using bivalirudin. So there are other people using different anticoagulants, but heparin did not work – a heparin drip. So we are using bivalirudin, and the circuits are being maintained.

We also ordered a circuit that had longer tubing so we can keep the machines outside the rooms, so – for the staff not to be exposed the whole time while they're maintaining the dialysis circuit. They're running out of – the dialysis companies are running out of this longer tubing, but they've given me information about where to purchase this from a third supplier.

We tried CAPD, and nephrologists actually went into the rooms and did – and the fellows did the exchanges themselves. But due the prolonged prone position of these patients, they were not getting proper clearance. Then we got 15 cyclers in the hospital, and we actually put these peritoneal dialysis catheter on – on laterally on the patient, and we still are not getting proper clearance. So it seems like that peritoneal dialysis has not been – it's only helpful on the patients that are on the regular medical ward, and they're able to not be prone 16 hours a day.

So we're having trouble getting fluids. We actually had to go a couple of days using PD as dialysate for a CRRT. But now we got – the company is mostly giving us lactate based dialysate. And they told me they have very low supply of bicarb. So we're using a lactate based dialysate starting yesterday. And we're not sure – they're not able to tell us how long they can supply us with dialysate at this time.

So our main concerns are that we're not – we might not have enough dialysate solution. We don't have enough dialysis machines. We're actually going to get some home hemodialysis machines into the hospital, and use those as CRRT machines. And we're renting those. And then we don't have enough nursing staff. Either nurses are getting sick and being called out, or – it's due to the patient load. They're not able to care for all these patients. So that's our three main concerns, is staffing, solutions and machines.

Jean Moody-Williams: Thank you. Thank you for – was there something additional? OK. Thank you for sharing that information. And so, Operator, I'd like to open it up for questions for our presenters. We have a limited number of subject matter experts on this call, but we'll take questions for CMS as well.

I will say that we do – started to have Office Hours on Tuesdays and Thursdays, where we bring our subject matter experts to answer the more technical questions. So we will take our first question now. Operator? Could you give instructions for questions.

Operator: My apologies. I was on mute. If you would like to ask a question, you may do so by pressing "star", then the number "1" on your telephone key pad. Again, that's "star" "1" to ask an audio question. We'll pause for a moment to compile the Q&A roster.

And our first question ...

Dan Weiner: This is Dan. Can I actually ask a question of Maureen while we're waiting?

Maureen Brogan: Sure.

Dan Weiner: So in terms of the acute PD. If you're somebody who's been on CVVHD in an ICU or PERT. Are you – and they're going to the floor, but still requiring kidney replacement therapy. Are you transitioning them to acute PD, or are you sticking with hemo in that case? Or it really just depends on your capabilities?

Maureen Brogan: It depends on our capabilities. We have a lot of hemodialysis nurses out as well. Some of them are starting to come back. But we are able to – we have radiology putting in peritoneal dialysis catheters on four patients, and we have transplant surgery putting in peritoneal dialysis catheters in the ICU, bedside laparoscopically.

So we have – you know, we're able to do either. We're actually – some patients who we think are going to stay on dialysis for a while, we are – some of the nephrologists are asking patients what their choice is, whether it's going to be peritoneal or hemo. Or they're asking the families.

Mike Ross: And one of things that we've – that we've done – a couple of things that we've done to increase our capacity to provide intermittent hemo is first of all, the patients who require off unit dialysis in their rooms, we've installed a bunch more water hook up basically wherever we could in the hospitals. We've installed water hook ups in patient rooms to increase their capacity to where we can perform dialysis.

And when the – when the pandemic first hit, we tried to do all the COVID positive patients off unit in their rooms. And that quickly became unsustainable, when essentially the whole hospital became positive. So we pretty quickly had to switch to allowing patients to come down to the dialysis unit.

And what we did was we tried to do all of the non COVID patients early in the day, get them out of there, and then we would do – bring in the patients who were – had coronavirus, and clustered them together in the (leaderships) and then in turn we cleaned the unit at the – at the end of each day.

Also critically important is to make sure that the staff – the dialysis nurses' – break room, locker room, all that area is – that they do a really good job social distancing, and not eating together. Because we think – we've had a lot of infections, especially a couple of weeks ago, among our staff. And I suspect some of it was staff member to staff member in some of the non patient care areas.

Dan Weiner: We've had the same experience.

Maureen Brogan: We also put – sorry, we also put many – all ESRD patients and AKI patients in the ICU on potassium binders. Everyone gets it daily. And we've also used high dose diuretics on anyone who's making urine. Or diuretic drips. So everyone got a – we made sure we talked to pharmacy when this was happening, and made sure they ordered enough potassium binders and diuretics for us. We're running out of phosphate binders. That's another thing you'll – that we all will need, is phosphate binders for all these patients. Their phosphorus run very high.

Jean Moody-Williams: Thank you. Operator, do we have a question?

Operator: Indeed. Our first question is the line of Gary Gelbfish. Gary, your line is open.

Gary Gelbfish: Yes. Hi there. Thanks so much, and again, I add my appreciation for everybody who's in the pits. I'm a vascular surgeon for the past 30 years, focusing on hemodialysis. I'm well known in the New York area. Right now, I have a backlog of five – of 50 new cases that I need to put dialysis access in, that have been dialyze via catheter.

The problem is that, as a quirk of New York, you need a certificate of need to do this in the office. We've done this in the office safely for many years, although we take a hit every time we do it. And the problem is that this is unsustainable. In other states, it may or may not be acute, because in other states, certificate of need is an easy thing to do. In New York, it's all but impossible.

CMS does provide, at this point, additional reimbursement if you do interventional radiology in the office, and that system has worked for the past 20 years. And I currently do that. I am open, and I take care of patients as an outpatient right now. We have not had to send any patient to the hospital, except one who was in congestive failure, which we placed a catheter in the office, and then sent him to the hospital. He was discharged a day later.

The bottom line is we perform thrombectomies on these patients, other complex procedures. But we can't do a simple access creation because of the prohibitive expense in doing that. Although CMS does approve for the professional fee, it doesn't approve of room fee.

To be short, here's my question – and I've sent letters both to the governor of New York, and to the director of CMS, and to the professional societies – ASDIN, VASA, and ASN. Is it possible, is it temporary which we can always talk about if it can be permanent – to permit people like myself, who are certified in the hospital to do these procedures of course – and I carry a (QuadA), and previously JCAHO certification for four outpatient operating

rooms – to do this procedure, which is literally little more than a scratch in the skin. And it's something that would help to decrease the backlog.

My fear is – and I'll be – I'll finish in a second – if we don't do this, it will take us six months or a year to creep out of this. And in addition, we'll have almost a generation of patients with central venous occlusions – problems, and a constant supply of septic patients who need to further overload the hospital system, merely because we couldn't appropriately reimburse people who are imminently capable of doing this in a certified outpatients setting. I hope that this can get to the people who can possibly consider this as an emergency method – measure. Thank you.

Jean Moody-Williams: Thank you for that question. There's a lot in there. I know we have issued a number of waivers that allow alternative locations to be used in various situations. Obviously we can't override state law that would permit you to be able to do this in that setting. So I guess if there's something that you see that CMS still needs to waive – and you said you've sent us a letter – if you can point to that, we can certainly take a look at that if there's anything else that CMS can do.

Gary Gelbfish: Is the microphone still open? Hello?

Jean Moody-Williams: Yes. I hear you.

Gary Gelbfish: Yes. OK. Well the state does not prohibit from doing it. The state lets us do this. But the state will not certify an office as a ambulatory surgery center unless you have a certificate of need. And in other states, the CMS will recognize the same facility simply because the state deems it as appropriate.

Now so I do these procedures in the office currently, OK. Reservingly, because of the big hit that I take. The problem is that the CMS can add a star code, where there's an additional reimbursement if done in the office. And they do this for many other procedures. A balloon angioplasty, if it's done in a hospital, is reimbursed at X. If it's done in the office, it's reimbursed at two or three X, in recognition of the fact that the doctor is responsible for supplies.

So this is – this is not a regulatory issue at all. This is simply a financial issue in the reimbursement structure that makes states with a certificate of need – which drives doctors to do as an office based setting, rather than as an ambulatory surgery setting – it makes those states impossible to have physicians do this in the venue that is appropriate in that specific state.

So this is a total reimbursement issue. There's nothing in the state regulations that permits me – that prohibits me from doing these in the office. I can, you know, send you the letters that I have, and further discuss this, but this is a critical issue in New York.

Jean Moody-Williams: Yes. That would be helpful. That would be helpful, because then we can get our payment people to take a look at it just to make sure. And I'm sure, Dr. Roach, you understood the situation as explained, and we can sit down with our payment people and take a look at it. So thank you for that.

Gary Gelbfish: I'll address my e-mail to Dr. Roach. Thank you.

Jean Moody-Williams: Thank you. OK, great. So we are at time. And again, appreciate you all tuning in. And we'll be back next week hopefully, with some additional news and information for you. Thank you. Alina?

Alina Czekai: Thank you, Jean, and thanks to our guest speakers, and everyone for joining our call. We hope that you'll join us for our CMS COVID-19 Office Hours tomorrow at 5 p.m. Eastern. And on that call, we'll have technical question and answer session with our CMS subject matter experts.

And in the meantime, please continue to direct your questions to our COVID-19 mailbox, and that is covid-19@cms.hhs.gov. Again, we really appreciate all that you're doing for patients and their families around the country as we address COVID-19 as a nation.

This concludes today's call. Have a nice evening.

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