Centers for Medicare & Medicaid Services
COVID-19 Call with Dialysis Providers, Nephrologists and Kidney Providers
Moderator: Alina Czekai
April 29, 2020
5:30 p.m. ET

OPERATOR: This is Conference #: 6965645

Alina Czekai: Good afternoon. Thank you for joining our April 29th CMS COVID-19 weekly call with dialysis providers, nephrologists and kidney providers. We appreciate you taking 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 are joined by CMS leadership, as well as some providers who have offered to share their best practices from the field.

I'd first like to turn it over to Jean Moody-Williams. Jean is the acting director at the Center for Clinical Standards and Quality at CMS for a brief update on the agency's latest guidance in response to COVID-19. Jean, over to you.

Jean Moody-Williams: Great. Thank you everybody for joining this afternoon. Always a pleasure to get with you all to talk about the challenges and the critical issues that we are facing with COVID-19. We are continuing to work with our colleagues in the CDC and FEMA, and the HHS and the Secretary's office, to work with you and industry to address some of the most pressing issues.

We continue to work through the dialysis supply issues in certain settings, coordinating. And I think we are seeing some progress there. I know that transportation continues to be an issue in some areas. And we have engaged the (inaudible) network to get information from you on the specific issues regarding locations, patients impacted, so that we can provide this information to those that might be able to help with this. So please, as they reach out to you, work with them in that area.

We're also looking at still getting some requests for waivers in. So we are addressing those. We also hope to be making announcements very shortly on some of the requests and rules that we have. So it's hoping that maybe have something to tell you today, but we'll keep your eye out.

So with that, though, I am very happy to be able to introduce to you our speaker for this afternoon, and then that will leave us time for questions, as we tend to run out of time. So I'm just going to go straight to Dr. Christopher Blosser, the Associate Professor of Nephrology, and Transplant Fellowship Director at the University of Washington.

Dr. Christopher Blosser: Thank you so much. I really appreciate the invitation to be with you today. I hope you hear me OK. I'm also really thankful for the engagement of local, state and national leaders as we continue to confront this challenge together, and use the growing scientific and clinical evidence to guide our decision making going forward.

What I hope to do in the next few minutes is to talk with you about my experience here in Seattle, and with collaborative work around the country and the world, on our experience caring for transplant recipients, the majority of which are kidney transplant recipients, but not all.

As we know, the population rates transmission wise of COVID-19 are quite high and the mortality rates are variable and concerning. And we, at this point, are assuming, based on the early data that we are seeing even higher transmission and mortality rates in organ transplant recipients because of a number of risks that they have.

Before I talk about those risks, I just want to name the symptoms that we commonly see in our transplant recipients, which are similar to the general population, but more variable. Fever is a common presenting symptom, yet in the case reports and series around the world, 50 percent or so of people will not have a fever before developing other symptoms including diarrhea, myalgias, a cough that may or may not be productive, dyspnea that can be quite progressive, but take days to get there, and then other sometimes delayed

symptoms, including anosmia – lack of smell – or a change in taste – dysgeusia. And headaches have been documented.

We're seeing in Seattle and around the country that older people, and men more than women, are contracting coronavirus. But the most notable are people with multiple comorbidities in various forms, including end stage kidney disease, or with immunosuppression after transplants, are at higher risk for getting the infection.

So we have shifted much of our care, as I know much of the country has, from in person care to telemedicine care, in order to try to prevent exposure, at the hospital level or the clinic level, for our patients. And that's including pre transplant evaluation, where we now are doing only telemedicine evaluations, and delaying any in person evaluation for surgical candidacy until the risks abate.

We are also not performing any living donor transplants at this time. And I think that's relatively true across the country right now, because of the risks to our donors, and to the entire team that needs to engage in that process, until elective surgeries are restarted, and system wide, institutional pre procedure testing is available for the – for coronavirus. I expect that we will not return to living donation until then.

Here at the University of Washington, we are able as of last week to test all inpatients, and all patients that are needing to go – undergo a procedure beforehand, to ensure that that is negative via nasal swab DCR. We are also continuing to see donor kidney transplants on a case by case basis. That's after the donor is negative for coronavirus by (BAL), and the recipient is negative by nasal swab.

We're not being as aggressive, per se, with our transplantation process, while on the other hand, we are concerning – considering if someone is highly sensitized, and may not have great opportunities for deceased donor transplant if they forgo the current opportunity for a transplant, we will, and have, performed kidney transplants. And then need to consider the level of induction and maintenance of immunosuppression after transplant, because of

the ongoing risk when they are in the hospital, and then return to the community.

When we think about the post transplant care, we continue to mostly attend to primary prevention, advising our transplant recipients to avoid crowds, including grocery stores, if somebody else can do the grocery shopping, or receive delivery of food.

We are also using local labs instead of hospital based labs, and even newly developed mobile phlebotomy options when possible, to minimize the risk of exposure.

When someone develops symptoms, we're trying to keep them home, and do the testing through an outpatient system. Here in the Seattle area, we were fortunate to have drive through testing relatively early on, and we continue to use that when someone develops any symptoms that are concerning, yet they do not require emergency room evaluation.

We try to keep them isolated at home, rather than hospitalized, just because of the additional risk to them in hospital. And most people that get infected do not require admission from what we're seeing in the transplant population. Yet if someone has progressive symptoms, or notable leukopenia or lymphopenia, which is common, we will admit them. And sometimes we'll directly admit them to a unit, and specifically a room within a COVID unit, rather than going through the emergency room if we can.

We know that those people who have lymphopenia and leukopenia have a proportionally higher risk of poor outcomes. And also we know that those who require ventilation have poor outcomes.

When we look at the chest x-ray results, many will have a negative chest x-ray to start with, but then have progressive findings on a future x-ray or CT scan, including diffuse interstitial infiltrates, ground glass opacities.

In terms of caring for people that end up getting admitted to the hospital with COVID while immuno suppressed, a few things that I would advise. One is that our University of Washington nephrology group has been avoiding

performing any urine microscopy, because of the risk of infection via the urine, until we have a better understanding of that transmission risk.

For people that get admitted to the hospital, it tells us that the risk is high enough that we need to minimize their immunosuppression to some extent. And so we've been holding the anti metabolite, such as mycophenolate if they're taking it.

At the same time, we have not wanting – wanted to decrease immunosuppression too much, because of the increased risk of cytokine storm system inflammatory response, or ARDS, along with rejection. So we've continued the calcium inhibitor at a low dose, along with low dose steroids for many people.

We haven't been using pulse dose steroids, mostly because people can have concomitant other viral or bacterial infections that would be exacerbated by the steroids. So those who have severe infection – we have used without specific clinical evidence to support the use – we have tried using hydroxychloroquine, il6 inhibitor, or remdesivir.

One of the treatment comment that I would make is that we have continued using ACE inhibitors or ARDs in our patients, if they came into the hospital with them, for cardiovascular support, recognizing that at this point there's no evidence that the medication increases the risk of infection or poor outcomes as we know it today.

When someone is finally stable enough to be discharged from home, we try to get them stabilized to the same extent that we otherwise would for discharge, and then ensure that they have the support at home, while also being isolated from the others in their home, so as to not transmit the infection if at all possible.

We know that our transplant patients shed the virus longer than the general population, up to even eight or more weeks. And so we've advised that patients remain isolated at home, with nasal swab testing every two weeks or

so, to ensure a negative test before they return to the hospital for follow up, or have lab testing outside of their home, if at all possible.

If that's not possible, we will have our patients who are previously treated for COVID come into specifically identified rooms within the clinic, with the first point of meeting at the door of the hospital, and a direct rooming without stopping anywhere else.

So I think at this point, I'm thankful for where we have achieved as a country, and knowing that there are certain parts of the country that are continuing to work very hard to overcome these market changes, I would – I would note that there are certain ongoing unmet needs across the transplant population and the providers that are caring for them that are probably obvious, but include the ongoing need for PCR testing to ensure adequate care for our recipients, for our donors before transplant, and related to that, the hospital staff and the public.

Serologies – while the tests are available, we're not yet aware of how to use them in our transplant patients. So we haven't been using that in any kind of clinical fashion yet, but rather in research fashions.

We are beginning to see the second wave of patients needing care that are not necessarily COVID related, but because they've delayed their care in the setting of the pandemic, we're now seeing more acute kidney injury that's possibly rejection, congestive heart failure, and exacerbated mental illness, that need attention.

So many of our staff are on the phone throughout the entire day, supporting these patients, trying to find safe ways for them to get care, including time for QUAINT evaluation, or hospitalization if necessary.

You've mentioned transportation being an ongoing challenge, and I would only add that when it comes to transplantation, ensuring that our patients can have the transportation to and from hospital for appointments, or at the time that they're called in for a transplant, is necessary, in addition to organs being transported from the procurement location to the transplanting location is an

additional current limitation that we understand will be – come online, as other options for transportation come online as well.

Finally, medication availability has been a challenge in certain parts of the country and around the world. And so attending to ongoing immunosuppression availability, so that our patients don't have rejection just by sheer fact that they cannot receive their medication is a transportation and a logistics challenge that will be an ongoing need for us.

So at this point I'll stop, and I appreciate any question that people may have. Thank you.

Jean Moody-Williams: Thank you so much. That was a great deal of information. And we haven't had the opportunity to focus as much on transplantation, so this has been a really great discussion. And Operator, I'd like to really open it up for questions now.

Operator: As a reminder, to ask a question, you will need to press "star" "1" on your telephone. To withdraw your question, press the "pound" key. Please stand by while we compile the Q&A roster. And your first question …

Dr. Jesse Roach: This is Jesse Roach. Oh, can I ask a question first?

Jean Moody-Williams: Yes, sure, (inaudible).

Dr. Jesse Roach: This is Jesse Roach. Thank you very much for doing this, Chris. I want to know what criteria were you using for – if you did decide to proceed with deceased donor transplant. Like, what was – what was the determination to make you do those?

Dr. Christopher Blosser: Thanks Jesse. I think the determination comes first on the recipient side. If we think that this person really would – would benefit from a transplant regardless of the increased risk of infection, whether it's because they are highly sensitized, and won't likely get a kidney as early – as soon in the future as we'd otherwise expect, or if the donor happens to be a really excellent kidney donor for this person. Then we'll proceed with it.

Dr. Jesse Roach: OK. Thanks.

Jean Moody-Williams: Great. Thank you. I would like to check to see if we have any questions on the line, Operator.

Operator: Yes we have. Your first question is from (Mackenny Rosalie). Your line is now open.

Jean Moody-Williams: Yes. Proceed with the question.

(Mackenny Rosalie): I'm sorry. What was that name? Or can you hear me?

Jean Moody-Williams: Yes I can hear you. Go ahead with your question.

(Mackenny Rosalie): OK. I'm sorry. I continue to hear from folks in both the dialysis space, and the nursing facility space, regarding the need to be able to dialyze patients with acute kidney injury in those spaces. And I know there have been waiver requests made, and we've discussed this on last week's call. Is there any movement on that yet – determining an increased need with the COVID virus, and people getting out of hospitals with kidney needs?

Jean Moody-Williams: Yes. I'm going to turn – go ahead, Dr. Roach.

Dr. Jesse Roach: I can answer that one. So this is something that we have gotten a lot of requests for. And it's something we're currently looking at. We are considering, or we're looking at the possibility of having some of the home dialysis take place outside of the unit for (AKI) patients, which currently isn't permitted under the billing rules. It would take another waiver and change in the upcoming rules to do that. But it's something we're looking at.

We are – right now, just want to make sure that we do this in a way that keeps the patients safe. We want to make sure that these patients aren't going home and – that they'll be monitored in a way that – accounting for the fact that they potentially can be sicker, is basically if they're going to be – if these are COVID positive patients that have been – that have recovered from kidney injury. And we want to make – make sure that they're still being checked for kidney function.

So it's something we're working on, and we just want to do it in the right way, to make sure that they – these patients are taken care of. But we've heard it, and it's something that we're looking at.

(Mackenny Rosalie): Great. And given – just the need for increasing – is there anything that we can help provide to you all? Or is there other information that you're looking for, or anything that we can do to help that decision making?

Dr. Jesse Roach: I think – not that I can think of. We've gotten lots and lots of requests for this. So we're quite aware of the acute need. And it's definitely high on our radar.

(Mackenny Rosalie): OK. Thank you so much.

Dr. Jesse Roach: Thank you.

Jean Moody-Williams: All right. Next question please.

Operator: There are no questions at this time. Please continue, Ma'am.

Jean Moody-Williams: OK. Great. Thank you all for – for tuning in. Also if you are interested in a particular topic, please let us know that as well. And I'm going to turn to Alina to talk about if you have more technical kinds of questions – billing questions, that kind of thing – how you can get those answered.

Alina Czekai: Thanks, Jean. Thanks everyone for joining our call this afternoon. We hope that you'll consider joining our CMS COVID-19 Office Hours tomorrow. That's an opportunity for you to ask more technical questions of our CMS subject matter experts. And that call is at 5p.m. Eastern tomorrow.

And in the meantime, you can continue to direct your questions to covid-19@cms.hhs.gov. Again, we 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 good evening.

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