Centers for Medicare & Medicaid Services
COVID-19 call with Dialysis Providers, Nephrologist & Kidney Providers
Moderator: Alina Czekai
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OPERATOR: This is Conference #: 3287645.

Alina Czekai: Good afternoon. Thank you for joining our May 20th CMS COVID-19 weekly call with nephrologist, dialysis providers and others who care for kidney patients. 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 leaders as well as providers in this field who have offered to share their best practices with you all. I'd first like to turn it over to Dr. Jesse Roach, a medical officer and nephrologist in the Center for Clinical Standards and Quality at CMS for an update on the agency's latest guidance in response to COVID-19. Dr. Roach over to you.

Jesse Roach: Thank you, Alina. Welcome everyone and thank you for joining us today. We all know that you're working incredibly hard to help the – to help combat the spread of COVID-19 within your communities. And we appreciate all of your efforts, thus far, to keep our patients safe while continuingly to compassionately care for those who still rely on you.

Just a couple of updates, on the kidneys space. We understand the stress on dialysis facilities right now and we're continuing to take steps to help ease some of the strain to allow each of you to continue focusing on patient care. We are continuing to work closely with our ESRD networks to refocus efforts to help reduce reporting burden for dialysis facilities while promoting infection control during the outbreak of COVID-19.

And then one general comment that is not specific to kidney disease, earlier this week, CMS announced new guidelines for state and local officials to ensure the safe reopening of nursing homes across the country which aligns with the president's Guidelines for Opening Up America Again.

New guidelines details and steps of nursing homes and community should take enough basis. They should progress prior to relaxing restrictions that are currently in place to spread – prevent the spread of COVID-19 within facilities, which includes rigorous infection, prevention and control, adequate testing and surveillance.

At a high level, CMS is recommending nursing homes avoid relaxing restrictions and advancing to the reopening basis until all residents and staff receive a baseline test. This is important to understand whether or not there are known cases of COVID-19 within the facility.

And with that, we're going – we will have questions and answer session and open discussion. We have a guest speaker that I would like to introduce today. His name is Brendan Bowman. He is an associate professor of medicine at the University of Virginia Medical Center and a dialysis medical director. And without further ado, I would like to introduce Dr. Bowman.

Brendan Bowman: Well, thanks, Dr. Roach, very much for the invitation to participate here. Yes, as Dr. Roach mentioned, I'm a medical director of our Outpatient Dialysis Program and I help co-direct our ICU consultation service. So, I'll try and touch on a couple of aspects.

I think there is a tremendous amount of data we might be on like many of this might be an information overload with so much helpful information coming at us from different places. So, I know a lot of things have already been said so I'll try and touch on a couple of other aspects that haven't been addressed so much and a couple of elements for outpatient and inpatient each. So, probably, we'll have couple of takeaways for folks.

Just a background for us. We are a small hospital-owned dialysis program. We have 11 clinics throughout Central Virginia and just under a thousand patients. So we're fortunate to have a hospital and some infectious disease specialists help us through this challenging time for our patients and our staff.

So, certainly, a lot has been said. The CDC guides out there is excellent and participating in giving feedback to CDC, receiving information. That's obviously our first resource. But everybody has to customize things to the –

to the local things facts on the ground if you will. So I didn't want to talk about necessarily anticoagulation or cohorting patients with COVID. I think that information is out there.

Just a couple of things, lessons learned from our standpoint, I think many of us have had staff members infected already in early on in this late March or early April. We did have a staff member infected. And because there was some exposure outside of the treatment floor with other staff members, we ended up with about seven patients on leave to quarantine for 14 days, and I think this is certainly been out there, but we're all short of dialysis nurses which are in incredibly wonderful partner for nephrologists but really precious resource during this pandemic and so it's very difficult to accommodate that.

And so, one of the things that we've worked on doing is try to the best of our ability to cohort teams, patients but also staff members to limiting them to shifts of Monday, Wednesday, Friday, Tuesday, Thursday, Saturday as much as possible.

And so that, if we have a staff member or a nephrologist that is potentially ill and there is an exposure then it doesn't potentially take out a large portion of our workforce. Otherwise, we'll have a difficult time caring for the patients and we certainly don't want anything to happen to our staff members or ourselves either.

And that generally has worked pretty well regarding the patients. One of the changes that we've made as much as we can as possible, of course, is for our fluid overload treatments. Typically, what we're trying to do is prior to this save that chair if you're a Monday, Wednesday, Friday patient for the TTS shift, and we would do an extra two-hour ultrafiltration session, for example.

And so, for many of our patients that struggled with fluid issues, we know that's going to be Monday or Tuesday. We've tried to rearrange chairs and schedule extended treatments for those patients. And so, right now what we're trying to do is favor later shifts with extended treatments that would allow us to do more ultrafiltration for those patients and less of the extra volume overload ones for that same reason.

We're just not sure at this point, I guess in the pandemic, what the interfacility transmission can be. We knew that happen with pandemic influenza, but it hasn't really been widely reported yet. I think if anyone read the JAMA paper from last week though and the zero conversions on that wasn't pediatric population though, it seems like interfacility transmission could happen outside of hotspots. So we're still behaving in that way until we know anything different.

I think there are some big open issues for us in outpatients still. A couple of issues that haven't really been answered is, should we be doing unit-wide testing on a regular serial basis as they're doing in skilled nursing facilities, and if we – I think CDC PrEP sees interfacility transmission. So, there's a lot of benefit of identifying this asymptomatic carriage then – well, maybe they'll move in that direction. But for now, we're still doing symptom-based testing for now.

And that's probably, you know, one of the things just to touch base on, there are some obvious issues around difficulty deploying Telehealth. I think we've all run into those problems too as well as some different aspects of that, which we can touch on if we have time. But since we're short here, I wanted to jump a little bit to inpatient. I'm currently covering our ICU service. So these things are very fresh.

And maybe what's changed, is we're seeing as the hospitals reopen with elective things – we've always been open, of course – we've always been working the folks on this call, I certainly know. But as we start to see elective surgeries picked up, what we're seeing as our volumes that are non-COVID are certainly returning to their kind of pre-COVID levels. And now, we have a bit of a crunch. We were very worried about dialysate volumes for our CRRT machines. Now, we're really just seeing that census.

And so, what we've – one of the – kind of newer aspects that we're moving as we move into a longer-term phase here is the crunch of staffing. And so what we have done as a way to try to accommodate the, again, renal staff shortages that are inevitable in this kind of scenarios to embrace more slight or longer

term intermittent therapies. So, whether this you call this SLED or whether you call that prolonged intermittent renal therapy, some people call this shift.

What we're working with our ICU teammates and colleagues is to basically deploy that. So what we're seeing is a lot of our COVID patients who are prolonged AKI, requiring dialysis, they're staying on isolation that would typically require a portable therapy from us, and one of our renal nurses would be in that – in that patient room for that period.

And so what we've been able to do is switch those over to using CRRT machines or other very simpler to use hemodialysis machines and run those in extended therapies. What that allows us to do is flex a little bit in the sense that the renal staff, tech or nurse is able to set up the machine.

The ICU staff that runs the machine as they typically would for, say, a CRRT session at kind of almost home therapy levels for six or eight hours session. And by doing that we're able to do multiple portable therapies that might otherwise consume a staff resource in that setting. And we've been able to use that for our hemodynamically stable patients and that has allowed us to use the renal nurse for other more traditional needs for portable therapies.

One – and those therapies makes sense when you have enough CRRT dialysate to use. In scenarios where we don't have enough CRRT dialysate, then it's trying to find some ICU nurse and physician champions on the intensive side to learn hemodialysis machine, ideally, a very simple SLED-type run and coach them through that and then that's another opportunity.

So it's all about kind of playing a little bit of this unfortunate whack-a-mole game, which shortage do I have? If I'm in a hospital with an intensive – ICU nurse shortage, I may deploy different strategy. If I'm having a renal nurse strategy shortage, then I might use a different strategy. And if I'm down CRRT solution, I need to conserve that, then I used a different strategy.

So try to game plan how that looks and project that out has been pretty important to us. And we have been able to kind of move things out. And, yes, I think from a nephrologist's standpoint, we always think which is better.

We have this debate in our profession CRRT versus SLED versus intermittent hemo. And if anything, this kind of pandemic shows us that you kind of use what you know and probably all these therapies are what are all of us expect probably equivalent. So you just kind of use the one that you can pull off. And I think early on we were trying to look for the superior therapy and it's the one you kind of know best.

The last point that I was going to talk about was a little bit around the anticoagulation issue. I think what we heard certainly out of the folks in Europe and China and then in New York directly from them when we had the chance to chat with them early on with things with the anticoagulation issue and kind of big doses of Heparin.

But certainly, as people have complications, bleeding complications as they stay in the ICU as they want to do whether that's GI bleeds, intracranial hemorrhages, we're going to be in scenarios where anticoagulation is contraindicated and you can use that and try to use that with some trepidation. But we've some luck with citrate in regional anticoagulation in CRRT using this and even sometimes in SLED-like fashion.

The main concern was patients on hydroxychloroquine or azithromycin, particularly those in clinical trials, were just being prescribed at with long QT and the concern was that potential hypocalcemia from the citrate being infused and not having adequate calcium replenishment on the return line to the patient down there and we've had some success with that in two or three cases where we really couldn't use systemic anticoagulation for dialysis.

It really requires strong teamwork and meticulous management of the calcium down there. But it is possible preferably that you wouldn't be using that the patient with – on azithromycin and hydroxychloroquine. I think there is much left for that now with the – with the recent data, you know, casting some data on the utility of those drugs.

But it can be done. I think the preference what we're hearing out there is high doses of heparin and that is our first go to 500 to 750 an hour. But we all will run into those situations where we can't use whether it's (inaudible) or others

where we really have a contraindication to systemic anticoagulation. And in those situations, you really have to do that.

And then the last piece is limiting exposure for the staff as we talked about the outpatient and the inpatient. We've really moved to a one physician team member doing the patient exam. And that is almost always the intensivist or the hospitalists and with a meticulous exam. We confer after their exam.

And here, she gives us a sense of what the thoughts all using the eyes and nose in their exam on volume management for those patients. And we have been able to prevent any of our nephrologist to date of being afflicted or exposed yet and we haven't lost any staff members on quarantine, which I think, again, that was a major concern as things went through especially hearing the experience out of New York.

So those are the couple of the more minutia things, but I think we've heard a lot of big stuff already. So, these are kind of lessons that we're picking up and learning as we go. Hopefully, that's information that maybe helpful to somebody out there. And I'll pause there.

Jesse Roach: Thanks, Dr. Bowman. We can open up for questions now. So, the operator could please give us instructions for answering questions.

Operator: Sure will do. And ladies and gentlemen, at this time I would like to remind you that if you would like to ask a question, please press “star,” “1” on your telephone's keypad. Again, to ask a question, simply press “star” and the number “1” on your telephone's keypad. We'll pause for just a moment to compile the Q&A roster.

Jesse Roach: And while we're doing that, I'll ask a question. So, Dr. Bowman, you've mentioned that you were using SLED and that you were using citrate – regional citrate anticoagulation.

For both of those, were these therapies that you were doing in a widespread fashion before the pandemic or is that something you used to adapt to what's going on? And then your next question is, if it was something that you have to adapt to how quickly – how quick was it to bring your staff up to speed?

Because that's one of the things that we've heard is that doing these things and training your staff to something that they're not used to might be somewhat dangerous in the pandemic setting. So, I'd be interested if you have to go through that.

Brendan Bowman: Yes. I know. That's absolutely true. And so, I think you can be choosy about what therapy – there was a lot of theory about CVVHS and middle molecule clearance as we – as we heard kind of in sepsis therapy that with the cytokine storm that this might – we kind of saw the resurgence of that theory down there. And that's fine.

I think for us, it's whatever dialysis you're most comfortable with. So, the answer to those questions is yes. We have, as part of our main plan, has always been to use the therapies we're comfortable with. And so, using these kinds of longer sessions eight, 10 hours in the evenings for patients so that they can do physical therapy during the day, it was kind of one of the keys of our CT surgery recovery program for those dialysis patients that we're a little tenuous and weren't ready for hemo.

So we have done that before in one of our ICUs. So it was really question of kind of normalizing that with a couple of other ICUs, but that wasn't difficult because it wasn't a change in machine.

I think the other component is, I completely agree with that point. I mean the idea of introducing a new modality to the team unless you absolutely have to. But I think what we discovered as we put together our surge plan and we have similar plans as many others do the course, so nothing noble on our side converting the UVA basketball stadium, the jump all jumps arena to potential hospital, I mean these are the volumes we were talking about. And then we would activate that kind of Phase 2 using more different machines from outpatient for SLED and those kind of things having to do that.

So we went through about three to four weeks of preparatory training for that with our staff in case we need to activate that component of our kind of intermittent therapies plan. So we haven't had the call on that portion yet. But

using those intermittent overnight therapies and prolonged durations and CRRTs those things, we were doing some of that already, fortunately.

Jesse Roach: Thanks. That's good information to you. Do we have any other questions?

Operator: We have a one question on the line. Coming from the line of Nathan Muzos with DaVita. Your line is now open.

Nathan Muzos: Hey Dr. Roach, it's Nathan with DaVita. I just wanted to ask if we should – as you open the call with your additional comments about looking at additional ways to reduce burden continue to put on guidance, should we expect additional guidance this month around 5-star waivers and the payment programs?

Brendan Bowman: So, I can speak to the 5-star programs. So, yes, we should be having additional guidance this month in terms of the – what's going to happen with the BFC and the 5-star refreshes, what is going to happen with – and what's going to happen with that submission for LEER and we're trying to do that and coordination with the QUIP. So we expect to have some guidance hopefully this month or next month, specifically what's going to happen with those.

Nathan Munoz: OK.

Brendan Bowman: And the payment issues, I don't know if anyone from CM – I don't know exactly what you're referring to, but I don't know if we have any payment people on the line.

Nathan Munoz: Yes. It was more just QUIP and 5-star together and if we should expect for guidance on both of those. So, you covered that. And then …

Brendan Bowman: Yes.

Nathan Munoz: I think your answer to the first question kind of dip into my follow up which is, should we expect guidance on how the ruling measures such as hypercalcemia, and then the standardized metrics were then will be calculated without certain months of data.

Brendan Bowman: Yes. That may take a little longer because evaluating the effects of that takes a little more time and study. So that may take a little longer but there will be guidance on that too.

Nathan Munoz: OK. Great. Thank you. I appreciate it.

Operator: And again ladies and gentlemen, if you'd like to ask a question, please press "star," "1". Again, to ask a question over the phone, please press "star," "1" on your phone's keypad.

Brendan Bowman: Dr. Roach if there – if we're waiting for a second, I will just kind of opine for a couple of minutes here if that's OK. Just so – since we got some outpatient folks down there, I think one of the things that many of us have struggled with this is Telehealth particularly if many of us work with some grade advanced practice providers. I am in the hospital and I have a nurse practitioner partner. And so, using Telehealth has been a challenge for a lot of folks out there too as well.

One of the things that has been useful for us is it's sometimes difficult to some of our colleagues and other organizations were using iPads passing back and forth. Carts are generally a no, no moving from station to station. So, it's difficult to operationalize that.

One of the things that's been helpful is having the admin staff kind of inventory our patients, what smartphone do you have? We did a survey of our patients back in 2014, and we found over 50 percent of our patients have smartphones then. But they might not know how to use them.

So, engaging with their care partners, be that the spouse, be that the child that's involve in their care already in doing those kind of telemedicine visits as part of their weekly, it's been very interesting to see our patients. It's almost like doing a home visit or house call.

So, if you have the ability to do that, that's been one way to try and to continue to keep up with our patients on a regular basis. Because the telemedicine for sure, even though that's available to us, it's certainly been a challenge to operationalize that and maintain infection control, passing a tablet patient to

patient to patient. It is a challenge and it's got to be done in a proper way to keep that safe, but that's been one of the aspects I think a lot of people had some difficulty with we have also.

Jesse Roach: OK. Thanks for that. And with Telehealth, I think – I feel like Telehealth is something that we got ahead of and we're very proactive and allowing some of these things. And so – and we're still working with the little bit of things with some people having some difficulty with then which we're aware of and we're still looking at. But it's – we gotten lots of good feedback about how well Telehealth has worked in this population so.

Brendan Bowman: Yes. This is exciting. We're seeing a lot of, you know, new lessons, learning lessons about our patients. We might not have otherwise learned if we weren't sometimes tele-helping with them at home. So, it's a very exciting development. I think patients really appreciate it.

Jessie Roach: Are there any other questions?

Operator: And again ladies and gentlemen, to ask a question please press “star,” “1”.

Jesse Roach: Well, if there aren't, then I will take it back to Alina and we can wrap this up a little early.

Alina Czekai: Great. Thanks so much Dr. Roach and thank you everyone for joining our call today. We hope that you will join us tomorrow for our CMS COVID-19 office hours, Thursday, May 21st at 5:00 p.m. for technical Q&A with our CMS subject matter experts. And please continue to direct your questions to covid-19@cms.hhs.gov.

Again, we appreciate all that you are doing for patients living with kidney disease and their families around the country as we address COVID-19 as a nation. This concludes today's call. Have a great rest of you night.

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