Centers for Medicare & Medicaid Services
COVID-19 Call with Dialysis Providers
July 22, 2020
5:30 p.m. ET

Operator: This is Conference #: 7692208.

Alina Czekai: Good afternoon. Thank you for joining our July 22nd CMS COVID-19 call with nephrologists, dialysis providers, and others who care for patients living with kidney disease. 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 the field who have offered to share best practices with you all.

First, I'd like to turn it over to Dr. Shalon Quinn, Director of the Division of Kidney Health at the Center for Clinical Standards and Quality for an update from the agency. Dr. Quinn, over to you.

Shalon Quinn: Thank you, Alina. Welcome everyone. Thank you for joining us again today. We want to, as always, first start by thanking all of you for everything that you're doing to help combat the spread of COVID-19 in your communities and with our dialysis patients.

So, we do have a few CMS updates for you. First, please be on the lookout for an announcement of a webinar series on the upcoming End-Stage Renal Disease Quality Incentive Program performance year 2021 preview period.

The preview period that starts on July 29th, 2020 gives facility representatives the ability to preview their total performance scores, download performance score reports, and submit inquiries regarding potential reductions in score. More information will be forthcoming via the ListServe.

Also, we recently posted a presentation focused on the calendar year 2021 End-Stage Renal Disease Prospective Payment System proposed rule. This is an on-demand webinar that provides information on the proposals for the

program and instructions on how to comment. You can find that information on the ESRD PPS webpage.

We also have a memo that we're working on. It's in process right now regarding some updated CMS dialysis guidance. So, please be on the lookout for that memo coming out in probably the next week or so.

We also want to thank all of you that were able to join our nursing home and dialysis COVID stakeholder roundtable meeting earlier this week. We're very interested in the intersection between these two facility types and we want to make sure we're caring for our nursing home patients that also receive dialysis. This includes ensuring that we're working to stop the spread of COVID between the two facility types.

We heard a number of best practices on that call regarding communication between providers. And we also heard about barriers, which also included regulatory barriers.

So, we really want to encourage you to continue this conversation. Feel free to e-mail us with your thoughts regarding COVID management between these two facility types.

So now, I am going to go ahead and transition to our guest speaker today. I'd like to welcome Dr. Daniel Weiner. He's a nephrologist and Associate Medical Director of Dialysis Clinic, Inc. in Boston, and associate professor of Tufts University School of Medicine. Dr. Weiner's clinical area of focus includes dialysis, hypertension, general nephrology, chronic kidney disease, diabetic kidney disease, conservative kidney care, cardiovascular disease in patients with kidney disease, and acute kidney disease.

I'll turn it over to you, Dr. Weiner.

Daniel Weiner: All right. Well, thank you so much for having me. And thank you to everyone who's working so hard to keep people safe. And I really appreciate the opportunity to talk for a few minutes and I'll keep it short.

As some of you know, I'm a nephrologist in Boston and I direct one of the hemodialysis facilities downtown, a DCI facility.

As we entered into COVID in the Boston Area, I also led an informal coalition of medical directors, representatives from the dialysis providers as well as from the ESRD network and the Massachusetts Department of Health.

And we spoke early on actually twice a week, and then weekly, and now, fortunately, we're down to about once a month, but really preparing some best practices, learning from each other, understanding the vulnerabilities, in particular, the hemodialysis population.

So, being in Boston, you guys probably know that we had our first, hopefully our only, but right now, I guess, we can say our first surge in April and May. We were on the early side of COVID. And I think we're very fortunate that things – knock on wood – are quite quiet here right now in Massachusetts.

This has really provided us time to kind of get together, debrief, talk about what we did right, talk about what we did wrong, and try to think about how we're going to approach this moving forward.

The other big difference as compared to April is we understand COVID more. And I think the resources to tests are, although still limited, better than they were in the first week of April.

So, just sort of beginning with what I think we did right. And I think we did one thing really very right in our facility. We did a lot wrong. And there's so much we didn't know. But the thing that I think we did right was once we got a few cases in our dialysis facility and we're seeing the number shoot up everywhere, we actually tested the entire facility. It's 105-ish patient facility.

And we tested everyone in the dialysis unit, while they were in the dialysis unit. And we were able to send the tests to the local hospital and have the results back before the patient was due to arrive for their next dialysis session.

This allowed us, as the numbers of people with COVID were rapidly increasing, to be proactive rather than constantly being reactive each time somebody would show up sick.

And what we learned from this, which is well known at the current time but wasn't as well known then, was just how high the asymptomatic COVID positive rates could be. We had, in our facility of 105 patients, we actually had five asymptomatic positives in the facility. So, that's a very real number and a group of people who can spread this to other people.

I think what we did wrong was we failed to really understand just how contagious COVID-19 could be. And we failed to recognize the number of positive patients who could be asymptomatic.

Moving into June as things were quieting down, we actually on these coalition phone calls, we gathered some data, many already who would offer data, actually I collated, and a few take homes. And I haven't seen a whole lot of data from broader dialysis facilities.

But in the Greater Boston Area, we had rates of COVID from anywhere from about 5 percent to more than 20 percent within a dialysis facility. The facilities that were the most impacted were those that were in the most densely populated urban areas where people living in apartment buildings and other things.

I think the other thing that came across is that among the facilities that responded – this around 15 or so facilities – our facility was the only one that did mass testing. So, there may very well have been more cases that were never revealed.

I think the other major thing is that with regard to this call, with regard to the long-term care facility residents, among all those facilities that responded, the rates of positivity among the long-term care facility residents was about 50 percent.

This may be something that was particularly notable in Massachusetts where looking at the data from this database, 65 percent of deaths among – in the

commonwealth occurred among long-term care facility residents. So, this proved to be a very vulnerable population.

Where Massachusetts made advance is, again, just like we tested everybody in the dialysis facility, the commonwealth started testing everybody who lived in long-term care facility. And each of these facilities was really able to learn (inaudible) forward and buckle down and improve cohorting and infection control issues.

But my take home from this time is just that both the hemodialysis patients and the long-term care facility residents are exceptionally medically fragile. These are vulnerable people, who when they get sick, have high mortality rates and they are in settings, both when they're in the dialysis facility as well as when in they're in the long-term care facility, and even more notably when they're transferring between these facilities where it's just not possible to socially distance and physically distance. They're exposed multiple healthcare providers in both settings.

So, my sort of – I think what we learned from this as we look at these very high-risk populations is that testing is exceptionally key. If you fall behind, if you have to be reactive rather than proactive, you're already too late.

So, once the community prevalence becomes even moderate, looking at these mandatory congregate populations and testing them and finding out who you need to cohort and who you need to isolate is really critical.

I think the second thing that we learned was that treating people who can't physical distance at their place of residence, so these are people who live in long-term care facilities, people live in assisted living, others as being at higher risk for COVID in times of community prevalence is really important.

We were lucky enough to have a few isolation rooms in our unit. And we used these liberally to isolate people who may not have had COVID or that we didn't know had it be we thought were at higher risk because of where they lived.

I think recognizing that transportation is a huge vulnerability as the third thing. And we never did come up with a solution to this. We struggled with how to get people safely from point A to point B and back again.

And then, the last thing, and maybe the most important thing is communication. Communication has never been great across healthcare settings; the dialysis facilities, long-term care facilities, hospitals, outpatient offices, anywhere. This is, I think, one of the limitations of the system that we have, but communicating not only the results of testing.

So, when Mr. S has a positive test, letting the long-term care facility know or if long term facility knows just letting the dialysis facility know but also communicating risk between facilities; dialysis facilities as well as long-term care facilities.

So, if we have cases on a shift where there's a patient, it's important that we let the long-term care facility know that there are cases here right now that we have discovered. Well, the dialysis unit takes steps, cohorts them, puts them on a COVID shift or in a COVID facility. But those are exposures that are important.

And the same thing that if there are cases at the long-term care facility that the long-term care facility lets other care settings know that this is present.

And I think a culture of safety is only possible when you have knowledge of exposures in a time of COVID.

So, I'll stop there. Those are sort of my experiences. And again, it's very limited to what I saw and what I got from talking to other people locally. But hopefully, there are at least a few things that translate more broadly. Thank you.

Alina Czekai: Thanks. So, I think we'll go ahead and open it up for questions either for Dr. Weiner, for us at CMS. So, operator, could you let us know how to open up the line?

Operator: Certainly. Ladies and gentlemen, if you would like to ask a question, please press star then the number one on your telephone keypad. Again, that will be star then the number one on your telephone keypad. We will pause for just a moment to compile the Q&A roster.

Male: While we're waiting, I got a question. So, when you were testing – I may have missed this – one of the issues that we are looking at when we're thinking about this is for mandatory testing, do you treat people as they're waiting their test any differently? How long do you – how long were they taking the turnaround and did that affect anything? And sort of how often were you deciding to do it and if that just sort of depend on your case load?

Daniel Weiner: It depends on our case loads. Once we got about half dozen cases in the facility, we tested everybody. We had nurses who are trained. We did this full PPE, everything.

For people who didn't have symptoms, we treated them using universal masking as was the case all along and the standard precautions that are in place in the time of COVID.

For people who did have symptoms, we would use our isolation rooms or try to cohort them appropriately.

But we were lucky in as much as even though it's a private dialysis facility, it's on the campus of the hospital. So, we were able to – and the hospital, by the time April rolls around – had an in-house test.

So, we were able to basically – if we had a Monday, Wednesday, Friday patient, we could test them on Monday and we would have the result back usually by Tuesday afternoon. I think that was absolutely critical because with what we understand about the incubation time, for those who are going to become symptomatic at the time from testing positive to becoming symptomatic, and at a time of exceptional community spread, we were able to identify and isolate and separately cohort people who turned positive.

And we found five people that way who were totally asymptomatic. Some of them did become symptomatic, some of them never became symptomatic.

So, I think that's really critical. And I think the ability to test asymptomatic and get the results back before you have to start your next dialysis session is going to be absolutely critical for this very fragile population that can't distance. I think I answered most of the questions there.

Lee Fleisher: Hi. This is ….

Male: Did you test – sorry. Go ahead.

Lee Fleisher: This is just Lee Fleisher. I'm the CMO and Director of CCSQ. I just started a couple of weeks ago, and I really want to thank you for presenting the information particularly the transfer of communication. That's all I just wanted to tell the community I'm listening in here now to help how we address these problems, and please proceed.

Daniel Weiner: Thank you, Dr. Fleisher.

Alina Czekai: Thank you. Operator, do we have …

Male: I think we can open it up for question. Sorry.

Alina Czekai: Operator, do we have any questions in the queue?

Operator: We do not have any questions over the phone. Presenters, you may proceed.

Alina Czekai: Thank you. Any other questions or comments from our CMS colleagues before we conclude today's call?

Male: I will ask another question. Did you – were you repeating this at an interval or was this just a one-time testing?

Daniel Weiner: It depended on the patients. We repeated testing in patients who resided in facilities where they could not physically distance. So, we repeated those in times by prevalence. We repeated weekly at first and spaced out. And now, we're actually not doing that anymore because – knock on wood and I pray this remains – it's been pretty quiet and facilities, nursing homes, long-term

care facilities in Massachusetts are hyper vigilant at the current point as our dialysis units. So, things have quieted down.

But we did test those patients. We ended up testing them – and we would deem anybody coming out of a high-risk situation to be a PUI. We would test them weekly. And we did capture people moving forward who would test positive using this criteria, a handful, only one or two, because the state shut down and everybody masked. And so, the community prevalence started going down after several weeks. But we continue that throughout the times of high community prevalence.

We also, obviously, tested anybody who developed symptoms, which sort of falls into a different PUI bucket, but doing the usual screening that every dialysis facility's doing questions, direct exposures, fever, cough, all the usual stuff. Anybody who would answer yes to that we test it.

Male: And you might have mentioned that staff, were you regularly testing asymptomatic staff?

Daniel Weiner: We were not. That was a harder sell to – again, it's a time where we didn't have a ton of testing available. I think if I had to do this over again and I have unlimited testing, I would have started testing asymptomatic staff. We did test any staff who had an exposure and anybody, obviously, who had symptoms. And we did have positive staff, unfortunately.

Male: OK. That's all I have.

Alina Czekai: Great. Thank you. And operator, if there are no other questions, we will wrap up today's call a bit early. Thank you, again, everyone for joining our call this afternoon. As always, we appreciate everything that you are doing for patients and their families around the country as we continue to address COVID-19 as a nation.

In the meantime, you can continue to reach out to us via our COVID-19 e-mail, which is covid-19@cms.hhs.gov. This concludes today's call. Have a great rest of your evening. END