Centers for Medicare & Medicaid Services
COVID-19 Call with Dialysis Providers
June 24, 2020
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Operator: This is Conference #: 6494855.

Alina Czekai: Good afternoon. Thank you for joining our June 24th CMS COVID-19 call with nephrologists, dialysis providers, and other clinicians who care for patients living with kidney disease.

This is Alina Czekai leading stakeholder engagement on COVID-19 in the Office of CMA 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.

And first, I'd like to turn it over to Dr. Shalon Quinn, acting director of the Division of Kidney Health at the Center for Clinical Standards and Quality here at CMS for an update from the agency. Dr. Quinn, over to you.

Shalon Quinn: Thank you, Alina. Welcome everyone. We're glad you all could join us again today for a dialysis stakeholder call. We know that you all are continuing to work hard to compound the spread of COVID-19 and keep our patients safe. So, we're really grateful for all of your efforts caring for those patients.

I have one quick update. I wanted to make sure that all of you are aware that we've recently posted an ESRD Quality Incentive Program or QIP FAQ – F-A-Q – document on the cms.gov website.

With that, we have a wonderful presentation lined up for you today. Our speakers will be discussing best practices, lessons learned, and planning for the new surges of COVID-19.

So, I'll introduce our two speakers. First, we have Annette Hyde. Annette is the facility administrator for Quality Renal Consultants, which is a group of

independent dialysis facilities in New York City. And she's a leadership committee member of North HELP, which is New York City's federally funded dialysis healthcare emergency preparedness coalition.

And our second speaker is Anna Bennett. She is the emergency manager and network quality improvement coordinator for IPRO ESRD network of New York, which is Network 2.

I will now turn it over to Annette and Anna.

Annette Hyde: OK. Thank you so much. Thank you. Good evening everyone and thank you for having me. So, in preparation of the new wave of COVID that we're anticipating, I think we should continue to implement those practices that made a positive difference in managing the initial COVID-19 pandemic.

And so, what we found to be instrumental is patient and staff education. Patient and staff should be re-educated regarding COVID-19 with the objective of bringing about a heightened awareness that COVID-19 remain an issue and a possibility of a second wave, which is to prevent you from getting – becoming complacent.

Re-education should include signs and symptoms of COVID-19, infection control precautions which include hand hygiene, and the importance of wearing the safe mask. Staff education on proper use of PPE is essential.

We found that staff demonstration of donning and doffing of PPE was a very effective in service strategy. So, this we will revisit it and I will encourage dialysis facilities to do the same.

Re-educating patients and staff regarding cohorting strategies is essential. Educating the patients is important because cohorting may require that they may have to be assigned to a different shift or seating area.

And let me just say a word regarding patient seating arrangement. One of the lessons learned was the importance of keeping the patient in the same section at all times, if possible. And I say this because it makes it easier to contact trace and also to decrease transmission. It's also a good idea and

advantageous not to rotate the dialysis staff from section to section and this is also designed to decrease widespread transmission of COVID-19 in the facility.

We are still conducting and will continue to conduct the patient, staff, and visitor screening. This really should continue. The screener must be given clear directives as to what to do in the event the screening suggests possible COVID. This is particularly important because when licensed personnel are conducting the screen, such as clerical staff, they may not know what to do if they have a positive, let's say a screen that suggests COVID. So, we have to ensure that the screeners are also re-educated.

In regard to some of the infection controlled practices in the facility, patients and staff are required to wear face mask while in the dialysis facility. This should continue. We believe very strongly that this also helps to decrease the transmission of COVID-19.

We found that there was a direct correlation between the type of PPE that was made of available to our staff to provide care for the COVID patients and the anxiety level of the staff. The anxiety level of the staff is decreased when they were provided with adequate PPE. So, the N95 mask was one of the most requested PPE. And in fact, the dialysis staff, their expectation, was that we will provide that for them.

It is imperative that inventory of PPE is performed to ensure that PPE are available to the staff. So, it may be worthwhile to reach out to vendors regarding their plans for stocking up on required PPE so that it's made available.

There were some issues with transportation during the initial series of COVID. So, in preparation for a new wave, we really should reestablish contacts with our transportation companies to determine their COVID policies on patient transportation as well as their infection control strategies. I don't think we should assume that they will be prepared if there was a second wave because there were some issues during the initial phase of COVID.

Also, I want to speak briefly about the communication between hospital and the nursing home. That proved to be invaluable during the early days of COVID and continue to be. If your dialysis facility is located on the premises of a skilled nursing facility or even if it's not, as long as you have a skilled nursing facility patient on your census, then it makes sense to reestablish and to continue to communicate with the skilled nursing provider. Get to know the leadership team of the skilled nursing facility, your DNS and your administrator, because it really does make it easier to communicate during the crisis.

At a minimum, the hemodialysis facility must be informed of any dialysis patients with signs and symptoms consistent with COVID-19 before that patient is transported to dialysis. Any patients who are being tested for COVID as well as the test results must be communicated to the dialysis facility and that should be our expectation.

The dialysis facility should be prepared to discuss measures to separate the skilled nursing facility patient from the community patients as well as all the cohorting strategies because we found that to be instrumental in decreasing the likelihood of transmission to the skilled nursing facility patients.

Communication and coordinating with the hospitals was also – is also very important. It makes sense that the dialysis facility informs the hospital in the event that we are transferring a patient to them for medical care who is COVID positive or if we suspect COVID. They really should be informed prior to us sending, transferring that patient there so that they can anticipate the arrival of the patient.

Coordinating discharge plans with the hospital prior to patient discharge from the hospital is important. During the early days of COVID, the hospitals were informing us when patients are being discharged from the hospital. This is very important because it assists us in determining an appropriate dialysis treatment schedule for that patient as well as to cohort as needed.

So, I have to say that the good news is, we know – we know more now that we knew in March. And I think that we are better prepared for the second wave should it become a reality. Thank you for listening.

Anna Bennett: Hi everyone. This is Anna Bennett. I'm the emergency manager and quality improvement coordinator for the IPRO ESRD Network of New York. And I work very closely with Annette during COVID. And the work that we've been doing together has really informed and help taking best practices and sharing them to the community has really helped to mitigate the impact of COVID-19.

We want to say thank you to CMS for this opportunity to highlight our work. It's an unprecedented time and we really do appreciate being asked to share.

I want to talk to you briefly about the ESRD Network. So, I'm – that you're aware – that you're aware of resource available to you at the national resource. It covers the entire United States and territories for dialysis facilities and transplant units. And CMS has us divided into 18 regions.

Annette and I are in Network 2. She is a provider with dialysis facilities. And we – I work for the ESRD Network. So, we work with – we work with the community.

Our emergency plan and our network operation center was activated in February of 2020 to respond to COVID-19. And that means that we started looking at the situation, reporting on the situation, and really monitoring our provider community to make sure that their needs will be met and to understand what was going on.

Now, we're in New York State and that was the epicenter of COVID for the United States for a very long time. The general population in New York State is 19.5 million patients – people. We, as of March 30th, we had a dialysis population of around 31,000 patients.

In the network in New York State, we have 330 dialysis facilities. Forty-two of those dialysis facilities are skilled nursing home based and 33 are hospital based.

Now, in New York City where Annette's working with her staff and her patients, we have 125 dialysis facilities. Twenty are skilled nursing facility based and 17 are hospital based.

And I will say that Annette has the first dialysis patient that was reported with COVID-19 in New York City and that happened very early. So, her facility really did have to rise to the occasion. And the patient was also in a skilled nursing facility. So, cohorting that started all of the – all of this work and guidance started, for us, it became real when Annette's patient was diagnosed.

So, in ESRD Network program, we're contracted by CMS to service conveners, organizers, motivators, and change agents. We are contracted to leverage technologies and provide outreach and education.

We're serving as partners and quality improvement with patients, practitioners, healthcare providers, other healthcare organizations, a lot of you on this call, and to other stakeholders. And this was even more important during the COVID environment.

We're trying to secure commitment to create collaborative relationships with other stakeholders and partners. And we do this so we can build their resilience and robust communities in our network in Network 2 and throughout the whole 18 networks. And we have the national Kidney Community Emergency Response coalition or KCER that also they're available nationally that can mean phone calls for us and share best practices, also a CMS contract.

We work to achieve measured changes at the patient level through data collection, analysis, and monitoring for improvement. And we did this especially during COVID where in the beginning, facilities were giving us their status on a daily basis, and then we went to a weekly basis. Now, recently, because it's died down a bit in New York, but we're always watching these numbers on a weekly basis for this wave two coming in.

We're disseminating and spreading best practices including those related clinical care, quality and prevention techniques and data collection, and

through information exchange. Annette spoke to you about really the importance of transition of care and keeping in touch with the nursing home and the hospitals because our patients move around a lot.

And with the 3000 patients we had – over 3000 patients diagnosed with COVID and hundreds of staff members diagnosed with COVID that we're aware of where people are and what the situation awareness is. And we're charged by CMS to participate in the development of a CMS national framework for providing emergency preparedness services for the entire ESRD community. So, we are your resource.

So, if you're not in contact with your network, reach out to them. That's ESRD Network coordinating center in the (NCC) as well. They can put you in touch with your local network.

So, we have a lot barriers and best practices that we – our barriers came very quickly and then the best practices, surprisingly, came fairly quickly after this. It's only been 90 days really since the epicenter.

Our first barrier was understanding and interpreting guidance in a rapidly evolving situation. So, we can work with our providers, staff, and we can work with our task force and our partners to make sure that we were giving the best advice and the best interpretation to our providers and patients so they understood and they knew where the resources were.

And the PPE shortages and Annette spoke about PPE and making sure dialysis facilities, their burn rate and where their PPE is and having it. And she spoke about how important it is for the staff and their level of comfort to be able to have the correct PPE for COVID.

We also dealt with transportation refusal. Annette dealt with that very early in her facilities where patients wouldn't be brought to dialysis or worse, they'll be brought to dialysis and then their ride wouldn't come and bring them back. And we dealt with staffing shortages. And we try to mitigate those as well.

We couldn't have done any of the work that we've been able to do to mitigate this issue without our pandemic partners and our community connections.

And that starts with CMS and all of our Federal workers that have been helping us with the Department of Health in New York State and also locally, especially in New York City, and Department of Health and Mental Hygiene, with our local offices of emergency management and our emergency support function.

We really do have to speak the language of emergency preparedness and emergency management so that we can translate the needs of the dialysis community to these agencies. And that's the Network's role to really help mitigate all of this.

And we couldn't have done it without our coalition work. And Annette was introduced as being on the leadership committee for North HELP, which is a federally funded dialysis healthcare coalition in New York City.

I encourage all of you as providers to not only get in touch with your ESRD Network but also reach out to your healthcare coalitions because many of the coalitions, they're in every state, are not just dialysis focus. They are total health care. So, you're in contact with your hospitals. You're in contact with nursing homes. You're in contact with EMS. And these connections are going to help you ease the path of the pandemic and any other emergency that you face.

So, with that, I think we can open up for any questions that you might have. Annette and I are available.

Shalon Quinn: Right. Thanks, Annette and Anna. We'll go ahead and open it up. Operator?

Operator: At this time, for the participants to ask a question, you may press star one on your telephone keypad. We will pause for just a moment to compile the Q&A roster.

Male: I have a question while we're waiting. Can you go – with all these patients moving all over the place and everything, can you talk about potential challenges you had with reporting of data – recording of data and also with billing or do you know about any of those?

Anna Bennett: Well, I can talk about patients on a high level and moving and tracking from the Network level, but Annette's going to have to talk about billing.

I can tell you that the first order of business for us was to (decant) the hospital facilities that were treating chronic patients and that was difficult to do because a lot of the hospitals were safety net hospitals. And in New York especially, we have issues with emergency Medicaid. And sometimes, it's hard to transition them to another community-based dialysis center because of billing and because if they're emergency Medicaid, it's not even the full Medicare bundle payment. So, we had a hard time to decanting some of the city hospitals, but we were able to do quite a good effort.

And then, in some cases, there were cohorted facilities that were precertification. So, what it happened was in New York State, the state – once the 1135 waivers came through, the state was allowed to take precertification facilities and allow them to become cohort units, so COVID-positive only.

That became a billing issue for some of the smaller independents because what would happen is because these facilities didn't have a CCN they would then just charge back to the referring facility. So, it was a bit of a barrier for some of our underinsured patient population.

And with that and to talk more about billing, I'll ask for Annette for any input she has on that because I know your facility absorbed a few patients.

Annette Hyde: Yes. So, what I would say in terms of patient transfer from one entity to the other, for us, if we transfer patient, it would be to the – it was to the hospital for higher level of care.

We were never faced with the option of transferring a patient from one dialysis to another dialysis facility. So, I did not have that – have that experience. So, in terms of billing, that was not an issue for our facilities.

Anna Bennett: And as far as tracking the patient population, that's something that we really, as a network because we're already doing our quality and improvement work and our access to care work on our normal blue skies days – we know what

the general population is for our facility. We also knew where the hot zones were.

We were very in touch with the state department of health, the local department of health. We knew where the outbreaks were. When it hit Westchester, the first thing we did was do an assessment of the dialysis facilities in the Westchester area so that we could see if they had any impact yet.

So, we would reach out. We already knew what their census was. And nationally, our large dialysis organizations; Fresenius, DaVita, DCI, American Renal in New York, they would – they would give their information nationally to KCER so that we wouldn't have to collect that data. So, that was all reported nationally by the corporate entity.

And we would work with the dialysis facility if they had any needs or they had any assessment. And in KCER would then give us the data for the LDOs.

As far as the independent facilities are concerned – and New York is about 42 percent independent facilities because we had – there'd originally back in 2005 been a law that all dialysis facilities in New York State were hospital-based or physician owned. So, LDOs are fairly new to the culture of New York State and (so a Certificate of Need) state as well.

So, we are aware who the independents were and we are reaching out to them in the hotspots. And then, by the 9th of April, we had a system in place for facilities to report their patient movement. And we were able to follow up on that.

Male: OK. Thanks. We'll see if anybody else has any other questions.

Operator: We don't have any questions over the phone at this time, presenters.

Shalon Quinn: OK. If there are no questions, I'd like to thank Anna and Annette for their great presentation. I think there was a lot of really good resources and information in your presentation. I really appreciate it.

So, I will turn it back over to Alina to close us up.

Alina Czekai: Great. Thank you and thanks everyone for joining our call today. We hope that you'll join us for our CMS COVID-19 Office Hours next Tuesday, June 30th at 5 p.m. Eastern for technical Q&A with our CMS subject matter experts.

In the meantime, you can continue to direct your question to our COVID mail box, which is covid-19@cms.hhs.gov. Again, we appreciate all that you are doing for patients and their families around the country as we address COVID-19 as a nation.

This concludes today's call and have a great rest of your day.

Shalon Quinn: Thank you so much. Thank you.

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