CDC Recommendations and Policy Updates for Current Challenges in the Dialysis Setting

Welcome and Opening Statement

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Environmental Cleaning and Disinfection

- Routine cleaning and disinfection procedures are appropriate for COVID-19 in dialysis settings.
  - Ensure HCP have access to EPA-registered, hospital-grade disinfectants
    - Refer to the EPA-website for List N: Disinfectants for Use Against SARS-CoV-2: [https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2](https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2)
    - When using products from List N, facilities should ensure the products also have a bloodborne pathogen claim (e.g., hepatitis B, HIV).

- Any surface, supplies, or equipment located within 6 feet of symptomatic patients should be disinfected or discarded.
Interim Additional Guidance for Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed COVID-19 in Outpatient Hemodialysis Facilities

Background

These recommendations should be used with the CDC’s Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019 (COVID-19) or Persons Under Investigation for COVID-19 in Healthcare Settings. This information is provided to clarify COVID-19 infection prevention and control (IPC) recommendations that are specific to outpatient hemodialysis facilities. This information complements, but does not replace, the general IPC recommendations for COVID-19.

This guidance is based on the currently available information about COVID-19. This approach will be refined and updated as more information becomes available and as response needs change in the United States. It is important to stay informed about COVID-19 to prevent introduction and minimize spread of COVID-19 in your dialysis facility. Consult with public health authorities to understand if community transmission of COVID-19 is occurring in your community.


Criteria for Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19 (Interim Guidance)

CDC guidance for COVID-19 may be adapted by state and local health departments in response to rapidly changing local circumstances.

Why this is for: Occupational health programs and public health officials making decisions about return to work for healthcare personnel (HCP) with confirmed COVID-19, or who have suspected COVID-19 (e.g., developed symptoms of a respiratory infection e.g., cough, sore throat, shortness of breath, fever) but did not get tested for COVID-19.

On This Page

Return to Work Criteria for HCP with Confirmed or Suspected COVID-19
Return to Work Practices and Work Restrictions
Crisis Strategies to Mitigate Staffing Shortages

Return to Work Criteria for HCP with Confirmed or Suspected COVID-19


March 1, 2020

Summary of Recent Changes

Update: This Interim Guidance was updated on March 9, 2020 to make the following changes:
- Updated recommendations regarding PPE contact tracing, monitoring, and work restrictions in selected circumstances. These exclusions allow for appropriate HIP who have been exposed to a COVID-19 patient to continue to work after options to improve staffing have been exhausted and in consultation with their occupational health program. (See Additional Considerations and Recommendations at the end of this document.)
- Updated recommendations that have been revised to reflect new information on community variability for PPE use for exposure to patients with COVID-19.

CDC guidance for COVID-19 may be adapted by state and local health departments to respond to rapidly changing local circumstances.


Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings (Interim Guidance)

Summary of Recent Changes

Guidance as of March 23, 2020

- Clarified that patients with COVID-19 can be discharged from a healthcare facility when clinically indicated. Meeting criteria for discontinuation of Transmission-Based Precautions is not a prerequisite for discharge.
- Updated guidance for a test-based strategy. The recommendation to collect both NP and OP tests at each sampling has been changed so that only onemonic.

COVID-19 Situational Status

- Web page updated regularly
**Reporting PPE Shortages**

- If your facility is concerned about a potential or imminent shortage of PPE, alert your state/local health department and local healthcare coalition, as they are best positioned to help facilities troubleshoot through temporary shortages.

- Link to identifying your state HAI coordinator: [https://www.cdc.gov/hai/state-based/index.html](https://www.cdc.gov/hai/state-based/index.html)

- Link to healthcare coalition/preparedness: [https://www.phe.gov/Preparedness/planning/hpp/Pages/find-hc-coalition.aspx](https://www.phe.gov/Preparedness/planning/hpp/Pages/find-hc-coalition.aspx)
Preserving PPE Supply in Times of Shortage cont.

- Implement extended use of eye and face protection (respirator or facemask)
  - Extended use means HCP remove only gloves and gowns (if used) and perform hand hygiene between patients while continuing to wear the same eye protection and respirator or facemask (i.e., extended use).
    - The same eye protection and respirator or facemask can also be worn (without removing) for repeated contacts with the same patient.
  - HCP must take care not to touch their eye protection and respirator or facemask.
  - Eye protection and the respirator or facemask should be removed and hand hygiene performed if they become damaged or soiled and when leaving the unit.

Preserving PPE Supply in Times of Shortage

- Prioritize isolation gowns for aerosol-generating procedures, care activities where splashes and sprays are anticipated, and high-contact patient care activities:
  - Initiating and terminating dialysis treatment, manipulating access needles or catheters, helping the patient into and out of the station, and cleaning and disinfection of patient care equipment and the dialysis station
Thank You!

For more information, contact CDC
1-800-CDC-INFO (232-4636)

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

Transportation of Dialysis Patients

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Hemodialysis Transportation

- 2013 USRDS Data
  - Private cars (drove themselves) 25.3%
  - Public transportation (bus/metro/taxi) – 7.9%
  - Help from others (van, ambulance etc) – 66.8%

- Medicare does not cover transportation costs unless an emergency

- If dual coverage (Medicare/Medicaid) or Medicaid only, transportation is covered

Cost of Transportation for HD

Dialysis Transportation Costs PPPY and Percent of Costs Attributable to Ambulance Trips, by Region

• Social workers assist dialysis patients with transportation information and referrals.

• Dialysis facilities are limited in directly helping patients with transportation, as providing transportation in their facility owned/managed private vehicles can be considered an inducement.

• Patients who experience barriers to transportation often delay dialysis altogether or seek treatments in the ER.

Nephrology news and issues, Dec 15, 2016

Public transportation guidance in NY

Routine cleaning is highly emphasized, with details of cleaning procedures/disinfectants.

High-risk locations warrant cleaning and disinfection on a regular schedule.

Clean and disinfect food service areas, including counters, tables, and chairs regularly (at least once daily).

Examples of frequently touched areas within transportation:

• Seats and handrails;
• Turnstiles and fare boxes;
• Door handles and push plates;
• Chairs and Tables;
• Bathroom faucets;
• Light switches;
• Handles on equipment (e.g., wheelchairs, hand carts);
• Buttons on vending machines and elevators;
• Desks and counters;
• Shared telephones;
• Shared desktops; and
• Shared computer keyboards and mice.
Information from Logisticare

- Transportation providers have been provided up-to-date CDC guidelines
- Regular communications to drivers
- Repetitive cleaning of vehicles per CDC guidelines
- No more signatures to verify trips (to avoid touching pens/electronic devices)
- Minimize hand-to-hand, door-to-door delivery as much as possible

Information from Logisticare

- Confirmed or presumptive cases – one-on-one transport via ambulance

- Solo rides for other patients who are deemed high-risk per CDC
ST. LOUIS EXPERIENCE DURING COVID-19 PANDEMIC

Transportation to HD Facilities

• Urban transit agency (Call-A-Ride)
• Logisticare (national company)
  • Medicaid contract
  • Contract out to other companies
Case 1

• 03/23 – patient transported to dialysis unit in the city from a nursing home
• Patient had temperature taken in waiting room – 101.7 F.
  • Also had cough and shortness of breath
• Mask placed, immediately isolated in a separate room
• Sent to ER for further evaluation
• Admitted, tested positive for COVID-19, decompensated, admitted to ICU

Case 1 – follow up

• Nursing home notified
• Public health department notified by dialysis unit
• Transportation company notified
• They identified/notified driver
• Driver provided information on other patients on the trip
• Driver advised to follow up/quarantined
• Vehicle was immediately grounded/thoroughly cleaned
Case 1 – follow up

Patient contact trace implemented
If patients went to other HD facilities, they were notified

Summary

• Dialysis center nurse managers should familiarize themselves on how their patients are being transported to dialysis facility
• Communicate with transportation company supervisors regarding mitigation/containment strategies
• One-on-one transport for suspected/infected patients, maybe via ambulance
• If a patient used a transportation company and has confirmed disease, notify transportation company immediately
• Other patients in same ride may need quarantine/isolation in dialysis
Outpatient Dialysis in the Era of COVID-19

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Policy Issues: Five Key Takeaways

During COVID-19 Pandemic:

1. Data submission requirements waived for most quality reporting and pay-for-performance programs (e.g. QIP, CrownWEB, MIPS, etc.)
2. Licensed professionals can practice across state lines (unless state-specific laws otherwise prohibit)
3. Telehealth care can be provided (and reimbursed) using two-way video communication for most outpatient, office, ED, initial and follow-up inpatient care, and ESRD MCP services
4. Telehealth care can be furnished to patients in any location
5. Telehealth is NOT permitted (although ASN is trying to change this):
   • To be conducted via telephone only
   • To substitute for at least one face-to-face in-person ESRD MCP visit in a month for in-center dialysis patients
Policy Issues: Quality Waivers

CMS Announcement Released March 22, 2020:

• Guidance applies to:
  • CrownWeb National ESRD Patient Registry and Quality Measure Reporting System
  • End-Stage Renal Disease (ESRD) Quality Incentive Program
• CMS recognizes that data derived during the COVID-19 crisis may not reflect the services provided throughout the year on measures such as cost, readmissions and patient experience and seeks to hold organizations harmless for not submitting data during this period.

Data Submissions

• For programs with data submission deadlines in April and May 2020, submission will be optional.

  2019 Data Submissions:
  • Deadlines for October 1, 2019 through December 31, 2019, data submission is optional.
  • If data is submitted, it will be used to calculate 2019 performance and payment.
  • If no data is submitted, 2019 performance will be calculated based on data from January 1, 2019 through September 30, 2019

  2020 Data Submissions:
  • If data from January 1, 2020 through March 31, 2020 is submitted, it will be used for CMS’ calculations for Medicare quality reporting and value-based programs.
Policy Issues

Practice Across State Lines:
• March 13, 2020 Guidance: “If they have an equivalent license from another State and are not affirmatively barred from practice in that State.”

Financial Assistance for Transportation:
• The OIG’s safe harbors already allows for provision of financial assistance or actual transportation services.
• 42 C.F.R 1001.952(bb)

ESRD Provider Telehealth and Telemedicine Guidance

Released March 17, 2020:
• Under the 1135 waiver authority and the Coronavirus Preparedness and Response Supplemental Appropriations Act, Medicare coverage for telehealth services was expanded starting March 6, 2020.
• Services can be furnished from patient’s place of residence or any healthcare facility.
• Services can be furnished by physicians, nurse practitioners, clinical psychologists and licensed clinical social workers.
• Providers have the flexibility to reduce or waive cost-sharing.
• The HHS Office for Civil Rights will waive penalties for HIPAA violations for providers serving patients in good faith using everyday communications technologies like FaceTime and Skype during the public health emergency.
Covered Types of Telehealth Services

• Medicare Telehealth Visits:
  • A visit with a provider using telecommunication between patient and provider
  • HCPCS/CPT Codes:
    • 99201-99215 for outpatient or office services
    • G0425-G0427 for ED or initial inpatient services
    • G0406-G0408 for follow up inpatient services

• Virtual Check-In:
  • A brief (5-10 minute) encounter via telephone or remote evaluation of images submitted by an established patient
  • HCPCS/CPT Codes: 99421-99423, G2061-G2063

Questions

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