



Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-20-36-ESRD

DATE: August 17, 2020

TO: Regional Offices, State Survey Agency Directors, Dialysis Facilities,
Stakeholders

FROM: Director
Quality, Safety & Oversight Group

SUBJECT: Key Components for Continued COVID-19 Management for Dialysis Facilities

Memorandum Summary

- **The Centers for Medicare & Medicaid Services (CMS) is dedicated** to ensuring the continued health and safety of patients receiving care within Medicare participating dialysis facilities during the COVID-19 pandemic. COVID-19 refers to the novel coronavirus causing the coronavirus disease 2019.
- **CMS Updates:** This memorandum updates and clarifies CMS guidance related to dialysis facility patients residing in Long Term Care (LTC) facilities; home dialysis services and essential procedures for dialysis patients is also included in this memo.
- **Dialysis Guidance and Actions** - To assist in preventing the transmission of COVID-19 within the dialysis population, CMS is reinforcing infection control guidance based upon the current Centers for Disease Control and Prevention (CDC) recommendations for dialysis facilities which include screening for COVID-19, patient placement, personal protective equipment, isolation, cleaning and disinfection.

Background

CMS is responsible for ensuring the health and safety within dialysis facilities by enforcing health and safety standards required to help facilities provide safe, quality care to dialysis patients. Due to the continued COVID-19 public health emergency (PHE), CMS is providing additional guidance for dialysis facilities to help prevent and minimize the risk of transmission among the dialysis population and reinforcing previously released infection control guidance.

Please check the following link regularly for critical updates to CDC's infection control guidance for healthcare professionals during the COVID-19 PHE: <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>.

Please check the following link regularly for the most up to date information on CMS' survey and certification policies: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions>

CMS Updates

Essential Procedures

Dialysis Access Placement: CMS previously released guidance to defer nonessential planned surgical procedures. Following the release of this guidance, we have received feedback that providers are experiencing difficulties scheduling for placement or repair of Arteriovenous Fistulas, Arteriovenous Grafts, and Peritoneal Dialysis catheters. We wish to clarify that these **planned procedures are essential in that establishing vascular access is crucial** for End Stage Renal Disease (ESRD) patients to receive their life-sustaining dialysis treatments. Without this, temporary access would be established using catheters, which pose a significantly higher risk of infection, morbidity and mortality. While recognizing this, there will be instances in which local conditions will not allow for these procedures to be done due to resource constraints related to the Public Health Emergency.

Organ Transplantation Procedures: Following the release of CMS' previously released guidance to defer nonessential surgical procedures (see CMS [recommendations for non-emergent, elective medical services and procedures here](#)), we received notifications of transplant programs voluntarily inactivating some or all of its transplant services. We wish to clarify that organ transplantation procedures are essential for patients that are suffering from irreversible organ failure. The delay of a transplant procedure may jeopardize the health and safety of a potential transplant recipient and any decision to delay such procedures should be made on a case by case basis by the medical providers, the patient, as well as local and state authorities with consideration given to factors such as staff and hospital resources and availability of necessary supplies and equipment.

Personal Protective Equipment (PPE) and Dialysis Supply Shortage

CMS is aware of the scarcity of some supplies in certain areas of the country. State and Federal surveyors should not cite facilities for not having certain supplies (e.g., PPE such as gowns, N95 respirators, surgical masks and Alcohol-Based Hand Rub (ABHR)) if facilities are having difficulty obtaining these supplies for reasons outside of their control. However, CMS does expect facilities to take actions to mitigate any resource shortages and show they are taking all appropriate steps to obtain the necessary supplies as soon as possible.

The facility should contact the local and state public health agency to notify them of the shortage, follow national guidelines for [optimizing their current supply](#), or identify the next best option to care for its dialysis patients.

Impact on Survey Activities

In order to allow health care providers time to implement the most recent infection control guidance from both CMS and the CDC, CMS shifted its approach for survey prioritization. As of June 1, 2020, once a state has entered into Phase 3 reopening as described in the nursing home reopening guidance noted in QSO memo-20-31, or earlier at the state's discretion, states are authorized to expand survey activity beyond the performance of 1) Complaints triaged at the immediate jeopardy (IJ) level, 2) Targeted infection control surveys and 3) Initial certifications surveys to also include the following types of survey activity:

- Complaints – triaged at non-IJ high level
- Revisit surveys with removed IJs but still out of compliance

If state or federal surveyors are unable to meet the PPE requirements from their own supplies, as outlined in the [latest CDC guidance](#) to safely perform an onsite survey, they are instructed to refrain from entering the facility and obtain necessary information remotely, to the extent possible. Surveyors should continue the survey once they have the necessary PPE to do so safely.

Dialysis facilities should utilize the focused infection control tool to perform self-assessments and ensure infection control plans and protections are effectively in place. To review the infection control tool and for more information on CMS' survey prioritization during the pandemic, reference [QSO-20-20-ALL and QSO-20-31-ALL](#). For updated guidance related to survey and certification activities and polices continue to monitor the CMS website at: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions>

Dialysis Patients Residing in Long-Term Care Settings

In order to maintain safe and effective care of dialysis patients, dialysis facilities and nursing homes alike should establish communication and reporting mechanisms which promote situational awareness between both healthcare facilities. Facilities should designate specific persons within the healthcare facility who are responsible for communication.

Dialysis facilities should educate patients, as well as the entities where their patients reside of their infection control policies and expectations for communication. Routine communication with details of the dialysis patient's status should ideally occur prior to the patient leaving the nursing home for treatment. Coordination among the two entities is vital to ensure healthcare staff are informed of the most up to date information relating to the patient's health status and to allow for proper planning of care and operations.

Additionally, communication should be maintained with the local ambulance and other contracted providers that transport patients between facilities to ensure appropriate infection control precautions are followed.

ESRD Network resources are available options for dialysis facilities looking to implement a communication tool that facilitates the timely exchange of information between entities. Some [examples of communication tools](#) can be found under the "Education" tab of the ESRD Network Forum website.

Applicable Waiver: For the duration of the (Public Health Emergency) PHE, CMS waived the regulation at 42 CFR §494.180(d) which requires dialysis facilities to provide services directly on its main premises or on other premises that are contiguous with the main premises. This waiver would allow in-center dialysis patients who reside in a long-term care setting to receive their dialysis treatments in their residence and bill as in-center. This waiver applies to patients residing in nursing homes, skilled nursing facilities, and assisted living facilities.

Reinforcement of Infection Prevention and Control Guidance

Screening

Individuals with COVID-19, the virus which is caused by the SARS-CoV-2 infection, have had a wide range of symptoms reported – ranging from mild symptoms to severe illness. Symptoms

may appear 2-14 days after exposure to the virus. People with these symptoms may have COVID-19:

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

Prompt recognition of potentially infectious patients and visitors is critical to prevent exposure to patients, staff and visitors in the dialysis facility. Visitors in the dialysis facility include any individual that enters the facility and is not a dialysis facility staff member or patient. Dialysis facilities should manage and limit visitors entering the facility. If possible, visitors that accompany patients should be requested to wait in an area that is separate from the staff and patients. If a visitor would provide necessary support to the patient to ensure quality medical care due to a communication or mobility limitation or disability, ask the patient how the staff could provide this support in their absence, if possible, and make every reasonable effort to do so to reduce the number of persons entering the treatment areas.

Patient Screening: Proactively, advise patients (and any visitor that accompanies the patient) to check their temperature at home before leaving for their dialysis session. Instruct patients to notify the facility before arriving if they have fever or symptoms of COVID-19 or exposure to others with SARS-CoV-2 infection. Patients should be instructed to put on a cloth face covering, regardless of symptoms, before leaving their home. If possible, limit and monitor points of entry to the facility and place a staff member near all entrances. Ask all patients upon entry to the facility if they have a fever or symptoms consistent with COVID-19. Facilities should make sure staff members who are screening patients remain 6 feet away from the patient until screening determines a patient is symptom-free and afebrile (temperature ascertained by patient report or active temperature monitoring). Once appropriate screening has been conducted, patients should be sent to the appropriate waiting areas, which should be organized to divide patients with symptoms from patients without symptoms. Separate patients by at least 6 feet, and the area for patients with symptoms should be at least 6 feet away from the area for patients without symptoms.

Provide patients with accessible information about in-person screening prior to the appointment or scheduled treatment. Ensure that any information provided before the visit is available in accessible format, providing the necessary reasonable accommodation and auxiliary aids and services (braille, 508 compliant electronic information for written information or through accessible verbal communication). To do this effectively, gather information from the patient at when scheduling an appointment to assess the communication needs.

For in-person screening, make communication fully accessible. For instance, provide written instructions as an alternative to verbal instructions, as well as using gestures and descriptive images, and providing staff with clear masks/face shields, if possible.

Post signs at entrances with instructions (in appropriate languages) to patients with fever or symptoms of respiratory infection to alert staff so appropriate precautions can be implemented. Signage posted at the facility should ensure full accessibility for persons with blind or low vision.

Visitor Screening: Facilities should encourage visitors to be aware of signs and symptoms consistent with COVID-19 and not enter the facility if they have such signs and symptoms. Screen all visitors entering the healthcare facility for symptoms consistent with COVID-19 or exposure to others with SARS-CoV-2 infection. Visitors exhibiting a fever or symptoms of COVID-19 or exposure to others with SARS-CoV-2 infection should be restricted from entering the facility and instructed to seek medical care if needed. Dialysis facilities should ensure that its visitors use cloth face coverings or facemasks to prevent spread of respiratory secretions. Actively take their temperature and document absence of symptoms consistent with COVID-19. According to the CDC, fever is either measured temperature $\geq 100.0^{\circ}\text{F}$ or subjective fever. Ask them if they have been advised to self-quarantine because of exposure to someone with SARS-CoV-2 infection.

Staff Screening: Screen all staff entering the healthcare facility for symptoms consistent with COVID-19 or exposure to others with SARS-CoV-2 infection. Dialysis facilities should ensure that its staff use cloth face coverings or facemasks to prevent spread of respiratory secretions. When available, facemasks are generally preferred over cloth face coverings for staff as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others. Actively take their temperature and document absence of symptoms consistent with COVID-19. According to the CDC, fever is either measured temperature $\geq 100.0^{\circ}\text{F}$ or subjective fever.

Staff who show signs of COVID-19 should immediately refrain from patient care, return home and notify their occupational health services for further evaluation. Facilities should implement sick leave policies that are non-punitive, flexible, and consistent with public health policies that allow ill healthcare personnel to stay home.

Patient Placement

Dialysis facilities should set up waiting rooms to allow patients to be at least 6 feet apart. If your facility's waiting area cannot accommodate this distancing, then partitions or signs to create designated areas or waiting lines may be used. Reduce crowding in waiting rooms by asking patients to remain outside (e.g., stay in their vehicles or in a designated outdoor waiting area), if feasible, until they are called into the facility for their treatment. Another option is to set up triage booths to screen patients safely. Patients with respiratory symptoms should be escorted to a designated treatment area for evaluation as soon as possible in order to minimize time in common waiting areas.

In the treatment area, facilities should maintain at least 6 feet of separation between patients with suspected or confirmed COVID-19 and other patients during dialysis treatment. Ideally, patients with suspected or confirmed COVID-19 would be dialyzed in a separate room (if available) with the door closed.

- Hepatitis B isolation rooms should only be used for dialysis patients with suspected or confirmed COVID-19 if: 1) the patient is hepatitis B surface antigen positive or 2) the facility has no patients on the census with hepatitis B infection who would require treatment in the isolation room.
- If a separate room is not available, the patient with suspected or confirmed COVID-19 should be treated at a corner or end-of-row station, away from the main flow of traffic (if available). The patient should be separated by at least 6 feet from the nearest patient (in all directions).

Patient placement in the waiting area and treatment areas should account for mobility disabilities and items such as wheelchairs and other durable medical equipment.

Provide for any needed reasonable accommodations to ensure proper distancing, such as accounting for wheelchairs or other mobility devices or accommodating service animals when separating and placing patients for screening, in waiting rooms and in treatment rooms. For information about how to increase physical accessibility of medical services, tools to assess your practice or facility's accessibility, and tips and training materials to support efforts to reduce barriers and improve quality of care for individuals with disabilities, see the CMS resource, [Modernizing Health Care to Improve Physical Accessibility: Resources Inventory](#).

Cohorting Patients

Designating areas or locations for patients with COVID, or patients under investigation (PUI) may help mitigate risk of transmission. If separation cannot be accommodated in a facility, consideration should be given to cohorting the patient(s) by shift, or location (dedicating an entire unit to treating for COVID positive patients).

If a hemodialysis facility is dialyzing more than one patient with suspected or confirmed COVID-19, consideration should be given to cohort these patients and the staff caring for them together in the section of the unit and/or on the same shift (e.g., consider the last shift of the day).

If the etiology of respiratory symptoms is known, patients with different etiologies should not be mixed (for example, patients with confirmed influenza and COVID-19 should not be placed together).

Universal Masking

Source control refers to the use of cloth face coverings or facemasks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are talking, sneezing, or coughing. Because of the potential for asymptomatic and pre-symptomatic transmission, source control measures are recommended for everyone in a healthcare facility, even if they do not have symptoms of COVID-19. Persons with COVID-19 may not report typical symptoms such as fever or respiratory symptoms; some may not report any symptoms. Unrecognized asymptomatic and pre-symptomatic infections likely contribute to transmission in these settings and other healthcare settings. All patients, regardless of symptoms should put on a cloth face covering during their transport to/from the facility (if using medical/contracted or public transportation) or at check-in (if not already wearing) and keep it on until they leave the facility.

If patients do not have a cloth face covering, a facemask or cloth face covering should be offered (if supplies allow).

Some patients may not tolerate, or refuse a face mask for the duration of their treatment. For these instances, patients should be educated on the importance of face covering to address universal source control in order to improve acceptance by the patients. If face coverings affect the patient’s respiratory status, the facility should take actions necessary to protect its patients and staff members while avoiding missed or incomplete treatments, for example placing the patient in separate room or area. Patient education on the importance of covering their mouth and nose with a facemask should be provided and reinforced prior to treatments, through accessible communication means so they are prepared to comply with the infection control measures in place at their facility.

Staff members should wear a facemask at all times while they are in the dialysis facility, including in breakrooms or other spaces where they might encounter co-workers and during their transport to/from the facility if using public transportation.

Testing

Decisions for staff and patient testing are made by the healthcare providers, as well as state and local authorities. Clinicians should use their judgment to determine if a patient has signs or symptoms compatible with COVID-19 and whether the patient should be tested.

Currently, there is no CDC guidance for testing that is specific for the dialysis setting and its population. Dialysis providers should follow CDC’s recommendations for [individuals](#) and [staff testing](#).

Testing Dialysis Patients*

Exposure Category	CDC Guidance
<u>Individuals with signs or symptoms consistent with COVID-19</u>	CDC recommends using authorized nucleic acid or antigen detection assays that have received an FDA Emergency Use Authorization to test persons with symptoms when there is a concern of potential COVID-19. Tests should be used in accordance with the authorized labeling; providers should be familiar with the tests’ performance characteristics and limitations.
<u>Asymptomatic individuals with known or suspected exposure to SARS-CoV-2</u>	Broader testing, beyond close contacts, is recommended as a part of a strategy to control transmission of SARS-CoV-2. This includes high-risk settings that have potential for rapid and widespread dissemination of SARS-CoV-2 or in which populations at risk for severe disease could become exposed. Expanded testing might include testing of individuals on the same unit or shift as someone with SARS-CoV-2 infection, or even testing all individuals within a shared setting
<u>Asymptomatic individuals without known or suspected SARS-CoV-2 exposure</u>	Certain settings can experience rapid spread of SARS-CoV-2. This is particularly true for settings with vulnerable populations in close quarters for extended periods of time. Local, territorial,

	<p>tribal, and state health departments can help with informed decision-making about testing at these or other settings.</p> <p>Before testing large numbers of asymptomatic individuals without known or suspected exposure, facility leadership should have a plan in place for how they will modify operations based on test results.</p>
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Testing Healthcare Personnel (HCP)*

<u>Exposure Category</u>	<u>CDC Guidance</u>
Staff with signs or symptoms consistent with COVID-19	<p>Clinicians should use their judgment to determine if facility staff have signs or symptoms compatible with COVID-19 and whether staff should be tested.</p> <p>Testing for staff with signs and symptoms of COVID-19 should be prioritized. CDC recommends using authorized nucleic acid or antigen detection assays that have received an FDA Emergency Use Authorization to test persons with symptoms when there is a concern of potential COVID-19.</p>
Asymptomatic staff with known or suspected exposure to SARS-CoV-2	<p>As part of community contact tracing efforts, viral testing is recommended for everyone, including staff, who have had close contact with persons with SARS-CoV-2 infection in the community (including household contacts).</p> <p>Assessment of staff exposures should be performed as described in the Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19. Due to their often extensive and close contact with vulnerable individuals, this guidance recommends managing occupationally exposed staff conservatively:</p> <ul style="list-style-type: none"> • For certain exposures believed to pose a higher risk for transmission, CDC recommends that exposed staff be excluded from work for 14 days following the exposure. • For other, lower risk exposures, staff may continue to work; however, CDC recommends screening for symptoms prior to starting work each day and using source control measures as described in CDC’s infection control recommendations. <p>If testing of exposed staff is instituted, test results should be available rapidly (i.e., within 24 hours), and there should be a clear plan to respond to results.</p>
Asymptomatic staff without known or suspected exposure to SARS-CoV-2	<p>Currently, testing asymptomatic staff without known or suspected exposure to SARS-CoV-2 is recommended for staff working in nursing homes as part of the recommended reopening process. There is no CDC guidance for testing that is specific for the dialysis setting and its population.</p>

*For additional guidance on the appropriate use of testing for individuals and staff, see links for “Overview of Testing for SARS-CoV-2” and “Testing Healthcare Personnel for SARS-CoV-2” in the “Additional Resources” section at the end of this memorandum.

Contract Tracing

State and or local public health departments or designees may contact the facility to obtain information to assist their efforts to perform necessary contract tracing to reduce the risk the risk of community spread of COVID-19. Facilities should obtain information on their state and local public health department's contract tracing protocols to ensure staff understand the appropriate information to request to validate the contract tracer calling and to provide the appropriate information to support this essential public health activity.

Cleaning and Disinfection

Current procedures for routine cleaning and disinfection of dialysis stations are appropriate for patients with COVID-19; however, it is important to validate that the product used for surface disinfection is active against SARS-CoV-2, the virus that causes COVID-19. Facilities should ensure they are following the manufacturer's label instructions for proper use and dilution of the disinfectant. Products with EPA-approved emerging viral pathogens claims are recommended for use against COVID-19. Refer to [List N: Disinfectants for Use Against SARS-CoV-2 \(COVID-19\)](#) on the EPA website for EPA-registered disinfectants that have qualified under EPA's emerging viral pathogens program for use against SARS-CoV-2.

Any surface, supplies, or equipment (e.g., dialysis machine) located within 6 feet of symptomatic patients should be disinfected or discarded.

Dedicated medical supplies and equipment should be used when caring for patients with suspected or confirmed SARS-CoV-2 infection. All non-dedicated, non-disposable medical equipment used for patient care should be cleaned and disinfected according to manufacturer's instructions and facility policies.

Home Dialysis

Dialysis facilities should continue to follow the guidelines as required regarding routine monitoring of home dialysis patients. While limiting the exposure to the virus that causes COVID-19 is a goal for all dialysis patients, complications of COVID-19 are particularly severe in older persons and those with chronic conditions including ESRD. It is important that home dialysis patients do not miss their onsite appointments, when applicable, to appropriately evaluate the dialysis care, services and individualized needs of patients.

Providers should utilize telehealth with necessary reasonable accommodations for communication as often as necessary, and as appropriate, to monitor their patients and address any needs.

Recommendations for screening that apply to in-center patients and visitors, will also apply to any home dialysis patient that comes into the facility for care. Facilities should be vigilant in monitoring any changes in guidelines as new information is available.

Additional considerations for home dialysis patients include the following:

- Facilities should ensure that home dialysis patients have all the supplies they need to continue their dialysis treatments and should work with suppliers to understand if shortages are anticipated in items such as peritoneal dialysis fluid.

- Facilities should coordinate with home dialysis supply companies to ensure supplies continue to be delivered to patient homes and stored appropriately. Contactless delivery might be impractical due to the size and weight of supplies.
- Facilities providing care to these patients should consider use of telehealth and other remote methods of care with necessary reasonable accommodations for communication, such as by telephone or secure text monitoring/messaging.

Applicable Waivers: For the duration of the COVID-19 PHE, CMS waived the requirement at §494.100(c)(1)(i) which requires periodic monitoring of the patient's home adaptation, including visits to the patient's home by facility personnel. We expect that alternative measures are in place to assess the patient's home adaptation when home visits are not a suitable option.

Flexibilities for Dialysis Facilities to Address COVID-19 Isolation Needs

As we noted in QSO-20-19-ESRD Revised, current Medicare law and regulations establish flexibilities for ESRD facilities in best meeting the needs of their patients during the COVID-19 PHE. There are various types of flexibility in care delivery models using current and new authorities available via waivers under section 1135 of the Act.

1. Dialysis facilities already certified for Home Training and Support services may consider providing home dialysis services to residents of LTC facilities in agreement with the patient's nephrologist and patient or patient representative. Since facilities are already certified to provide home dialysis services, adding home dialysis in a LTC facility only requires notification to the designated State Agency via the Form CMS-3427. No additional approval or survey is needed in this instance.
2. Dialysis facilities may choose to add Home Dialysis Training and Support services to an existing Medicare-certified facility. Facilities who choose to add Home Dialysis Training and Support services will need to complete the following actions:
 - a. Complete the Form CMS-855A—Medicare Enrollment Application
 - b. Complete the Form CMS-3427—End Stage Renal Disease Application and Survey and Certification Report and submit to the designated State Agency (SA).
 - c. For approval of each home dialysis modality for which a dialysis facility is applying, there must be at least one patient on census who, and/or their caregiver, is in the process of being trained or has been trained by that facility.
 - d. Demonstrate compliance with the ESRD CFCs
3. Establish a Special-Purpose Renal Dialysis Facility (SPRDF) – with CMS approval. This designation is permitted under current regulatory authority.

Applicable Waiver: CMS authorizes the establishment of SPRDFs under 42 CFR §494.120 to address access to care issues due to COVID-19 and the need to mitigate transmission. During the PHE, CMS issued a waiver to exclude the normal determination regarding lack of access to care at §494.120(b) as this standard has been met during the period of the COVID-19 PHE.

Additional Key Resources:

- [Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 \(COVID-19\) Pandemic](#)
- [Interim Additional Guidance for Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed COVID-19 in Outpatient Hemodialysis Facilities](#)

- [Symptoms of Coronavirus](#)
- [Strategies to Optimize the Supply of PPE and Equipment](#)
- [Screening Dialysis Patients for COVID-19](#)
- [Criteria for Return to Work for Healthcare Personnel with Suspected or Confirmed COVID-19 \(Interim Guidance\)](#)
- [Strategies to Mitigate Healthcare Personnel Staffing Shortages](#)
- [Overview of Testing for SARS-CoV-2](#)
- [Testing Healthcare Personnel](#)
- [Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to Coronavirus Disease 2019 \(COVID-19\)](#)
- [Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings \(Interim Guidance\)](#)
- [ESRD Provider Telehealth and Telemedicine Tool Kit](#)
- [CDC Factsheet- How our Facility is Keeping Patients Safe from COVID-19](#)
- [Frontline Staff Toolkit Videos- Tips for Outpatient Hemodialysis Facilities During COVID-19](#)

Contact: ESRDQuestions@cms.hhs.gov

Effective Date: Immediately. This policy should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators within 30 days of this memorandum.

/s/
David R. Wright

Attachment (s)- Checklist for Dialysis Facilities in COVID-19 Hotspots

cc: Survey and Operations Group Management