March 26, 2018

CTS INSPIRATIONS

CTS NEWS

President's Message

On March 15th, Scott Gottlieb, commissioner of the Food and Drug Administration, tweeted: "Today #FDA took a historic first step to advance our rulemaking process to render combustible cigarettes minimally or non addictive through regulation of nicotine levels under the FDA's tobacco product standard." This announcement came on the same day that a FDA funded study was published in the New England Journal of Medicine. The study, by Apelberg and colleagues, used a simulation model to estimate the population-level effects of a regulatory policy limiting the nicotine content of cigarettes. It found that reducing nicotine levels to 0.4 mg/g of tobacco filler would drop the smoking rate from 15% to 1.4% of adults, resulting in 8.5 million fewer tobacco-related deaths by the year 2100. If true, this would have an undeniable public health benefit. There are, however, "real world" concerns related to this strategy. Smokers can compensate for the reduced nicotine content in a variety of ways, and it is unclear how the tobacco industry would "engineer" these lower nicotine cigarettes. The FDA's "advance notice of proposed rulemaking" is currently posted on the Federal Register and open for public comment for 90 days. As health care professionals, it behooves us to be actively involved, whether it be to support the notice or raise concerns early in the process.

https://www.federalregister.gov/d/2018-05345

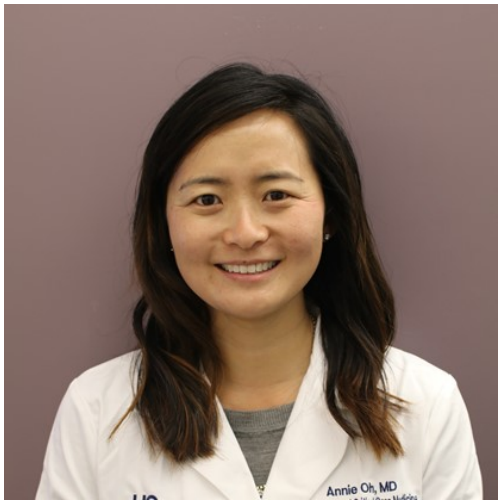
Thank you

Philippe Montgrain, MD
President, California Thoracic Society

Clinicians, Scientists and Advocacy

One of the things that I am most proud about CTS, is our advocacy. Although we did not plan for an advocacy theme, the articles in this issue serendipitously came together and give a sample of the wide-ranging concerns of our membership — from CTS President Philippe Montgrain's message raising awareness of the 90 day window for public comment on the FDA's proposal to decrease the nicotine content of cigarettes, to longtime CTS members and former CTS Presidents Chris Garvey and Rich Casaburi and current Executive Director Phil Porte's editorial on reimbursement for pulmonary rehab, to UCSF Pulmonary Fellow Anita Oh's recent testimony at an EPA hearing on its proposal to roll back the Clean Power Plan. Whether it be through science, education or advocacy, CTS strives to improve the health and lives of its members and patients.

Angela Wang, Editor



UCSF PULMONARY FELLOW TESTIFIES ON BEHALF OF CTS AT EPA "Listening Session" held on FEBRUARY 28, 2018

https://www.sfchronicle.com/news/article/At-EPA-hearing-support-for-Clean-Power-Plan-12718124.php

Good Morning!

My name is Anita Oh, and I am a physician and pulmonary fellow in training at the University of California, San Francisco.

I am speaking today on behalf of the California Thoracic Society, a professional society committed to the mission of improving the quality of care for patients with respiratory diseases in our state through advocacy and education. This society represents pulmonary physicians, nurses, scientists, respiratory therapists and other allied health care professionals in California. I also am speaking on behalf of my fellow trainees in the Pulmonary and Critical Care Medicine Fellowship Program at UCSF.

I want to focus my talk today on wildfires. This past October, Northern California experienced the most costly wildfires in California history. 250 separate wildfires burned up to 245,000 acres, destroyed 8900 structures, and were responsible for 44 deaths and 185 hospitalizations. The cause of this massive destruction is most likely related to climate change.

Since 1980, global temperatures have escalated steadily and rapidly. This rise in temperature is caused by greenhouse gas and CO2 emissions from fossil fuel-fired power plants in the U.S. Warmer air dries soil and vegetation, creating an abundant supply of combustible materials that are able to ignite more readily. Stronger winds also allowed the fires to spread more rapidly across greater distances. During the period that these fires burned, the air quality index was in the unhealthy and very unhealthy levels for several days in surrounding areas in Northern California.

Wildfire smoke creates particulate matter, which has been studied extensively in the scientific literature and is known to cause many negative health effects. Exposure to and breathing in of small particulates has been correlated with increased visits to physicians, emergency rooms, and more hospital admissions for asthma, COPD, respiratory infections, and heart failure. A rise in particulates in air has also been correlated with increases in respiratory medications prescribed by physicians and reductions in lung function in our patients. Those individuals that are most vulnerable to the effects of particulate matter created from the flames of fires include the elderly, females, small children under the age of 4, and those with lower education and of lower socioeconomic status.

In my training as a pulmonary fellow at UCSF, I see many patients at the San Francisco VA Medical Center in an outpatient clinic. The majority of patients that I take care of are over the age of 65 and many live in areas that were in very close proximity to the wildfires. In October, when the Northern California fires were continuing to burn, I received numerous phone calls from concerned and worried patients. They called to inform me they were having increasing shortness of breath and difficulty with their breathing due to asthma and COPD exacerbations. They inquired if they should evacuate and try to stay with to protect their lungs. They told me they had not left their homes for several days because they did not want to breath extra smoke into their lungs. My patients requested new or increases in the dose of their pulmonary medications. One patient told me that he had ongoing

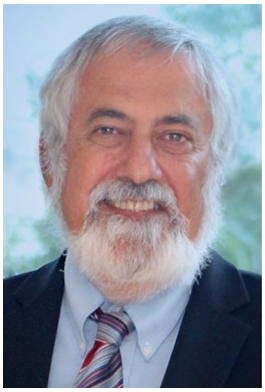
difficulty with his breathing that limited his physical activity that persisted from October until January. Numerous patients also called to inform us that their medical devices and medications had been lost when their homes caught fire.

Climate change and wildfire are affecting the health of our citizens. The proposal to repeal the Clean Power Plan will increase air pollution, CO2 emission and accelerate climate change, which could increase the number of devastating fires similar to the Northern California fires such as the one we witnessed this past October. The Clean Power Plan is crucial to help protect the health of our citizens, particularly the young, elderly, and socially disadvantaged. The mission of EPA is to protect human health and the environment and ensure that all Americans have clean air. I urge you to honor this commitment to create a healthy world for all of us and our future generations.

Pulmonary Rehabilitation Reimbursement Challenges and Strategies for Survival – by Chris Garvey NP, Phil Porte and Richard Casaburi PhD, MD

Chris Garvey, NP

Phil Porte



Richard Casaburi, PhD, MD

- Pulmonary Rehabilitation (PR) is the standard of care for improving physical funtion, symptoms, health-related quality of life and mood in persons with chronic lung disease.
- Inadequate reimbursement and limited availability hinder effective PR delivery
- A new COPD billing code introduced in 2010 established a bundled charge code which incorporated a fourfold increase in rehabilitation time and significant involvement of the PR medical director.
- The vast majority of US PR programs are undercharging for PR which has had a direct impact on inadequate and declining PR reimbursement.
- Improved reimbursement requires that pulmonary physicians, scientists and clinicians partner with PR providers to educate hospital financial leadership of the need to use PR charges that adequately reflect the cost of providing PR

Despite growing evidence for the clinical effectiveness of Pulmonary Rehabilitation (PR), inadequate reimbursement and limited availability continue to hinder the effective PR delivery in the US.(1) A recent analysis indicates that, in 2012, only 3.7% of Medicare-eligible COPD patients received PR (2). Low reimbursement undeniably influences the availability of what is now the standard of care in chronic lung disease.

The decline in PR reimbursement in the US is at least in part tied to a Medicare change in PR reimbursement in 2010, when a new ‘bundled’ payment code ‘G0424’ for COPD was introduced. This code pays for one hour of PR including all costs of staff, medical director, rehabilitation facilities,

overhead, etc. Initially in 2010, Medicare arbitrarily established a payment rate of $50 for one unit of G0424. Medicare acknowledged in 2011 that "failure to carefully construct the charge for G0424 that reports a combination of services previously reported separately under-represents the cost of providing the service described by G0424 and can have significant adverse impact on future payments" [*Federal Register 11/30/11*].

Historically, PR had been paid for in 15 minute increments for most services. The majority of PR providers and hospitals have never adequately modified PR charges to reflect the increase in time and resources used for the 'bundled' G0424 billing code. The impact on reimbursement is due to Medicare's use of PR charges (as well as information from the hospital cost report) to calculate annual changes in PR reimbursement. A recent review of charges for PR for COPD patients submitted to Medicare in 2015 from claims billed by 1350 US hospitals indicates that lower charges for the PR bundled code continue to persist. This practice has likely contributed to the reality that, as indicated below, cardiac rehabilitation reimbursement is now double that of PR.

CMS Final CY 2017 Outpatient Services Payment Rates

HCPCS Code	Short Descriptor	APC	Payment Rate
93798	Monitored cardiac rehabilitation	5771	$110.18
G0424	Pulmonary rehabilitation w/ exercise	5773	$54.53

It is possible that PR clinicians are not aware that the amount actually paid for services is often a small fraction of submitted charges. Below is an example of amount charged for services vs. what Medicare pays.

Summary for Medicare Outpatient Prospective Payment System Hospitals for 2015

Ambulatory **Payment** Classifications (APC)	Average Estimated Submitted Charges	Average Total Payments
0269 - Level I Echocardiogram Without Contrast	$2,386.36	$409.22
0369 - Level II Pulmonary Function Test	$1,354.23	$229.25

https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Outpatient2015.html accessed 10/1/17

What can be done? Hospital administrators set charge rates for all their services, including PR services. These administrators need to be aware of the concerns regarding G0424 billing and the impact of undervalued charges on Medicare payment. A Pulmonary Rehabilitation Toolkit is available that details resources for PR billing at https://www.aacvpr.org/Advocacy/Pulmonary-Rehabilitation-Toolkit.

It is time for the pulmonary medicine and scientific community to bring these concerns to hospital administration. It is also time for practitioners and scientists to partner with PR clinicians and administrators to determine if charges for their PR program reasonably represent the complexity of the intervention, the acuity of the target population, and the value of this evidence based intervention.

References

1. Rochester C, Vogiatzis I, Holland A, et al. An Official American Thoracic Society/European Respiratory Society Policy Statement: Enhancing Implementation, Use, and Delivery of Pulmonary Rehabilitation. Vol. 192, No. 11 | Dec 01, 2015
2. Nishi S, Zhang W, Kuo Y, et al. Pulmonary Rehabilitation Utilization in Older Adults With Chronic Obstructive Pulmonary Disease, 2003 to 2012. Journal of Cardiopulmonary Rehabilitation and Prevention: September/October 2016 - Volume 36 - Issue 5 - p 375–382

ANNOUNCEMENTS

PG 26: Practical Strategies to Enhance Patient Engagement in Healthcare

Co-Chairs: Felicity Blackstock, PhD, Marilyn Moy, MD, and DorAnne Donetsky, PhD

Saturday, May 19, 2018

Join us for this hands-on and interactive day-long PG course.

Details can be found here:

http://www.abstractsonline.com/pp8/#!/4499/session/522

We will use various formats including Motivational Interviewing, Journal Club, Role Playing, Demonstrations, and Roundtable Discussion to understand and apply strategies to effect behavior change.

Topics include smoking cessation, oxygen use, inhaler use, and physical activity.

You will leave with practical strategies to make the most of your time with every patient or research participant to improve adherence and compliance!

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Health Professional Program

7:30 a.m. to 5:00 p.m. | Registration Fee: Varies | Register online

This course meets the requirements for **8 CEUs** for RCPs and Nurses in California

Patient/Caregiver Program

9:00 a.m. to 3:00 p.m. | Register online, fax, mail, or call | Fee: $10 (**early bird special** by 3/31/18), $15 (after 3/31/18) per participant. Pre-registration is required.

Attire

Please dress comfortably. Professional casual is welcome. Since conference rooms can vary in temperature, you may want to dress in layers.

Oxygen Refills

Oxygen refills will be available to attendees. Please bring a copy of your prescription.

For More Information/Special Requests contact:

Victoria Howard, Ed.D., M.A. at 510-982-3151 or Victoria.Howard@Lung.org

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Southwestern Journal of Pulmonary and Critical Care Medicine

Volume 16, Issue 2							
Title (Click on title to open the manuscript, **CME in Bold**)	**Journal Section**	**First Author**	**Year**	**Vol**	**Issue**	**Pages**	**Date Posted**
Medical Image of the Week: Acute Pneumonitis Secondary to Boric Acid Exposure	Imaging	Ateeli H	2018	16	2	108-9	2/28/18
Tacrolimus-Associated Diabetic Ketoacidosis: A Case Report and Literature Review	Gen Medicine	Pak S	2018	16	2	103-7	2/27/18
The Dangerous Airway: Reframing Airway Management in the Critically Ill	Editorial	Mosier JM	2018	16	2	99-102	2/25/18
Linking Performance Incentives to Ethical Practice	Editorial	Boudi FB	2018	16	2	96-8	2/23/18
Medical Image of the Week: Traumatic Aortic Dissection	Imaging	Caskey JS	2018	16	2	94-5	2/21/18
VA Announces Aggressive New Approach to Produce Rapid Improvements in VA Medical Centers	News	Robbins RA	2018	16	2	91-3	2/15/18
Medical Image of the Week: Blue-Green Urine and the Serotonin Syndrome	Imaging	Ateeli H	2018	16	2	90	2/14/18
Healthcare Payments Under the Budget Deal: Mostly Good News for Physicians	News	Robbins RA	2018	16	2	88-9	2/13/18
Medical Image of the Week: Acute Encephalopathy in a Multiple Myeloma Patient	Imaging	Ateeli H	2018	16	2	86-7	2/7/18
Brenda Fitzgerald, Conflict of Interest and Physician Leadership	Editorial	Robbins RA	2018	16	2	83-5	2/6/18
Sleep Board Review Question: Restless Legs	Sleep	Omobomi O	2018	16	2	81-2	2/5/18
Ultrasound for Critical Care Physicians: Ghost in the Machine	Critical Care	Davidson R	2018	16	2	76-80	2/4/18
February 2018 Imaging Case of the Month	**Imaging**	**Gotway MB**	**2018**	**16**	**2**	**67-75**	**2/3/18**
February 2018 Critical Care Case of the Month	**Critical Care**	**Raschke RA**	**2018**	**16**	**2**	**62-6**	**2/2/18**
February 2018 Pulmonary Case of the Month	**Pulmonary**	**Wesselius LJ**	**2018**	**16**	**2**	**55-61**	**2/1/18**

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