

November 25, 2019



CTS INSPIRATIONS

CTS NEWS

President's Message

Dear CTS members,

For me, the month of November is a time to give thanks. It reminds me to to be thankful for the wonderful people in my life both at work and at home, and grateful for a career that enables me to strive to make a difference in people's lives and in the world every day. Thank you to all of you who are a part of this community – helping to improve the lives of your patients and their families!



If you are a CTS member, please remember to take a moment to vote. Elections for the next Treasurer for our society are currently open. Please submit your ballot by December 4, 2019. New officers will be installed during our Northern California conference.

Everyone is now invited to register for the conference which will be held January 17-18, 2020 in Monterey. Topics will include Oxygen Therapy, COPD Updates and Ethics, Updates on Pulmonary Hypertension, and Hot Topics in Pulmonary Medicine. I encourage you to check out the impressive lineup of speakers. Registration for the meeting, the hotel, and the poster competition are now all open. Information can be found on our website here: <https://calthoracic.org/events/2020-annual-educational-conference/>

Also, please check out the full details including the exciting new offerings for early career professionals on Friday night and the [Spark!](#) Event to empower the women of our community on Saturday night.

Happy Thanksgiving

A handwritten signature in cursive script that reads "Lorriana Leard".

Lorriana Leard, MD
President, California Thoracic Society

Editor's Note:

COPD: Dismissed and Disrespected no more.

The idea was simple. An outpatient pulmonary "Bridge" clinic that saw patients hospitalized with COPD and other pulmonary issues within 7-14 days of being discharged from the hospital with the intent of ensuring that their recovery was proceeding as expected and to review medications and overall plan of care during a time when patients are still tenuous and at high risk of relapse.

Not needed, was the reply. Our hospital COPD readmission rate meets Medicare standards. *Great!*, I thought only to find out later that the national rate for COPD readmissions is **20.2%** and that our hospital rate of **18.5%** (<https://hospitalcaredata.com>) is considered to be *good enough*.

Good enough. Really? From a medical standpoint, having 1/5 patients relapse and return to the hospital may be acceptable to a hospital administrator but seems outrageous to a clinician who bears the individual responsibility for the care of the patient.

As a community pulmonologist, It's hard to think of another lung disease that is as dismissed and disrespected as COPD. Reduced to a simple definition based on a spirometric ratio that remains controversial even among pulmonologists, COPD has been dumbed down. An unintentional consequence of the well intentioned desire to simplify and codify, guidelines sometimes make people stop thinking. It's hard to get people to appreciate the complexities of a multi system disease when in the end all you are going to do is prescribe an inhaler. All that other stuff, obesity, sedentary life-style, anxiety gets shuffled aside in favor of easier to order, more highly reimbursed and frankly, more glamorous pharmaco-molecular-techno therapies.

A lot has been written about moral injury and burnout, the physical, emotional and intellectual damage that healthcare professionals suffer when they are constrained from providing the best care that we can give our patients. But there are other costs, as well, resulting in the intellectual diminution of our profession when good enough becomes just that, good enough to get the patient out the door. Reminding ourselves that we are healers of spirit and mind-not just of the body- is a good way to protect our own souls.

Our annual COPD issue in honor of COPD month features contributions from [Dr. Richard Casaburi](#), [former CTS President Chris Garvey](#), [Nazmin Shah, RRT](#) and [Jimmy Slover, ALA California Captain](#).

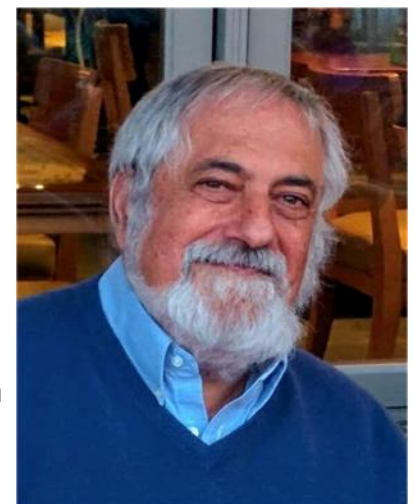
With their refreshing and frank insights, they remind us that COPD is more than a guideline and an inhaler. From doctor to RRT to nurse, there is no better way to learn that COPD is more than a spirometric diagnosis than caring for patients with COPD over years, guiding them through the nuanced, unpredictable, ravages of a debilitating disease. The critical work that Dr. Casaburi describes, led by the COPD Gene Network, our authors and so many others is slowly changing longheld stereotypes. It is imperative that frontline respiratory health clinicians work together and with their patients to raise awareness and improve understanding of COPD.

*Special thanks to **Krystal Craddock**, Clinical Educator and QI Coordinator at UC Davis for her assistance.*

Richard Casaburi, PhD, MD
Medical Co-Director Rehabilitation Clinical Trials Center
Lundquist Institute for Biomedical Innovation at Harbor-UCLA
Medical Center

At my age, you'd think that my travel schedule would slow down a bit. But, no, I've been putting on the miles in recent weeks: Just about all related to COPD-oriented meetings. Some were in anticipation of COPD month (November), but all demonstrating continuing efforts to beat back this persistent plague.

In late September, I participated in the annual Stanford Medicine X conference titled "It's COPD Dammit", the first time this conference had been dedicated to a single disease. Grace Anne Dorney Koppel and her husband Ted Koppel led a series of sessions that laid out the problems and advanced out-of-the-box solutions. Please see what I think is the most effective short video explaining the frustration we (and our patients) feel



about COPD (1). While you're at it, please see the recent video that CNN carried featuring Grace Anne and Ted explaining how the lack of availability of pulmonary rehabilitation is a major, major problem (2).

The annual meeting of the Global Initiative for Chronic Obstructive Lung Disease (GOLD) group was held in Philadelphia in early November. No radical changes in the 2020 COPD diagnosis and treatment recommendations (3), but a clear sense that almost 20 years of work has unified the approach to this disease.

Just last week (mid-November) the COPDGene group met in Boston. It's been 12 years since this NHLBI project was funded, initiating the gathering of a 10,000+ group of smokers for intensive evaluation. Over 350 papers have been published from this productive group. The most recent is a proposal to redefine COPD to include subgroups not previously included...interesting reading (4).

Finally, closer to home, the Pulmonary Education and Research Foundation (PERF), long a champion of pulmonary rehabilitation, has redesigned its website. Give it a look and subscribe to its blog (5)! While you're at it, you might drop a note to Mary Burns (6), the founder of PERF and one of the early pulmonary rehabilitation practitioners in the State. On December 11th, Mary will be 90 years young...and going strong.

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3. <https://goldcopd.org/>
4. <https://journal.copdfoundation.org/jcopdf/id/1254/COPDGene-2019-Redefining-the-Diagnosis-of-Chronic-Obstructive-Pulmonary-Disease>
5. <https://perf2ndwind.org/>
6. maryrburns@gmail.com

Chris Garvey NP, UCSF Pulmonary Rehabilitation Update

Pulmonary rehabilitation (PR) is well established as the standard of care in persons with chronic lung disease. PR has been found to improve functional capacity, dyspnea, quality of life and mood in persons with COPD (1,2). Improvements following PR appear to be similar across other chronic lung diseases, although the intervention must be tailored to the needs of the individual. Current areas of importance related to PR include PR reimbursement inequities, emerging PR 'alternatives' such as home PR, access to PR and PR immediately post-acute exacerbation of COPD.



Medicare coverage for PR has generally remained flat since 2010 at \$56 per hour, whereas payment for cardiac rehabilitation (CR) has risen to \$116 per hour. A new ATS work group is charged with addressing these challenges and developing strategies and educational tools to improve payment. CTS members who value PR and its role in improving outcomes in persons with chronic lung disease should communicate the value of PR to hospital financial leads who may be unaware of this serious challenge (3).

A recent survey of national PR programs by the American Association of Cardiovascular and Pulmonary Rehabilitation found there is gradual emergence of home and community based PR

programs throughout the US. By meeting the growing need for PR and helping to improve access to PR, home PR models appear to be a reasonable alternative to center based PR, yet several factors should be considered to assure that effective models of PR are available for patients. A recent study using Tai Chi in COPD concluded that the Tai Chi intervention is 'a substitute for PR' (3) yet the study did not result in gains in functional capacity normally seen in center-based programs (4). Another large study from Australia suggested home-based PR as equivalent to center-based PR, yet the center-based arm did not demonstrate normally anticipated gains in functional capacity (5) and the cost savings for home PR was only \$14 (Australian dollars). **There are currently no evidence based guidelines for home PR and no established reimbursement in the US, further suggesting the need for greater study and analysis prior to understanding the potential benefits and limitations of home PR.**

ATS has taken an important step forward to improve access to PR in development of livebetter.org an extensive PR resource for patients and clinicians. It includes an updated PR program directory as well as important resources for understanding and accessing PR. The resource was developed with a generous grant from Ted and Mary Gawlicki.

A growing area of importance is the potential role of PR in reducing readmissions following an acute exacerbation of COPD. PR following exacerbation is considered safe in stable patients, and may improve both clinical outcomes and reduce financial penalties incurred by hospitals following a readmission within 30 days of an index COPD acute exacerbation.

CTS has played a critical role in advancement of the science and clinical importance of PR, thanks to the work of former CTS leaders and volunteers Rich Casaburi, Andy Ries, Paul Selecky, John Hodgkin, Phil Porte, Trina Limberg, Karen Lui, and countless others.

References

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5. Holland AE, et al. *Thorax* 2017;72:57–65. doi:10.1136/thoraxjnl-2016-208514

Jimmy Slover, COPD patient, ALA California Captain

What is the biggest issue for someone living with COPD?

Left untreated, COPD can cause or contribute to other serious health issues, such as cardiovascular disease, respiratory infections (colds, flu, and pneumonia), lung cancer, and depression. Many patients around the world do not have proper care.

Getting and affording the proper medication(s): Doctors are prescribing life saving medications that we as patients cannot afford. Insurance companies and big pharma have to get better at helping and not lining their pockets.



Oxygen is another major concern and I am not even sure where to start with it. But we need to look at the way it's being delivered, maintained and again cost to the patient.

Knowledge: Pulmonary Rehabilitation courses must become a standard practice for ALL hospitals. Teaching a COPD patient who is scared from the start to deal with his/her illness is a huge plus for all concerned.

What is your hope for COPD in the future?

More and better research: Funding for COPD research is far behind and needs to be taken seriously or this world is soon to see major disaster. It is only a matter of time.

Better education in the primary doctor setting: We need a front line defense and I think that we need to really consider putting respiratory therapists in doctors offices everywhere to help bridge the gap of education from doctor to patient.

One piece of advice you would give to someone newly diagnosed with COPD?

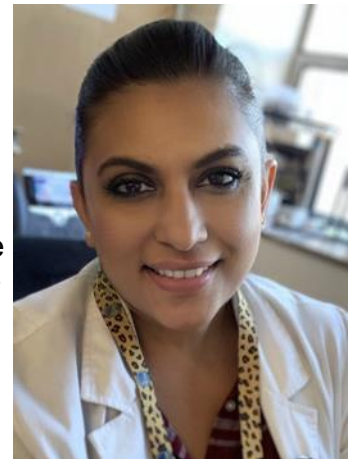
"It's not all gloom and doom" With some proper education and basic skills applied to your daily routine you can and will live a long life with COPD.

Smoking cessation is the number one priority if you are still a smoker. I am living proof that you can slow the progression down and arm yourself with knowledge on how to live with COPD and begin your new journey with COPD. "Not saying it will not be easy, but am saying it will be worth it in the end."

Getting into a support group like the 360 Social on the COPD FOUNDATION site is a good starting point to curb your fears and concerns about Chronic Obstructive Pulmonary Disease. I am a 20 year survivor and a 10 ten year tracheostomy survivor. Just try to remember this: One size does not fit all. Each patient comes to the table with different issues and concerns.

Nazmin Shah MBA, RRT RCP, CTTS, NCTTP - COPD Case Manager, UCSF

Living with COPD is a huge challenge in itself for those diagnosed with the chronic illness. The largest issue for someone who is living with this disease is the decline in their quality of life; leading to many limitations to their daily activities. Patients often feel guilty of relying on their caregivers or family members for help with simple tasks that they were previously able to accomplish on their own. Many former smokers with COPD blame themselves for the disease and express regret for the previous habit that was beyond their control. It is important for patients to realize that they are not at fault for the illness that they did not deliberately attain. Studies have shown that regret leads to a negative effect on the patient's mind and body that limits individuals from re-engaging with life. Emotional distress can trigger hormonal imbalance and lowered immune systems leading to larger risks of deterioration from COPD. Therefore, development of a strong emotional support system for the patient and their caregiver is necessary. More research in coping mechanisms that supports improvement in quality of life for COPD patients can be conducted in the future; promoting a larger awareness to the consequences of the disease and potential opportunities to conduct further studies to attain a cure. Until then, adherence to maintenance drugs, healthy diet, exercise and education on symptom management can allow for a better quality of life for a newly diagnosed patient with COPD.



Spark!

A gathering of CA Women in Pulmonary, Critical Care and Sleep Medicine

SATURDAY January 18, 2020 6 pm to 830 pm

Women continue to be under-represented in leadership positions within the medical profession. There are many causes, including lack of access to career opportunities that afford critical training needed to hone leadership skills as well as enhance visibility within the workplace and profession. Women also face unique obstacles, including cultural, society and biological factors that can hamper their professional and personal growth, causing them to stagnate and merely survive when they should be thriving.

The intent of this session is to provide a forum for women healthcare professionals in pulmonary, critical care and sleep medicine to gather in a relaxed environment, create meaningful connections and learn from each other as well as invited experts. Ideally, each woman will return to their families and home institutions ready to make at least one positive change in her life and career.

California Thoracic Society

18 Bartol St. #1054 | San Francisco, CA, 94133 | 415-536-0287

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CTS Editors:

Angela Wang, MD
Chris Garvey, NP

Laren Tan, MD
Sachin Gupta, MD