

June 18, 2020



CTS INSPIRATIONS

CTS NEWS

President's Message

Once again, our society is faced with yet another crisis. As we hear and watch the news, we can't help but feel that more must be done for black Americans. While violent protests and looters have tainted the pure intentions of the many crying for change, the fundamental drive to identify and eliminate racism must not be derailed. We must be honest and forthrightly acknowledge how we as a nation have failed to address societal and healthcare inequalities in a meaningful manner.

I have struggled deeply about whether and how we as a professional organization should respond. Since 1940, CTS has experienced and lived through many crises while upholding its mission to improve California lung health and, through advocacy and education, advance the science and practice of pulmonary and critical care medicine. As a professional society, we remain energized and focused on our mission and when needed, provide public societal statements as it relates to the lung, critical care and sleep health of Californians.

We embrace the pain and hurt felt by so many races. Let our message during these times be communicated through action without having to wait for clarion calls from our political leaders. We take these initial thoughtful steps towards healing, understanding that this is a struggle of not weeks or months or even years, but of a lifetime.

It has been an unprecedented year thus far, but I take solace that there is still good and hope in the world. Let CTS continue to be that hope and change for good...

Sincerely,

A handwritten signature in black ink, appearing to be "Laren Tan".

Laren Tan, MD
CTS President
LaTan@llu.edu



EDITOR'S NOTE

Abraham Flexner's Legacy

American medicine is renowned for its scientific rigor, due largely to Abraham Flexner and a small circle of elite American men who were responsible for the creation of the modern American medical education system over 100 years ago. Although the Hopkins Circle with whom Flexner associated also included William Osler, who was a strong patient advocate, it was Flexner together with William Welch and the backing of the Carnegie and Rockefeller Foundations who defined American medicine in the 20th century as first and foremost a scientific discipline. While medical school curricula have expanded their humanistic focus over the past 10 years in an effort to balance what many have felt to be an excessive focus on scientific advancement, academic medicine continues to deal with other pernicious legacies including its lack of diversity.

The simple fact is that, at least for Pulmonary and Critical Care Medicine, we are not doing a very good job at creating diversity in our field. As Drs. Santhosh and Babik point out: *“Striking disparities remain in gender, race, and ethnicity in the pipeline of trainees in PCCM programs; these have not improved (for gender) or have even worsened (for race and ethnicity) over the last decade.”* What the data and statistics don't describe, of course, are the real lives and pain behind the numbers. They do not address a culture that just by classifying some types of behavior as “micro” aggression diminishes the pain these acts cause. The absence of diversity has not only affected how our profession has pursued its scientific interests but also the care that we deliver our patients.

We need to speak through our actions to make change happen. American physicians and scientists are among the most highly trained and skilled people in the world. Surely we can do what it takes to make this profession that we love more truly reflect the values we proclaim.

References

1. [The Flexner Report—100 years later](#)
2. [Abraham Flexner and the Black Medical Schools](#)
3. [Diversity in the Pulmonary and Critical Care Medicine Pipeline. Trends in Gender, Race, and Ethnicity among Applicants and Fellows](#)
4. [Changing How Race is Portrayed in Medical Education](#)
5. [Career Development Strategies for the Clinical Educator](#)
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I Can't Breathe is Deeply Personal

by Dr. Erica Farrand (originally published June 9, 2020 [CNN.com](https://www.cnn.com))

Like many brown and black skinned children in this country I was raised to dream big and aim high ... just with a caveat. Whatever I thought it would take to accomplish my goals, I would have to work harder and be better. That message was internalized so early on in childhood, that although I can recall questioning its fairness, I never questioned its truth. It was in fact self-evident.



And so I set about playing the game. I got used to classrooms, lecture halls, and then conference rooms where few people looked like me. I understood the power of privilege, and believed that by gaining economic security, a professional network, and strong reputation one could secure a platform. And I believed that from that platform you would be seen and heard.

So I hung the degrees and dressed the part of a doctor every day. I diligently cared for my patients and I built community with my colleagues. I was careful with my words and actions ... too careful really, all the while painfully aware of the ease with which I could be labeled "angry," "defensive" or "confrontational."

Six months ago while at an academic meeting, I gathered with colleagues at the end of a long day. Several minutes into the conversation I found myself exhale and relax. I felt so much myself, that during a round of sharing stories of mistaken identities, I shared my own.

In the last month, I told them, I had been mistaken for a member of the custodial staff, food services, patient transport, and interpreter services, all the while dressed the part of a doctor. A colleague leaned over to me and said, "I had no idea you were so ...". He trailed off before ending the sentence, and although curious, I let it go. Whatever the word, of course he didn't know. How could he? In an effort to work harder and be better, to fit the mold and gain a platform, I had unconsciously (or consciously) stopped bringing my whole self to work.

I returned to my institution resolved to be braver, bolder, better. I cashed in the little capital I had acquired, and I pressed harder and spoke with refreshing directness. Shortly after the pandemic hit I received an email from my department chair identifying me as an "essential employee" and I allowed myself that moment. Yes. I was essential. The work I did mattered. I mattered.

Several days later, I walked out of the hospital after a particularly exhausting day with two minority colleagues. As we made our way home to the sound of neighbors cheering health care workers from their doorsteps, we felt seen. For a minute there we felt seen, and heard and safe.

The moment was fleeting. In the weeks that followed, as coronavirus relentlessly uncovered the pervasiveness of systemic injustice, as we measured the toll of the pandemic with the mounting deaths of brown and black lives, I watched privileged black leaders cash in their capital and shout from their platforms that RACISM. IS. A. PUBLIC. HEALTH. CRISIS. I saw them. I heard them. But it felt like they were shouting into an abyss. Where was the collective outrage?

And then came May. Any delusions of equality or progress that I managed to hold onto after weeks, no decades, of watching black people die, any belief in justice that I resurrected between the deaths of Trayvon Martin and Eric Garner, between Tamir Rice and Atatiana Jefferson, were shat-

Three days after George Floyd's plea "I can't breathe" was met with apathy and violence, I stood at the bedside of another black man. His bed in the ICU was surrounded by machines and monitors, the tubing for three different masks snaked toward his face. I leaned in close and introduced myself. "I'm Dr. Farrand. I'm a pulmonologist and I am here to help." He pulled his oxygen mask down and replied, "I can't breathe."

Triggered. So triggering are those three words for me, that as a new physician, I left my job in primary care, moved my family across the country, and signed up for three more years of training as a pulmonary and critical care doctor. So triggering are those three words for me, that even though I now hear them daily, their utterance stops me in my tracks and launches me into action. So triggering are those three words for me that when this patient whispered them, my immediate response was, "I promise you are safe."

And for that moment he was. In that moment, in our defined roles as patient and physician we were seen. We were heard. We were essential. Together we each took a breath in the safety of that space, even as we were flooded with a lifetime of images that told us just how disposable we were.

In the last week we have witnessed collective, unequivocal outrage. Black leaders are being seen and heard from their platforms. Their discourse essential. But listen to them ... really listen. They are expressing sorrow, anger, fear, exhaustion, but not surprise.

They have known for centuries what many are just coming to grips with -- that the deep currents of institutional racism which pulse through our most respected institutions, are the lifeblood of the overt violence we now collectively reject. Although less defined and less apparent, structural racism is no less detrimental, no less erosive to our humanity, and no less deserving of our outrage and rejection.

So, yes, we can exhale that charges were filed. There is no justice without accountability. But dismantling racism requires holding ourselves, each other, and our institutions accountable every day. It requires treating 42,000,000 lives like they are essential, not by training or trade, but by birth.

Considerations for Remote Pulmonary Rehabilitation by Chris Garvey NP



The evidence base for remote pulmonary rehabilitation (PR) has been explored in Canada (1), Australia (2) and other countries. The US has minimal experience in this emerging area of therapy excluding a few clinical trials (3) and isolated commercial models. This is at least in part due to lack of reimbursement, evidence-based guidelines and clinical experience. The COVID-19 pandemic has brought with it physical distancing, shelter-in-place, and the increased risk of infection and sequelae for older people and those with chronic lung disease. This has led to a need and possibly an opportunity for PR programs to consider a remote approach while center-based PR programs are closed, are functioning at reduced capacity, and/or patients are uncomfortable returning to clinical and/or group settings.

Reimbursement for remote PR is not currently provided by Medicare, despite uncertainty regarding safe provision of center based PR during the pandemic. All major US pulmonary organizations have collaborated to request Medicare payment for remote PR. The author suggests that providers contact all other insurers to request authorization for payment of remote PR.

Remote PR should deliver the essential components of pulmonary rehabilitation, including exercise training, education, and behavior change. Remote PR can be one of home exercise under supervision, telerehabilitation, video rehabilitation, and home exercises with the aid of online tools and videos. An Australian study included a phone based intervention with motivational interviewing by trained clinicians (2). Presented below are general resources that focus on helping patients understand the necessary interface with the PR clinician and safety considerations.

Exercise assessment, recommendations and prescription including progression should be derived from evidence based guidelines such as those published by the ATS (4) or the American College of Sports Medicine (5), and adapted by the prescribing provider to be appropriate for the individual patient and for use in a remote setting. The following resources are a compilation of information from various guidelines and PR providers. Importantly, these considerations lack the evidence base of center-based PR and extensive experience in the US. Exercise prescription, in particular, must utilize a collaborative approach by the prescribing clinician, patient and (ideally) family and/or caregiver, and must include safe and appropriate approaches that consider:

- ◆ The patient's disease, severity and symptoms.
- ◆ Comorbidities that are optimized before undertaking remote PR.
- ◆ Assessment of hypoxemia and appropriate management, including prescription and appropriateness of the O₂ system.
- ◆ Patient understanding of monitoring and self-management during rest and exercise.
- ◆ Barriers to safe remote exercise and PR including cognitive, psychiatric, neurologic, musculoskeletal, cardiovascular, balance and other clinical factors that may dictate the need for center-based PR and/or physical therapy.
- ◆ Technological literacy and preferences (e.g. phone vs video calls).
- ◆ Hearing and visual limitations that may increase the challenge of using technology.
- ◆ Psychosocial factors including the nature of the home environment and whether support from caregivers is available.
- ◆ General safety considerations include evaluation of unstable cardiac arrhythmias, oxygen use with exertion that may not be matched by home oxygen delivery devices, fall risk, etc.

An exercise assessment is needed for effective PR, yet is often not included in remote models. A center-based exercise test pre-PR should be performed to assess exercise capacity and desaturation, and enable individualized exercise prescription. This may not be possible in all settings but should be included when local infection prevention guidelines permit, and prioritizing patients for walk tests that cannot safely start remote PR without it.

Successful remote PR must also include exercise progression and reassessment with an expectation that the exercise prescription will increase over time. These features of PR should be based on national guidelines such as ACSM, ATS or AACVPR. It needs to be acknowledged that for a substantial number of patients with chronic lung disease, remote rehabilitation will not be an appropriate mode of therapy. For those who are judged good candidates, effective remote rehabilitation can be accomplished only with close and continuing contact between the patient and the rehabilitation team. Technological aids such as videoconferencing and remote monitoring may be useful adjuncts.

Suggestions for Remote Pulmonary Rehabilitation

The options below are not an endorsement of a specific approach to remote PR. Any approach or information should only be used by patients with involvement and agreement of their provider. These considerations are not medical advice. The author, CTS, and UCSF make no warranty or representation that these considerations will ensure the health of patients or preclude the possibility of negative outcomes. This is not a comprehensive approach, and it does not contain all available information on the subject matter. This document was prepared based on available information existing at the time of publication and therefore may be superseded by later developments.

Below are general recommendations for exercise in chronic obstructive pulmonary disease (COPD) from the American College of Sports Medicine (ACSM). They require clinical assessment and insights regarding exercise prescription in lung disease from the prescribing clinician.

ACSM FITT Aerobic Recommendations for Those with COPD

FITT	AEROBIC EXERCISE
Frequency	3-5 days/week
Intensity	Moderate intensity (i.e., 4-6 on the Borg Category Ratio 10 Scale).
Time	20-60 minutes/day. If the 20-60 minute durations are not achievable, accumulate >20 minutes of exercise interspersed with intermittent rest periods of lower intensity work or rest.
Type	Common aerobic modes including walking (free or treadmill), stationary cycling, and upper body ergometry.

ACSM: American College of Sports Medicine

FITT: Frequency, Intensity, Time, Type

ACSM FITT Resistive Exercise Recommendations for COPD and Asthma

FITT	RESISTANCE EXERCISE
Frequency	2-3 days/week
Intensity	Assessment of dyspnea and/or RPE using a validated scale may be considered.
Time	<i>Strength:</i> 2-4 sets, 8-12 repetitions <i>Endurance:</i> ≤2 sets for 15-20 repetitions.
Type	Elastic bands, free weight, or body weight exercises.

Key: RM = repetition maximum, RPE = rating of perceived exertion

These considerations are for the general information of PR professionals and clinicians. Each rehabilitation program, its clinicians and patients must decide which practices if any to implement based on a collaborative approach involving the PR team, medical director and potential patients. Please refer to the ACSM Guidelines for Exercise Testing and Prescription, 10th edition, Wolters Kluwer Health (5) for full information.

Remote Pulmonary Rehabilitation Information to be provided to patients

Thank you for considering remote pulmonary rehabilitation (PR). Below are a few considerations we would like you to know.

We will be evaluating you for exercise in your home using established questions and tools. We are eager to know what your goals are and what you would like to do differently or improve. Below is information about remote pulmonary rehabilitation and factors that will help it to be safe and effective.

Please let us know if you have questions, and most importantly, **if any of the exercises create discomfort before, during, or after the PR sessions or any exercise or activity.** Any pain is a signal to stop doing what you are doing and rest. Muscle or joint pain can occur with exercise. Mild pain often responds to rest, ice (apply to area of soreness for 20 minutes to every 4 hours using an ice pack or frozen peas/corn wrapped in a towel or thick cloth), elevation, and mild pain medicine such as acetaminophen (provided you are not allergic to the medication). Alert us for **any pain you have. If you experience moderate to severe joint or muscle pain, contact your physician promptly or call your local emergency room. Chest pain requires prompt medical attention normally in an ER setting.**

We will provide you with suggestions for exercise. We want and need your input regarding what you feel you can do fairly easily without discomfort, somewhat severe or severe breathlessness or other abnormal symptoms. **Below are examples of symptoms that should alert you to stop exercising and to get help.**

When to Stop Exercise and Seek Help



- Moderate to severe breathlessness, fatigue or weakness beyond normal levels that don't improve with rest or usual management (e.g., O₂, rescue inhaler or nebulizer, tripod position)
- Chest pain or tightness
- Muscle pain that does not improve
- Feeling dizzy or faint
- Leg pain, weakness, and/or cramping
- Sweating more than you usually experience with exercise

Monitoring your oxygen saturation level, heart rate and shortness of breath at rest and during exercise is an important and required part of remote pulmonary rehabilitation.

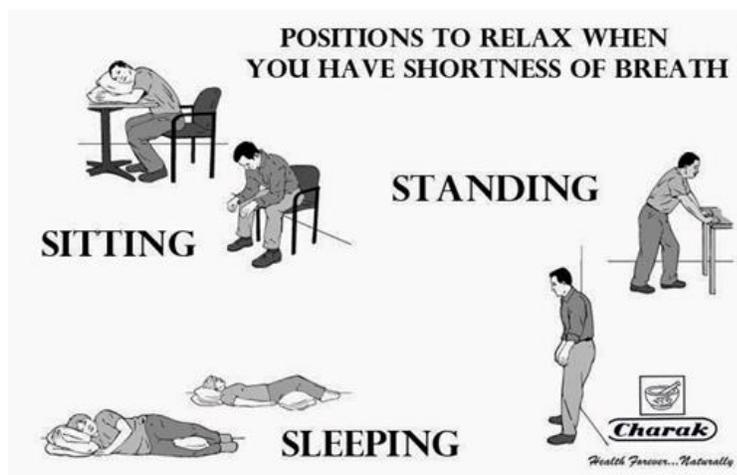
Oxygen is an essential nutrient for muscle, brain, and heart function and for human life. We will need you to **purchase and use a ‘finger oximeter’ to measure oxygen saturation at rest before and during exercise.** <https://www.thoracic.org/patients/patient-resources/resources/pulse-oximetry.pdf> These are available at from many suppliers (e.g., Amazon and various local pharmacies).

Your doctor may prescribe oxygen and advise you what ‘flow rate’ or how many liters per minute of oxygen to use at rest and with exercise. We want you to check your oximeter reading (oxygen saturation) and heart rate at rest and during exercise daily. If your saturation level is below 89% (below 90% in people with pulmonary hypertension or pulmonary fibrosis), slow down and rest. Your goal is to keep your oximeter reading at or above this number. Ask your lung specialist or rehabilitation clinician what your goal is for oxygen saturation and heart rate at rest and during exercise. Let him/her know if you need assistance with monitoring oxygen saturation or heart rate.

Shortness of breath is common in persons with breathing disorders. Breathlessness can be frightening, especially if severe. We use the Borg scale to rate your breathlessness and fatigue on a scale of one to ten. Exercise in persons with breathing disorders results in some breathlessness. This occurs normally with exercise at a moderate or greater level of work. Mild to moderate breathlessness is normal and usually safe during exercise. **If your shortness of breath is greater than 5 or ‘strong’ on the Borg scale, slow down or rest.** If you quickly return to your baseline, it’s usually OK to resume exercise at a slower pace. **Your goal is 2-3 on the Borg scale or mild to moderate breathlessness with exercise unless your therapists recommend otherwise.**

Borg Scale

0	Nothing at all
1	Very weak
2	Weak
3	Moderate
4	Somewhat strong
5	Strong (heavy)
6	
7	Very strong
8	
9	
10	Extremely strong



Foot Peddlers



Rollator

Resources for home exercise are important. A few are listed below. These are not for everyone but may offer options for you to get stronger and feel better. Discuss any option you wish to explore with your physician.

- **Living Well with COPD** <https://www.livingwellwithcopd.com/>
- **LIFT** <https://liftclass.com/pulmonary/>
- **Pulmonary Wellness Foundation** <https://pulmonarywellness.org/>
- **Live Better** from the American Thoracic Society: Pulmonary Rehabilitation Information, Resources and program directory from the American Thoracic Society <http://www.livebetter.org/>
- **British Thoracic Society** resources
Stay Active and Stay Well from the British Lung Foundation
<https://www.blf.org.uk/exercise-video>
Resource Pack from the British Thoracic Society (scroll down for Pulmonary Rehab)
- **AACVPR Remote PR** video https://www.youtube.com/watch?v=t2Nf1eisymA&feature=emb_title
- **Home Based Rehab:** A resource for the development of home-based pulmonary rehabilitation programs from Australia: <https://homebaserehab.net/>
- **Better Living with Chronic Obstructive Pulmonary Disease—A Patient Guide:** The State of Queensland (Queensland Health) and Australian Lung Foundation. 2008. <http://www.lungfoundation.com.au/lung-information/patient-educational-material/better-living-with-copd-a-patient-guide>
- **Telerehabilitation for people with chronic lung disease** by Anne E Holland and Narelle S Cox.
<https://www.thoracic.org/members/assemblies/assemblies/pr/quarterly-bite/telerehabilitation-for-people-with-chronic-lung-disease.php>

The author gratefully acknowledges Richard Casaburi PhD, MD, Anne Holland Phd, PT and Surya Bhatt MD for their expert review and recommendations.

References

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2. Holland AE, Mahal A, Hill C, *et al.* Home-based rehabilitation for COPD using minimal resources: a randomised, controlled equivalence trial. *Thorax* 2017;72:57–65. doi:10.1136/thoraxjnl-2016-208514.
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4. Spruit MA, Singh SJ, Garvey C, *et al.* An official American Thoracic Society/European Respiratory Society statement: key concepts and advances in pulmonary rehabilitation. *Am J Respir Crit Care Med* 2013;188:e13–64.
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Telemedicine Exhaustion

By Dr. Ni-Cheng Liang, CTS CCR Representative



I'm angry. The sound cut out... again, for the fifth time in the last hour. "Why can't I get through one telemedicine visit without some technical problem?" I ask myself. I can feel the chest discomfort, my shoulders tense, I start to flush, tell-tale signs of frustration and anger bubbling up. I did not go to medical school to become tech support. After 11 patients, it's finally time for lunch. I get up from my chair and notice that my low back is sore, as are my shoulders, and my eyes are very dry. All occupational hazards of telemedicine, sitting in one location for much of the workday.

We live in a new world now, and telemedicine is here, more fully integrated into our healthcare system than ever. Overall, I believe this is a positive, as it improves access for many of my patients who are geriatric, limited in their mobility, or do not drive anymore. But there is a cost. I strain to get a sense of how my patient is really doing by only looking at their face. I miss hearing lung sounds, having true eye contact, and firm handshakes of connection before and after the clinic visit.

After a day of telemedicine patients, I find myself more physically and emotionally exhausted than had I seen them in person. Part of this is due to the ergonomics of the telemedicine set up- feeling stuck in the same place in mostly the same position, looking at the same screen(s), and repeating, over and over again the same words of, "Can you hear me? How about now, can you hear me now?" I'm worried about her. "What ifs..." – our expert catastrophizing for our patients has become more prevalent for me, worried I am missing a key physical exam finding that could mean the difference between life and death because some of my patients are not great historians. Telemedicine requires us to rely even more on the accurate recounting of a patient's subjective experience, as we try to distill it down into some semblance of objectivity, but with less objective data- namely the lack of the physical exam. And when our patients are not capable of being historians, we rely on their loved ones or caretakers to provide a third-person history, but without the physical exam to help us assimilate valuable, sometimes nuanced information about our patients that a clinician is trained to detect.

Telemedicine exhaustion is real, and it is yet another potential source of burnout that healthcare professionals face. May I offer some tools that have helped me?

1. **Ergonomics**- ensure that your work space is set up to provide you with maximum physical comfort- screen at eye level, chair height that enables you to place both feet flat on the ground, keyboard, mouse, speaker/microphone located where you do not have to strain to reach, keeping your elbow as much as possible at a right angle while you are typing. If you do notice any tension or pain, take a moment and think about what you could do to help bring more physical comfort to you, and do it--might be as easy as doing a few shoulder and neck rolls. Work standing if you have that option.
2. **Breaks**- During lunch, I go outside for a walk, looking at the sky and the trees around me. This is an intentional mini-mindfulness practice. It helps reset me and refreshes me for the next 10 patients. Can the "start" button on the telemedicine window become a reminder for you to take an intentional deep breath as a moment of reorienting to the present moment before the visit?
3. **Intentional social curiosity**- Part of the exhaustion is the loss of physical and emotional connection we have with our patients over the contrived atmosphere of telemedicine—can you broaden your curiosity about your patient to include something in their environment that you might not have known about your patient? I've met more pets than I can remember now and

seen more meaningful artwork hanging in my patient's homes with fascinating stories behind them, a social connection that otherwise would not have been forged had it not been for this unique opportunity to have a view inside our patient's homes and be authentically curious about some new facets of their life.

4. **Blue-light filter screens or glasses.** We know that the blue-light emitted from monitors and our phones decreases melatonin secretion, hence adversely affecting our circadian rhythms, and increasing irritability amongst other detrimental effects to our well-being. Being mindful about not looking at screens 2-3 hours prior to bedtime and protecting eyes can be extremely helpful in reducing dry eye and optimizing sleep hygiene.

As Steve Hickman, PsyD so eloquently suggests, "Let's be present to absence, without becoming absent to presence." We are doing the best we can. Our patients are doing the best they can. We are in this unprecedented time of adjusting to our new normal, together. Let this time be a much-needed reminder that we cannot care for others unless we care for ourselves.

Dr. Ni-Cheng Liang is one of the California Chapter Representatives to the ATS and is in private practice at Coastal Pulmonary Associates, as the Director of Pulmonary Integrative Medicine, affiliated with the Scripps Health Network. She is a cancer survivor and as a result, a mindfulness teacher, as the immediate past Executive Director for the UC San Diego Center for Mindfulness, and healthcare professional wellness advocate who has led national workshops, presentations, and retreats on mindfulness and healthcare professional wellness. She founded the Mindful Healthcare Collective, a group of physicians with additional training in mindfulness and wellness to provide live sessions for healthcare professionals and the general public during the pandemic.

For more information on Dr. Liang and resources, see her websites at <https://www.ncliangmd.com/> and <https://www.mindfulhealthcarecollective.com/>.

SWJPCC Journal - Volume 20 Issue 4

Volume 20, Issue 4							
Title (Click on title to open the manuscript, CME in Bold)	Journal Section	First Author	Year	Vol	Issue	Pages	Date Posted
Informe de políticas: Fatiga, sueño y salud del personal de enfermería, y cómo garantizar la seguridad de los pacientes y el público	Sleep	Caruso CC	2020	20	4	137-46	4/29/20
Healthcare Layoffs During the COVID-19 Pandemic	News	Robbins RA	2020	20	4	135-6	4/21/20
Choosing Among Unproven Therapies for the Treatment of Life-Threatening COVID-19 Infection: A Clinician's Opinion from the Bedside	Critical Care	Raschke RA	2020	20	4	131-4	4/10/20
Sleep Tips for Shift Workers in the Time of Pandemic	Sleep	Yuan RK	2020	20	4	128-30	4/6/20
Tips for Circadian Sleep Health While Working from Home	Sleep	Lammers-van der Holst HM	2020	20	4	126-7	4/6/20
Medical Image of the Month: Late-Onset Pompe Disease	Imaging	Hernandez Z	2020	20	4	124-5	4/2/20
April 2020 Critical Care Case of the Month: Another Emerging Cause for Infiltrative Lung Abnormalities	Critical Care	Luedy H	2020	20	4	119-23	4/1/20

SWJPCC Journal - Volume 20 Issue 5

Volume 20, Issue 5							
Title (Click on title to open the manuscript, CME in Bold)	Journal Section	First Author	Year	Vol	Issue	Pages	Date Posted
Improving Testing for COVID-19 for the Rural Southwestern American Indian Tribes	Editorials	Chhabra A	2020	20	5	175-8	5/16/20
Medical Image of the Month: An "Intubation Box" to Protect Healthcare Professionals	Imaging	Nissim L	2020	20	5	173-4	5/15/20
Does the BCG Vaccine Offer Any Protection Against Coronavirus Disease 2019?	Editorials	Rehman M	2020	20	5	170-2	5/13/20
2020 International Year of the Nurse and Midwife and International Nurses' Day	Editorials	Baldwin CM	2020	20	5	165-9	5/6/20
Medical Image of the Month: Viral Pneumonias	Imaging	Gotway MB	2020	20	5	163-4	5/2/20
May 2020 Imaging Case of the Month: Still Another Emerging Cause for Infiltrative Lung Abnormalities	Imaging	Panse PM	2020	20	5	147-62	5/1/20

Appendix:

1. California Clinical Trials:
 - 1) [UC Davis](#)
 - 2) [UCLA](#)
 - 3) [UCSD](#)
 - 4) [UCSF](#)
 - 5) [USC](#)
 - 6) [CEDARS-SINAI](#)
 - 7) [STANFORD](#)
2. Outpatient Workup/Management of Covid-19 (<https://calthoracic.org/covid-19-central/>)
<https://calthoracic.org/wp-content/uploads/2020/04/CTS-Outpatient-workupmanagement-of-COVID-19-422020.pdf>
3. Remote Pulmonary Rehabilitation—Information for Patients (.pdf)
https://mcusercontent.com/68651de2529a45c9625202512/files/9703a317-6535-49fd-97db-56104ddb8767/Remote_Pulmonary_Rehabilitation_Consideratio.pdf
4. Better Breathers Club Zoom Meeting—See page 16

California Thoracic Society***18 Bartol St. #1054 | San Francisco, CA, 94133 | 415-536-0287******Connect with CTS at <https://calthoracic.org/>******CTS Editors:******Angela Wang, MD******Chris Garvey, NP******Laren Tan, MD******Sachin Gupta, MD***



Virtual Better Breathers Club

1st Tuesday of the Month
12 noon – 1 pm

Instructions

Join from a PC, Mac, Linux, iOS or
Android device (computer or smart
phone):

<https://ucsf.zoom.us/j/2858728213>

Telephone:

US: +1 669 900 6833
or +1 646 558 8656

Meeting ID: 285 872 8213

For more information on Zoom:

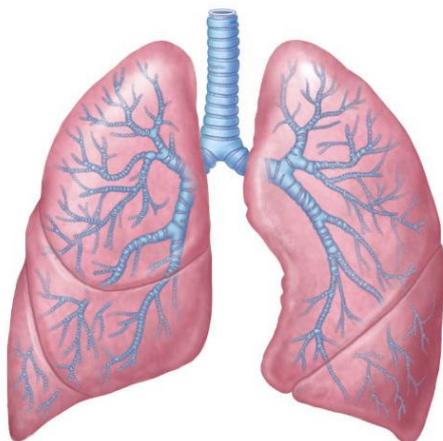
<http://ucsf.zoom.us>



Better Breathers Clubs are an American Lung Association in California support group for people with lung disease, such as COPD, asthma, pulmonary fibrosis or lung cancer, their families, friends and support persons. Please join us at any time.

Monthly topics include:

- What's happening in my lungs?
- Symptom management
- Home medical equipment and oxygen
- Nutrition and Exercise
- Medications
- Pulmonary test results
- Integrative therapies
- Sleep
- Enjoying life with chronic illness
- Coping strategies



For more information contact DorAnne Donesky, 925-323-6471

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MONTHLY SUPPORT GROUPS ARE FREE AND OPEN TO ALL!