April 20, 2021

CTS INSPIRATIONS

CTS NEWS

President's Message

On behalf of the CTS Executive Committee, Michelle Cao, George Su, Tisha Wang, Nicholas Kolaitis and Ni-Cheng Liang, I want to thank all our members for your continued support of CTS. We were very excited to be able to connect with so many of you on our virtual platform despite the COVID limitations during the past year. I also want to thank Dr. Devereaux for putting together the excellent *COVID State of the ICU* zoom series during our winter surge.

We launched the CTS new educational series of webinars this month and have a robust lineup of webinars and symposia planned for the 2nd and 4th Friday of each month. The inaugural webinar, developed in collaboration with Boehringer Ingelheim, focused on Interstitial Lung Disease with Justin Oldham, MD, as the speaker on April 9th. This webinar may be viewed on our website at: https://calthoracic.org/view-past-webinars-presentations/. Our second educational webinar, supported by SmartVest (Electromed, Inc.), is scheduled for Friday, April 23rd at 5:00 pm. The webinar is entitled: Strategies to Break the Cycle of COPD Exacerbations with speaker, Brooks Thomas Kuhn, MD, MAS from UC Davis. To register for the April 23rd webinar and/or view the upcoming educational webinar dates, click on the following link: https://calthoracic.org.

Please mark your calendars for a "*Post-COVID Summit*" on May 7th led by Dr. Lekshmi Santhosh focusing on post-COVID care; and many more interesting topics in the pipeline. We are reinventing our CTS website that will soon include a *CTS Job Board* as well as a calendar of upcoming virtual events. We have also launched a new institutional membership tier "the Platinum Plus" which allows for unlimited registrations for all CTS virtual events and have added over 250 new CTS members this year. We have also strengthened our ties with corporate partners and are stronger financially. I am honored to be a part of this great organization and remain committed as the current CTS President to maintaining CTS' forward momentum.

Sincerely,

Vipul V. Jain, MD, MS
UCSF Fresno

Brief Perspectives from Two Navy Intensivists from a COVID-19 Texas Deployment
By Dr. Nikunj Bhatt, MD, MS, LCDR, USN, MC and Dr. Jonas Carmichael, MD, CDR, USN, MC

In January, the state of Texas, like the majority of the United States, faced surging critical cases of COVID19 patients following the Christmas and New Year holidays. There was a desperate need for staff and expertise to assist and provide some relief to overwhelmed community-based hospitals. The military was utilized in multiple locations throughout the nation to provide medical support. In mid-January, two intensivists, in addition to five respiratory therapists and eight ICU nurses from U.S. Naval Hospital San Diego along with multiple other medical military support from throughout the country deployed to Texas in late January with the mission to provide COVID19 support.

As the two intensivists, we were sent to Eagle Pass, Texas (see Figure 1 map). Eagle Pass is a small community border town on the Rio Grande. The main hospital there is Fort Duncan Regional (FDR), a Level-IV community hospital with a 10 bed open-ICU model staffed by Internal Medicine and Family Medicine doctors with a usual plan to transfer patients to higher levels of care in San Antonio, Texas. Telecritical care was not an option at FDR. In early-mid January 2021, FDR was approaching their hospital's capacity, had doubled occupancy in their ICU rooms, and had started to expand into their PACU. As the hospital census increased and the ability to transfer to hospitals with intensivist support became very limited, the management of higher acuity patients was forced to occur on the regular medical wards.

As we were only two intensivists, and the need for 24 hour direct care was substantial, we made a decision where Dr. Carmichael covered the day shifts and I would cover the night shifts, each 12 hours in length, for five days. On our two "off days" we would split taking home call for the local internists to answer any questions or assist if needed. In the Navy, we call this "going port-and-starboard" with a plan to continue this model until there was better control over the census. Over the course of 4 weeks, we performed a combined 65 procedures and 25 admissions. Around the third week, a bizarre snowstorm occurred throughout Texas, surprising everyone (see Figure 2). Several homes and businesses in the local community, including our own hotel, did not have water for four days, and some areas in the community had no electricity during the winter storm. The hospital had to divert patients for dialysis but overall we were able to maintain safe-patient care during this crisis. By the last week, our ICU census for COVI-19 patients was near zero and the hospital was resuming its normal operations.

The disaster response in Texas provided a unique opportunity to reframe Critical Care medicine response. Rapidly integrating into hospitals in crisis with new workflows and capabilities is in essence its own skillset. It requires a balance of a systematic understanding of the requirements for critical care and an altruistic empathy of the medical system and community in need. These missions can occur at a moment's notice, and the Texas COVID-19 Rural Rapid Response missions reaffirmed

flexibility, and resilience that are fundamental traits of military medical personnel will meet the needs of communities in crisis.

Figure 1: Eagle Pass, Texas Map (source: https://www.expressnews.com/news/local/article/Eagle-Pass-erects-migrant-tents-amid-massive-13939966.php)

Figure 2: Texas Snowstorm

Pulmonary Rehabilitation – Live Better and Live Longer National Campaign by Chris Garvey FNP, MSN, MPA,[1] Richard Casaburi PhD, MD[1] Carolyn Rochester MD, Brian Carlin MD, Alex Jenkins PhD, James Lamberti MD, John Studdard MD, Katherine Menson MD, Grace Anne Dorney Koppel JD, MA, Judy Corn, Gary Ewart, Anne Marie Hummel, Phil Porte, [2] Trina Limberg RRT, BA,[1] Karen Lui RN, MS[2], Aimee Kizziar MHAL, BA, RRT-NPS, RCP, [1] Rebecca Crouch PT, and Mary Gawlicki.

[1] CA representatives, [2]CTS affiliation

The ATS Pulmonary Rehabilitation (PR) Assembly Reimbursement work group, in collaboration with 18 national pulmonary societies is working to improve pulmonary rehabilitation awareness, access and ultimately lay the foundation for improved payment. Our focus is to alert patients, providers and payers of the multi-dimensional benefits of PR. The impetus for this effort is based on the recent demonstration by Lindenauer and colleagues, Association Between Initiation of Pulmonary Rehabilitation After Hospitalization for COPD and 1-Year Survival Among Medicare Beneficiaries - PubMed (nih.gov), of a substantial survival benefit for COPD patients who received PR after a hospitalization for exacerbation. We suspect that this benefit extends to other chronic pulmonary diseases and adds to the already well-demonstrated benefits of improved function, symptoms, mood and quality of life, as well as reduction in exacerbations.

How can you help?

- Send the advocacy letter below to your organization's **members, your contacts,** others you deem appropriate, **persons with COPD and other chronic lung diseases, and encourage them to get the message out about the benefits of pulmonary rehabilitation.**

- **Consider Including the advocacy letter and infographic below on your website, and consider a press release.**

- **Include the infographic below on your social media sites and** send via #PulmonaryRehabiliationMatters #PulmonaryRehabilitationWellnessDay #WorldHealthDay'

We hope that better recognition of PR as the standard of care for symptomatic lung disease will lay a foundation to support more equitable access and payment for this key intervention. Please let us know if you have questions or if we can be of further help. Contact Chris Garvey NP, on ehalf of the ATS Pulmonary Rehabilitation Assembly US Reimbursement Work Group chrisgarveysf@gmail.com.

Pulmonary Rehabilitation
—Live Better and *Live Longer*

Over 16 million people in the US have COPD[1] and up to 60% of COPD cases go undiagnosed[2]. According to the World Health Organization, COPD is the third leading cause of death globally.[3] COPD continues to be a leading cause of disabling symptoms and suffering. Pulmonary Rehabilitation (PR) is the standard of care for persons with COPD and is associated with improved physical function, symptoms, mood and quality of life. Although PR is well established as a highly effective treatment for COPD and other chronic respiratory diseases,[4,5] in the United States only 3–4% of Medicare beneficiaries with COPD receive PR.[6] Similarly low estimates exist for the rest of the world.[7]

A recent study by Peter Lindenauer and colleagues found that, in persons hospitalized due to acute exacerbation of COPD, PR within 3 months of discharge vs. later or no PR, was associated with a highly significant lower risk of mortality at 1 year (hazard ratio, 0.63; i.e., a 37% lower risk of death over the year following discharge).[8] The study utilized claims data of 197,376 Medicare beneficiaries discharged after hospitalization for COPD.[8] The findings support PR as a high priority following hospitalization for COPD.

Patients suffering from COPD should know that PR not only has potential for helping them feel better and being more independent, but also to *live longer*. We are asking for your support in communicating these important findings of improved survival after PR to providers and patients. Thank you in advance for your help and collaboration.

- Allergy & Asthma Network
- Alpha 1 Foundation
- American Association for Cardiovascular Pulmonary Rehabilitation
- American Association for Respiratory Care
- American Academy of Allergy, Asthma & Immunology
- American Lung Association
- American Thoracic Society
- CHEST/American College of Chest Physicians
- COPD Foundation
- Dorney-Koppel Foundation
- LAM Foundation
- Lung Transplant Foundation
- phaware Global
- Pulmonary Education and Research Foundation
- Pulmonary Fibrosis Foundation
- Respiratory Compromise Institute
- Respiratory Health Association
- Right2Breathe
- US COPD Coalition

1. COPD. Centers for Disease Control and Prevention. Published June 6, 2018. Accessed December 28, 2020. https://www.cdc.gov/copd/index.html
2. Martinez C, et al. Undiagnosed Obstructive Lung Disease in the U.S. Annals ATS. 2015;(12):1788-1795.
3. https://www.who.int/news-room/fact-sheets/detail/the-top-10-causes-of-death Accessed February 7, 2021.
4. Spruit MA, et al; ATS/ERS Task Force on Pulmonary Rehabilitation. An official ATS/ERS statement: key concepts and advances in pulmonary rehabilitation. Am J Respir Crit Care Med. 2013;188(8):e13-e64. doi:10.1164/rccm.201309- 1634ST
5. McCarthy B, et al. Pulmonary rehabilitation for COPD. Cochrane Database Syst Rev. 2015;2(2):CD003793. doi:10. 1002/14651858.CD003793.pub3
6. Nishi SP, et al. Pulmonary rehabilitation utilization in older adults with COPD, 2003 to 2012. J Cardiopulm Rehabil Prev. 2016;36(5):375-382. doi:10.1097/HCR.0000000000000194
7. Desveaux L, et al. An international comparison of pulmonary rehabilitation: a systematic review. COPD. 2015;12(2):144-53. doi: 10.3109/15412555.2014.922066
8. Lindenauer PK, Stefan MS, Pekow PS, et al. Association between initiation of pulmonary rehabilitation after hospitalization for COPD and 1-year survival among Medicare beneficiaries. JAMA. 2020 May 12;323(18):1813-1823. doi: 10.1001/jama.2020.4437.

Pulmonary Rehabilitation

—Live Better and *Live Longer*

Pulmonary Rehabilitation & Mortality in the United States

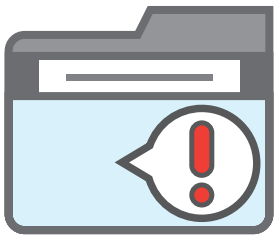
- COPD is the 3rd leading cause of death worldwide
- >16 million people diagnosed with COPD in the US

- Recent assessment of claims data for 197,396 Medicare beneficiaries discharged after hospitalization for COPD

Pulmonary Rehabilitation

- ↑ Exercise capacity
- ↑ Quality of life
- ↓ Exacerbations

↓37% in mortality in those who received pulmonary rehabilitation within 3 months of hospital discharge



- **But only 3-4% of Medicare beneficiaries with COPD receive Pulmonary Rehabilitation**

Lindenauer et al., (2020). Association Between Initiation of Pulmonary Rehabilitation After Hospitalization for COPD and 1-year Survival Among Medicare Beneficiaries. JAMA. 323:1813-1823

Pulmonary rehabilitation helps patients feel better and live longer, but is underutilized

For more information about pulmonary rehabilitation, visit www.livebetter.org

California Society for Respiratory Care update - COPD Awareness: California in Action!

By Krystal Craddock MSRC, RRT, RRT-NPS, AE-C, CCM

California requires the Department of Public Health (CDPH) to award grants for projects aimed to prevent tobacco-related disease by way of local programs providing education directed at schools as well as a media campaign[1]. As such, CDPH is also tasked with submitting recommendations for ambient air quality standards[1]. However, these efforts do not consider chronic and progressive lung diseases, nor do they bring awareness to this public health issue. Assembly Bill (AB) 619 establishes a COPD awareness campaign and would require counties to create plans for managing the adverse effects of wildfire smoke on California's vulnerable populations[1].

As pulmonologists, respiratory care practitioners (RCP), nurses, and members of CTS, we are all too aware of the impact that COPD has on our patients, their families, and our communities. COPD is the fourth leading cause of death and an estimated 15.7 million Americans have been diagnosed with COPD[2]. In California, 19.4 percent of people living with COPD do not have a primary care provider[1]. Additionally, more than one-third of Californians with COPD live below the federal poverty line[1].

As part of the CRSC's Advocacy Week this year, the RCP's of California met with members of the States Congress to support this bill. Assemblymember Jim Wood (chair) and Chad Mayes (vice-chair and originator of the bill) both personally met with CSRC members during Advocacy Week. Assemblymember Wood was pleased to hear that one of the members joining on his call was one of the RCPs involved in fire evacuations in his district a few years ago. CSRC Members also met with staff for those serving on the Health Committee, including Wendy Carillo, Health Flora, and Luz Rivas.

RCP member and Secretary, Monique Steffani, provided testimony to the Assembly Health Committee last week where both Assembly members Jim Wood and Chad Mayes asked to co-author the bill. The bill has now passed the Health Committee with a 13-0 vote. This means that it will be moving to the Emergency Management Committee for a vote. Keep an eye on this bill, which is co-sponsored by Breathe Southern California, the Emphysema Foundation of America, and the CSRC, as it progresses though the Assembly.

References

1. AB-619 Lung health. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB619. Published April 12, 2021. Accessed April 13, 2021.

2. Burden of COPD. World Health Organization. https://www.who.int/respiratory/copd/burden/en/. Accessed April 13, 2021.

SWJPCC Journal - Volume 22 Issue 3

Volume 22, Issue 3							
Title (Click on title to open the manuscript)	**Journal Section**	**First Author**	**Year**	**Vol**	**Issue**	**Pages**	**Date Posted**
Medical Image of the Month: Pulmonary Aspergillus Overlap Syndrome	Imaging	Janapati B	2021	22	3	76-80	3/2/21
Presenting with ABPA, Multiple Bilateral Aspergillomas							
March 2021 Pulmonary Case of the Month: Transfer for ECMO Evaluation	Pulmonary	Blackstone NG	2021	22	3	69-75	3/1/21

California Thoracic Society
18 Bartol St. #1054 | San Francisco, CA, 94133 | 415-536-0287
Connect with CTS at https://calthoracic.org/