2026 California Thoracic Society Annual Educational Conference

& Chronic Obstructive Pulmonary Disease Symposium

Thursday March 12, 2026-Sunday March 15, 2026

Earn up to 19 CME/CEU/MOC Credits

Jointly Provided by AKH Inc., Advancing Knowledge in Healthcare and the California Thoracic Society

PORTOLA HOTEL & SPA
AT MONTEREY BAY

Thursday March 12, 2026 (6 CME/CEU/MOC Credits)
COPD Symposium
Friday March 13, 2026 (6.5 CME/CEU/MOC Credits):
Advances in Interventional Pulmonary, Remote Monitoring in Pulmonary and Sleep Medicine, Approach to Symptom Management in Chronic Lung Disease and Critical Care
Saturday March 14, 2026 (6.5 CME/CEU/MOC Credits)
Sepsis and Shock, Extracorporeal Membrane Oxygenation, Inpatient Pulmonary Complications of Cancer Care
Sunday March 15, 2026
Fellow and Resident Track Symposium

California Thoracic Society
ATS Chapter Serving California and Arizona

AKH INC.
ADVANCING KNOWLEDGE IN HEALTHCARE

California Thoracic Society
Annual Conference
March 12-15, 2026
Portola Hotel and Spa, Monterey, CA

Friday March 13, 2026

Advances in Interventional Pulmonary

8:00 am – 8:10 am: Welcome and Introduction

8:10 am – 8:55 am: Keynote Address – Evolution of Bronchoscopy in Diagnosing Lung Nodules

- **Christine Argento, MD (Johns Hopkins) -** This speaker will discuss the recent advances in bronchoscopy from radial EBUS, to electromagnetic navigation, to robot technologies, and how advancement has improved lung nodule diagnosis.

8:55 am – 9:20 am: Implications of the new TNM9 staging for lung cancer

- **Colleen Channick, MD (UC Los Angeles) -** This speaker will discuss the new TNM staging system, how staging is currently performed, and how to approach staging in the patient with suspected lung cancer.

9:20 am – 9:45 am: Management of Central Airway Obstruction

- **Raed Alalawi, MD (Arizona-Phoenix)-** This speaker will discuss how interventional pulmonary practitioners can manage and treat central airway obstruction.

9:45 am – 10:10 am: The Changing Landscape of Pleural Disease Management

- **Joon Chang, MD (Stanford) -** This speaker will discuss advances in management of pleural disease by the interventional pulmonologist including when to use an intrapleural catheter, and when to use

10:10 am – 10:20 am: Question and Answer

10:20 am – 10:50 am: Break

Remote Monitoring in Lung Disease and Sleep Medicine

10:50 am – 11:15 am: Developing a home spirometry program

- **Steven Hays, MD (UC San Francisco) -** This speaker will discuss how to approach the development of a home spirometry program to monitor lung disease, how to use digital health technologies to integrate results into the EHR.

11:15 am – 11:40 am: Home Non-Invasive Ventilator Monitoring

- **Christal Hawkins, RRT (UC San Diego) -** This speaker will review how to monitor home non-invasive ventilators for compliance and for adequate control of sleep disordered breathing.

11:40 am – 11:55 am: Pro: Virtual Pulmonary Rehabilitation is Ready for Prime Time

- **Aimee Kizziar, RRT (UC Davis) -** This speaker will argue in favor of virtual pulmonary rehabilitation programs.

11:55 am – 12:10 pm: Con: Virtual Pulmonary Rehabilitation is not ready for Prime Time

- **Julia Rigler, BA. RRT (UC San Francisco) -** This speaker will argue against virtual pulmonary rehabilitation programs.

12:10 pm – 12:20 pm: Question and Answer

12:20 pm – 1:00 pm: Awards Ceremony

1:00 pm – 2:00 pm: Lunch

Hands On Session:

2:00 pm – 3:00 pm: Robotic Bronchoscopy **Raed Alalawi, MD (Arizona-Phoenix) & Joon Chang, MD (Stanford)** Cough Monitoring **Lauren Eggert, MD (UCSF)**; Endobronchial Ultrasound **Pranjal Patel, MD (Stanford)**; Home NIV **Krystle Leung, MD (Stanford)**

3:00 pm – 3:20 pm: Break

Approach to Symptom Management in the Pulmonary Patient

3:20 pm – 3:45 pm: Addressing the Unmet Needs of Refractory Chronic Cough

- **Krishna Sundar, MD FCCP FAASM ATSF (UC Davis) -** This speaker will discuss the etiology behind refractory chronic cough and the treatment approaches for management

3:45 pm – 4:10 pm: Frailty in Pulmonary and Critical Care Medicine

- **Jonathan Singer, MD MPH (UC San Francisco) -** This speaker will discuss the concept of frailty and how it impacts health in patients with lung disease. The speaker will also discuss how frailty can change as lung disease is treated.

4:10 pm – 4:35 pm: Palliative Care for the Patient with Chronic Lung Disease

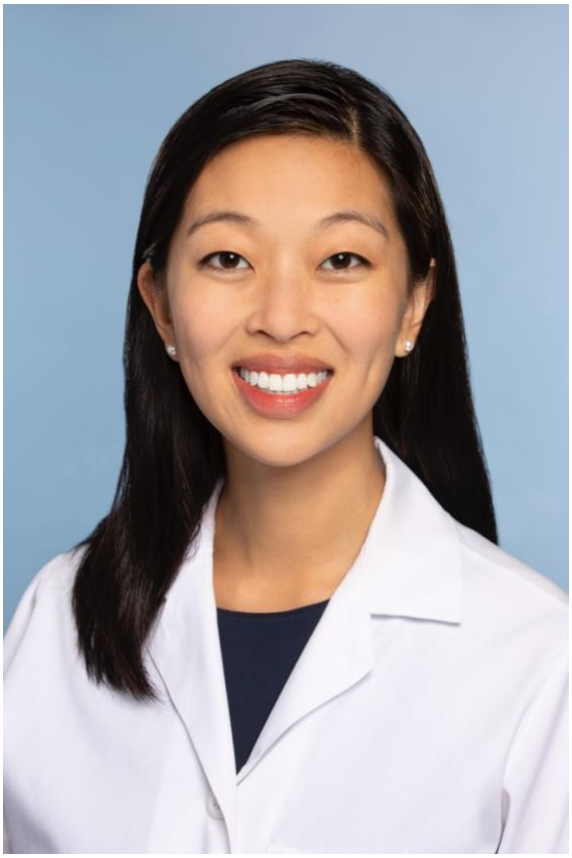
- **Grace Amadi, MD (UC Davis) -** This speaker will discuss how palliative care teams can benefit patients with chronic various lung disease including ILD, COPD, and pulmonary hypertension.

4:35 pm – 5:00 pm: Palliative Care for the Patient with Critical Illness

- **B. Corbett Walsh, MD, MBE (UC Los Angeles) -** This speaker will discuss how palliative care teams can benefit the inpatient with advancing lung disease, the importance of advance care planning, and palliative care in the intensive care unit.

5:00 pm – 5:10 pm: Question and Answer

5:30 pm – 7:00 pm: Women in Pulmonary, Critical Care, and Sleep Medicine (NON-CME) – Food and beverages will be served



Dr. Grace Amadi received her medical degree from University of Michigan before completing Family Medicine Residency at Thomas Jefferson University Hospital and a Palliative Medicine Fellowship from Christiana Care Health Services. Currently, she is an Associate Clinical Professor at UC Davis where she oversees the Palliative Medicine clinics for patients with Pulmonary, Cardiology, and Nephrology related illness.

Palliative Care for the Patient with Chronic Lung Disease

Grace Amadi, MD

UC Davis

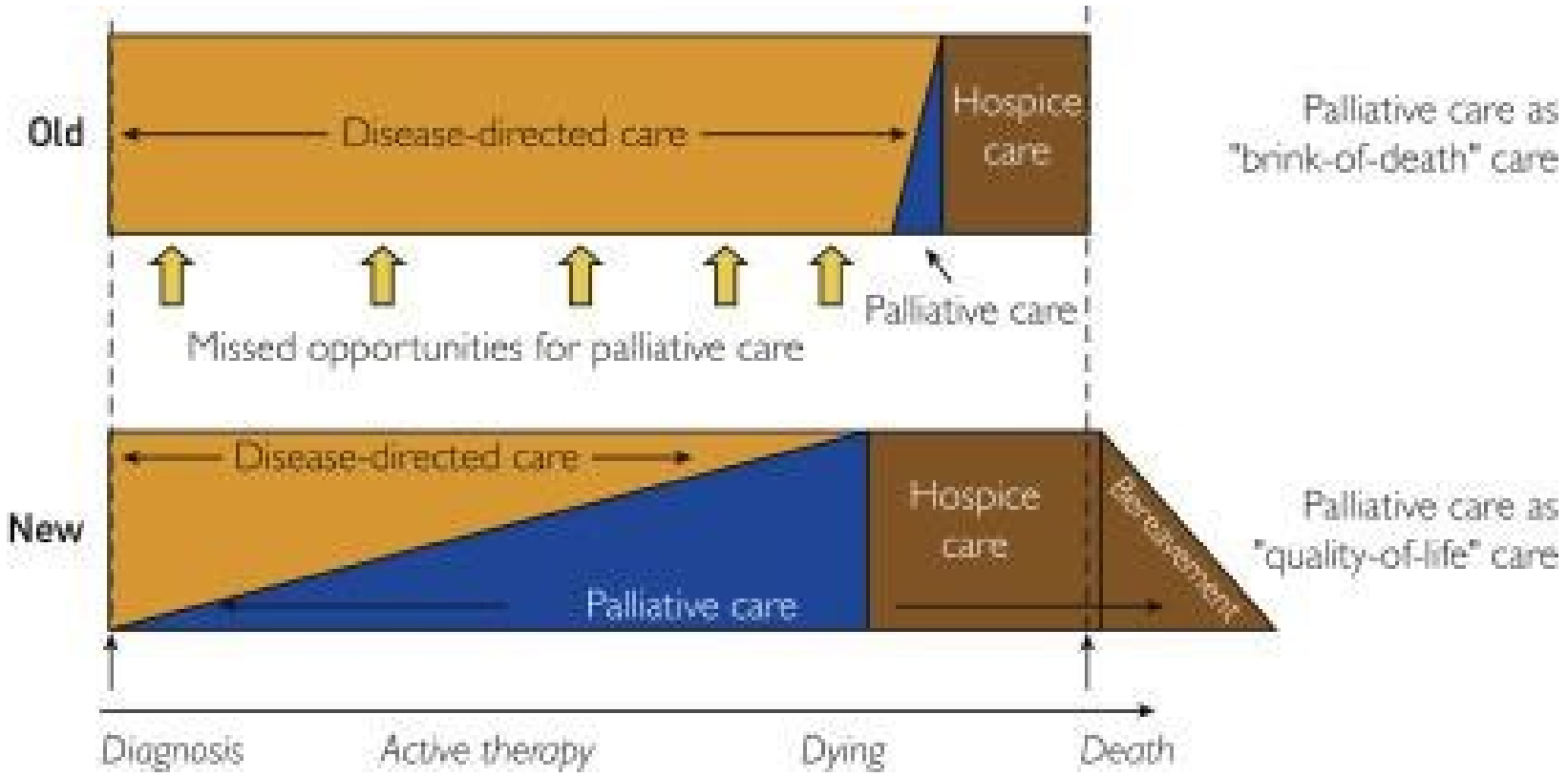
Disclosures

- I have the following relationships with ACCME defined ineligible companies:
- **[none]**
- I **WILL NOT** discuss off-label use and/or investigational use of any drugs or devices.

Objectives

- What is Palliative Care?
- Why is early palliative care important for patients with advanced lung disease?
- How can you help patients with advanced lung disease receive early palliative care?

What is Palliative Care?



Buss MK Mayo Clin Proc 2017

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What is Palliative Care?

- Palliative care is specialized medical care for people living with a serious illness
  - **Provides relief from the symptoms and stress** of the illness
  - Improves quality of life for both the patients and the family
  - Appropriate at any age and at any stage in a serious illness
  - Based on the needs of the patient, not the prognosis
  - Extra layer of support
  - Can be provided along with curative treatment

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Why is Palliative Care Important for Patients with Advanced Lung Disease?

- People with advanced lung disease are very sick
- People with advanced lung disease have many healthcare challenges
- There are many people with advanced lung disease

Prognosis in Advanced Lung Disease

- Advanced COPD and end stage ILD carry mortality rates similar to metastatic cancer

Symptom Burden

Table 2 Summary of the prevalence of symptoms in Cancer, AIDS, CHF, COPD, ESRD and PIF-ILD (figures for other conditions taken from Solano et al. 2006 [36])

Symptoms	PIF-ILD	Cancer	AIDS	CHF	COPD	ESRD
Pain	9%	30–94%	30–98%	14–78%	21–77%	11–93%
Depression	10–49.2%	4–80%	17–82%	6–59%	17–77%	2–61%
Anxiety	22–58%	3–74%	13–76%	2–49%	23–53%	7–52%
Fatigue	7.6–29%	23–100%	43–95%	42–82%	32–96%	13–100%
Breathlessness	54.7–98%	16–77%	43–62%	18–88%	56–98%	11–82%
Insomnia	6–46.6%	3–67%	40–74%	36–48%	15–77%	1–83%
Nausea	13%	2–78%	41–57%	2–48%	4%	8–52%
Diarrhea	2%	1–95%	29–53%	12%		8–36%

AIDS Adult Immune Deficiency Syndrome, *CHF* Chronic Heart Failure, *COPD* Chronic Obstructive Pulmonary Disease, *ESRD* End-stage Renal Disease

Carvajalino BMC Pulmonary Medicine 2018

Patients with COPD have large number of symptoms (regardless of severity of disease)

Table 6

Total Number of Symptoms and MSAS Subscale Scores for the Total Sample and Differences in the Total Number of Symptoms and MSAS Subscale Scores Among Patients With Moderate, Severe, and Very Severe COPD

	Total Sample ($n = 267$)	Moderate COPD ($n = 83$)	Severe COPD ($n = 61$)	Very Severe COPD ($n = 123$)	
MSAS Scores	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	*P*value
Total number of symptoms (0–32)	12.4 (7.0)	12.0 (7.9)	11.9 (7.1)	12.8 (6.3)	0.623
MSAS-PSYCH subscale score	1.0 (0.9)	0.9 (0.8)	0.9 (0.9)	1.1 (0.9)	0.187
MSAS-PHYS subscale score	0.8 (0.6)	0.8 (0.6)	0.8 (0.6)	0.9 (0.5)	0.425
MSAS–Global Distress Index score	1.0 (0.8)	0.9 (0.8)	0.9 (0.8)	1.1 (0.7)	0.171
MSAS total score (0–4)	0.8 (0.5)	0.8 (0.6)	0.8 (0.6)	0.9 (0.5)	0.448

MSAS = Memorial Symptom Assessment Scale; COPD = chronic obstructive pulmonary disease; PSYCH = psychological; PHYS = physical.

Christensen JPSM 2016

Shortness of Breath and Fatigue increase with worsening COPD

Table 3

Symptom Severity Scores for the Total Sample and Differences in Severity Scores Among Patients With Moderate, Severe, and Very Severe COPD

Symptom	Total Sample ($n = 267$) Mean (SD)	Moderate COPD ($n = 83$) Mean (SD)	Severe COPD ($n = 61$) Mean (SD)	Very Severe COPD ($n = 123$) Mean (SD)	OR	CI (95%)	Group Contrasts
Shortness of breath	2.74 (.76)	2.33 (.66)	2.55 (0.68)	3.04 (.72)	2.63[a]	1.89–3.66	VS > M and S
Lack of energy	2.32 (.77)	2.06 (.71)	2.17 (.60)	2.50 (.80)	1.96[a]	1.36–2.83	VS > M
Feeling drowsy	2.08 (.69)	2.06 (.70)	2.00 (.64)	2.12 (.71)	1.12	0.78–1.61	
Dry mouth	2.20 (.78)	2.10 (.82)	2.44 (.72)	2.16 (.77)	1.02	0.72–1.46	
Cough	2.03 (.76)	2.04 (.70)	2.03 (.78)	2.03 (.79)	0.97	0.69–1.37	
Worrying	2.07 (.80)	1.82 (.83)	2.19 (.98)	2.15 (.70)	1.50[b]	1.02–2.21	[c]
Feeling bloated	2.02 (.75)	1.95 (.83)	1.96 (.84)	2.08 (.66)	1.23	0.84–1.79	
Pain	2.21 (.76)	2.45 (.76)	2.04 (.77)	2.11 (.71)	0.67[b]	0.46–0.98	[c]
Feeling sad	1.96 (.75)	1.79 (7.81)	2.40 (.68)	1.90 (.72)	1.10	0.74–1.63	
Problems with sexual interest or activity	2.45 (1.04)	2.33 (1.71)	2.14 (1.06)	2.63 (.92)	1.36	0.92–1.99	
Difficulty sleeping	2.16 (.81)	1.89 (.70)	2.24 (.83)	2.29 (.84)	1.56[b]	1.05–2.32	[c]
Feeling nervous	1.94 (.72)	1.86 (.76)	2.11 (.58)	1.93 (.75)	1.08	0.70–1.65	
Feeling irritable	1.92 (.75)	1.97 (.78)	1.82 (.73)	1.94 (.76)	1.00	0.64–1.54	
Difficulty concentrating	1.71 (.67)	1.67 (.76)	1.83 (.62)	1.69 (.65)	1.04	0.66–1.66	

COPD = chronic obstructive pulmonary disease; OR = odds ratio; VS = very severe; M = moderate; S = severe.
Symptom severity scores can range from 1 (slight) to 4 (very severe) in patients who reported the symptom.
[a] $P < 0.01$.
[b] $P < 0.05$.
[c] No significant between-group differences identified.

Christensen JPSM 2016

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Healthcare Needs

- Progressively debilitating breathlessness
- Unrecognized and undertreated psychological symptoms
- Social isolation
- Declining functional status
- Frequent hospitalizations near the end of life

- Compared to patients with lung cancer, patients with COPD are…
  - Older
  - Similar symptom burden/level of quality of life
  - More comorbidities
  - More likely to have problems with ADLs/IADLS
  - More likely to have end of life ICU care
  - Less likely to have caregiver support; more likely to have caregiver burden
  - Less understanding of their illness

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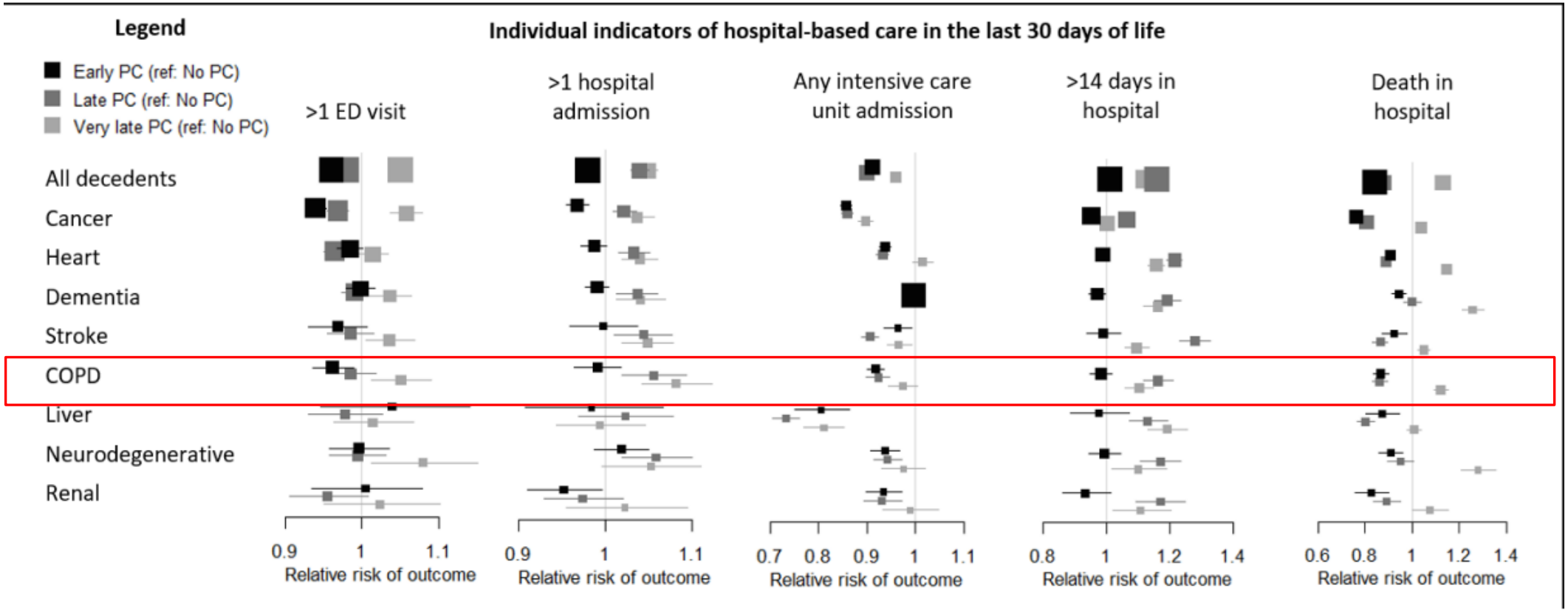
  - More comorbidities
  - More likely to have problems with ADLs/IADLS
  - More likely to have end of life ICU care
  - Less likely to have caregiver support; more likely to have caregiver burden
  - Less understanding of their illness
  - **Less likely to have advance directive**
  - **Less likely to be referred to palliative care**
  - **Less likely to enroll in hospice**
  - **More likely to have later palliative care consult**

Patient Centered Utilization



Earp BMJ Open 2021

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Early Palliative Care in ILD

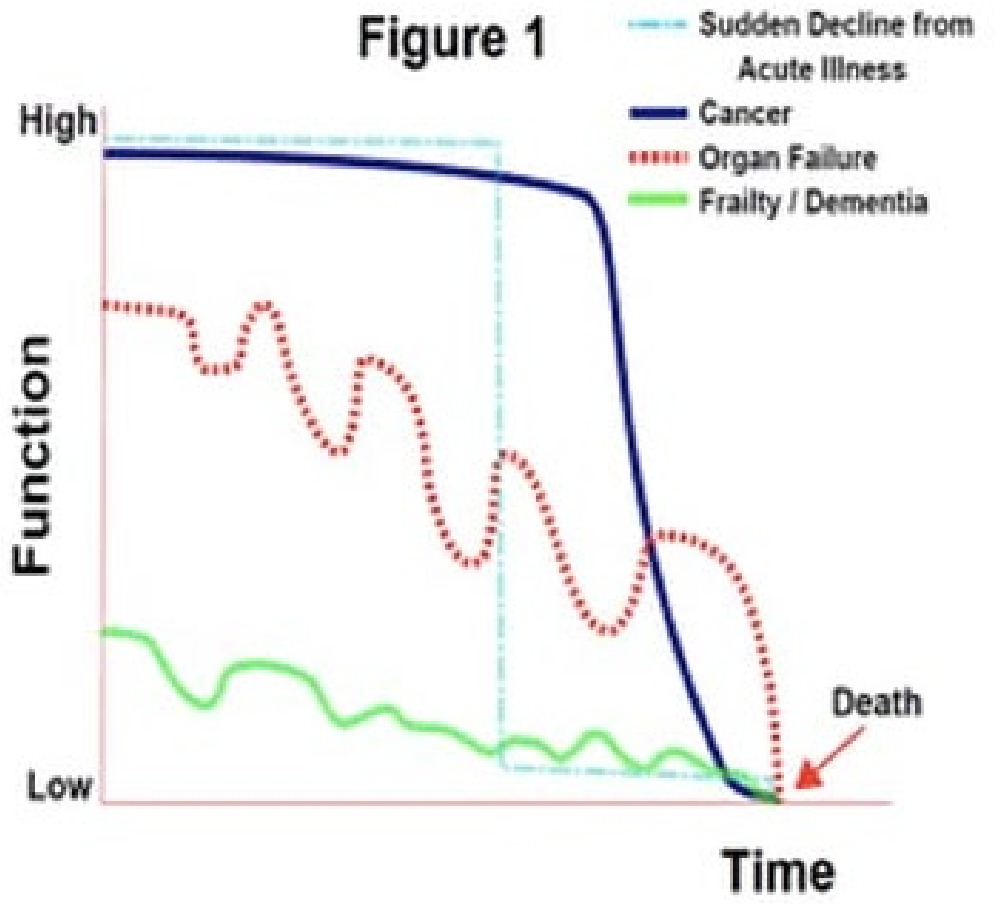
- Reduction
  - Odds of hospital admission in the last year of life
  - Odds of dying in the hospital
  - Respiratory-related ED visit
  - Respiratory-related hospitalization
- Improvement
  - Survival
  - Quality of Life
  - Anxiety and Depression (both patients and caregivers)
  - Mastery of breathlessness
  - Rates of advance care planning

Bekelman JAMA 2024; Kreuter Lancet 2017; Bischoff JPM 2021; Rodrigo-Troyano JPM2022; Kalluri JPSM 2018

Why Not Palliative Care?

- Uncertainty
- Destroying Hope
- Time

Disease Trajectories



Lunney et al JAMA 2003

Zimmermann JAMA Oncol 2022

1. Palliative Care is the umbrella, not the rain
2. Predicting the rain can be difficult.
3. Having an umbrella does not bring on the rain.

Zimmermann JAMA Oncol 2022

Holding Hope

- Hope for more time
- Hope for less symptoms
- Hope for control and peace
- Hope that life has meaning
- Hope to repair relationships
- Hope to finish some practical things before death
- Hope that people will deal with me honestly
- Hope to have some pleasurable experiences in life

> The role of clinicians is not to prioritize a single likely or unlikely hope. Rather […] to help their patients recognize the diversity and breadth of their hopes. With time, doing so allows patients to psychologically adjust, identify goal-concordant decisions, and more successfully navigate their illness.

Rosenberg JAMA 2021

How to Provide Palliative Care

Symptom Management	Patient Education & Support	Care Coordination	Advance Care Planning

How to Provide Palliative Care

Symptom Management	Patient Education & Support	Care Coordination	Advance Care Planning
- Acknowledgment and normalization that symptoms are common - Palliation of symptoms			

Edmonton Symptom Assessment Scale

Pain
Fatigue
Nausea
Depression
Anxiety
Drowsiness
Shortness of Breath
Appetite
Well-Being
Sleep
Average

Edmonton Symptom Assessment Scale

	A
Pain	0
Fatigue	0
Nausea	5
Depression	7
Anxiety	2
Drowsiness	5
Shortness of Breath	1
Appetite	7
Well-Being	7
Sleep	5
Average	4

Edmonton Symptom Assessment Scale

	A	B	C	D	E	F
Pain	0	0	0	0	0	0
Fatigue	0	10	6	3	0	5
Nausea	5	0	9	2	2	5
Depression	7	0	5	1	0	3
Anxiety	2	4	7	3	3	3
Drowsiness	5	2	4	1	0	1
Shortness of Breath	1	8	4	7	2	5
Appetite	7	7	10	3	2	5
Well-Being	7	5	7	3	2	3
Sleep	5	8	5	3	2	2
Average	4	4.4	5.7	2.6	1.3	3.2

How to Provide Palliative Care

Symptom Management	Patient Education & Support	Care Coordination	Advance Care Planning
- Acknowledgment and normalization that symptoms are common - Palliation of symptoms			- Process of uncovering patient goals and values; then, aligning healthcare with those goals - Documentation through advance directive and/or POLST

How to Provide Palliative Care

Symptom Management	Patient Education & Support	Care Coordination	Advance Care Planning
- Acknowledgment and normalization that symptoms are common - Palliation of symptoms	- Health Literacy - Information Preferences - Past Experiences with Health System - Coping with illness		- Process of uncovering patient goals and values; then, aligning healthcare with those goals - Documentation through advance directive and/or POLST

How to Provide Palliative Care

Symptom Management	Patient Education & Support	Care Coordination	Advance Care Planning
- Acknowledgment and normalization that symptoms are common - Palliation of symptoms	- Health Literacy - Information Preferences - Past Experiences with Health System - Coping with illness	- Resource connection - Bereavement support - Psychosocial support - Hospice Referrals	- Process of uncovering patient goals and values; then, aligning healthcare with those goals - Documentation through advance directive and/or POLST

When to start

- "It always feels too early until it's too late", "Hope for the best; prepare for the worst"
  - It's hard to predict, so don't try to
- Triggers
  - Hospitalizations
  - Complex symptom burden (physical and emotional)
  - Disease progression (changes in oxygen needs, FEV1)
  - Prognosis (Surprise Question, BODE)
  - Lack of standardized tools
- Patients may be ready before their providers are ready

Primary Palliative Care

Symptom Management	Patient Education & Support	Care Coordination	Advance Care Planning
- Consider symptom scales beyond SOB - anxiety, depression, fatigue, sleep, appetite	- What changes have you noticed in your health lately?	- How does your illness impact your everyday life or those around you?	- What are you hoping for? - What are you most worried about? - Who should be involved in making decisions if you are too sick to speak for yourself?

Responding to Emotions Disguised as Questions

What are you going to do?

- - Cognitive Question
- - Requesting data
- - Physician is expert in data

Responding to Emotions Disguised as Questions

What are you going to do?

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“WHAT ARE YOU GOING TO DO?!?!”

- - Emotional Response
- - Unable to hear data
- - Expressing fear, worry, anger
- - Patient is expert in emotion

Responding to Emotions Disguised as Questions

What are you going to do?

- - Cognitive Question
- - Requesting data
- - Physician is expert in data

- "We will try a new treatment; check labs; follow up in 3 months"

"WHAT ARE YOU GOING TO DO?!?!"

- - Emotional Response
- - Unable to hear data
- - Expressing fear, worry, anger
- - Patient is expert in emotion

"This is not the news you were expecting. I wish things were different."

www.getpalliativecare.org

Palliative Care Provider Directory

Search Results: 20 results found

ENTER ADDRESS, ZIP CODE OR CITY & STATE

monterey, ca

RADIUS

Closest 20 results

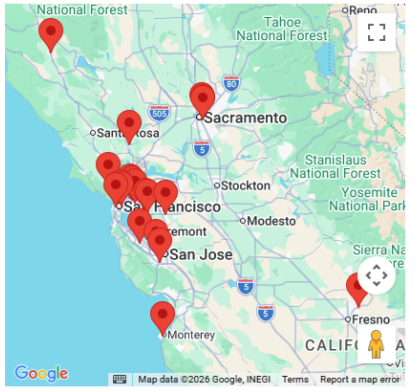
CHECK THE ONE THAT APPLIES:

☐ Hospital ☐ Nursing Home ☑ Office/Clinic ☐ Home

Search

The Palliative Care Provider Directory is a resource to help you or a loved one locate palliative care in your area. It includes all programs that have listed themselves with us. Please contact the palliative care program directly to confirm eligibility.

Outpatient Supportive and Palliative Care	1.66 mi
Stanford Palliative Care (Outpatient, San Jose)	45.43 mi
Pediatric Palliative Care Clinic	51.33 mi
Stanford Palliative Care (Outpatient, Palo Alto)	59.94 mi
Stanford Palliative Care (Outpatient, Pleasanton)	75.43 mi
Sutter East Bay Medical Foundation Palliative Care and Support Services	76.82 mi
George Mark Children's House	77.71 mi
Highland Wellness Center	85.01 mi
UCSF Health Symptom Management Service (SMS)	85.22 mi
UCSF Health Outpatient Palliative Care Service (OPCS)	86.29 mi
Sutter East Bay Medical Foundation Palliative Care and Support Services	86.86 mi



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Summary

- Palliative Care is an extra layer of support for patients living with serious illness to help with the symptoms and stress
- Early palliative care has been associated with improved symptoms and quality of life, decreased hospital utilization at the end of life, and no decrease in length of life.
- Primary palliative care can be provided by any doctor by remembering to address symptoms and stress.