California Society for Pulmonary Rehabilitation
North Meeting

Friday, March 16, 2018
0900-1500

Type of Meeting: *CSPR Quarterly North Region*
Meeting Facilitator: *John Muir Hospital – Concord, CA*
Attendees: *Aimee Kizziar, Angela Coburn, Leslie Rusnak, Missy Van Luchte , Julia Stedifor, Sherry Harrington, Nancy Danielsen, Lori Wray, Cindy Cayou, Dorothy Smith, Ali Enoch, Chris Garvey, Margaret Stephens, Frances Owens*

I. __Announcements and Opening__*: Aimee Kizziar, MHAL, BA, RRT-NPS, RCP; CSPR North Region President*

a) Lana retired. Her position will not be replaced at John Muir. She will be dearly missed by all at John Muir and CSPR.

b) Approval of minutes from last meeting: Julia took minutes from last meeting. She read the highlights and the group approved

II. __MAC update__*: Aimee Kizziar*

a) MAC task force has a MAC lead in every state. Lana was the MAC lead for CA and Hawaii. Lana has asked Aimee to step into this position. Under each MAC lead there is a resource group. They reach out the CR and PR regarding changes. Meetings take place as issues come up or changes need to be made. Dr. Oakes is the MAC doctor.

b) The latest information can be found on AACVPR.org under Advocacy, Medicare administrator contacts, what's new in my MAC, our jurisdiction is J-E.

c) Any feedback on MAC can be sent to Aimee so she can follow up on

d) Pulmonary Rehab orders still need to be by MD, not a PA or NP

    a. This was passed but not implemented until 2024 when NP or PA can supervise PR but still cannot sign ITP.

e) 30 day signature on ITP. It can be signed before the 30 days, but not after. Once it's signed the 30 days starts again from that signature date.

    a. The day of signature is day one

    b. If the program ends after 30 days, an assessment is still to be made and ITP signed at or before 30 days and a new 30 days begins.

    c. To ensure the ITP gets signed by day 30, many programs are working on ITP ahead of time and doing reassessments during the 3rd week.

d. Attendees shared how they make this work with their programs i.e.: 6MWT, ITPs, use of EPIC vs paper

III. **CSPR Service:** *Aimee Kizziar*

a) Aimee asked for feedback on goals coming to the meetings and what do we all need to help our programs improve and what everyone would like to see from CSPR. Everyone wrote down their thoughts on a paper and these were handed to Missy for future meetings. She also encouraged everyone to consider taking on a role in CSPR

b) Aimee is resigning from the president position and Missy was nominated for the position. She accepted.

c) Julia is resigning from the treasurer position and the position is available for nominations. If anyone is interested please let Aimee know right away.

d) Angela offered to resign from the secretary position, the position remains open. Angela was nominated and accepted to stay on as secretary if there is no one else that would like this opportunity. If you are interested let Aimee know.

IV. **2018 Conference update** *Aimee Kizziar*

a) Aimee went over how to use the updated CSPR.org website and details on how to register. If you're part of a group you get a 20% discount on your registration. Put that you're in a group in the comment section.

b) We went over the conference agenda in detail. Attending the workshops on Friday is highly encouraged as they are going to be a fantastic way to get some hands on learning. These are not concurrent so all workshops can be attended.

c) There will be a 20 minute presentation during lunch by New Aera regarding the "Sidekick".

V. **Research review:** *Chris Garvey, FNP*

a) Susan Jacobs led a research study regarding oxygen and DME companies. Medicare was not responsive to this problem. Nearly 2000 patients were surveyed and most of them on 24/7 oxygen, 1/3 with high flow, most of them not happy. Lack of instruction with use of oxygen, unprepared to operated system, most had 3 or more problems. This research is being taken to publishing. They met at ATS last May, with pulmonary foundation, lead person from Apria, head person from Medicare, and more, total of 35-45 attendees. Problems are being looked at from DME, Medicare, and more. Every large patient group was represented. Another meeting is scheduled and a statement will be written to change how things are done, and so that standards can be set. This statement will become an international process. Questions to be asked are: Who needs it? Who benefits from it? How much? Call 1-800-MEDICARE to express concerns. Have patients call this number

to draw attention to this matter. A three way call can be set up with Medicare and DME. Patients don't know how to complain, this can help them.

b) Patients with COPD and acute exacerbation and cardiovascular disease have a higher risk of a cardiovascular event after an exacerbation. Hazzard ratio elevated to 3.8 x more likely for 30 days and stayed elevated for a year after the event. Promote strategies to reduce the risk of exacerbation and pay close attention to these patients for the risk of a cardiovascular event.

c) Study on 6200 patients that had over 3 PFTs found that women who did no cleaning at no difference in their PFT, women who cleaned their homes or as an occupation had a decline in FEV_1 and FVC. Men had no changes.

d) 22 studies of COPD patients and the influence of their weight on outcomes. Underweight is bad, normal weight is good. However, a higher BMI did not have a bad outcome. The theory could be that once you're overweight you get more attention and more MDs are keeping an eye on these patients. This calls our standard BMI into question for our patients and how much over the "normal" BMI is ok, vs. excess weight having a negative impact on overall health. Chris mentioned a BMI of over 35 is where she has that conversation about weight loss. She mentioned how successful bariatric surgery has become and how it can improve patient's orthopedic system. Missy focuses on nutrition, eating habits and food choices. Nancy gives her patients test in the nutritional section of the COPD reference guide called "Are You at Risk". Other programs refer patients to nutritional counseling.

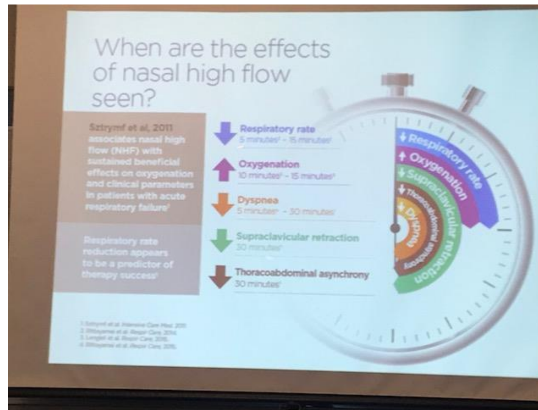
e) Rich Casabury, MD put together information on reimbursement from Chris and Lynn. They worked on a 2 page article that will be published in the CTS newsletter. AACVPR, ARC and New and Views will also publish. We know we have limited voice to our hospital admin. Physicians have a bigger voice. Pulmonologist can get more interested and have a voice on PR behalf. If Physicians can become more aware and involved in talking with CFOs and letting them know we are not being reimbursed in comparison to CR yet we are taking on patients in need of more care. Pulmonary Rehab programs are being lost. Once they're gone they are not being counted. We all need to do everything we can but also talk to our Medical Directors and get their help with administration. Thoracic surgeons are a good voice for PR as well.

VI. **Lunch and presentation on HFNC by F&P:** *Clemmis Futrellm BS, RRT; Brent Honn, Product Sales Specialist*

a. AirVo is the hospital device, My AirVo is for home. The cannula is Optiflow

b. High flow (HF) was implemented in the 1960s. ICUs use them for acute severe hypoxemia. F&P talked about their HFNC, AirVo, for the chronic patient with severe hypoxemia needing HF outside of the hospital. This product helps to decrease dead space in the airway. It also supplies a dynamic positive airway

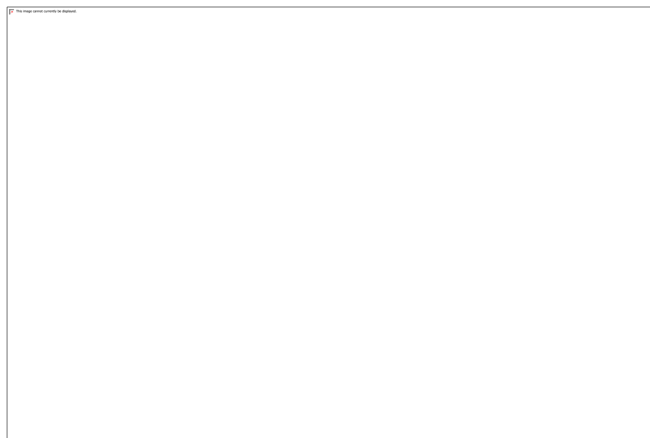
pressure (mimicking pursed lip breathing) Inspiratory pressure decreases making inspiration easier. Expiratory resistance increases leading to prolonged expiration. NHF increases airway pressure, end-expiratory lung volume and tidal volume. Low flow oxygen can be provided with NHF. Optimal humidity prevents desiccations of the airway epithelium and improves mucus clearance.



i. Frat et al 2015 study: HF reduces escalation of care. Significantly fewer patients were re-intubated in ICU with use of HFNC post extubation.

ii. Benefits:

1. Decreased RR ~15 minutes
2. Increased oxygenation within ~15 minutes
3. Decreased dyspnea within ~30 minutes
4. Decreased supraclavicular retraction within ~30 minutes
5. Decreased thoracoabdominal asynchrony within ~30 minutes



c. Exercise capacity outcomes- increase in overall exercise capacity with HFNC therapy

    i. May improve the exercise performance in severe COPD

    ii. PR HFNC may allow a given high-intensity load to be sustained for a longer time with less symptoms

d. Clinical outcomes: reduces mortality, escalation of care, improves comfort and patient compliance and symptomatic relief.

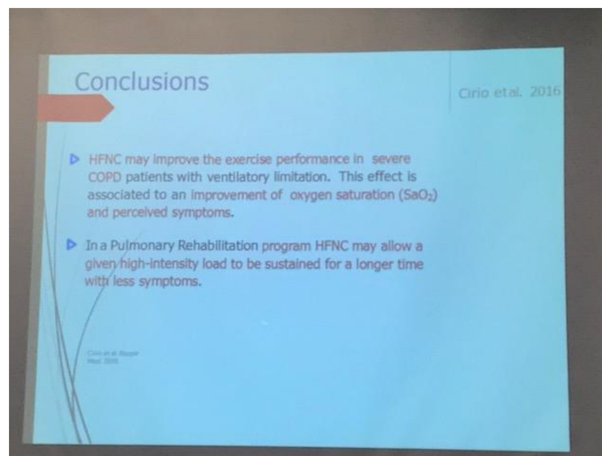
    i. Improved mucocillary clearance

    ii. Reduce respiratory rate

    iii. Reduced tissue CO_2

    iv. Reduced WOB

    v. Reduced minute ventilation



e. F&P contact info:

    i. Customer Service: 800-446-3908

    ii. Clemmis Futrell, BS, RRT: 301-379-4884; clemmis.futrell@fphcare.com

    iii. Brent Honn: 480-229-5112; brent.honn@fphcare.com

VII. **Open Forum: Share your PR program:** *All*

a. Mercy San Juan is an 8 week program. Goal is 15 patients. Tues/Thurs 12:30 – 3:30. Patients come in groups of 5. Referral wait time is 5 month wait time. No one/one or condensed program. Discussing waiting for authorization until patient

is scheduled to come in so they don't end up needing a reauthorization. Evaluation does not include exercise. Mon/Wed/Fri 815 – 1400 maintenance program with some structured led exercise. They are monitored and have a paper chart – HR, SpO2, BP.

b. El Camino – Leslie works referrals, initial contact, works with MDs, schedules, gathers patient information, works with authorizations. Program is 8 weeks/16 sessions. Patient evaluations are Mon/Wed – 2 per day. Each evaluation takes 90+ minutes. Missy and Leslie work together to run program. They have "rolling enrollment". Class starts at 1000 check in, 1015 warm up strength and balance, 1050 cardio, 1120 cool down, last hour is education for 45-60 minutes. Class size averages 16. New patients start every Tuesday and have a 6MWT. 2 – 3 patients start every week. They come in early – 930 to perform walk. Some days the lecture can be a group lecture, however other days there could be up to 4 lectures. Occasion 1:1 and condensed program – one time 2 ½ hour session, all education and no exercise – cash program for $250.00 Patients get education material, a DVD and an inspiratory muscle trainer. They are introduced to exercise log. No ITP for this program. Maintenance is Tues/Thur 1330-1430. Vitals checked, they're scheduled in EPIC, vitals and quick note. Cash only billed through hospital, $16.00 per session. M- Thur patients, Friday admin day. Support groups on Mondays – 1st Monday of month- Better Breathers and 2nd Monday of month bi-monthly MAC support group. Missy speaks or has guest speakers. Better Breathers - 30 minutes of harmonica, 30 minutes of support, 60 minutes of education. They also have a smoking cessation for $125 one-time fee for 2 session and 3 f/u phone calls – 1 month, 3 months, 6 months.

c. UC Davis, Aimee and Aimee. Tues/Thurs 2 groups of up to 8 x 2 for 16 total. Exercise/Education/Exercise. Group 1 is 0900-1130; Group 2 is 1030-1300. Maintenance is M/W/F 0900-1130. Support group every Wednesday – Singing second and fourth Wednesday, Catch my Breath third Wednesday and Mindfulness first Wednesday. Referral phone interview is 30 – 60 minutes, eval includes exercise both upper body and cardiac, balance test, weight/waist/neck. Detailed vitals and sometimes 6MWT. They come back for an appt with Medical Director. One more apt for 6MWT and ITP review. One on one patients, one and done with home exercise plan

d. Margaret - Sequoia hospital Redwood City - 2 sessions per day on T/Th 930-1200, 1300-1530– first hour exercise 2nd hour education. Maintenance M/T/W/Th $10 per class, after 8 paid classes the rest is free

e. Enloe Medical in Chico- rolling enrollment 8 weeks. Tu/Th 3 class times 0900-1100, 1030 – 1230 (education in middle for 30 minutes) and afternoon class 1330-1530. Monday or Friday they can come in to exercise with maintenance. Maintenance is M/W/Fr 930-1045, 1330-1445. $45 per month. BP and weight

once a week logged in patient own chart. More BP if watching them. No exercise during eval. Second Wind support group meets once a month.

f. Lori Sutter Roseville – 9 week rolling enrollment program 2 class Tue/Thur 10-12 and 1300-1500. Will start up M/W again soon from 1200-1400. First half hour education, exercise remainder. Initial eval is charged. Includes 6MWT and exercise. Initial eval is considered day one with ITP. NP in department manages CR and PR and hired resource person to do initial call of referrals, registration, scheduling and auths.

g. Nancy Stanford Valley Care. 2 programs 6 weeks M/W 1000-1300; T/Th 1200-1500 6-8 patients per group. Mon-Thur maintenance 20- 30 patients. $45 per month.

h. Sherry – one/one only – 12 hour shifts. Patients at 8, 10, 13, 15, 17. Support group once a month, Sherry runs with up to 40 patients. Sherry does HAST, Stress Tests. RTs do PFTs. 6MWT with interview and with day one. No maintenance

i. John Muir - Sessions are 2 hours, G0424 can charge for 2 sessions. Exercise at least 31 min with lecture. Charges 4 sessions if not lecturing and exercise for 91 minutes. Usually consist of an hour of education and an hour of exercise. Group classes 3 days week for 7 weeks. M/W/F. 1000-1200 or 1300-1500. M/W/F 0800-1000, 1200 – 1400, T/Th 0730-1000, 1100-1400. $60.00 charge

VIII. <u>Next meeting Fall 2018, TBD at a later date</u>

IX. <u>Meeting Adjourned.</u>

Minutes taken by: *Angela Coburn, RRT-RCP, North Region Secretary*