International 2-Day Training Programme

Leading Change in Bronchiectasis Care: Clinical Reasoning, Communication and Networks

Course acronym: LEAD-BE

Venue

Humanitas University
Via Rita Levi Montalcini 4
20072 Pieve Emanuele (Milan) – Italy
@ Mario Luzzatto Simulation Center

Faculty

Professor Stefano Aliberti
Dr Mattia Nigro
Dr Veronica Polelli
Eng. Fabio Carfagna

Number of participants: 15

Scientific rationale

Over the past 12–24 months, the management of bronchiectasis has changed substantially. Major advances in clinical and translational research, the publication of the 2025 European Respiratory Society (ERS) Guidelines, and the rapid evolution of therapeutic strategies have profoundly reshaped both the conceptual framework and the practical organisation of care. Bronchiectasis is no longer managed through rigid, algorithm-based pathways. Contemporary care is now centred on a structured, patient-centred process that begins with the shared identification of priorities and common goals between clinician and patient. This process integrates a systematic assessment of disease activity, disease severity and treatable traits. Based on this multidimensional assessment, clinicians define priorities and timing for diagnostic investigations and therapeutic interventions, adopting a treatable-traits approach primarily driven by disease activity. Treatable traits must be prioritised together with the patient and addressed within a longitudinal care pathway that unfolds over months rather than single visits. This pathway is built on a clear therapeutic alliance — a shared “care contract” between physician and patient — that is continuously revisited and adapted over time. In parallel, recent years have witnessed the rapid development of bronchiectasis centres across Europe operating at first-, second- and third-levels of care. While this expansion represents a major opportunity to improve access and quality of care, it also creates a strong need for structured networking. Effective integration between specialised centres and primary care physicians is essential to ensure a fluid, functional and coherent patient journey, both diagnostically and therapeutically.

The LEAD-BE programme is designed to reflect and respond to these changes. By combining short, high-yield teaching with immersive simulation using professional actors, the course equips a new generation of bronchiectasis specialists with the clinical reasoning, communication skills and organisational vision required to deliver modern, patient-centred care and to act as drivers of change within their local healthcare systems.

Educational objectives

By the end of the course, participants will be able to:

1. Understand and critically interpret the recent paradigm shift in bronchiectasis management, integrating translational research, ERS 2025 recommendations and emerging therapies.
2. Apply a structured clinical approach based on disease activity, disease severity and treatable traits.
3. Prioritise diagnostic and therapeutic decisions over time using an activity-driven framework.
4. Develop advanced shared decision-making skills and build longitudinal therapeutic alliances.
5. Manage complex bronchiectasis phenotypes and difficult clinical scenarios.
6. Understand and apply hub-and-spoke models across different levels of bronchiectasis care.
7. Implement or refine local SOPs and act as change leaders within their institutions.

Teaching format

30% short lectures with moderated discussion
High-yield sessions (15–20 minutes) focused on key conceptual and practical issues.

70% simulation-based learning with professional actors
Ambulatory simulations reflecting real-world complexity, with structured debriefing focused on reasoning, communication and implementation.

Each simulation cycle includes:
briefing (5 min) → scenario (30–45 min) → debrief (30 min) → take-home practical messages, slides and guideline discussion (15 min)

Pre-course preparation // Assessment and follow-up

Participants receive ERS 2025-based written and video materials.
Pre-event assessment: baseline knowledge and reasoning
Post-event assessment: repeated evaluation (identical pre–post option)
3-month follow-up web meeting: review implementation of SOPs, barriers and successes

PROGRAMME

Day 1 – From recognition to risk stratification and deterioration

10:30 – 11:15 Registration of participants

11:15 – 11:30 Welcome and course framing
– LEAD-BE philosophy
– Psychological safety and simulation rules
(Prof. Stefano Aliberti)

11:30 – 13:30 **Simulation Session I**
Scenario 1 – Second opinion: high-risk bronchiectasis with chronic MDR *Pseudomonas*
Focus: high disease activity, severity, long-term prevention, shared decision-making
(Stefano Aliberti, Fabio Carfagna, Mattia Nigro, Veronica Polelli)

Specific objectives:

1. Identify high disease activity using exacerbations, symptoms and quality of life.
2. Assess disease severity integrating lung function, imaging and microbiology.
3. Recognize chronic infection and mucus burden as key treatable traits.
4. Apply ERS 2025 criteria to define high-risk bronchiectasis.
5. Compare long-term preventive strategies using activity-driven reasoning.
6. Conduct a structured and respectful second-opinion consultation.
7. Co-create a longitudinal management and monitoring plan with the patient.

13:30 – 14:15 Lunch

14:15 – 15:15 **Lecture 1 - Phenotypes, endotypes and identification of the high-risk patient**
– Activity-driven risk stratification
– Implications for timing and intensity of treatment
(Dr Mattia Nigro)

15:15 – 16:15 **Lecture 2 - Critical appraisal of ERS 2025 bronchiectasis guidelines**
– What has changed
– What to implement immediately
– Where flexibility and judgement are required
(Prof. Stefano Aliberti)

16:15 – 17:00 **Simulation Session II**
Scenario 2 – Clinical deterioration without increased exacerbation frequency

Focus: recognizing active disease beyond exacerbations, re-prioritization of care
(Stefano Aliberti, Fabio Carfagna, Mattia Nigro, Veronica Polelli)

Specific objectives:

1. Distinguish deterioration from exacerbation-defined activity.
2. Identify ongoing disease activity despite stable exacerbation counts.
3. Recognize non-exacerbation drivers as treatable traits.
4. Re-prioritize diagnostic investigations appropriately.
5. Decide when to stop, switch or escalate therapy.
6. Communicate treatment failure transparently and empathetically.
7. Reset goals and timelines within a longitudinal care framework.

17:00 – 17:15 Coffee break

17:15 – 18:15 **Simulation Session III**
Scenario 3 – Airway clearance and physiotherapy as central treatable traits
Focus: integrating physiotherapy into disease activity and severity assessment
(Stefano Aliberti, Fabio Carfagna, Mattia Nigro, Veronica Polelli)

Specific objectives:

1. Recognize mucus retention as a marker of active disease.
2. Assess physiotherapy-related treatable traits (technique, device, adherence).
3. Integrate physiotherapy into overall disease severity assessment.
4. Prioritize feasible airway clearance strategies.
5. Use motivational communication to address adherence.
6. Define response criteria for physiotherapy interventions.
7. Incorporate physiotherapy outcomes into follow-up planning.

18:15 – 18:45 **Lecture 3 - Everything you wanted to ask a respiratory physiotherapist**
– Practical integration into follow-up and SOPs
(Dr Veronica Polelli)

Day 2 – Therapeutic decisions, complexity and networks

08:30 – 09:00 **Day 1 synthesis**
– Key take-home messages
– Open clinical questions from participants
(Prof. Stefano Aliberti)

09:00 – 09:30 **Lecture 4 - Anti-inflammatory strategies and DPP1 inhibition**
– Positioning along the activity–severity trajectory
– Safety and monitoring
(Prof. Stefano Aliberti)

09:30 – 11:00 **Simulation Session IV**
Scenario 4 – One exacerbation, severe symptoms: macrolide vs inhaled antibiotic
Focus: symptom-driven activity, preventive therapy decisions
(Stefano Aliberti, Fabio Carfagna, Mattia Nigro, Veronica Polelli)

Specific objectives:

1. Recognise that disease activity is not defined by exacerbations alone.
2. Use symptom burden and QoL as treatment drivers.
3. Identify treatable traits supporting long-term therapy.
4. Compare macrolide and inhaled antibiotic strategies.
5. Apply ERS 2025 guidance to non-classical scenarios.
6. Practice shared decision-making around preventive therapy.
7. Define reassessment timelines and response markers.

11:00 – 11:15 Coffee break

11:15 – 12:45 **Simulation Session V**
Simulation 5 – Complex social context, poor adherence and high-risk behaviours
Focus: non-biological treatable traits, alliance and harm-reduction
(Stefano Aliberti, Fabio Carfagna, Mattia Nigro, Veronica Polelli)

Specific objectives:

1. Identify social determinants contributing to high disease activity.
2. Recognize non-biological treatable traits.
3. prioritize achievable interventions aligned with patient readiness.
4. Build alliance in resistant or distrustful patients.
5. Apply harm-reduction communication strategies.
6. Activate multidisciplinary and network-based support.
7. Prevent disengagement through realistic longitudinal planning.

12:45 – 13:30 Lunch

13:30 – 14:15 **Simulation Session VI**

Scenario 6 – Microbiology uncertainty and escalation of investigations

Focus: NTM/fungal suspicion, avoiding under- and over-testing

(Stefano Aliberti, Fabio Carfagna, Mattia Nigro, Veronica Polelli)

Specific objectives:

1. Interpret complex microbiology in relation to disease activity.
2. Distinguish colonization from clinically relevant infection.
3. Identify microbiology-driven treatable traits.
4. Decide when to escalate investigations (NTM, fungi, bronchoscopy).
5. Avoid under- and over-testing.
6. Integrate microbiology into therapeutic prioritization.
7. Communicate uncertainty clearly to patients.

14:15 – 15:00 **Simulation Session VII (interactive MDT format)**

Scenario 7 – Network-based decision-making and referral pathways

Focus: hub-and-spoke logic, coordination with primary care

(Stefano Aliberti, Fabio Carfagna, Mattia Nigro, Veronica Polelli)

Specific objectives:

1. Understand roles of first-, second- and third-level centres.
2. Identify referral needs based on activity and severity.
3. Apply hub-and-spoke principles to patient pathways.
4. Coordinate effectively with primary care.
5. Balance local autonomy with specialist input.
6. Define shared responsibilities across care levels.
7. Translate network principles into local SOPs.

15:00 – 15:30 **Final roundtable**

(Stefano Aliberti, Mattia Nigro, Veronica Polelli)

– Translating LEAD-BE into local SOPs

– Barriers and facilitators to change

– Personal implementation commitments

15:30 Conclusions and course closure