Snoozzz Newzzz

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Wisconsin Sleep Society

Wisconsin Sleep Society 2nd Annual Conference

"Navigation a Sleep Center of Excellence"

DATE:

FRIDAY, OCTOBER 18, 2013

TIME:

7:00AM—5:30PM

LOCATION:

BROOKFIELD SUITES HOTEL AND CONVENTION CENTER

1200 SOUTH MOORLAND

BROOKFIELD, WISCONSIN

Keynote Speakers:

Teofilo Lee-Chiong, MD

Management of Complicated Sleep Apnea

Ruth Benca, MD, PhD

The Future of Sleep Medicine: Where Are We Going?

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Home Sleep Testing

Home sleep testing devices are cheaper, more accurate, and easier to use than ever before. But the question stands how to integrate that technology into an established sleep practice?

Medicare decreased reimbursement beginning this year for HST to less than one-third the reimbursement value for an overnight polysomnogram in a sleep facility. Many sleep experts expect that private carriers will soon follow suit.

The home sleep testing (HST) wave has moved and appears to be here to stay in spite of many arguments. We have to accept that CMS and other payers now recognize HST as a diagnostic tool rather than a screening tool, so we as sleep technicians needs to learn to work with this. The roles of the sleep technician may change for some with an increase in HST. In-lab polysomnogram will not go away, but it may not be highly utilized as it was. The sleep technician will move into new roles such as clinical sleep educators.

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Keeping Up With the Journals

"Sleep Review" May 2013 had an article on the "American Sleep Apnea Association" (ASAA). This reminded me of what an excellent organization they are, and also what a great resource for people with sleep apnea. The ASAA was founded in 1990, and are a not-for-profit advocacy organization for people with sleep apnea. Their mission is to reduce injury, disability and death from sleep apnea. The A.W.A.K.E. network of support groups has been a great help to CPAP users in many areas of the country. I found 8 groups listed in Wisconsin. Their web site, www.sleepapnea.org, has a vast amount of information for people with sleep apnea, people wondering if they have sleep apnea, and for health care professionals too. I've gotten good information from their site in the past.

"Sleep Review" also had an article on Patient Direct Home Testing, which seemed to be intentionally scary. Basically, the article stated that sleep labs are in danger of losing revenue from Home Sleep Testing (HST), which we've all heard. Also, to control quality and cost, insurance company benefits managers may contract with "a handful of national or regional providers of the test or suppliers of any needed therapy equipment". Yikes! This article suggests that sleep labs adopt their own HST as part of their business, if for no other reason than to retain referrals.

There were a couple of articles in the "Journal of Sleep Medicine", volume 36, issue 6, addressing children. One study showed that adenotonsillectomy (AT) was less effective in treating obese children with OSA. These children had significant residual adenoid tissue and an increase in the volume of the tongue and soft palate.

Another study showed that chronic sleep restriction during adolescence caused increased consumption of food with a high glycemic index, particularly desserts and sweets. Hmm, it appears that I have more in common with sleep restricted adolescents than I'd thought.

The June 2003 issue of "A2Zzz" had lots of good articles. One article was on central hypopneas, which always provokes a knee jerk reaction in me when I hear the term. Seems like "central hypopnea" is an oxymoron. There has been more discussion in the past few years about what constitutes a central hypopnea. The recent update to the scoring manual states that "if electing to score central hypopneas, score a hypopnea as central if NONE of the following criteria are met:

a. Snoring during the event.

b. Increased inspiratory flattening of the nasal pressure or PAP device flow signal compared to baseline breathing.

Associated thoracoabdominal paradox occurs during the event but not during pre-event breathing."

The example shown in the article looks as if central hypopneas could be marked during Cheyne-Stokes breathing if no snoring is present, even if flow and effort don't get all the way down to flat line. It sounds as if there is disagreement amongst the sleep physicians about whether to score central hypopneas or not. What's a poor sleep tech to do? Whatever their Medical Director tells them to do.

Another article addressed the psychological components of treating sleep apnea. We, as sleep techs, have a strong influence on how successful a patient will be in using PAP. Our patience and expertise during a PAP titration can make all of the difference.

This fall, the AASM will publish a revision to the 2005 International Classification of Sleep Disorders. There will continue to be 6 main chapter headings: Insomnia, Central Disorders of Hypersomnolence, Circadian Rhythm Sleep-Wake Disorders, Sleep Related Breathing Disorders, Movement Disorders, and Parasomnias. There will be changes in most of these categories. One of the main changes will be in dealing with the newly created diagnosis of "Complex or Treatment Emergent Apnea". Also, a diagnosis for "Obesity Hypoventilation Syndrome" has been added.

Last but not least, there was an article on when to have staff meetings for sleep lab staff. I doubt there are many sleep labs that have staff meetings at 11:00 a.m. anymore, but this article went even further, suggesting that there shouldn't be meetings early in the day when the night shift is just finishing up their shift. Hellooo!! It's sometimes difficult to sit upright in your chair and remain conscious, much less participate in intelligent conversation, when you've worked all night. Instead, the author of this article, who should be nominated for some sort of award as far as I'm concerned, suggests having sleep staff meetings an hour before the night shift starts, and that PIZZA OR OTHER DINNER should be ordered for everyone. Excellent!

Mary Lowenberg, BS, RPSGT

AASM Scoring Manual Changes: N3 Scoring

In October of 2012 changes were made to update the *AASM Manual for the Scoring of Sleep and Associated Events* to version 2.0. In today's article, we will outline the changes to the scoring of N3. Scoring rules for sleep staging can be found under the visual rules section of the manual.

For the scoring of N3 sleep, the changes are fairly simple, and possibly something that some of you were doing already. The following statement was added to scoring of N3: 'K complexes would be considered slow waves if they meet the definition of slow wave activity'. The definition for slow wave activity remains unchanged. It is defined as 'waves of frequency 0.5 Hz-2Hz and peak to peak amplitude of greater than 75uV, measured over the frontal regions'. Criteria for scoring of N3 remain the same. Score N3 when 20% of the epoch consists of slow wave activity, irrespective of age. On a side note, you may wonder why age is mentioned in criteria. Elderly patients frequently have wave forms that meet the duration for slow waves, but lack the amplitude. This scenario does not meet all the criteria for scoring N3, and therefore, should not be scored as such. We welcome your comments or questions regarding the scoring rules. Please email us at: info@wisleep.org

By Marla Van Lanen

RRT, RPSGT

PAP-NAP

So....What is a PAP-NAP and who are the candidates for one?

Simply, a PAP-NAP procedure is offered as an alternate option to be conducted prior to (not in place of) a full night PAP titration study.

Do you ever struggle and wonder what to do with those patients that wake in the middle of a titration study and pull off their mask having a full panic attack? What is our role as a technologist to see to it that our patient succeeds at therapy?

Research has shown adherence to PAP therapy for treatment of sleep disordered breathing (SDB) is much improved when patients are engaged in their therapy. Patients with more hands on education, clinical follow-up, sleep tech coaching, telephone calls, objective data monitoring and repeat polysomnography (if needed), tend to have better compliance outcomes.

A PAP-NAP is a tool we can use on those patients with mental health disorders, co-morbid insomnia and SDB. Common co-morbid insomnia conditions include those patients with anxiety, nightmares, depression, post-traumatic stress disorder (PTSD), panic attacks and claustrophobia. It is billable under CPT 95807-52 as a reduced service code (less than 6 hours) and is attended by a technologist. Unfortunately, since March of 2013, Humana insurance will no longer covers this procedure.

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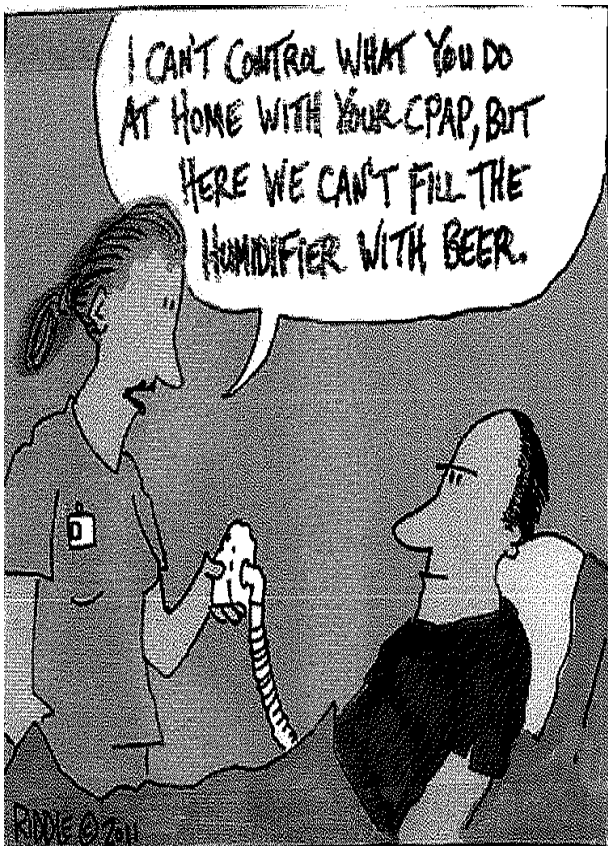

Continue PAP -NAP

The 6 main components are listed and BRIEFLY explained below:

1. Pretest instructions:

Patient's come sleep deprived, no napping prior to test, refrain from caffeine, have lunch prior to nap, wear/bring comfortable clothing, take usual medications, arrange a ride to and from, allow 3-5 hours for the procedure. They may bring music/ iPod if it helps them to relax.

2. Pre-nap interview and survey's:

NOSE-30 used to identify barriers to nasal breathing, Mental Imagery Selective Survey (MISS-7), extensive sleep medicine history and validate scale Insomnia Severity Index (ISI).

3. Introduction of PAP therapy and Barrier Assessment:

PAP therapy involves mask fitting and desensitization: best mask for patient full vs. nasal vs. pillow, fit for comfort, lack of leak, of pressure points. Pressure desensitization is used to determine if CPAP is tolerable or if a trial of bi-level or other modes of ventilation may be required if CPAP is difficult.

Barrier assessment involves emotional focused therapy-reassuring of helping vs. harming. Engage the patient in "feelings" surrounding PAP use. Mental imagery-coaching using "Mind's Eye" to divert attention from mask/pressure sensations.

4. PAP therapy hookup:

10 channel- snore, PAP flow & pressure, mask leak, respiratory belts (chest & abdominal), heart rate, SpO2, video, and position. Additional helpful channels include leak, Vt or target MV.

5. PAP therapy testing:

60-120 minutes in bed. The goal is to help the patient adapt to PAP therapy sensation via exposure to the device. It may also identify problems that may emerge during the titration such as central apneas, mouth breathing, nasal congestion or adverse mental or emotional reactions. Success is measured by subjective sleep or patient's ability to tolerate PAP use despite falling asleep. Sleep is not scored, presumptive sleep is based on heart rate, respiratory rate, and/or presence of snoring. Assessment is made as to the patient's ability to tolerate mask/pressure and the likelihood of tolerating a full night or split-night titration. Pressure changes are made for comfort, to improve airflow signal, to increase physiologic exposure, but to not titrate.

6. Post-test follow-up:

This involves completion of a questionnaire, report generation, reviewing the results with the patient and assessing their motivation for a full or split-night titration, and then scheduling the titration or possible clinic appointment with their sleep specialist.

In conclusion: Technologist will need exceptional LISTENING capacity coupled with the use of humor to diminish anxiety, ability to navigate patients through basic imagery exercises (guided daydreaming) and recognize those with unstable imagery aspects (PTSD or nightmare patients) that require sleep specialist intervention, and empathy in the form of repeatedly asking "how are you feeling, how does this feel and can you see yourself using it?" and then responding appropriately to the situation.

Consistent PAP therapy is the best way to improve your patient's quality of life and reduce the health risks associated with SDB. Don't we owe it to our patient's to share our expertise and knowledge to help them to be successful in their quest for quality sleep? I think so.

Nancy Ruff RPSGT

Sleep Disorder Facility Supervisor

Ministry Door County Medical Center

Sturgeon Bay, WI

Continue Home Sleep Testing

Home sleep testing has many advantages. It cost much less than a facility based polysomnogram, it is more acceptable to patients, easier to schedule, does not interfere with daily activities and is performed in the comfort of the patient's home, which reduces the "first night effect" which may influence the results of a facility-based study. The HST allows more rapid turnaround of results, provides more access for many patients in need of diagnosis and treatment, and could allow some patients to start on AutoPAP or an oral appliance. But it is very imperative that we understand HST is a limited channel and unattended study. Patient's need to be properly screened and the appropriate protocols need to be in place, so that further diagnostic testing is recommended when indicated.

It is very imperative that we use education in the medical community, to the public, and to the payers about the risk and understanding of the consequences of undiagnosed and untreated OSA, as well as the benefits of proper treatment. We need to use a screening tool such as the Epworth Sleepiness Scale, STOP, STOP-BANG or Berlin. We also need to incorporate protocols for HST based on the patients BMI, neck circumference, and cardiopulmonary and upper airway evaluation. Special criteria may be necessary for reimbursement issues. Patients should also have screening criteria for certain co-morbidities.

The Local Coverage Determination (LCD) established the following rules applicable to billing Medicare for HST's. The LCD requires a face to face education and device application with the patient before the study is performed. The education and application should be performed by a technician holding any one of the credentials: RPSGT, CPSGT, CRT-SDS, RRT-SDS or RST. Also, the physician or physicians who supervise or interpret the HST must be a boarded sleep physician. The LCD requires that the physician's sleep testing program be accredited before billing Medicare for the sleep test.

It is an exciting and interesting time for anyone involved in the field of sleep technology and sleep medicine. Innovative approaches to the treatment and diagnosis of sleep disorders are on the rise, creating expanded and new roles for sleep professionals, all of which will lead to better patient care and outcomes.

Kala Bingham RPSGT

Susan Susan Hoefs, RPSGT, RST, was honored with The Peer A. McGregor, RPSGT Service Award for 2013 at SLEEP 2013 in Baltimore. Susan was recognized for her outstanding service and contribution to the AAST and organizational development.
Established in 1995, the Peter A. McGregor Award recognizes a member of the AAST who has exhibited outstanding service and contribution to the association and organizational development. Mr. McGregor was instrumental in forming the AAST in 1978 and his vision and leadership has left an indelible mark on both the organization and field.

Visit the website at:

www.wisleep.org

The website continues to be updated.

Please send suggestions, comments or if you have something you would like to share for the next newsletter to the website.

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