EDITORIAL

Analysis and Perspectives

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Embracing Change, Responding to Challenge, and Looking Toward the Future

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As the 25th president of the American Academy of Sleep Medicine (AASM), I look forward to my upcoming year. Our field has benefited greatly from those who have preceded me in this position, who have made, and in many cases, continue to make significant contributions to Sleep Medicine. It is truly and an honor and a professional highpoint to be able to serve the membership as president of the AASM. I would like to take this opportunity to highlight and expand on some themes that I discussed at the 2010 General Membership meeting in San Antonio.

The upcoming year will present some important challenges to American medicine in general and Sleep Medicine in particular. As the percent of the gross domestic product devoted to healthcare continues to grow, the re-engineering of prospective payment is inevitable.[1] What ultimate shape this will take remains to be determined. The field of Sleep Medicine has already been touched by this change. In May of this year the American Medical Association Relative Value Scale Update Committee (RUC) convened to revalue the codes for diagnostic and therapeutic polysomnography. The specialty society stakeholders in conjunction with the AASM worked collaboratively to accurately inform the committee of the relevance and impact of revaluing the common procedural terminology (CPT) codes 95810 (attended diagnostic polysomnography) and 95811 (attended therapeutic polysomnography). The ultimate decision by the Centers for Medicare & Medicaid Services (CMS) has not yet been rendered, but there is the expectation that a reduction will occur in both the professional and technical fees for 95810 and 95811. This change that will go into effect in January 2011 will impact all of us who practice Sleep Medicine.

In conjunction with the impending revised reimbursement for attended polysomnography, the adoption of out of laboratory testing for obstructive sleep apnea (OSA) will undoubtedly be further integrated into Sleep Medicine practice. There now exists a CMS national coverage decision allowing out of laboratory testing (known as "home sleep testing") to be used for the diagnosis of OSA. The reimbursement is determined by the local Medicare carriers and has not been fully implemented to date.[2] It is likely that reimbursement for the most commonly used types of devices (AASM Type III), which typically employ a measure of airflow, ventilatory effort, heart rate, and oxyhemoglobin saturation will be modest at best.[3]

So there you have it, the economics of the core activities of clinical sleep programs that involve diagnosing and initially introducing positive pressure therapy for obstructive sleep apnea will change, and our community will need to respond in order to serve our patients and provide the best evidence-based care. Can we do it? I think we can. This will require redefining our approach to these patients who need and deserve the best value for the health care dollars that are spent.[4]

What should the AASM be doing to insure the future of Sleep Medicine? Let me share my vision for the areas in which I believe that we need to focus on in the coming year. These include the following:

1. The development of new diagnostic and therapeutic tools for sleep providers
2. Clinical registries for AASM Sleep Centers
3. Sleep Research Networks in order to efficiently implement translational research
4. Expanded opportunities for Sleep Research training
5. Defining the role of the Sleep Specialist in the Patient Centered Medical Home

For the most part, the core clinical activity that revolves around the diagnosis and treatment of OSA has changed little since the 1981 original report of continuous positive airway pressure as a therapy.[5] Modest improvements in the technology have occurred, but the approach to this clinical problem is for the most part the same. It is essential that we develop new tools to diagnose and treat OSA as well as the other important sleep disorders that we care for in our clinics. In the early fall, the AASM will be sponsoring a conference on the "Future of Sleep Medicine"—this will build on the first conference held by the Academy last December and include a variety of stakeholders in the field. The focus will be on new tools and the integration of care.

I have been working with the AASM staff to explore the feasibility of establishing a cost-effective, user friendly, society based clinical registry for sleep disorders. As the AASM representative for the AMA physician consortium for performance improvement, it has become clear that clinical registries can be one of the essential components of quality- and value-based initiatives. On a systems level, registries can help identify variations in costs and outcomes. Evidence driven best practice initiatives can be facilitated. In addition, clinical registries can also be effectively used for individual provider's performance improvement requirements in maintenance of certification. The lack of availability and interoperability of the electronic medical record in many practices is a current barrier, but not one that is a technological impossibility.

Our ability to translate research into practice has been limited in part by the lack of sleep research networks to support large

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scale clinical trials. This has put our field at a disadvantage as we move toward the goal of personalized medicine. In order to understand how variations in phenotype/genotype affect risk, disease progression, and impact of treatment, well designed, multicenter investigations will need to be implemented. Over the past 2 years, a Sleep Research Network comprised of 38 of the 46 National Institutes of Health (NIH) Clinical and Translational Science Award Institutions has been formed.[6] Multi-institution grants have been submitted to examine the impact of sleep deprivation on medical error and treatment of insomnia. Other clinical trials proposals are under development. It is crucial that federal funding agencies support these important initiatives and help us move the field forward to improve the health of the American population.

The generation of new knowledge through research is the life blood and vital to any field of medicine. Compared to other medical specialties, there are a meager number of NIH funded institutional research training grants (T32) to support the development of physician scientists and Ph.D. investigators. Currently, there are approximately 5 T32 grants at 4 universities (Harvard, University of Pennsylvania, Case Western Reserve, and the University of Pittsburgh). The exact number of T32s needed for our field can be debated, but the number required is surely greater than 5. In order to attract the best and the brightest pre- and post-doctoral students for research careers additional strategies will need to be developed. One particular concern that has been raised is the lack of pulmonary fellows progressing to clinical sleep fellowships and subsequent research careers in Sleep Medicine. The creation of new Accreditation Council for Graduate Medical Education (ACGME) programs coupling Sleep and Pulmonary training has been discussed at SLEEP 2010 by the Sleep Medicine Program Directors. The Program Directors are currently exploring the need and feasibility of creating these additional ACGME training programs. One “early pipeline” initiative has been started by the AASM immediate past president, Clete Kushida, M.D., Ph.D. A successful high school essay writing campaign that involved 80 students was launched. A “Teach the teachers” summer program on the science of sleep targeting middle school science teachers is currently under development.

Finally, integrating the specialty of Sleep Medicine into the Patient Centered Medical Home (PCMH) will be an important consideration. The PCMH has been identified by the current administration as a prominent component of health care reform.[7] The use of chronic disease registries (see above), information technology, and enhanced communication all figure prominently into this model of care. Most of the conditions that we care for are chronic (i.e., insomnia, OSA, narcolepsy, restless legs syndrome) and are frequently associated with comorbid disease (i.e., cardiovascular, metabolic). It is unlikely that Sleep Specialists will themselves provide a PCMH but it will be essential that we are “good neighbors” and prominently involved care delivery and management. This would be particularly the case in complex patients.

We need to address the important areas discussed above and re-define some aspects our practice as many of our colleagues in other specialties will also need to do. Despite the downward economy, change associated with healthcare reform, and the prospect of cutbacks in funding for clinical and research activity, I believe the future is bright. There continues to be a great need for care rendered by Sleep Specialists. The science of Sleep Medicine is fascinating with many basic and clinical questions left to be explored. Shifting from a focus on diagnostic testing to chronic disease management is long overdue. Some of our challenges are unique but none are insurmountable.

REFERENCES

1. Chernew ME, Baicker K, Hsu J. The specter of financial armageddon—health care and federal debt in the United States. *New Eng J Med* 2010;362:1166-8.
2. Phurrough S. Coverage Decision Memorandum for Continuous Positive Airway Pressure (CPAP) Therapy for Obstructive Sleep Apnea (OSA) (CAG-00093R2). In: Centers for Medicare and Medicaid; 2008.
3. Collop NA, Anderson WM, Boehlecke B, et al. Clinical guidelines for the use of unattended portable monitors in the diagnosis of obstructive sleep apnea in adult patients. Portable Monitoring Task Force of the American Academy of Sleep Medicine. *J Clin Sleep Med* 2007; 3:737-47.
4. Boat TF, Chao SM, O'Neill PH. From waste to value in health care. *JAMA* 2008;299:568-71.
5. Sullivan CE, Issa FG, Berthon-Jones M, Eves L. Reversal of obstructive sleep apnoea by continuous positive airway pressure applied through the nares. *Lancet* 1981;1:862-5.
6. Collaborative Sleep Research Network First of Its Kind in U.S. In: 2006-2008 Progress Report National Center for Research Resources: National Institutes of Health; 2009:15.
7. Casalino LP, Rittenhouse DR, Gillies RR, et al. Specialist physician practices as patient-centered medical homes. *New Eng J Med* 2010;362:1555-8.

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