



The Future Of Sleep Medicine: Will You Be A Part Of It?

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The American Academy of Sleep Medicine's (AASM) Board of Directors has proactively been examining the future of our field since the presidency of Dr. Susie Esther, at which time she initiated the "Future of Sleep Medicine" taskforce. As an outgrowth of this process one of our most comprehensive efforts has been the careful consideration of how care is delivered to patients with sleep disorders and how the AASM accreditation process can shape a long-term care model that considers the evolution of practice based on technological advancements, and, includes standardized measures and outcome reporting. We have long recognized the need for change and have already taken several steps—similar to the blueprint outlined by John Kotter and referenced by Dr. Pack in his commentary—to create a transformative strategy for the sleep medicine field that ensures the quality of care our patients receive is the best possible, considers the changing needs of our members, and addresses the economic and political realities currently faced by American medicine.

Dr. Pack suggests in his commentary that AASM accreditation is the key to transforming the field to an outcomes based practice model. Perhaps the question he should have asked is what role should accreditation play in the Future of Sleep Medicine. AASM Accreditation provides a framework for quality sleep medicine services. The Standards have been crafted such that they can be adapted to many practice models. The accreditation experience over the past 15 years has taught us that no one accreditation model works for all or in all regions of the country. While we agree that the field and the accreditation standards will shift emphasis to a disease management model, there is no reason to believe mandating one model through accreditation will be doing the field or the public a favor.

There are economic and political realities that all health care providers, including sleep medicine physicians, must recognize right now. Economically, the cost-and-investor return drives all financial decisions, which means those who pay for health care are focused on containing cost. In the case of sleep medicine, this has been realized with the adoption of policies for out of center testing (i.e., portable monitoring) and contracting with companies that offer competitive pricing. Quality, unfortunately, is not always

the driving factor in the creation of these policies, as the corresponding costs are considered too expensive. Health insurers often do not keep subscribers for more than 2-5 years, so they are more interested in the short-term cost-benefit ratio. Since most sleep disorders will cause related morbidity in subsequent years, there may not be a perceived need to actually treat their subscribers' sleep disorders to reduce subsequent comorbid disorders (e.g., treat someone's obstructive sleep apnea to reduce their stroke risk). The private insurers therefore make economic choices, not quality of life choices.

The political reality is as somber as the economic reality. Politicians from both parties have taken a different approach to addressing costs associated with health care. Recently, legislation was passed in the House of Representatives and Senate to raise the nation's debt ceiling. One provision of this legislation was the formation of a "super group" of 12 member of Congress that is mandated to find \$1.3 trillion in expenditure cuts by the end of November. If agreement can't be reached by the designated date, automatic cuts will go into effect that total 50% from the nation's defense program and 50% from the Medicare program. Moreover, the proposed 50% cuts to Medicare are on top of a projected 23% decrease in reimbursement to physicians for services provided to Medicare beneficiaries, which is commonly known as the "doctor fix." Healthcare in the United States has always revolved around "the procedure." This is because it is easy to track and to assess cost. It is much more difficult to put a dollar amount on time spent with a patient, even though it is really what patients value the most. Now medicine is attempting to move to more "accountable care." The idea is that we pay if the outcome is better, not by the number of tests or procedures one does.

So where does this leave sleep medicine? As mentioned, the AASM's Board of Directors has been engaged and proactive in response to this reality of change. The AASM launched accreditation programs for Out of Center Sleep Testing and for Durable Medical Equipment, hence creating standards for the diagnostic testing outside the sleep center and furnishing therapeutic devices to patients with sleep disorders. Additionally in the October issue of JCSM, a technol-

ogy evaluation of out of center testing devices was published to lend guidance to device selection.

For many years, the practice of sleep medicine has focused on the testing and diagnosis of patients with obstructive sleep apnea (OSA). Federal law, and in many cases state law, has prevented us from providing treatment to our patients; this service has been left to DME companies. This has greatly fragmented the care of our patients. Throughout the spring of 2011, the Board of Directors and staff worked on developing the proposal for the Integrated Sleep Management Delivery Model. This proposal is available for review on the website at <http://www.aasmnet.org/members/resources/pdf/innovationproposal.pdf>, and we strongly encourage you to read this document. The basic concept of this proposal focuses on the sleep physician providing diagnostic testing as well as the treatment and tracking outcomes for their patients over a two-year period. Eligibility for an integrated sleep medicine program would require sleep centers to obtain three levels of accreditation—AASM Accreditation of Sleep Center, AASM Accreditation of Out of Center Sleep Testing Accreditation, and AASM Accreditation for Non-Medicare DME Suppliers. Participation in the integrated sleep medicine program would be strictly voluntary, and all current accreditation programs would still be available to eligible facilities. The Board of Directors believes this is the future of clinical sleep medicine.

Representatives of the Board of Directors met with the Centers for Medicare & Medicaid Services (CMS) on May 5, 2011, and presented an earlier iteration of the Integrated Sleep Management Delivery Model proposal. CMS warmly received our proposal and encouraged us to finalize our model. As of this writing, CMS is considering two options with respect to our plan. The first and preferred option is to pilot the program through the Center for Medicare & Medicaid Innovation. The second option is for CMS to develop and institute a determination policy for an integrated care model. The important takeaway is that CMS is very interested in what we have proposed for the future of sleep medicine and patient care. Our intent is to present this plan to all insurance carriers

and hopefully have our model for care incorporated into their coverage policies.

This proposal has been well received because it shifts the focus of sleep medicine from strictly diagnostic testing to long-term disease management. We recognize this plan is a working document and that it will change over time as necessitated by changes in insurance policies, practice models, technology, and other factors. Further, this plan will be expanded to include outcome measures for all sleep disorders, not just OSA.

What will make this plan better is the feedback of our membership. Specifically, we need to gauge the commitment of our members to shifting their practice pattern from diagnostic testing to an integrated approach that includes testing, treating, and disease management. We are currently engaging focus groups to review this plan and give us feedback.

Finally, we are well aware of the fear in the sleep medicine community over the contracts for OCST on a local basis. We are working with you on plans like this as well as enhanced education programs to help you manage this change. Change is upon us, and it will do our field and our patients no favor to resist it. Rather, we must accept the challenges presented, manage them, and by doing so turn these challenges into opportunities.

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DISCLOSURE STATEMENT

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