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Alzheimer’s Disease Biomarkers in Children With OSA
By Regina Patrick, RPSGT, RST

Various studies have indicated that obstructive sleep apnea (OSA) is associated with an increased risk of developing Alzheimer’s disease and that people with OSA have increased levels of certain biomarkers (e.g., amyloid beta protein) associated with Alzheimer’s disease. Scientists have recently noted increased levels of biomarkers associated with Alzheimer’s disease in young children with OSA.

Sleep Disturbances Associated With Post-Traumatic Stress Disorder
By Shana Hansen, Lt. Col., USAF, MC, and Shannon N. Foster, Major, USA, MC

The Start School Later Movement: Putting Sleep Health on the National Radar
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Support Groups in Sleep Disorders Medicine
By Kimberly Trotter, MA, RPSGT
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REGISTER TODAY
As I look back over my career in sleep medicine and technology, I realize just how far we have come in the past 30 years, and as far as how far we have to go to define who we are and our roles as sleep professionals. As interest in sleep and availability of information expand, our roles as educators and providers of information also expand. Along with this come responsibilities. Research into why we sleep and the health consequences of insufficient or disordered sleep is providing new avenues for our exploration and learning. As professionals, we are responsible for remaining current in our knowledge and providing education that is current and useful — in all of our roles.

It is also our responsibility, as professionals, to know the players and the rules in our field. There is, unfortunately, much misinformation available, particularly regarding the rules in our field and the processes that surround our credentialing and licensing. We pulled the original article entitled “How to Survive a BRPT Audit” from the last issue of A2Zzz because of just this; it contained misinformation provided by those in the field who do not understand which organization does what or the rules. We strive to always provide accurate information that supports our profession, and, as such, Jessica Schmidt, BRPT president, and I revised that article to assure that accurate information on an important topic for our members and credential holders is available. I hope you will review this article and learn from it, as well as pass on accurate information to those you interact or work with.

A2Zzz has always focused on education — bringing you high quality current educational offerings to assist you to further your knowledge and flourish in your profession. Many new educational initiatives are underway at A2Z, fueled by new and essential knowledge that supports our professionals and addresses expanding educational needs. As editor, I am pleased to see that each new issue of A2Zzz addresses some aspect of new findings in sleep research. This issue is no exception, with fascinating articles on a possible connection between OSA in children and Alzheimer’s disease and research surrounding post-traumatic stress disorder (PTSD) that led to a proposal for a new parasomnia with unique features called trauma-associated sleep disorder (TSD). Offerings such as these provide opportunity for continued learning that assists us to grow and to keep up with the latest information in our field.

This issue of A2Zzz contains a new feature called Trends. This column, authored by Matthew Anastasi, BS, RST, RPSGT, will focus on leading-edge developments in the field and offer practical advice that you can use in your own sleep center or practice. This issue, the column provides information useful to those who are seeing higher-acuity patients in the sleep laboratory, which is most of us. I expect this to be

a popular feature that provides practical and thought-provoking information. Our Compliance Corner feature, authored by Laura Linley, CRT, RPSGT, FAAST, continues to provide valuable regulatory information that is focused on providing timely information applicable to our field. These features and our articles highlight the changes that have been occurring and that will continue to occur as our field grows and our roles in the sleep medicine arena grow and change. Keep abreast of the changes!

The AAST Program Committee is hard at work on preparing our 2019 AAST Annual Meeting program. This year’s meeting in St. Louis is scheduled for Sept. 6-8, and registration is open. The committee has prepared an exciting program that includes a variety of topics that are sure to interest attendees, along with some workshops and a special offering for those who are interested in qualifying to sit for the CCSH credential examination under a new RPSGT eligibility pathway.

A2Zzz is pleased to present our first CCSH-focused education program as a full-day program on Sept. 6 in St. Louis.

I hope you will review the offerings at this year’s meeting and join us in St. Louis. The CCSH program is offered as a separate, all-day certificate program; however, it can be bundled with meeting registration at a discounted rate. If you attend the meeting and/or the CCSH program, you will be well prepared for the challenges of the continued advances in the profession. I look forward to seeing you at the meeting this year!

Wishing you all a wondrous spring!
Sleep well!
Rita
Instructions for Earning Credit

AAST members who read A₂Zzz and claim their credits online by the deadline can earn 2.00 AAST Continuing Education Credits (CECs) per issue, for up to 8.00 AAST CECs per year. AAST CECs are accepted by the Board of Registered Polysomnographic Technologists (BRPT) and the American Board of Sleep Medicine (ABSM).

To earn AAST CECs, carefully read the four designated CEC articles listed below and claim your credits online. You must go online to claim your credits by the deadline of Aug. 15, 2019. After the successful completion of this educational activity, your certificates will be available in the My CEC Portal acknowledging the credits earned.

COST
The A₂Zzz continuing education credit offering is an exclusive learning opportunity for AAST members only and is a free benefit of membership.

STATEMENT OF APPROVAL
This activity has been planned and implemented by the AAST Board of Directors to meet the educational needs of sleep technologists. AAST CECs are accepted by the Board of Registered Polysomnographic Technologists (BRPT) and the American Board of Sleep Medicine (ABSM). Individuals should only claim credit for the articles that they actually read and evaluate for this educational activity.

READ AND EVALUATE THE FOUR FOLLOWING ARTICLES TO EARN 2.0 AAST CECs:

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A₂Zzz provides current sleep-related information that is relevant to sleep technologists. The magazine also informs readers about recent and upcoming activities of the AAST. CEC articles should benefit readers in their practice of sleep technology or in their management and administration of a sleep disorders center.

**READERS OF A₂ZZZ SHOULD BE ABLE TO DO THE FOLLOWING:**
- Analyze articles for information that improves their understanding of sleep, sleep disorders, sleep studies and treatment options
- Interpret this information to determine how it relates to the practice of sleep technology
- Decide how this information can improve the techniques and procedures that are used to evaluate sleep disorders patients and treatments
- Apply this knowledge in the practice of sleep technology

You must go online to claim your CECs by the deadline of Aug. 15, 2019.

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**Alzheimer’s Disease Biomarkers in Children With OSA**
*Objective:* Readers should understand the factors that contribute to neuronal damage and destruction as it relates to Alzheimer’s disease.

**Sleep Disturbances Associated With Post-Traumatic Stress Disorder**
*Objective:* Readers should understand the sleep patterns that correlate with combat veterans who have PTSD.

**The Start School Later Movement: Putting Sleep Health on the National Radar**
*Objective:* Readers should understand the current science behind adolescent sleep needs and the trend toward pushing start-time policies that align with those needs.

**How to Survive a BRPT Audit**
*Objective:* Readers should understand their recertification responsibilities and the recertification audit.
Alzheimer’s Disease Biomarkers in Children with OSA

By Regina Patrick, RPSGT, RST
Approximately 200,000 Americans under the age of 65 have early-onset Alzheimer’s disease.

Inflammation

Inflammation is associated with an increased number of glial cells in the brain. In the healthy brain, glial cells normally remove waste and toxins. For example, one type of glial cell, called a microglia, engulfs and destroys waste and toxins. In the Alzheimer’s brain, microglia collect around neurons but do not clear debris such as amyloid beta plaques. The cells instead release chemicals that cause chronic inflammation and further damage the neurons they would normally protect. Why the microglial cells do not remove waste is unclear.

Neurodegenerative and inflammatory changes noted in Alzheimer’s disease have also been noted in people who have OSA, a sleep disorder in which a person stops breathing (i.e., has apnea) intermittently during sleep. The cessation in sleep occurs because upper airway structures collapse into the airway and block airflow. The blood oxygen level consequently falls. The
respiratory center in the brain ultimately induces a brief arousal during which a person takes a few deep breaths to restore the blood oxygen level. Once the oxygen level is restored, the person resumes sleep. In people with OSA, disrupted sleep caused by respiratory-related arousals and hypoxia have both been associated with cognitive impairment and neurodegenerative changes in brain regions involved in learning and memory.\textsuperscript{14} In children, obesity is associated with an increased risk of having OSA.\textsuperscript{15} Obesity and OSA are both associated with an increased risk of developing Alzheimer’s disease.\textsuperscript{4,5} With this in mind, Keirandish-Gozal and colleagues\textsuperscript{14} examined whether obese children with OSA would have increased plasma levels of two biomarkers for Alzheimer’s disease: amyloid beta 42 and presenilin 1. The mean age of the children in the study was approximately 7 years. Plasma samples were obtained from healthy children who had obesity only, OSA only, OSA and obesity (OSA + OB), or no OSA or obesity (i.e., the control group). Plasma samples were also obtained from children with OSA who had undergone adenotonsillectomy. The amyloid beta 42 and presenilin levels were similar between the obese children and the control group. Compared to these two groups, children with OSA only, but more so children with OSA + OB, had significantly higher levels of the two biomarkers. In the subgroup of children that had undergone adenotonsillectomy, the levels of amyloid beta 42 and presenilin 1 were significantly reduced. The researchers concluded that OSA — in particular, OSA + OB — increased the plasma levels of the biomarkers, whereas weight did not seem to increase the level of the biomarkers, and that OSA treatment reduced the levels of the biomarkers. However, some research indicates weight may have an impact on the levels of biomarkers of Alzheimer’s disease. In a study of preschoolers and adolescents of various weights (i.e., normal, overweight, obese), Luciano et al.\textsuperscript{16} demonstrated a correlation existed between weight and amyloid beta 42 and presenilin 1 in the total sample: the highest levels of amyloid beta 42 and presenilin 1 were in the obese children, followed by (in decreasing order) overweight children and normal weight children. When evaluating the preschooler and adolescent groups separately, the trend of increasing levels of the biomarkers with increasing weight was more pronounced in the adolescents than in the preschoolers. However, because of certain methodological problems in the study (e.g., the use of preschoolers and adolescents but not children between these age ranges, which may have impacted the results), Luciano is uncertain of the clinical importance of the findings and encourages more research.

Once symptoms are apparent, the disease has no cure. Reducing the risk factors for Alzheimer’s disease could theoretically reduce its prevalence. The pathophysiological processes that contribute to Alzheimer’s disease begin long before the disease manifests. Once symptoms are apparent, the disease has no cure. Reducing the risk factors for Alzheimer’s disease could theoretically reduce its prevalence. The findings that pathophysiological changes associated with Alzheimer’s disease can occur in young children with OSA and that treating OSA reduces these changes are interesting. These findings could potentially be important in preventing or delaying the development of Alzheimer’s disease. For example, treating OSA in children or reducing childhood obesity may help to maintain or restore normal biochemical processes in the brain (e.g., the interaction between tau protein and amyloid beta protein) and thereby prevent or delay the development of Alzheimer’s disease. Future research may determine the extent that treating OSA in children and/or reducing childhood obesity can prevent or delay the development of Alzheimer’s disease.

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sleep apnea: a hypothesis with emphasis on the nucleus tractus solitarius. Sleep Disorders. 2012;2012:251096.


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Sleep Disturbances Associated With Post-Traumatic Stress Disorder

By Shana Hansen, Lt. Col., USAF, MC, and Shannon N. Foster, Major, USA, MC

Post-traumatic stress disorder (PTSD) is a trauma and stress-related disorder characterized by re-experiencing, avoidance, hyperarousal and negative alterations in cognition or mood. Events that involve threat to integrity of self or others such as rape, physical assault, natural disasters and combat exposure are commonly associated with the development of PTSD. The lifetime prevalence of PTSD among adults in the United States ranges from 6-10%, with women being more than twice as likely to have PTSD at some point. Significantly higher estimates have been reported in combat veterans (15-30%). Rates of PTSD in veterans are higher if they were stationed in combat zones, had tours of longer than one year, experienced combat or were injured. Specifically, among veterans with deployments to Iraq and Afghanistan, 31-86% report multiple traumatic combat exposures and 11-20% endorse significant PTSD symptoms.

Sleep Disturbances Associated With PTSD

Following traumatic experiences, sleep complaints are common. Subjective and objective sleep disturbances are associated with an increased risk of meeting PTSD diagnostic criteria; and insomnia and nightmares are core diagnostic features of PTSD. Sleep terrors, sleep avoidance, nocturnal anxiety, acting out dreams, increased motor behaviors and vocalizations are also frequently reported by PTSD patients. These sleep disturbances are known to exacerbate daytime symptoms and contribute to worsened clinical outcomes. This stresses the importance of monitoring for the development of sleep disturbances in patients with trauma history and the role they may have as mediators for clinical outcomes in PTSD. Sleep disturbances in this population are often resistant to first-line PTSD treatment. Sleep-specific interventions are commonly employed to alleviate insomnia and nightmares. Effective treatment has been associated with improved daytime PTSD symptoms, depression, quality of life and subjective physical health.

Nightmares

Nightmares are characterized by disturbing, well-remembered dreams that cause distress or daytime impairment (ICSD). Nightmares in the general population are not uncommon, with up to 85% of adults reporting at least one nightmare per year. In patients with PTSD and psychiatric disorders, occurrence of nightmares is much more common. Additionally, nightmares are associated with an increased risk of suicidal ideation. Despite this, nightmares are frequently under-reported by patients and thus under-recognized by clinicians. The high prevalence of PTSD and psychiatric disorders in military personnel leads to an even higher rate of nightmares. In military personnel referred for a sleep evaluation, nightmares at least weekly were reported in 31%, which is significantly higher than the general population of 0.9-6.8%.

Treatment options for nightmares include a combination of behavioral techniques and medical therapy. Imagery rehearsal therapy (IRT) is a technique where patients are taught to “rescript” their nightmares and thus unlearn the behavior. This therapy has been successful in combat veterans as well civilian trauma victims. A variation of IRT, called exposure, rescripting and relaxation therapy (ERRT) incorporates aspects of traditional cognitive behavioral therapy (CBT) with IRT. A combination of CBT for insomnia and IRT shows promising short-term effects in veterans with PTSD. Finally, pharmacologic therapy with prazosin or positive airway pressure (PAP) therapy in patients with obstructive sleep apnea (OSA) can also be successful in nightmare patients.

Trauma-Associated Sleep Disorder

In a subset of PTSD patients, trauma-related nightmares (TRNs) are accompanied by parasomnias. Trauma-associated sleep disorder (TSD) is a recently proposed unique parasomnia that describes the clinical features of TRNs in association with disruptive nocturnal behaviors (DNBs). DNBs consist of abnormal vocalizations (screaming, groaning) and movements (thrashing, turning, sleepwalking) as well as combative behaviors (striking or kicking bed partner). It is not uncommon for the DNBs to mimic nightmare content. Autonomic hyperarousal signs (increased heart rate, quickened breathing, night sweats) are often linked with these behaviors. Polysomnogram (PSG) evaluation commonly shows dream re-enactment behavior and increased muscle activity during REM (REM without atonia). Nightmares are almost universally reported in these patients. TSD may also present along with insomnia and OSA. Therefore, in patients who present with symptoms of TSD, a PSG is recommended to look for sleep disordered breathing (SDB) in addition to evaluating whether the patient has abnormal REM behavior and/or movements. Currently, no evidenced-based guidelines for treatment of this newly proposed sleep disorder are available. Obtaining an adequate quantity of sleep, avoiding triggers and promoting a safe sleep environment are critical. In some cases, medical therapy to suppress these events may be necessary. Some patients respond well to a combined treatment with prazosin for nightmares and DNB, behavioral therapy for insomnia and PAP therapy for OSA.
OSA prevalence is higher in PTSD patients than the general population.

Insomnia
Insomnia is the most common sleep complaint in civilian as well as military populations (MSMR 2013). It is also the most reported symptom among service members returning from deployment and in combat veterans with PTSD. Up to 74% of combat veterans with PTSD meet clinical criteria for insomnia. In addition, veterans who have experienced sexual trauma have higher rates of insomnia symptoms (61%) than veterans who did not experience trauma (53%). Insomnia is associated with higher PTSD severity and does not tend to resolve spontaneously over time. Treatment options for insomnia in patients with PTSD are similar to those for the general population. However, insomnia in PTSD patients can be complicated by their symptoms of PTSD as well as comorbid sleep disorders and unhealthy sleep practices. CBT improves sleep quality as well as daytime PTSD symptoms in this population. Treatment options for insomnia in patients with PTSD are similar to those for the general population. However, insomnia in PTSD patients can be complicated by their symptoms of PTSD as well as comorbid sleep disorders and unhealthy sleep practices. CBT improves sleep quality as well as daytime PTSD symptoms in this population. In addition, combined therapy of CBT and IRT can be beneficial in those patients with comorbid nightmares. There are currently no evidence-based guidelines on pharmacologic treatment of insomnia in the PTSD population due to lack of quality studies. While PSG is not routinely recommended by the American Academy of Sleep Medicine (AASM) in chronic insomnia patients, patients with PTSD have high rates of comorbid sleep disorders, such as OSA and periodic limb movement disorders. PSG should be considered in PTSD patients with insomnia, especially if standard insomnia treatment fails.

Sleep-Disordered Breathing
While insomnia and nightmares have been the most frequently reported sleep symptoms in PTSD literature, recently, more attention has been given to the prevalence and significance of SDB in PTSD patients. SDB, most commonly in the form of OSA, affects 9-38% of the adult population, with higher estimates among men, the elderly and obese populations. In addition, OSA rates of up to 60-85% have been reported in military samples. Further, recent literature indicates that individuals with PTSD have a disproportionately higher rate of SDB than the general population, with rates of co-morbid PTSD and OSA being reported, depending on diagnostic methodology used. Krakow et al. proposed a novel hypothesis involving a bidirectional pathway to explain why high rates of sleep breathing disorders among PTSD patients have been observed. In this pathway, the sleep fragmentation (nightmares, insomnia) seen in PTSD affects the airway, causing upper airway collapsibility and SDB events. These events further fragment sleep, leading to exacerbation of insomnia and nightmares, which worsens overall PTSD symptoms. This may have clinical implications for a subgroup of PTSD patients who also suffer from SDB, and more research is needed in order to clarify best diagnostic and treatment practices. Studies evaluating treatment in patients with comorbid PTSD and SDB suggest that positive airway pressure therapy (PAP) may improve sleep by decreasing sleep fragmentation and nightmares. Unfortunately, patients with PTSD typically have suboptimal PAP adherence. Due to the potential adverse outcomes of comorbid mental illness and sleep disorders, including suicide, interventions should begin early.

Conclusion
Sleep disturbances are prevalent in patients with PTSD and are often resistant to standard first-line treatments. This can lead to worsening of PTSD symptoms and poorer clinical outcomes. Insomnia and nightmares are the most commonly reported sleep problems in patients with PTSD, and treatment consists of a combination of behavioral methods and pharmacologic therapy. TSD is a newly described parasomnia that can occur in some patients with PTSD. OSA prevalence is higher in PTSD patients than the general population. Thus, PSG should be considered in PTSD patients with sleep disturbances, especially if resistant to initial treatment. PAP therapy can improve daytime functioning as well as PTSD symptoms, but compliance is generally low. Evaluation and treatment of sleep disorders should be an integral part of PTSD treatment in order to limit their adverse effect on daytime symptoms and overall functioning.

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Anyone raising children expects challenges along the way, from those sleepless first nights and toddler tantrums to the trauma of teaching teenagers to drive. But few are prepared for the recurring nightmare of waking a teenager for school at the crack of dawn. Getting a teenager up and off to 7 or 8 a.m. classes can feel like waking the dead — even in homes that enforce reasonable bedtimes. If you understand sleep science, you know why. Essentially, these early start times force families to fight biology. They fly in the face of everything we know about adolescent sleep needs and patterns and create a sizable sleep debt every week.

The heart of the problem is a well-documented shift in sleep cycles (circadian rhythms) beginning at puberty that makes it difficult for most adolescents to fall asleep as early as younger children or older adults — or to wake for very early classes. The science showing that early school hours are unsafe, unhealthy and counterproductive for adolescents is so compelling that many major health organizations, including the American Academy of Pediatrics, the American Medical Association, the American Academy of Sleep Medicine, the Society of Behavioral Medicine and the Centers for Disease Control and Prevention (CDC) are calling for an end to middle and high school start times before 8:30 a.m. Yet according to the CDC, nearly five in six U.S. middle and high schools still start before then. Over 10% of high schools start regular class before 7:30 a.m., with nearly half starting before 8 a.m. Bus runs begin as early as 5 a.m. in some districts.

The good news is that an increasing number of communities are realizing later school start times benefit kids and communities. Hundreds of schools have already found ways to run classes at more developmentally appropriate times by prioritizing health and learning. Others never moved to such insanely early hours in the first place.

A Proven Policy Solution to Teen Sleep Insufficiency

Lest you think the solution is taking away screens, consider that the same circadian shift occurs at puberty in other mammals, who almost certainly do not have iPhones or computers. For both biologic and cultural reasons (e.g., late-night practices, excessive homework), teenagers often have trouble falling asleep before about 11 p.m., even if they are “put to bed” much earlier. If they have to wake at 5 or 6 a.m. to get ready and then commute to an early-start school, they can only get six to seven hours of sleep at most, far less than the approximately nine they typically need. In addition, they miss out on the bulk of critical REM sleep, which is concentrated in the last third of the night and where most memory consolidation and emotional regulation occur.

The result is a nation of adolescents suffering from chronic sleep insufficiency at a huge — and unnecessary — cost to health and well-being. According to the CDC, nearly three-fourths of American high school students today get under eight hours of sleep per night, and over two-fifths get six or fewer.

While there are many factors involved, only one policy change has been proven to make a difference in adolescent sleep insufficiency: delaying school start times. Schools that start class at 8:30 a.m. or later not only see more students getting more sleep but also see improved graduation and attendance rates, test scores and mood; less depression, stimulant and illegal substance use, tardiness and falling asleep in class; and lower teen car crash rates. When it comes to school performance, students from disadvantaged backgrounds benefit disproportionately,
more traditional bell times. County boards of health supported them. So did state health associations. Grassroots groups of parents arose, trying to delay start times, as well. These efforts largely failed and continue to fail.

Creating the Will to Change

The problem with returning to more traditional, healthier school hours was not science. It was, and continues to be, politics. Contrary to popular belief, however, the politics does not involve logistic issues such as daycare, transportation costs, sports, after-school jobs or traffic. Fears about these perceived obstacles are real. So is the power of those fears to block change. However, these fears have consistently turned out to be red herrings — or, if not, resolvable with creative thinking by stakeholders committed to change. The bigger challenges are more fundamental: fear of change, failure of imagination and pervasive ignorance about sleep.

Communities that delay start times successfully prioritize sleep, health and learning.

The hundreds of schools that have delayed bell times have overcome these challenges. Specific solutions vary by community, depending on a budget, topography, demographics, values, etc. However, communities that have delayed bell times successfully have certain commonalities, including leadership from within the school district, clear communication about reasons for change, and authentic engagement with stakeholders to facilitate creative solutions and build consensus. Allowing stakeholders time to plan for changes may be required, together with sustained advocacy, often by sleep or health professionals, before, during and after the change.

Above all, communities that delay start times successfully prioritize sleep, health and learning, creating a climate in which people want school hours that allow for healthy sleep. This “political will” reduces the fear of change and failure of imagination that made change so hard. Perceived obstacles melt away, and solutions to unsolvable problems become readily available.

Joining Forces for Sleep Health

Building the political will to start school later for most of the nearly 14,000 school districts in the United States will require a multipronged approach by a diversity of players collaborating on local, state and national levels. Sleep professionals can play a critical, even essential, role here in waking up communities to the value of sleep and healthy school start times. In the clinical setting, they can do this by talking to patients or by distributing flyers and displaying posters, as well as by mentoring and modeling healthy sleep. However, when it comes to building political will and turning science into policy, sleep professionals will also need to step outside of traditional roles to serve as public ambassadors for sleep health and healthy school hours.

This is already starting to happen. Many sleep professionals are speaking out via social media and community forums. They are also increasingly joining forces with pediatricians, superintendents, social workers, community advocates and legislators via Start School Later and other sleep advocacy organizations. Some sleep professionals are leading local Start School Later chapters, and many others regularly make themselves available as resources and sources of expert testimony. Some are playing key roles in the passage of sleep and healthy school start time legislation. Others are encouraging their professional associations to generate position statements on the need for school hours compatible with healthy sleep.

Communities that understand that sleep matters will not only prioritize sleep-friendly school hours but also respect and value sleep health more generally and the sleep professionals who make it possible.

AAST strongly supports the School Start Later initiative.

References


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Quarter Two 2019
How to Survive a BRPT Audit

By Jessica Schmidt, MA, FACHE, RPSGT, CCSP, BRPT President, and Rita Brooks, MEd, RPSGT, REEG/EPT, FAAST, AAST President

Editor’s Note: An article titled “How to Survive a BRPT Audit” ran in the Quarter One 2019/Volume 28/Number 01 edition of A2Zzz magazine. The intent of the article was to remind sleep technologists that they are responsible for assuring they have the appropriate continuing education credits to maintain their credentials and to explain the audit process. Unfortunately, the article unintentionally contained misleading and, in a number of cases, incorrect information, which was confirmed by reviewing message history, document uploads and login records that are tracked and time-stamped in BRPT’s certification database. That article was retracted, has been edited, and is republished here, conveying the important message that AAST and the BRPT continue to work together to assure that correct information is consistently provided for our members and credential holders. The revised article and the information that follows below provide an accurate description of recertification responsibilities and the recertification audit as well as tips for facilitating a smooth and efficient audit process.

At some point in your career as an RPSGT or CCSH, you may be asked to participate in a credit audit. A credit audit is not the same thing as a credential renewal.

What is a credential renewal? Every sleep technologist recertifies periodically to maintain their credential. Those holding the RPSGT or the CCSH credential must recertify every five years. You can either renew by retaking the credentialing examination or by accumulating 50 continuing education credits (CECs) — sometimes referred to as continuing education units (CEUs) — you’ve earned during the five-year credential window to maintain your credential. Most opt to collect CECs rather than take the boards again, and earning CECs fosters ongoing learning and keeps you current with changes in the field.

Did you know that CECs must be directly sleep or sleep-respiratory related, or prior approved by AAST or the BRPT?

Courtesy recertification reminders are sent monthly during the six months leading up to your credential expiring. However, it remains the sleep technologist’s sole responsibility to be aware of the expiration of their credential and follow procedures to renew it ahead of that specific date. It is your responsibility as a professional to maintain your credential and, in some states, your license.

It is critically important to track your CECs if you plan to use them for recredentialing (and/or licensing). Tracking can be as simple as keeping your certificates in a folder or scanning them to an electronic file (with a backup) for safekeeping. There are also tracking programs (such as the one offered to AAST members) that can assist with this process. If you are an AAST member, CECs earned that are approved for AAST CECs are automatically tracked for you in the CEC portal as a member benefit. CECs earned outside of AAST can also be added to your member portal for tracking.

Regardless of how you track your CECs, you should always keep documentation of the CECs you have earned to support your credential. The BRPT portal allows you to enter and upload CECs as they are earned; however — and this is an important however — the BRPT does not upload certificates sent to them and can only provide a basic transcript of what you have submitted. You are still responsible for maintaining your certificates, and you must also keep copies for a minimum of one year after your recertification date in the event of an audit.

A word to the wise: There are many CEC tracking portals now available on the internet. Use extreme caution if you are tracking your CECs on a website or in a portal other than

one supported by your professional and/or credentialing organization. We have heard reports of CECs being lost due to a website or portal shutdown.

If you have properly maintained your CECs, when your credential comes up for renewal, you will have all of your information in one safe place for entry into the BRPT portal. Another important bit of information to note: Don’t wait until the last minute! You can submit up to six months before your due date, and you should submit no later than three weeks prior to your expiration date. This gives you sufficient time to address any issues you may encounter when entering your CECs for recertification. Also note that you must enter each individual program for which you are presenting CECs — by course title, date and ID with number of credits earned — not your transcript from a meeting.

So, what might go wrong? Did you know that CECs must be directly sleep or sleep-respiratory related, or prior approved by AAST or the BRPT? Are you aware that the BRPT will not accept duplicate CECs within the five-year recertification window? That means you cannot submit a mask-fitting workshop CEC on the same mask more than once, or
a duplicate journal review or learning module. Did you know that you must also submit a valid BLS certification (or international equivalent) that includes skills testing?

My best advice for anyone preparing for recertification is to go to www.brpt.org and read the Recertification Guidelines well in advance of your credential expiration date.

Now that you have everything in order, go to the BRPT site, sign on to your portal, and begin the appropriate application, which includes re-committing to the BRPT Code of Conduct, entering your continuing education credits, uploading your live/skills CPR/BLS and paying the recertification fee ($150 online). If you have been diligent, this will be a straightforward process.

How Is a Recertification Audit Different from a Credential Renewal?

An audit is conducted after you have already recertified and includes a formal review of your CECs by requiring more information/documentation to prove you actually procured credits submitted for recertification and approved by the BRPT to maintain your credential.

BRPT Audits: The Basics

The BRPT must perform these recertification audits in order to maintain their accreditation with the National Commission for Certifying Agencies (NCCA), which maintains stringent standards for professional certification.

Jessica Schmidt, president of the BRPT, explains the process for determining who receives an audit is randomized. “Registry numbers are entered into a list randomizer,” she says. “We input the entire list of credential holder names of those who recertified during the quarter that we are auditing, and it randomizes it. We then take the first 10% off the top of the list, and the results are who are being audited.”

In other words, the BRPT does not hand-pick who will receive an audit.

“Our accreditation requires that we randomly audit 10%, with a max of 40 credential holders, per quarter,” Schmidt says. “At this point in time, with the number of RPSGTs that we have currently, it is always 40 credential holders.”

If a sleep technologist is selected for an audit, they receive up to 90 days to complete the task. “We send out 30-day notices twice after the original notice is sent,” Schmidt says. “That is more than enough time to gather what is needed.”

How to Complete a BRPT Audit

If you receive a notification that you have been audited, you will receive a Recertification Audit spreadsheet that lists the CEC entries that were made during your renewal that did not include an uploaded certificate highlighted in red. You will be required to email, fax or mail the auditor the certificates belonging to the red highlighted entries within 30 days of receiving your spreadsheet.

Schmidt believes sleep technologists won’t be surprised by an audit if they recertify their credentials “at least three weeks prior to expiring.” This should make for a smooth audit experience if you are chosen for an audit.

“A huge benefit of being a member of the AAST is being able to track your credits on the website.”

Is it Really This Simple?

According to contacts at the BRPT, yes, it’s this simple. However, sleep technologists who’ve undergone credit audits cite a variety of experiences that show differing results.

President-Elect Melinda Trimble recounts her experience with an audit in 2016 when she received an email following her five-year credential renewal announcing she’d been selected for a random audit.

“I went to the AAST website, which is where I keep all of my credits, and uploaded my transcripts,” she says. Then, Trimble logged into her BRPT portal to complete the process, sometimes adding credits individually when they came as bundles from conferences. She was given the option of sending them, at that time, via email or regular mail by a specific deadline. Trimble opted to send them in electronically. However, after a week, she did not hear back from the BRPT.

“The first time, I sent them in email and assumed I would receive a confirmation of receipt,” she says.

Concerned that there might have been an electronic glitch, Trimble then printed her credit list off the BRPT site and mailed it to assure they received it. She was relieved to receive a receipt in the mail that said they had received her package. A few weeks later, she received an email confirming she had “passed the audit.”

Interestingly, not long after, Trimble’s respiratory credential renewal came up for review, and she participated in a second audit. Like she’d done with the BRPT, she uploaded her materials digitally. This time she received what she hoped for: a receipt of notification the very next day.

For Trimble, “the process itself was easy.” Fortunately, she had regularly updated her credits using her private CEC Portal at the AAST website. “A huge benefit of being a member of the AAST is being able to track your credits on the website,” she says. “I didn’t even appreciate this feature that much until I had to go through the audit process myself. It is really useful to store all that information in one location.”

Trimble also discovered that, while updating her AAST credits, she had forgotten about other credits she earned but were not accounted for in her
transcripts. She was able to add those as well and use them for her credit audit.

Other sleep technologists have run into issues that also show the process isn’t always simple.

A tech, who wishes to remain anonymous, says she acquired “tons of good CEUs, and they had already been approved by BRPT” through the site CME.FORMD.com. However, when she went to visit the site in mid-November 2018, it had been taken down. This is an example of what can go wrong when CECs are tracked on a website without backup. There is no guarantee that a site providing education, even education approved for CEC by a reliable entity such as BRPT or AAST, will reliably track your CECs. In this particular instance, the portal appears to be a physician CME portal that has gone out of business.

Tracking CECs is not the responsibility of the BRPT; this is the credential holder’s responsibility. As an example, many educational programs are approved for CEC via AAST; however, the program director submitting for CECs is responsible for providing the certificate of completion (CEC) to participants — not the AAST (or any other CEC provider). In addition, although AAST is tracking AAST approved CECs in the member portal, these CECs will not be in the portal unless the program director submits the program participant list. Once again, the credential holder is responsible for attaining and maintaining their own CECs.

Meanwhile, sleep technologist Steve Morris reports when he was audited he had actually uploaded his certificates with each CEC entry that he used for his recertification. When the BRPT randomly selected to audit him, all of his documentation was there already; therefore, his audit was completed within two days.

**Keeping Track of CECs Is Due Diligence**

All sleep technologists need to be diligent about filing away CEC information in a safe repository throughout the years, and not just begin to prepare at the last minute prior to credential recertification.

Schmidt advises when individuals recertify, they should have all of their ducks in a row and be ready for the possibility of an audit.

Don’t put yourself in a position of having to scramble. She recommends technologists read the [Recertification Guidelines](#).

“Check them periodically during your five-year cycle, and make sure you read the BRPT Blog and News announcements periodically for important recertification notices,” she says. It’s also important to keep a current email address on file. For those who don’t meet the deadline, they risk the good standing of their credential being reviewed by the BRPT Professional Review Committee.

Fortunately, AAST’s CEC portal can make this process friendly and simple. Members simply log in to their private profiles at the [AAST website](#) then click on “My CEC Portal” and can survey their transcripts. As a member you can see, print and/or download all the AAST transcript credits you’ve earned from the point you joined the organization forward.

It’s easy and affordable to acquire credits through AAST by way of the Case of the Month or the Journal Club offerings, or by [reading A2Zzz](#). Just doing one of these a month can help you maintain the balance of credits needed to maintain your credential.

If you earn CECs from other sources, it is highly recommended that you keep tabs on them in a simple spreadsheet that lists the program name, completion date, CECs earned and program ID number along with a copy (print or electronic) of your certificate. Or, upload them to your AAST CEC portal. In addition, all emails you receive that issue your CECs should be saved in an electronic file folder, in your email program, or even as printouts to serve as proof of attendance in the event you need them for an audit.

**Final Advice About BRPT Audits**

Sleep technologists who have been audited already should not think they will never have to go through another audit again. Schmidt says previously audited credential holders can face a re-audit in the future “if their name appears on the randomized list at the time of a following renewal.”

Keep in mind the BRPT will only accept credits that are directly related to sleep or are sleep-respiratory related. EEG credits are acceptable if earned through ASET, but only if they are EEG 209 online course credits. Duplicate credits are unacceptable, as well.

This is important: According to the BRPT CEC page, “Some education providers are automatically approved by the BRPT Portal once the credential holder enters them. These entries are still subject to BRPT approval at the time of your renewal application submission and may be retroactively rejected if they do not comply with the requirements.” If you do post credits that are rejected later, this may be the reason. Credits can be re-reviewed on appeal by emailing the corresponding certificate for your rejected CEC to Ashley Shelton, BRPT Credentialing Director.

**BRPT Contact Information**

To fax documents to the BRPT: 202-747-2933

Any hard-copy submissions of credits should be mailed to: Board of Registered Polysomnographic Technologists 1420 New York Ave., Fifth Floor, Washington, D.C. 20005

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**JESSICA SCHMIDT, MA, FACHE, RPSGT, CCSH, is the president of the BRPT. RITA BROOKS, MED, RPSGT, REEG/EPT, FAAST, is the president of AAST.**
Starting a support group for your patients can be very rewarding. They can be beneficial for the community and for the sleep center as a way to market the program. There are many different types of support groups — OSA, RLS, insomnia and narcolepsy being a few.

Is a Support Group Necessary?
This is a great first question before planning to start a group meeting. When the UCSF Sleep Disorders Center and I started our support group for patients with sleep apnea, we sent out a survey to find out the level of interest, meeting topics, time of the meeting (day or evening) and frequency (monthly, quarterly, etc.). In the age of online communications, you can also consider creating or joining an existing online community, such as one within social media (e.g., Facebook).

Who Leads the Meetings?
Now that you have your framework down for which group you wish to form, you need to decide if it will be sustainable if you or someone from the sleep center is to lead it. You may be lucky and find a volunteer meeting attendee who can take it over, or at least be an active participant and assist with running the meeting or planning the speakers. Making the time for you or one of your staff to coordinate the meeting is best, and if the sleep center has a room available for the meetings to take place, even better. Our group is attended by one of our lead technologists, who introduces the speakers and is available after the meeting for questions. I coordinate the website and schedule, and book the speakers. We also invite different DME companies from the community to support the meetings with refreshments and a knowledgeable respiratory therapist (RT) for mask or PAP machine questions.

Virtual/Online Support
The idea of online support may be appealing to some, especially if the patient is homebound, lives far from the facility, or if the facility is hard to get to (parking, city, traffic). If you decide to pursue an online support group, there are many different ways to do this. You can have a synchronous “virtual” meeting using some of the many platforms available like WebEx or Zoom. This would allow for a set time, and all members can get online and have a real-time discussion or view a presentation. You would want to make sure everyone has access to the technology needed to do this. Another way to achieve an online support system involves asynchronous contact, which means patients can post questions, videos, etc., and read or post responses at other times. Examples of asynchronous contacts are Facebook posts, group email and online discussion boards.

General Rules of Support Groups
No matter the type of group you create, you will want to make sure you lay some ground rules prior to each meeting to make sure your patients have a meaningful and respectful experience.

Here are some general support group ground rules:
• Keep what you hear confidential.
• Do not talk when others are speaking.
• Allow others to ask questions.
• Do not monopolize the time of the speaker; three minutes per person if others are waiting is standard.
• Be respectful of other’s opinions.

As a support group, patients should support each other and assist with each other’s success with therapy. If they cannot commit to these ground rules, then we ask them not to attend until they can.

These rules may seem like common sense; however, if you have ever been to a support group, I’m sure you have experienced people who monopolize the meeting and talk over others.

There are resources for starting whichever type of support group you are interested in. Below are the four main sleep disorders that have established support groups and their resources.

OSA
For a sleep apnea support group, as with any, you have to decide if the group is for the community or for your sleep center patients only. The upside to opening it to the community is the

Support Groups in Sleep Disorders Medicine
By Kimberly Trotter, MA, RPSGT

Quarter Two 2019
sleep center exposure and marketing opportunity. We have offered different types of meetings, including those with guest speakers and a yearly equipment fair. Topics have included Understanding Your Sleep Study Results, Current Research in Sleep Medicine and Coping Strategies for Using PAP Therapy. We began our meetings years ago by utilizing the ASAA AWAKE resource. They have a great website and a virtual online presence on Facebook.

Restless Legs Syndrome (RLS)
The Restless Legs Syndrome Foundation has a great website for patients to get information about support. The groups have a similar framework as OSA support groups. Guest speakers talk on topics such as medications, supplements and behavioral aspects of treatment, as well as advocacy. These groups also share coping strategies.

Insomnia
When I did a search on insomnia support groups, there were many online forums and discussion boards. The search also came up with some informational websites sponsored by drug companies (surprise, surprise). I also saw some Facebook groups dedicated to those suffering from insomnia. I did not, however, find a single go-to website or organization that could support the foundations of creating an in-person group. There were a few clinics that see insomnia patients in groups, but they are considered services, with payment necessary. Similar to these clinics, and different than a support group, is cognitive behavioral therapy for insomnia, or CBTI. CBTI group sessions last approximately eight weeks and are also billable services. The results of CBTI are very promising. Online CBTI used to be offered for a fee through a company called SHUTi, but these services are no longer available. There may be other online resources available.

Narcolepsy
The Narcolepsy Network (NN) is a great resource for patients with narcolepsy and for those interested in starting a narcolepsy support group. You can also direct your patients to the NN website for their personal support and information. This nonprofit group has been around since 1986 and is a great advocacy organization that has a wealth of information. They have annual conferences for people living with narcolepsy and their families. Online support might be the best way for your patients to connect with others, as they also have a Facebook page.

Regardless of what type of meeting you decide to create, it is important to evaluate the necessity of the meetings periodically, to make sure you are meeting the patients’ needs, and balancing the time you or your staff can devote to these ongoing activities. Don’t be afraid to change the format, or if you feel the meetings are no longer attended regularly, then perhaps, in these changing times of getting most of our information through the web, you may find an in-person meeting is obsolete and you need a creative online presence.

KIMBERLY TROTTER, MA, RPSGT, began her sleep career while completing her master’s degree in psychology with an emphasis in behavioral sleep research. She started as a clinical sleep technologist, conducting sleep disorders testing in a sleep disorders center, and has been in the field of sleep for over 30 years. Over the years, she has published and presented sleep research, created and taught insomnia classes, coordinated support groups for sleep apnea sufferers, presented educational talks on sleep and health to the public, written numerous articles on sleep, taught sleep disorders medicine to future technologists and physicians, and accredited two sleep disorders centers. She served on the AAST Board of Directors from 1996–1998, was the 1999 recipient of the Carskadon Research Award, and the 2006 recipient of the Allen Devibiss Literary Award. She is currently the administrative director of the University of California San Francisco Adult and Pediatric Sleep Disorders Center, AAST Ethics Committee member, founding member of the California Sleep Society, adjunct professor at Skyline College and has a very active support group for sleep apnea sufferers.
Today’s Trends in Sleep Technology: Higher-Acuity Patients

By Matthew Anastasi, BS, RST, RPSGT

Welcome to the very first “Trends” article, a new A2Zzz department. In each issue, you can seek out this column for a snapshot of a leading-edge development in the sleep field and some practical advice on how to adapt and implement an approach back at your sleep center, practice or clinic. With so many advances in clinical practice, technology, industry, research, insurance, regulatory or something else, there is always something new to explore. Today is an exciting time to be a sleep professional! If you encounter a challenge that you need a solution to, please feel free to reach out to me directly for consideration for a future “Trends.”

Higher-Acuity Patients

In this first article, we will share solutions to one of the biggest challenges brought about by affordable care: the high-acuity patient. One of the root causes for the shift over the past few years to higher-acuity patients in our field has been the pre-authorization insurance process, which pushes healthier (i.e., no comorbid illness) sleep patients toward home sleep apnea testing (HSAT) for cost savings. This drives up the percentage of acute patients in the sleep center who are contraindicated for HSAT. These patients pose significant medical and cognitive issues, which degrades study quality and increases risks for these patients tested in the sleep center. This trend creates pressure on programs to mitigate the risks and address the increased care needs that accompany this patient population.

Comorbid population disease states are contraindicated for HSAT because they pose significant medical and cognitive issues which degrade HSAT study quality. Following is a list of acute patient populations that you can now expect to see on a typical night in the sleep center, along with the specialties that are referring them:

- Moderate to severe pulmonary or neuromuscular disease (pulmonology-referred)
- Patients suspected of other sleep disorders including parasomnias and narcolepsy (neurology-referred)
- Insomnia and circadian rhythm disorders (psychiatry-referred)
- Congestive heart failure (CHF) (cardiology-referred)
- Severe obesity (endocrinology or orthopedic-referred)
- Epilepsy (neurology-referred)

A review of these comorbid conditions suggests significant clinical, operational and practical implications for the in-lab sleep study. It means that a strong focus on intake criteria, patient preparation, staff competencies, safety protocols and sleep center readiness is needed to safely and effectively accommodate these patients.

Severe Obesity: A High-Acuity Population

Take the morbidly (severe) obese patient, defined as having a BMI ≥35 kg/m². Besides a 1.5 dose-response effect (1.5 times the relative risk of death (Aune, 2016)) on “all-cause” mortality, the general downstream effects of obesity on comorbidities include OSA, metabolic syndrome (a cluster of disorders including increased BP, diabetes, cholesterol, central adiposity and QOL) (Must, 2012), GI reflux, urinary stress incontinence and osteoarthritis.

It is an acute population that has dramatically increased to one in 20 of the U.S. population (Flegal, 2012). There are more patients living with extreme obesity than with breast cancer, Parkinson’s, Alzheimer’s and HIV together (Hobbes, 2018). Given the overlap between obesity-related comorbidities and sleep disorders, the rate is significantly higher in our sleep programs and, therefore, so are the health complications these patients present. The severely obese patient, then, presents the perfect opportunity to unite the clinical, operational and practical elements of the sleep program.

As you will see, by selecting just one acute disease, a whole host of comorbidities pop up and present themselves in a cascading effect of challenges for the sleep center. The comorbidities seen with severe obesity introduce immobility, multiple medication use (including insulin), enuresis and obesity-hypoventilation syndrome complications, among others.

A Model of Care That Meets the Acuity Challenge

Before we get to patient preparedness, it is critical that a staff is in place that meets the minimum level of competency needed to handle the acute patient, and that this staff is clear on the scope and limits of their responsibilities, because this can be a fine line that is tested every day and evening depending on the presenting patient. Minimum competency educationally is fast becoming an associate’s level degree. The profession has transitioned from a trade to a profession that deals with complex policies, regulations, treatment modalities, disease states and communication demands (e.g., documentation and safety handoffs) that is best prepared for by post-secondary education. Alongside education a credential (and in some states a license) establishes that staff meet the specific skills needed for the profession (i.e., RPSGT, RRT-SDS, RST). For specific diseases like severe obesity with its associated comorbidities, specific safety training should be provided as part of annual staff competencies and include arrhythmia recognition, transfer board training and Hoyer Lift operation.
The best clinical preparation we can offer the high-acuity patient is to establish a set of patient acceptance criteria based on the resources in place and require a history and physical (H&P), list of medications and progress notes from the referring physician before a patient is scheduled for a sleep study. In other words, staff should perform a thorough intake to which the order can be matched and patient can be verified for appropriateness. A sample list of conditions that may necessitate exclusion from a sleep center, depending on the resources available for provision of a safe study, includes:

- Fall risk (requires two-person assistance to ambulate or transfer)
- Wander risk
- Isolation (contact precaution)
- Developmental, intellectual and/or cognitive disability
- Severe psychiatric diagnosis
- Nursing home resident
- Patient under 18 years old
- Any of the following required during a PSG:
  - Cardiac monitoring
  - Incontinence care
  - Significant pain or sedation
  - Active wound care
  - Continuous infusion
  - Nursing care required for any other reason

Many of these conditions can be overcome and the patient can be tested if accompanied by a skilled caregiver or nurse and/or with a one-to-one patient-to-staff ratio. It is important that the scope of practice for the sleep center staff clearly defines responsibilities; these often do not extend beyond basic patient care and technical duties, and typically do not extend to nursing care.

These controls may sound extreme, but it is necessary not only to verify that the correct study is being matched to the patient, but also that safety measures are in place in the event of a medical issue. If a medical emergency occurs in the sleep center in the middle of the night, is a medically compromised patient able to accurately communicate their medical status? Does the technologist have the necessary medical information to assure appropriate care for the patient? Another important clinical goal is to focus on patient preparation and communication about expectations for the sleep study. Many patients are not well informed by their referring physician about the study and would benefit from educational videos, a tour or a conversation over the phone about what will take place — something more than scheduling and paperwork. Some additional clinical preparation tips include having all staff review charts ahead of time and bring concerns to management; understand all relevant policies and procedures, particularly those related to safety; and master the skills needed to manage complex patients effectively.

The operational accommodations that the sleep center can arrange for the morbidly obese patient include ambulation accommodations, facility accommodations, and policies and procedures that address their needs. Some of these interventions include preparing a bariatric bed with a 750 lb.+ rating and full adjustability, bariatric chairs with no arms, an ADA-accessible bedroom and bathroom that contain arm rests and a reinforced toilet to accommodate a higher weight limit, a medication self-administration policy and storage or policy for self-storage of medications typical for the obese population, some of which may require refrigeration, and a policy and procedure for recognizing and responding to hypoglycemia.

Finally, the primary practical implications of the obese patient in the sleep center are related to the performance of polysomnography and provision of PAP. These include the introduction of artifact (e.g., sweat necessitating more frequent electrode reattachment and environment cooling, movement and alpha-intrusion), the impacts on sleep architecture (e.g., medication impact, REM-rebound, sleep fragmentation, wake after sleep onset or WASO, increased awakenings) and sleep micro-architecture (e.g., snoring, severe oxygen desaturation and irregular EKG), and PAP interface challenges such as a need for larger masks. The obese patient with severe OSA will more likely require higher PAP pressures, which means a greater likelihood of CPAP to bilevel protocols and perhaps very high PAP levels.

An effective model of care includes a thorough patient intake, preparation and accommodation tailored to the complex patient. It takes clinical, operational and practical implications of acute disease and its comorbidities into account. Carefully managing complex patients is an investment in resources, time, education and preparation, but consider what the cost is for not planning for the risk.

**References**


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**MATTHEW ANASTASI, BS, RST, RPSGT,** is the CEO of Limina Sleep Consulting, LLC, and can be contacted at LiminaSleepConsulting@gmail.com. He has served the field of sleep medicine as a manager, technologist, author, researcher, conference organizer and volunteer for 20 years in a variety of clinical and research settings, including the University of Pennsylvania, Main Line Health System and the University of Pittsburgh Medical Center. He is the past president of the Pennsylvania Sleep Society, secretary/treasurer of CAAHEP’s Committee on Accreditation for PSG Technologist Education (CoA PSG), and vice chair of the AAST Standards and Guidelines Committee.
Updates
All Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) competitive bidding program contracts expired on Dec. 31, 2018. As of Jan. 1, 2019, there is a temporary gap in the entire DMEPOS competitive bidding program that CMS expects will last until Dec. 31, 2020. For additional information, please see the Temporary Gap Period fact sheet.

On March 7, 2019, CMS announced plans to consolidate the competitive bidding areas (CBAs) included in the Round 2 Recompete and Round 1 2017 DMEPOS competitive bidding program into a single round of competition named Round 2021. Round 2021 contracts are scheduled to become effective on Jan. 1, 2021, and extend through Dec. 31, 2023.

Program Overview
The DMEPOS competitive bidding program was mandated by Congress through the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). The statute requires that Medicare replace the current fee schedule payment methodology for selected Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) items with a competitive bid process. The intent is to improve the effectiveness of the Medicare methodology for setting DMEPOS payment amounts, which will reduce beneficiary out-of-pocket expenses and save the Medicare program money while ensuring beneficiary access to quality items and services.

CPAP and CPAP supplies are included in this program. Provider contracts were awarded to select Medicare providers and the contract suppliers must agree to accept assignment on all claims for bid items.

Temporary Gap Period
During the temporary gap, any Medicare enrolled DMEPOS supplier may furnish DMEPOS items and services to people with Medicare. In most cases, people with Medicare won’t need to switch suppliers.

- Suppliers must continue to furnish capped rental items through the remainder of the 13-month rental period. Title to the equipment must be transferred from the supplier to the patient after the end of the 13th month.
- Oxygen and oxygen equipment must be serviced throughout the remainder of the 36-month rental period, and the supplier must continue to provide oxygen and oxygen supplies for the remainder of the five-year reasonable useful lifetime of the oxygen equipment (exception to this is if the patient moves outside the supplier service area).

Educate Our Patients
Medicare is alerting beneficiaries to be aware of aggressive marketing by suppliers:

- Don’t let anyone persuade them to switch suppliers without talking to their existing provider first.
- Medicare/Medicaid will not send representatives to beneficiary homes to sell products or services.
- Be wary of advertising.

Round 2021 Updates
CPAP, RAD and CPAP supplies are one of the 16 product categories included in this next round of bids along with oxygen supplies. CMS is consolidating the competitive bidding areas (CBA). For a complete list of the Round 2021 CBA, you can view a ZIP code list on the DME competitive bid website.

Timeline
March 7, 2019
- The Centers for Medicare and Medicaid Services (CMS) begins the pre-bidding supplier awareness program

May 2019
- CMS announces dates for registration and bidding
- CMS begins the bidder education program

June 2019
- Bidder registration period to obtain user IDs and passwords begins
- Bid window opens

To stay current on the DMEPOS competitive bidding program, you can subscribe to email updates.