

VOLUME 9—NO. 1  
WINTER 2002

# AASM BULLETIN

THE BULLETIN OF THE AMERICAN ACADEMY OF SLEEP MEDICINE

## Medicare Fee Schedule for 2002

---

Academy Announces Mini-Fellowship Training  
Program in Sleep Medicine for International  
Physicians

Sleep and Fatigue Conference

FEATURE: Evidence-Based Medicine: Is It Here  
to Stay? by Michael Littner, M.D.

PRESORTED  
STANDARD  
US POSTAGE PAID  
ROCHESTER, MN 55901  
PERMIT NO. 719





## EDITOR'S NOTES

News events from the past six months have made everyone in America realize that, now more than ever, we live in a highly interconnected world. We simply can't ignore what's happening in other cities, or indeed, in countries half way around the world. Even

those events happening far away can directly affect our professional and private lives. On a smaller scale, the AASM is learning a similar lesson. As you will read in this issue, our organization is affected in very important ways by activities going on in Washington, across the country, and even in China.

The most important development coming out of Washington is the publication of new rules regarding reimbursement for nasal CPAP treatment, published by the Center for Medicare and Medicaid Studies (CMS). President John Shepard, who led the fight for change in the rules, provides a very thoughtful discussion in his column. Are the new rules perfect? No. Are they an improvement over the previous rules, based on empirical data, and better representing clinical reality? Unquestionably.

You will also find a summary of an interesting conference entitled, "Sleep, Fatigue, and Medical Education." Together with co-sponsors from the Sleep Research Society, the American Medical Association, the National Center on Sleep Disorders Research, and the Agency for Healthcare Research and Quality, the AASM reviewed data on sleep loss in medical trainees in order to develop an outline for future education, research, and intervention. A "white paper" will be published subsequently. This hot-button issue gives the AASM an opportunity to provide leadership for the broader medical community in the provision of high-quality medical care and high-quality medical training.

Our dealings with the larger medical community also involve more formal recognition of sleep medicine as a distinct specialty. One way of doing this is to gain recognition of our fellowship training programs by the Accreditation Council on Graduate Medical Education (ACGME). The AASM has begun a dialog with ACGME to prepare an application, as described in this issue. Look for further developments in coming months.

Another mark of legitimacy is recognition of sleep medicine as an important area for medical research. The update from the National Center on Sleep Disorders Research indicates that sleep research has continued its growth in funding from the National Institutes of Health. Excellent sleep medicine healthcare begins with high-quality sleep medicine research.

Finally, as the world's largest sleep medicine organization, the AASM has a responsibility to educate our colleagues around the world about the importance of sleep and sleep disorders. Dr. Edward Morgan reports on a recent Sleep Medicine and Polysomnography course held in Beijing. The AASM contributed educational materials to help make the conference a success. The International Affairs Committee will continue to look for ways to position the AASM as the leading organization for sleep medicine across the globe.

Wishing you all a healthy, happy, and successful 2002.

Daniel J. Buysse, M.D.  
Editor-In-Chief

# IN THIS ISSUE

## Winter 2002

VOLUME 9, ISSUE 1

President's Perspective 4-5

Letter to the President 6

### COMMITTEE UPDATES

AASM Committee Updates for Winter 2002 8-9

### RELATED ORGANIZATION NEWS

Sleep Medicine Education & Research Foundation 10

American Insomnia Association 10

American Board of Sleep Medicine 11

### NHLBI-NIH REPORT

NIH Requests for Applications 13

### MEMBER BENEFITS

Academy Announces Mini-Fellowship Training Program in Sleep Medicine for International Physicians 14

Personalized Brochure Campaign 16

International Affairs Committee to Sponsor Case Studies on International Sleep Centers 16

### CME NEWS/EDUCATION

Sleep and Fatigue Conference 17

Academy Reaccredited by ACCME for Another Four Year-Term 17

National Sleep Medicine Course Moves to North Dallas, Texas 18

### HEALTH POLICY/ GOVERNMENT AFFAIRS

You Have Questions? We Have Answers! 20

News Briefs 21

Medicare Physicians Fee Schedule for 2002 22

Summary of the Department of Health & Human Services (HHS) Guidance on HIPPA Privacy Regulations 23



**SLEEP MEDICINE & POLYSOMNOGRAPHY TECHNOLOGY COURSE, BEIJING, CHINA**—Edward J. Morgan, MD, PhD (a member of the AASM International Affairs Committee), made a formal presentation of the AASM materials to the Tongren Hospital Sleep Disorders Laboratory to Han Demin, MD, PhD, President of the Tongren Hospital.

### FEATURES

2001 Sleep Medicine & Polysomnography Technology Course 26-27

AASM Accreditation Continues to be the Gold Standard for Developing Programs 28

Evidence-Based Medicine: Is It Here to Stay? 29

### ADDITIONAL NEWS

Viewpoint 30

New AASM Accredited Sleep Disorder Centers and Laboratories 32

Fellowship Training: ACGME Recognition 33

Accreditation Briefs 36

National Sleep Research Plan to be Revised 40

### CLASSIFIEDS

Calendar of Events, Positions Available, Sleep Fellowships, Announcements 41-42

AASM Bulletin: The Newsletter of the American Academy of Sleep Medicine, Vol. 9, No. 1, Winter 2002

Editor: Daniel J. Buysse, M.D., Past President; Associate Editor: Lawrence J. Epstein, M.D.

Production Editor: Thomas Meyer; Production Assistant: Adrienne Schwarte, Advertising Sales Representative: Ryan Seaton

Editorial Advisers: John W. Shepard, Jr., M.D., President; Andrew L. Chesson, Jr., M.D., President-Elect; Jerome A. Barrett, Executive Director  
American Academy of Sleep Medicine, 6301 Bandel Road, Suite 101, Rochester, MN 55901

phone: (507) 287-6006, fax: (507) 287-6008, e-mail: aasm@aasmnet.org, Web site: http://www.aasmnet.org

**ADVERTISING POLICY:** Acceptance of advertising for a product or service in this issue does not constitute an endorsement or approval by the AASM of the quality or value of the advertised item or of the claims made by the advertiser. Professional products and services are accepted subject to editors' approval. The AASM Bulletin reserves the right to refuse any advertisement deemed unacceptable for accuracy, content, or appearance. The AASM Bulletin does not honor advertising agency discounts.



# PRESIDENT'S PERSPECTIVE

By John W. Shepard, Jr., M.D., AASM President

## Patience, Persistence and Progress

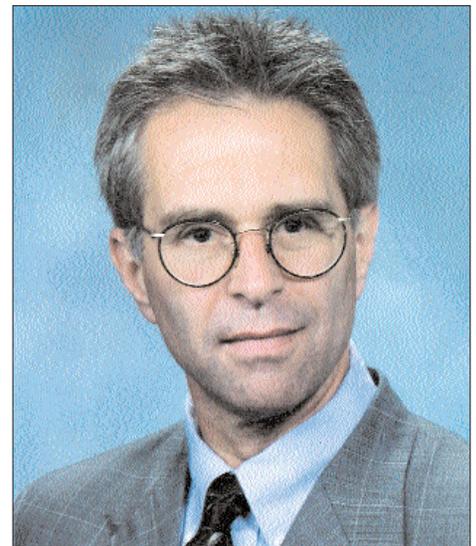
**Good news!** The 30-apnea rule has been changed. **Bad news:** not everyone agrees or is pleased by the changes. The politics of promoting policy reform has required both patience and considerable persistence in order to achieve the progress recently announced by the Centers for Medicare and Medicaid Studies (CMS, formerly HCFA). On October 30, 2001, CMS published new rules that will govern reimbursement for nasal CPAP under the Medicare and Medicaid programs on their web site. I would encourage everyone to visit <http://www.hcfa.gov/coverage/download/8b3-bbb1.rtf>, download a copy of the new policy (see below), and read the excellent summary document reviewing the evidence and thought process that resulted in the revisions.

Before I address some of the comments that we have received regarding the new policy, I will briefly review the efforts made by the AASM over the past five years. The problems resulting from the 30-apnea rule were initially brought to the attention of our Health Policy Committee by Dr. David Franco. Working in concert with Dr. Baldwin Smith, the Health Policy Committee and then AASM President Dr. David White, a letter was sent to HCFA on April 17, 1997 requesting that changes be made to the existing 30-apnea rule. Because of a lack of action, Dr. Stuart Quan, then AASM President, wrote HCFA in March 2000 again requesting changes to the 30-apnea rule. On May 21, 2000, I became involved as a member of the AASM delegation under the leadership of then AASM President Dr. Dan Buysse that visited HCFA to present our rationale for

the inclusion of hypopneas in the definition of obstructive sleep apnea.

While the results of this meeting were very discouraging, we did learn that there were two issues of critical concern to HCFA. First, hypopnea would have to be explicitly defined as well as accurately and reproducibly measurable. Second, that scientific evidence must exist linking OSA to serious adverse medical outcomes in order for them to justify reimbursement. With these issues in mind and knowledge that the Sleep Heart Health Study (SHHS) provided important relevant information, Dr. Conrad Iber worked with Dr. Amy Meoli, chair of the Clinical Practice Committee, to develop an AASM position paper entitled, "Hypopnea in Sleep-Disordered Breathing in Adults (1)". By endorsing the criterion of at least a 4% oxygen desaturation in the definition of hypopnea used in the SHHS, this AASM position paper achieved our combined objectives. It provided an accurate and reproducible definition of hypopnea as well as important linkage to the adverse clinical outcomes of hypertension and cardiovascular disease. Much careful thought, debate and discussion of alternatives occurred before the Board of Directors accepted this definition of hypopnea.

On July 24, 2001, Mr. Jerome Barrett, Dr. Peter Gay, AASM lobbyist Ellen Riker and myself met with Dr. John Whyte and members of his staff at CMS. We again presented our recommended changes to the policy on nasal CPAP reimbursement. We were well received and encouraged by their increased knowledge and understanding of the problem. Letters in support of our recommendations quickly followed from the American Thoracic Society, American College of Chest Physicians, Nation-



al Sleep Foundation, American Sleep Apnea Association and National Association of Medical Directors of Respiratory Care. In general, there has been a very favorable response to the new CMS policy that covers reimbursement if either of the following criteria is met:

### CMS Policy Guidelines for nasal CPAP reimbursement

AHI  $\Rightarrow$  15, or

AHI  $\Rightarrow$  5 and  $\leq$  14 with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorder or insomnia, or documented hypertension, ischemic heart disease or history of stroke.

The AHI is equal to the average number of episodes of apnea and hypopnea per hour and must be based on a minimum of 2 hours of sleep recorded by polysomnography using actual recorded hours of sleep (i.e. the AHI may not be extrapolated or projected). Two hours of recorded sleep is consistent with current practice.

Apnea is defined as a cessation of airflow for at least 10 seconds. Hypopnea is defined as an abnormal respiratory event lasting at least 10 seconds with at least a 30% reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a 4% oxygen desaturation.

The polysomnography must be per-

formed in a facility-based sleep study laboratory, and not in the home or in a mobile facility.

Following the publication of these guidelines, I sent a letter to Dr. John Whyte expressing our appreciation for new guidelines and complimenting both him and his staff on the excellent decision memorandum.

In addition to the generally positive comments, I have received a number of letters expressing disappointment about our decision to focus on desaturations and cardiovascular consequences rather than nocturnal arousals and daytime sleepiness as recognized consequences of OSA. Dr. Joe Modrak, whose letter is reprinted on page 6, has concisely raised this important issue. Clinicians recognize that patients use nasal CPAP when it improves the quality of their nocturnal sleep and enhances daytime alertness. In contrast, the government justifies the expenditure of society's resources when scientific evidence points toward a reduction in cardiovascular morbidity and/or mortality.

Moving forward, we now need to ask ourselves whether the new CMS policy is appropriate for all patients with sleep disordered breathing.

The problem arises in symptomatic (hypersomnolent) patients in whom sleep may be highly fragmented but who do not meet the requirement for apneas (complete cessation of ventilation) or hypopneas because they do not desaturate by at least 4%. There are a considerable number of these patients and they are commonly diagnosed as having sleep disordered breathing (SDB), either OSA without desaturation or upper airway resistance syndrome. Because they are often less obese and younger in age, their lung function, oxygen stores and baseline arterial oxygen saturations are greater. This prevents their oxygen level from falling sufficiently to meet the 4% criteria to score events as hypopneas. Despite having an AHI < 5 per hour, these patients may be significantly

hypersomnolent and at risk for motor vehicle or other types of accidents that may result from impaired alertness.

Consequently, most practitioners of sleep medicine feel it is important that insurance companies provide reimbursement for nasal CPAP in younger individuals with SDB who do not qualify for a diagnosis of OSA based on less than 4% desaturations with their hypopneas. It is very important to remember that the scientific evidence derived from the SHHS was based on analyzing the data in a population whose mean age was approximately 65 years. Gas exchange and lung function is known to decrease with age while weight increases. Because of these physiological events, older and heavier subjects will desaturate more readily with apneas and/or hypopneas. Therefore, to apply reimbursement criteria derived from data obtained in older patients to younger individuals is not appropriate.

In addition, it may be economically counter-productive for health insurance companies not to cover nasal CPAP therapy for patients with SDB without desaturation (UARS) as motor vehicle accidents related to sleepiness may be more costly than preventing them by using CPAP therapy to enhance alertness. Furthermore, individuals purchasing their own health care insurance have the right to request coverage for effective therapies that alleviate disabling symptoms and risk from accidents related to excessive sleepiness. The AASM will continue working to make certain that patients with SDB without desaturation will remain eligible for reimbursement for nasal CPAP therapy.

In other areas I am pleased to announce that the AASM has been awarded 4 years of accreditation (maximum allowable) by ACCME for its continuing medical education programs. Special thanks go to Dr. Daniel Glaze chair of the CME Committee along with Dr. Stephen Sheldon (Board Liaison) and Jennifer Markkanen (Administrative Support) for this meritorious achievement.

Dr. Barbara Phillips is currently working with multiple members of the Board of Directors to complete our application for submission to ACGME requesting approval for one year Fellowships in Sleep Medicine. This will require a major effort on the part of many individuals. If anyone has experience in this area and would like to help, please contact Dr. Phillips or myself.

The AASM co-sponsored a highly successful Workshop on Sleep, Fatigue and Medical Training October 28-29 with the SRS, AMA, NCSDR and AHRQ. Thanks to Drs. Daniel Buysse, David Dinges, Judith Owens, Allan Pack, Ray Rosen, Sigrid Veasey and our colleagues at the AMA, AHRQ, and NCSDR who devoted many hours to making this workshop a tremendous success. See article on page 16.

Finally, our strategic planning process under the direction of Dr. Andrew Chesson is nearing completion as is the background work of the Health Policy Committee chaired by Dr. Baldwin Smith in preparation for the AMA Practice Expense Advisory Committee (PEAC) meeting scheduled for this January.

My wish to you for the coming year is for 8 hours of great sleep every night.

**Reference:**

1. Clinical Practice Review Committee. Hypopnea in Sleep-Disordered Breathing in Adults. *SLEEP* 24:469-470, 2001

# Letter to the President

Dear Dr. Shepard,

I was disappointed that you used only cardiovascular health impacts of OSA to justify a change in the 30 apnea rule. The most important rationale for treatment is to eliminate excessive sleepiness and this was not even mentioned in your letter.

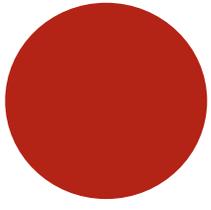
Also if you used this rationale then we could be able to use arousals to help define hypopneas and not be so dependent on desaturations. There are now a number of good studies using arousals to help define hypopneas that have shown benefit for treatment of mild OSA in

symptomatic patients. OSA is much more than its effects on cardiovascular health and we should be careful that we don't box ourselves in by defining the importance of treatment solely on the basis of preventing cardiovascular disease. I appreciate all that the AASM is trying to do to change this misguided rule but lets make sure that we educate about all the morbidities associated with OSA and not just the cardiovascular ones.

Sincerely,

**Joe Modrak, M.D.**  
Strong Sleep Disorders Center  
University of Rochester  
Rochester, NY

# COMMITTEE UPDATES



## Accreditation Committee

The accreditation committee has approximately 65 applications in process for accreditation through the AASM. Sixty-three percent of those applications are applying for reaccreditation and the others are new applicants. The total number of facilities accredited by the AASM is currently 566. A total of 137 facilities have gone through the accreditation or reaccreditation process in 2001. Additional information on accreditation and the committee's activities can be found on pages 28 & 36.

## Behavioral Sleep Medicine

### Presidential Committee

In the last issue of the Bulletin the BSM Committee requested input from the AASM membership on the BSM training program. That input has been received and is under review by the committee. The next stage for the committee is to create an examination subgroup that will be responsible for assembling questions in an effort to develop and maintain a Behavioral Sleep Medicine examination.

## Clinical Practice Review Committee

The main focus of the Clinical Practice Review Committee continues to be on a paper regarding anesthesia use on patients with obstructive sleep apnea when surgery is performed.

## Continuing Medical Education Committee

Reaccreditation for CME was approved by the Accreditation Council for Medical Education (ACCME). The AASM continues to be able to offer CME credits for another four years. If you would like to have the AASM sponsor CME credit for an educational activity please contact the National Office. For more information on ACCME and obtaining CME credit please refer to pages 17 and 42.

## Fellowship Training Committee

Fellowship Training Committee efforts are focused on the recruitment of new training programs, the evaluation of the current program requirements, and the matching of those guidelines with the ACGME structure. There are currently 29 accredited programs with two programs in the application process. For additional information on the pursuit of ACGME accreditation please refer to page 33.

## Government Affairs Committee

The Government Affairs Committee and the AASM leadership have been working with the AMA on the 2002 physician fee schedule. The focus of these efforts is to reduce the impact of the 5.4% reduction in RVU's. The 2002 Election year is here and the Government Affairs Committee will be actively reviewing candidates who support the field of sleep medicine. Once the review and ranking of these candidates is complete recommendations of support will

be requested to the Board. This in turn will put your PAC contributions to work for you.

## Health Policy Committee

The AASM will be sending representatives from the Health Policy Committee to the PEAC to review CPT code 95810 (and family 95811, 95808, and 95807). A business practices course was submitted to the APSS Program Committee for consideration in the 2002 APSS Annual Meeting. The objectives of this course are to discuss issues pertinent to opening and running a sleep disorders center, provide resources to run a more efficient sleep center, and answer questions for individuals who have recently started a sleep disorders center. The course is expected to last a full day. For more information on the Health Policy Committee's activities on CPT codes, reimbursement payments, and the *Health Policy Question & Answer* section please refer to pages 20 and 21.

## International Affairs Committee

The International Affairs Committee has developed a Mini-Fellowship Training Program for International Physicians. The Committee is also requesting that interested clinicians and researchers submit case studies for an informal discussion group slated to be held at the 2002 APSS Annual Meeting. For more information on these programs please refer to pages 14 and 16.

## Medical School Education Committee

The Medical School Education Committee continues to review and update the Sleep Academic Awards. These resources are available through the AASM website at: <http://www.aasmnet.org/MEDSleep/medsleephome.HTM>

## Membership Committee

The Membership Committee would like to remind you that it is once again time to renew your membership with the AASM. The AASM has made available the ability to renew your membership online at: <http://www.aasmnet.org/Membership/dept1.asp>. Any questions regarding your membership can be directed to Greg Mader at the National Office (email: [gmader@aasmnet.org](mailto:gmader@aasmnet.org) or phone 507-285-4373). Center members should look for information regarding the 2002 personalized brochure campaign to arrive in the mail this month. Individual members wanting information on this popular campaign may call Ryan Seaton at 507-285-4393. See the article regarding the campaign on page 16.

## National Sleep Medicine Course Committee

The National Sleep Medicine Course Committee efforts are focused on the 2002 course and the development of an advanced sleep medicine course. The upcoming year's course will be changing venues to allow more participants. Please refer to page 18 for more details.

## Publications Committee

The Publications Committee continues to work on the update of the Insomnia slide set and this should be available in the spring of 2002. The Narcolepsy and Sleep Apnea slide sets are now available on CD-ROM. The Sleep Apnea slide set has incorporated new information into this product. The Committee is also working on the production of a video that will show patients undergoing in-laboratory polysomnography for the diagnosis and treatment of obstructive sleep apnea.

## Research Committee

*NCSDR Research Plan—Review and Recommendation:* The National Center on Sleep Disorders Research (NCSDR) is in the process of updating their current Research Plan. The AASM Board of Directors has invited the Research Committee to review this plan and offer comments on its success, as well as recommendations for the future plan.

*APSS Grant Writing Course:* A task force of the Research Committee, comprised of Drs. Beth Malow, Susan Redline, Edward Weaver, and Terri Weaver, have submitted a proposal for a four-hour postgraduate course to the APSS Annual Meeting. Pending acceptance by the Program Committee, the course will be offered on either Saturday, June 8, or Sunday, June 9. The course, entitled "Clinical Grant Writing for Career Development,"

pressure (APAP) have become available. Such devices continually adjust pressure, as needed, to maintain airway patency (APAP titration). This paper reviews the efficacy of auto-titrating CPAP (APAP) for treatment of obstructive sleep apnea.

*Sleep Diagnostics in the Home Update—* Research Triangle Institute is nearing completion of data extraction on the published literature for portable monitoring. The Evidence Review Committee has received the extracted data and scientific articles to begin the step of assembling the material for a draft of the background paper. Once the review paper is drafted the Guideline Committee will begin assembling the material for making guideline recommendations on sleep diagnostics in the home. The project is progressing and the Academy is looking forward to providing a sound evidence based medicine approach to the use of portable diagnostic tools in the home.

# AASM Board Meeting March 8-10

will be aimed at individuals new to the grant writing process. If accepted, further information on course objectives and registration will be printed in the APSS Preliminary Program.

## Standards of Practice Committee

New Practice Parameters and review from your Standards of Practice Committee, are to be published in the March 15, 2002, issue of *SLEEP*. This new practice parameter is titled, "Practice Parameters for the Use of Auto-Titrating Continuous Positive Airway Pressure Devices for Titrating Pressures and Treating Adult Patients with Obstructive Sleep Apnea Syndrome." The accompanying review is titled, "The Use of Auto-Titrating Continuous Positive Airway Pressure for Treatment of Adult Obstructive Sleep Apnea. An American Academy of Sleep Medicine Review." Recently, devices using new technology that automatically titrate positive airway

## Website Editorial Advisory Committee

The Website Editorial Advisory Committee has continued to make enhancements to the AASM website. These efforts have recently included the Classified Advertisement section that allows searchable job postings by location or position category. Another option that will soon be available online is the ability to post searchable resumes. The resume/C.V. will be uploaded to the AASM website as a PDF for viewing. The cost for posting a classified ad is \$150.00 and for posting a resume is \$75.00.

# ORIG NEWS

RELATED ORGANIZATION NEWS

The American Insomnia Associations (AIA) is a new organization that coordinates efforts and resources for persons who suffer from insomnia and those who treat patients.

## SLEEP MEDICINE EDUCATION & RESEARCH FOUNDATION

The 2002 Request For Proposals for Foundation Research Grant opportunities were released in November, 2001. This year the Foundation will fund up to five grants in two categories: young investigator and high risk. Each grant will be funded for \$30,000 per year for two years. Proposal deadline is January 15, 2002. Awards will be reviewed and results announced at the 2002

APSS Annual Meeting in Seattle.

The Foundation will also be sponsoring a fund-raising activity to further efforts in sleep medicine education and research. Please be watching the AASM list serves, the APSS web site and preliminary program for further details.

## AMERICAN INSOMNIA ASSOCIATION

The American Insomnia Association (AIA) was established to provide patients, clinicians, and researchers the opportunity to interact with each other. This new organization coordinates efforts and resources for persons who suffer from insomnia and those who treat patients. One main focus is to provide persons with insomnia support, advocacy, and education.

Several initiatives and plans are underway to further the goals of the AIA. These include a quarterly published newsletter, a web site with features such as updates on research and treatment options and a chat room, and the creation of a patient registry. Membership recruitment will be a top priority for 2002.

# AMERICAN BOARD OF SLEEP MEDICINE

## Changing Requirements

In light of its goal to encourage fellowship training in sleep medicine as the route to Board certification, the American Board of Sleep Medicine has adapted the following changes in the eligibility requirements:

Waiver 2, which is based on clinical experience in sleep without formal training, will be eliminated beginning with the examination cycle of 2003-2004. All applications for Waiver 2 are due by March 1, 2002. All training requirements under Waiver 2 must be completed by June 30, 2002. Applicants accepted for the examination under Waiver 2 must have successfully completed the Part II examination by the end of 2005, not withstanding any other requirements to the contrary.

Waiver 1, which is based on a combination of training and clinical experience in sleep medicine, will be changed beginning with the examination cycle of 2003-2004. All applications for Waiver 1 under the current requirements (12 months, which a minimum of six months shall be training under a Diplomate of the ABSM) are due by March 1, 2002. All training and clinical experience requirements under the current requirements for Waiver 1 (12 months) must be completed by June 30, 2002. Beginning with applications for the 2003-2004 examination cycle, this waiver will require 18 months of experience, or which at least six months full-time (or equivalent part-time) must be training under a Diplomate of the ABSM.

Waiver 1 will be eliminated beginning with the examination cycle of 2005-2006. All applications for Waiver 1 must be postmarked no later than March 1, 2004. All training requirements under Waiver 1 must be completed by June 30, 2004. Applicants accepted for the examination under Waiver 1 must have successfully completed the Part II examination by the end of 2007, not withstanding any other requirements to the contrary.

Successful completion of a sleep fellowship (regular or alternate track) accredited

by an organization recognized for this purpose by the ABSM will be required by candidates taking the ABSM examination beginning with the Part I examination of 2005. At present, the only organization so recognized is the American Academy of Sleep Medicine (AASM). All applications under regular or alternate tracks based on one year of training NOT accredited by an organization recognized for this purpose by the ABSM must be postmarked no later than March 1, 2004, all training requirements must be completed by June 30, 2004.

## Computerization of the Part II Exam

The ABSM is taking the first step towards computerization of the board exam by computerizing sections of the Part II examination, which will take place on April 8, 2002. The locations of the Part II examination will include Chicago, IL, Dallas, TX, Tampa, FL, and Tucson, AZ. The ABSM plans to computerize the entire exam by 2003.

## Important Dates and Deadlines

### 2001-2002 Exam Cycle

January 15, 2002

Deadline for receipt of Part II letter of intent and examination fee

### April 8, 2002

#### Part II Examination

June 15, 2002

Notification of Part II results

### 2002-2003 Exam Cycle:

March 1, 2002

Deadline for postmark on application and examination fee

July 1, 2002

Notification of Credentialing Committee decisions

### October 4, 2002

#### Part I Examination

January 1, 2003

Notification of Part I results

January 15, 2003

Deadline for receipt of Part II letter of intent and examination fee

### April 14, 2003

#### Part II examination

June 15, 2003

Notification of Part II results

# NATIONAL INSTITUTES OF HEALTH NATIONAL HEART, LUNG, & BLOOD INSTITUTE

## NIH Requests for Applications

The National Institutes of Health has recently announced several Requests for Applications that may be of interest to sleep and circadian researchers. Brief summaries and deadlines for each pertinent announcement are listed below. If you have any questions about any of these, please access the website listed under each program.

### 1. Bioengineering Research

a. Bioengineering Research Grants (PA-02-008). Supports basic, applied, behavioral, or clinical bioengineering research. You will find a complete list of the Standard Application Receipt Dates at <http://grants.nih.gov/grants/funding/submissionschedule.htm>. For further information, download the full text of the announcement from the website listed below, and contact the appropriate program staff listed under "inquiries."  
<http://grants.nih.gov/grants/guide/pa-files/PA-02-011.html>.

b. Bioengineering Research Partnerships (PAR-02-010) (R01 grants)  
<http://grants.nih.gov/grants/guide/pa-files/PA-02-010.html>. This program supports multi-disciplinary research team of bioengineering/allied quantitative scientists and biomedical/clinical investigators applying integrative, systems approaches to prevent, detect, diagnose, or treat disease or to understand health and behavior. Application Receipt Dates: January 24, 2002; August 12, 2002.

### 2. Informal Caregiving Research for Chronic Conditions (RFA-NR-02-001)

The National Institute of Nursing Research (NINR) and the National Institute on Aging (NIA) have announced a research program (R01) for the development of interventions to improve the health of caregivers and the burden of caregiving. Fatigue and sleep difficulties are thought to be significant problems in certain categories of caregivers. Topics of potential interest to sleep and circadian researchers include interventions that improve the caregiver's health and quality of life across and within different geographic, racial/ethnic, and recipient health conditions categories; interventions to assist caregivers to cope with personal lifestyle sacrifices; and interventions that improve the quality of caregiving outcomes. Application Receipt Date: February 26, 2002. For further information, download the full text

of the announcement from the website listed below, and contact the appropriate program staff listed under "inquiries."

<http://grants.nih.gov/grants/guide/rfa-files/RFA-NR-02-001.html>.

### 3. Elucidation of the Underlying Mechanisms of Placebo Effect (RFA-AT-02-002)

NIH has announced a program (R01 and R21) to investigate mechanisms by which a placebo leads to its ultimate physiological and psychological effects. Topics which may be of interest to sleep and circadian researchers include: the biological pathways (neurological, endocrinological, immunological) leading to specific placebo responses; and the development of animal models to study placebo effects related to analgesia, stress, depression, and drug abuse. Application Receipt Date: April 11, 2002. For further information, download the full text of the announcement from the website listed below, and contact the appropriate program staff listed under "inquiries."

<http://grants.nih.gov/grants/guide/rfa-files/RFA-AT-02-002.html>.

### 4. Ancillary Studies in Heart, Lung, and Blood Disease Trials (HL-00-012)

The National Heart, Lung, and Blood Institute (NHLBI) has announced an RFA program for mechanistic (not clinical) studies using ongoing heart, lung and blood related clinical trial cohorts. Selected areas of potential interest to sleep and circadian researchers include the pathogenesis of cardiopulmonary disease, diabetes, coagulation factors, vascular reactivity, and inflammation; and surrogate markers or biomarkers of disease activity and therapeutic effect. Remaining Application Receipt Dates: March 11 and June 10 of 2002. Further information can be obtained by downloading the full text of this announcement from the web site listed below, and by contacting the program staff listed there under "Inquiries."

<http://grants.nih.gov/grants/guide/rfa-files/RFA-HL-00-012.html>.

### 5. Plasticity of Human Stem Cells in the Nervous System (PA-02/025)

The National Institutes of Health has announced a program for Exploratory (R21) and Research Project (R01) grants to study the plasticity and behavior of human stem cells, and the regulation of their replication, differentiation and function in the nervous system. A selected topic of potential interest to sleep and

circadian researchers would be stem cells as promising candidates for the development of cellular and genetic therapies for neurological diseases, including sleep disorders. Find the full list of Standard Application Deadlines here: <http://grants.nih.gov/grants/dates.htm>. For further information, download the full text of the announcement from the website listed below, and contact the appropriate program staff listed under "inquiries."

<http://grants.nih.gov/grants/guide/pa-files/PA-02-025.html>.

### 6. Interaction of Genes and Environment in Shaping Risk Factors for Heart, Lung, Blood, and Sleep Disorders (RFA-HL-02-010)

The National Heart, Lung, and Blood Institute (NHLBI) has announced an RFA program (R01) to identify novel genes that interact with specific environmental exposures to modify risk factors for heart, lung, blood, and sleep (HLBS) disorders. A selected example of potential interest to sleep and circadian researchers includes genes influencing weight loss and change in sleep disordered breathing (SDB) in response to exercise. Application Receipt Date: March 22, 2002. For further information, download the full text of the announcement from the website listed below, and contact the appropriate program staff listed under "inquiries."

<http://grants.nih.gov/grants/guide/rfa-files/RFA-HL-02-010.html>.

### 7. Pathophysiology and Treatment of Chronic Fatigue Syndrome (PA-02-034)

The National Institutes of Health have updated a program announcement (R01) for grant applications on CFS. Selected topics of potential interest to sleep and circadian researchers include studies to identify the frequency and severity of sleep loss, impaired sleep and daytime sleepiness in CFS; elucidating the basic mechanisms in CFS contributing to impaired/ineffective sleep, altered sleep state, or altered circadian regulation; and studying the consequences of dysregulation in major physiological systems. Find the full list of Standard Application Deadlines here:

<http://grants.nih.gov/grants/dates.htm>.

For further information, download the full text of the announcement from the website listed below, and contact the appropriate NIH or NSF program staff listed under "inquiries."

<http://grants.nih.gov/grants/guide/pa-files/PA-02-034.html>.

# member benefits

## Academy Announces Mini-Fellowship Training Program in Sleep Medicine for International Physicians

by Mansoor Ahmed M.D., Chair, International Affairs Committee

**S**leep health care is a relatively new clinical discipline and is a grossly under served area of medicine in most countries. Many countries around the world lack adequate training and educational resources in sleep medicine. The Board of Directors is pleased to announce the establishment of the Mini-Fellowship Training Program in Sleep Medicine. The Mini-Fellowship program is developed to provide international physicians practical training in clinical sleep medicine so they can develop and/or improve sleep health care in their respective countries. This training program is open to all foreign physicians practicing outside of the United States. Four fellows will be selected the first year.

The mini-fellowship will consist of a four-week training program that includes three weeks experience at an accredited sleep center, which will encompass teaching and training for the fellow. The last week of the fellowship duration will be spent at the APSS Annual Meeting where the fellows have an opportunity to attend desired courses and academic sessions offered.

### SELECTION CRITERIA

Minimal qualifications for selection

1. Graduation from a nationally or regionally accredited medical education program AND licensure to practice medicine in their home nation.
2. Documentation of an active medical practice affiliation with a national or regional medical facility in their home nation.
3. A letter of recommendation to study sleep medicine from a senior faculty medical officer at the affiliated medical facility with an assurance that the applicant will practice this specialty in their home nation upon his/her return.
4. Financial support from their affiliated medical facility for the study visit with evidence of financial support for travel and personal expenses during the training period.
5. A one to two page letter describing the existing state of affairs of the practice of sleep medicine in their home country, detailing their own professional experience, and

reasons why the candidate is interested in sleep medicine. This information will be provided to the host center in order to begin setting up a curriculum.

6. A valid Passport from their home country and eligibility to obtain a Visa to travel to the US if selected.

Additional qualifications that the applicant may include with their application:

1. Copies of publications and/or experience related to the area of sleep medicine (pulmonology, neurology, psychiatry, etc).
2. Evidence of certification in a specialty area by a national or regional medical specialty group.
3. A letter of recommendation to study sleep medicine from a senior medical officer in the certifying medical specialty group.
4. A record of grants funded in content areas related to the medical area of sleep (pulmonology, neurology, psychiatry, etc).
5. Email/internet access. (The fellow will be able to maintain contact with his/her mentor and also have access to additional outside resources before/during/after the fellowship.)

Curriculum will be individualized for each fellow in order to match their individual educational needs. The fellow shall be given a brief examination that will provide a basic assessment of sleep knowledge at the beginning of the fellowship. Based on the performance on the examination and on the mentor's interview with the fellow, a schedule regarding the three-week training period will be formulated. At the end of the three weeks, the mentor again meets with the fellow, gives him/her a post-test and discusses further development with the fellow.

The last week of fellowship training will be spent at the APSS Annual Meeting. In addition to attending the scientific portions of the meeting, the fellows will be able to register for courses of their choice. Individuals accepted into the mini-fellowship program will also be given a select group of reference materials. The recipient candidate is responsible for expenses that include airfare, accommodations, and meals.

Applicants may connect with the Academy's website at [www.aasmnet.org](http://www.aasmnet.org) for application instructions.

## Personalized Brochure Campaign

Information regarding the 2002 Personalized Brochure Campaign will be mailed to member centers this month. The campaign is your opportunity to team with the Academy to promote your practice and publicize your services.

Member centers have the opportunity to purchase AASM produced brochures with information specific to their sleep program imprinted on the back panel of any of the twenty-one patient educational brochures. We are introducing three new brochures with this year's campaign! The newest Academy brochures are "Drowsy Driving", "Sleepwalking and Other Childhood Parasomnias", and "Teenagers, Young Adults and Sleep".

Member sleep centers may highlight their address, phone numbers, websites and staff and many provide patients with a map showing the location of their facility.

Individual members are able to promote the name and specific information about their practice on brochures (but may not list a sleep center that is not a current member of the Academy). Last year, the Academy imprinted over 400,000 personalized brochures for members and have imprinted more than two million brochures since the inception of this membership benefit.

Personalized brochures will be sold at the discounted rate of 36-cents each through April 1, 2002, which is a further discount beyond the regular member discounted price of 40-cents. *You will save \$40 on an order for just 1,000 brochures!* All brochures must be ordered in lots of 100 and the minimum total order is 500 brochures. Orders received after April first will be surcharged an additional 10% to the regular 40-cent price. Since the ten percent discount is limited to the January-April window, you are encouraged to print enough brochures for the entire year of

2002, however you may reprint at any time during the year.

Individual members wishing further information or order instructions may contact Ryan Seaton at 507-285-4393. **Center members should watch for your personalized brochure order kit in the next few weeks!**

## International Affairs Committee to Sponsor Case Studies on International Sleep Centers

The American Academy of Sleep Medicine's International Affairs Committee requests that interested clinicians and researchers submit case studies for an informal discussion group that will be held at the 16th Annual APSS Meeting in Seattle, June 8-13.

This special session will be dedicated to members' shared experiences of starting and running a sleep center. Any individual who has first hand experience in establishing a sleep center or operating a sleep center in countries outside the United States or any individual who has visited such a program is encouraged to submit an application to present their work. Presentations will be limited to ten slides.

This educational forum is sponsored by the International Affairs Committee in order to educate the Academy's membership of the desires and needs of sleep clinicians who are in the forefront of establishing sleep centers in areas of the world where sleep medicine is in its infancy and sleep technology hardware is in short supply.

This year's presentations will represent the third year of the forum. Presentations from the previous two years have resulted in lectures regarding sleep centers in the countries of Japan, Egypt, Israel, England, and the People's Republic of China.

You may obtain a presenter form by contacting the National Office at 507-287-6006 fax: 507-287-6008 or email [gmader@aasmnet.org](mailto:gmader@aasmnet.org). The Committee looks forward to your submission and hopes to hear your presentation during the APSS Meeting in Seattle.

## SLEEP AND FATIGUE CONFERENCE

“Sleep & Fatigue and Medical Training: Optimizing Learning and the Patient Care Environment”

Nearly 100 nationally recognized experts attended the "Sleep, Fatigue and Medical Training: Optimizing Learning and the Patient Care Environment" conference that was held October 28th and 29th in Alexandria, Virginia. Participating members included experts in sleep research, sleep disorders medicine, educators, resident physicians, medical students, patient safety advocates, and other healthcare professionals.

The conference, co-sponsored by the American Academy of Sleep Medicine, the Sleep Research Society, the American Medical Association Council on Medical Education, and the National Center on Sleep Disorders Research (National Heart, Lung, and Blood Institute, NIH), was supported by a conference grant from the Agency for Healthcare Research and Quality. Funding was also provided by the National Center for Sleep Disorders Research and the other sponsoring organizations.

The group came together to review existing data and discuss the potentially serious effects of sleep deprivation and fatigue in a learning and patient care environment by resident physicians. The conference also identified gaps in the existing data and identified areas where more research is needed. Two principle objectives were maintained throughout the conference: enhance the quality of patient care and preserve the integrity of graduate medical education.

Day one was filled with scientific based presentations supported by published data in leading medical and research journals. Much of the information presented was the result of years of research on sleep deprivation and performance collected from studies of other professions. While similar information, where available, was presented on the effects of sleep deprivation in medical settings, there have not been comparable research studies conducted.

Day two, the participants met independently in four working groups to chart a course of action which the organizations believe is necessary to craft solutions that are in the best interest of the patients, resident physicians and the healthcare system. The working groups included: Research Implications, Educational Implications, Patient Safety Implications, Medical Student and Resident Implications.

A formal report addressing the discussion, findings, and recommendations is in process and is scheduled to be available Spring 2002. For more information regarding the conference or the follow-up report, contact Charlene Wibben, Senior Director of Administration and Special Services at 507-285-4374 or by e-mail at cwibben@aasmnet.org.

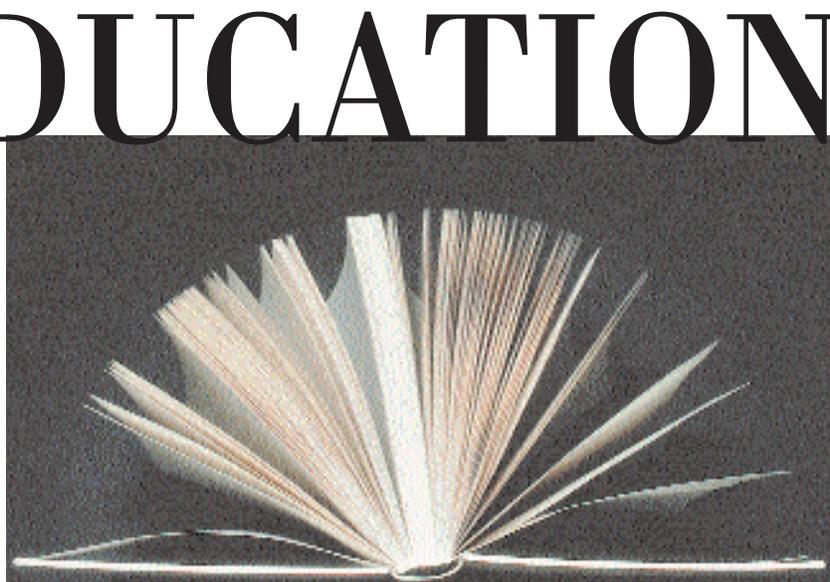
## ACADEMY REACCREDITED BY ACCME FOR ANOTHER FOUR YEAR TERM

The Academy was recently notified of its reaccreditation status granted by the Accreditation Council for Continuing Medical Education (ACCME). The AASM received approval for the standard 4-year accreditation term and was in compliance in all Essential Areas and Elements as required by the ACCME. In order to be reaccredited by the ACCME, the AASM was required to complete a detailed self study report documenting the activities sponsored for credit over the last 4 years and conduct a reverse site visit/interview at the ACCME offices in Chicago, IL. This process began last spring and concluded in November with notice of our approval.

The Continuing Medical Education Committee approves category 1 credit for the National Sleep Medicine Course, the APSS Annual Meeting, the journal *SLEEP*, and various other activities that arise throughout the year.

EDUCATION NEWS CONTINUED ON PAGE 18

CM  
E  
EDUCATION  
NEWS



# NATIONAL SLEEP MEDICINE COURSE MOVES TO NORTH DALLAS, TEXAS

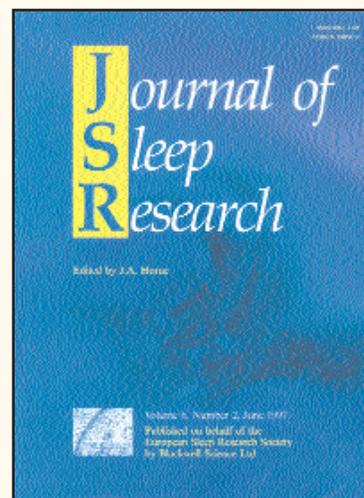
The 2002 National Sleep Medicine Course (NSMC) will be August 10-14, at The Westin Stonebriar Resort in North Dallas, TX. After meeting for several years in Virginia and in order to meet the needs of those preparing for the sleep board exam, the Academy elected to relocate the course to a more central venue that is better suited for a larger group of people. As a result, the NSMC will be open to 250 registrants in 2002, the largest audience ever. Registration information will be available early this spring. Watch for updates on how you can attend this highly regarded educational event!

The National Sleep Medicine Course Committee recently conducted a needs assessment of 150 board certified sleep specialists to determine the interest for an advanced sleep medicine course. The responses were overwhelmingly in favor of an advanced course. As such, the Committee plans to implement this course in the winter of 2003, tentatively planned to be held in San Antonio, TX or Phoenix, AZ.

## JOURNAL OF SLEEP RESEARCH VOLUME 11 (2002) 4 ISSUES

American Academy of Sleep Medicine and Sleep Research Society members (2002 membership fees paid) may subscribe to the *Journal of Sleep Research* for \$68.00 through special arrangements with the European Sleep Research Society. Sponsored by the ESRS, the *Journal of Sleep Research* is an international journal that encourages important research papers presenting new findings in the field of sleep and wakefulness. The regular subscription rate to the *Journal of Sleep Research* for US and Canadian subscribers is \$332. Orders must be received in the national office by February 20, 2002. Subscription payments (US checks, US dollars) in the amount of \$68.00 should be made payable to the AASM and include your name and mailing address. Please mail to:

American Academy of Sleep Medicine  
*Journal of Sleep Research*  
6301 Bandel Road, Suite 101, Rochester, MN 55901



Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

# February 2002

Association Name	Meeting Name	Dates	Location
National Institute on Alcohol Abuse & Alcoholism	Advisory Council Meeting	February 7	NIH
Sleep Research Society	Board of Directors Meeting	February 7	Conference Call
National Heart Lung and Blood Institute	Advisory Council Meeting	February 7—8	NIH
National Institute of Neurological Disorders and Stroke	Advisory Council Meeting	February 14—15	NIH
American Association for the Advancement of Science	Annual Meeting	February 14—19	Boston, MA
National Institute on Drug Abuse	Advisory Council Meeting	February 20—21	NIH

# March 2002

Association Name	Meeting Name	Dates	Location
Sleep Research Society	Board of Directors Meeting	March 7	Conference Call
American Academy of Sleep Medicine	Board of Directors Meeting	March 8—10	Naples, FL

# April 2002

Association Name	Meeting Name	Dates	Location
National Sleep Foundation	National Sleep Awareness Week	April 1—7	Washington, DC
Society of Behavioral Medicine	Annual Meeting	April 3—6	Washington, DC
Sleep Research Society	Board of Directors Meeting	April 4	Conference Call
American Board of Sleep Medicine	Part 2—Board Exam	April 8	Multiple Locations

of events

FOR

YOU HAVE QUESTIONS? WE HAVE ANSWERS!

**Q** • What is happening with Medicare's hospital outpatient department prospective payment system?

**A** • The first year of the Medicare Hospital Outpatient PPS seemed to come and go without much complaint. While neither hospitals nor physicians were entirely comfortable with the Ambulatory Patient Care Groupings (APCs), CMS at Congress' direction had established a generous system of pass-through payments (additional payments) for technologies, drugs and other high cost services. However, with the publication of the rule for the hospital outpatient department system in 2002, the hospital industry has raised concerns. CMS plans to significantly reduce pass through payments for drugs and devices.

Sleep testing codes 95805, 95807, 95808, 95810 and 95811 are included in APC 0209. The hospital facility payment for this APC is \$536.53. The unattended sleep study is in APC 0213, which pays a facility fee of \$134.90. The APC rates do not include the professional component fee that the physician bills separately.

CMS announced in December that the new APC rates and the other changes in hospital outpatient system detailed in the November 2nd rule would not be implemented until April 1, 2002. The American Hospital Association and other hospital groups have threatened to sue CMS over the lack of notice and opportunity to comment on these changes. AASM will notify its members of any further changes or delays in the outpatient system.



# Newsbriefs

---

## **CPT Assistant - Correction:**

In the November 2001 issue (Volume 11) of the *CPT Assistant* there was an error on page 15. The table on page 15 indicates that CPT Code 95805 - MSLT is being deleted. The AASM has followed up the AMA and have been notified that 95805 is not scheduled to be deleted. This error will be corrected in the next issue of the *CPT Assistant*.

## **CPT Code 99508**

### **Home Visit for Polysomnography and Sleep Studies**

At the AMA's Annual CPT/HCPAC meeting CPT Code 99508 - Home Visit for Polysomnography and Sleep Studies conducted by a non-physician was reviewed. It was pointed out that this code is exceedingly vague and does not define whether it is a simple hook-up or for continuous monitoring, nor does the code provide whether the service is in an unattended or attended environment. Currently CPT Code 95806 describes a sleep study unattended by a technologist. The CPT Editorial Panel recognized the redundancy that would exist with CPT Code 99508 and recommended that it be removed.

## **CMS October 30th Decision—Medicare 30 Apnea Rule**

The long awaited revisions to Medicare's coverage policy on Continuous Positive Airway Pressure (CPAP) occurred on October 30, 2001. Following significant pressure from American Academy of Sleep Medicine (AASM), the Centers for Medicare and Medicaid Services (CMS) has agreed to update its coverage criteria for Continuous Positive Airway Pressure for the treatment of Obstructive Sleep Apnea. The complete coverage criteria and CMS' decision memo can be found at their website:

<http://www.hcfa.gov/coverage/download/8b3-bbb1.rtf>

John W. Shepard, Jr., MD, President of the AASM, with members of the Health Policy Committee, met with the CMS coverage policy staff earlier this year to reiterate AASM's concerns with the "30 apnea rule." AASM has been asking for the revision of this policy for several years. Dr. Shepard provided CMS with the best available clinical information on the treatment of Obstructive Sleep Apnea (OSA). AASM sought specific revisions to the existing policy related to the inclusion of hypopneas in assessing OSA, and a definition of a hypopnea. Many of AASM's recommendations were adopted by CMS.

CMS' recommendations are as follows:

CMS will revise the National Coverage Decision for CPAP for the treatment of OSA (CIM 60-17) to the following: CPAP will be covered under Medicare in adult patients with OSA if either of the following criteria is met:

- (1) AHI  $\geq 15$ , or
- (2) AHI  $\geq 5$  and  $\leq 14$  with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders or insomnia, or documented hypertension, ischemic heart disease or history of stroke.

The AHI is equal to the average number of episodes of apnea and hypopnea per hour and must be based on a minimum of 2 hours of sleep recorded by polysomnography using actual recorded hours of sleep (i.e. the AHI may not be extrapolated or projected). Two hours of recorded sleep is consistent with current practice. Apnea is defined as a cessation of airflow for at least 10 seconds. Hypopnea is defined as an abnormal respiratory event lasting at least 10 seconds with at least a 30% reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a 4% oxygen desaturation. The polysomnography must be performed in a facility-based sleep study laboratory, and not in the home or in a mobile facility.

CMS is in the process of notifying DME Carriers of the policy change. CMS has not determined an effective date for this policy change. CMS announced the effective date will be April 1, 2002.

## **Update—2002 Physician Fee Schedule**

In November, the Centers for Medicare and Medicaid Services (CMS) announced that the 2002 conversion factor for the Medicare physician fee schedule would be cut by 5.4%, from \$38.26 to \$36.20. This reduction is due to the fact that the formula for the conversion factor is based on changes in the Gross Domestic Product which has declined over the past year.

The conversion factor is the same for all physician services. It is multiplied by the relative value units assigned each CPT code to determine Medicare payment.

The Academy joined the AMA and other specialty societies in asking Congress to address this issue. The AASM supported two bills S.1707 and H.R.3351 which would have trimmed the reduction in Medicare's 2002 physician conversion factor to 0.9%. Unfortunately, Congress did not take up either bill before the session ended in late December.

## **2002 AASM PAC Event**

The AASM PAC is planning a breakfast fund raising event that will be held at the 2002 APSS Annual Meeting in Seattle, WA. The event is tentatively scheduled for Sunday morning, June 9th. The Government Affairs Committee is planning to invite a member of the Washington state congressional delegation to discuss health-care issues and allow questions and answers. Additional information will be available when the plans are finalized. If you are interested in attending, you will be able to sign up on the 2002 APSS Annual Meeting registration form (available March 1st).

# MEDICARE PHYSICIAN FEE SCHEDULE FOR 2002

The Centers for Medicare and Medicaid Services published the final values for physician services for 2002. At the request of the AASM, the rank order anomaly in the relative values for CPT codes 95808, 95810 and 95811 have been corrected. This year is also the last year in the transition to the fully phased in practice expense values for all physician services. Chart 1 shows the relative value units for the global bills for all sleep services.

Chart 2 is an estimate of the national average payments for sleep services in 2001 and 2002.

The 2002 estimate is based on a conversion factor of \$36.20, which was published in the Federal Register in November. This conversion factor represents a reduction of 5.4% from the 2001 level. AASM and other specialty societies worked with AMA to support legislation in the House and Senate to minimize this reduction. At press time, it is unclear if Congress will pass this legislation, which would set the conversion factor at \$37.90, before the end of the year.

## Practice Expense Relative Value Units—Chart 1

Final Values from the November 1, 2001 Federal Register

Code <sup>1</sup>	Description	Current 2001 Values	Proposed 2002 Values	Final 2002 Values
95805	MSLT	7.25	7.82	5.89
95806	Sleep Study, Unattended	3.08	1.74	4.31
95807	Sleep Study, Attended	10.34	10.85	10.70
95808	Polysomnography, 1-3	15.51	19.34	9.54
95810	Polysomnography, 4+	13.83	16.46	16.92
95811	Polysomnography, w/CPAP	13.04	14.73	17.19

<sup>1</sup>the listed PE RVUs are for global component

## Comparison of Average Medicare Payment for Sleep Medicine Services—Chart 2

CPT Codes	YR 2001 Payment (Conversion Factor - \$38.26)	YR 2002 Payment (Conversion Factor - \$36.20)
95805	\$362.32	\$293.58
-26	\$99.48	\$95.57
-TC	\$262.85	\$198.01
95806	\$200.10	\$227.70
-26	\$106.75	\$82.90
-TC	\$ 93.35	\$144.80
95807	\$474.42	\$461.91
-26	\$ 99.86	\$82.17
-TC	\$374.56	\$379.74
95808	\$711.64	\$457.21
-26	\$156.87	\$135.03
-TC	\$554.77	\$322.18
95810	\$682.18	\$757.30
-26	\$199.72	\$177.74
-TC	\$482.46	\$579.56
95811	\$663.05	\$777.58
-26	\$213.87	\$190.77
-TC	\$449.17	\$586.80

# SUMMARY OF THE DEPARTMENT OF HEALTH & HUMAN SERVICES (HHS) GUIDANCE ON HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) PRIVACY REGULATIONS

The Department of Health and Human Services (HHS) has begun to inform interested parties about the implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) - Privacy Rules. On July 6th, the first guidance document was published to clarify some of the provisions of the privacy regulations. The first guidance can be accessed at <http://www.hhs.gov/ocr/hipaa>.

As background, on April 14, 2001 Secretary of Health and Human Services (HHS), Tommy Thompson, and President Bush finalized the Privacy Regulations to protect personally identifiable medical information. These privacy regulations resulted from the passage of the HIPAA. The rule allowed for a two year period for covered entities to become compliant. Physicians will be required to follow these regulations by **April 14, 2003**. Other groups covered under this regulation include health plans, and health care clearinghouses.

The following is a general summary of certain sections of the July 6th guidance document.

## General Requirements for Physicians

*The average provider will be expected to inform their patients of their rights regarding their medical information and how that information will be used. A physician will need to ensure the security of their patients' medical information so that any person without clearance or a need to see such information will not have access.* This would include persons who are not involved in the treatment, payment and health care operations for the patient (TPO). A provider will need to have privacy procedures for their practice and ensure that their employees understand and abide by those procedures. Within a practice, there will need to be a person responsible for the adoption of the practice's privacy procedures. The privacy regulations do not provide a strict outline for privacy pro-

cedures because it is understood that practices vary by size and need.

## Consent

*Consent is a general document that gives a provider permission to use and disclose protected health information (PHI) to carry out treatment, payment, and health care operations (TPO).* Consent is mandatory, but a provider is not required to provide treatment to an individual who refuses to sign a consent form. Consent obtained before the compliance date of April 14, 2003 can be still be used and new consent is not required. Providers should keep the signed consent for six years from the last day the consent is in effect.

An exception to the prior consent requirement is when there is an emergency situation where taking time to obtain consent would jeopardize the patient's care. The provider should gain consent as soon as possible after the patient is stabilized.

A patient can revoke their consent if it is done in writing. If a patient revokes consent after receiving treatment, the provider is allowed to disclose PHI to obtain payment for that service.

For other disclosures of PHI, including providing information directly to a family member, a provider will need to obtain an authorization from the patient. Authorization would be needed to give information to a third person as requested by the patient and would require an expiration date.

## Minimum Necessary

Providers must ensure that only the minimum necessary amount of information should be disclosed. This minimum necessary provision is exempted for disclosure of PHI for treatment purposes. *The office policies that providers will be required to have should list which office personnel should have access to which pieces of PHI for routine disclosures.* The reasons for disclosure of a complete medical record

should be included in the office privacy policy. Non-routine disclosures should be handled in a case by case manner.

## Oral Communications & Business Associates

*Oral communications are also protected.* Physicians should make reasonable efforts to keep information transmitted orally secure. Such efforts would include speaking in a lower tone when other people are present, or using curtains, when present, to prevent others from hearing patient information. The rule does not require patients to be kept in separate rooms and physicians are not prohibited from discussing patient care over the telephone with the patient, family members or other involved providers.

## Business Associates

The privacy guidance defines a business associate as a person or entity who provides certain functions, activities, or services for or to a covered entity involving the use and/or disclosure of PHI. This does not include a member of the physicians workforce and physicians are exempted when they provide PHI to a hospital where they have admitting privileges. *When working with a business associate, the provider must obtain reasonable assurances that the business associate will only use the information they receive for the contracted purpose and will prevent the misuse of such data.* A contract must include a provision that requires the business associate to inform the physician if misuse occurs. A provider would be required to take efforts to correct the problem if one occurs or to terminate the contract. If the contract cannot be terminated, the incident should be reported to the Department of Health and Human Services.

## Parents and Minors

*Generally, parents have access to their minor's protected health information.*

There are exceptions, including when the minor has a legal right to choose services without parental consent, when a court or law allows for someone other than the parent to make medical decisions for the minor, or when the parent agrees to waive their access to the PHI. This guidance does not preempt state law and the Secretary of HHS plans to make additional modifications to this part of the rule.

## Research

Regulations apply to health information with patient identifiers. *De-identified health data can always be used and disclosed by a covered entity.* When a researcher needs to use PHI without patient authorization one of the following conditions must be met:

- The use of the data must be approved and documented by an Institutional Review Board (IRB) or, if an IRB does not exist, by a privacy board.
- The researcher must provide a written or an oral statement indicating that the information being used is to prepare for a research project, that PHI will not be removed, and the PHI is necessary for the project.
- The researcher must provide a written or oral statement indicating that if PHI of deceased persons is being used, that such information is necessary for the

research and that the documentation of death is being sought for the persons whose PHI is being used.

A researcher also needs to have a statement documenting the approval of the IRB or the privacy board, the date of approval, a series of criteria were met that insure that the disclosure was necessary, the patient and their information are not harmed from the disclosure, the benefits from the research would outweigh any risks, there are plans for the protection of the data, the destruction after the research is completed and data will not be disclosed to another source.

*These actions are not necessary when a patient authorizes the use or disclosure of their PHI. Researchers can condition enrollment in a study on the participants authorization to use their PHI.*

Research participants are allowed access their PHI that is maintained in their 'designated record set' which would include the records used to make medical decisions regarding the patient. The exceptions to this occur during a clinical trial (patients can have access afterwards) and if the patient waives their right to have access.

## Marketing

The privacy guidance defines marketing as a communication about a product or serv-

ice with a purpose to encourage the purchase or use of that product or service. *The guidance does not consider sending out reminder notices for appointments, annual exams, prescription refills, recommending a particular pharmaceutical for treatment or physician referral marketing activities.* Disclosure of protected health information (PHI) is permitted in the following instances:

- The communication occurs during a face-to-face encounter with the patient
- The marketing concerns a product or service of nominal value (i.e., a toothbrush or pen with the provider's name or health care manufacturer)
- The marketing concerns health related products of the provider or third party and identifies the source of the marketing call or materials, indicates when the provider is being compensated for the marketing, allows the patient to opt out of future marketing communications, and explains why the patient has been targeted for the communication.

All other types of marketing require authorization from the patient for the release of PHI. *Providers may not sell or give away patient's PHI to third parties for unrelated use or patient lists to pharmaceutical companies for drug promotions without patient authorization.*

# 2002 IS AN ELECTION YEAR



What's the most important thing you can do this election year other than vote?  
Invest in the American Academy of Sleep Medicine Political Action Committee! (AASM PAC)  
By investing in the AASM PAC, you are doing the following:

- Participation:** Your contribution allows you to have an active voice at the Capitol.
- United Voice:** Your contribution combined with other members of the AASM are working toward a common goal.
- Educate:** Your contribution helps educate both government agencies and legislators about changes in the field of sleep medicine.
- Price of Doing Business:** Your contribution helps the Academy get a seat at the table with decision makers.
- Strength in numbers:** Your participation shows legislators that members of the Academy are concerned about the future of sleep medicine.
- Relationships:** Your contribution allows the AASM PAC to maintain relationships with legislators by supporting fund-raisers and organizing meetings between legislators and members of the Academy.
- Goals:** By contributing, you are ensuring the voice of sleep medicine is heard; achieving the Academy's goal of advancing sleep medicine and increasing value to the work you do.

Members of the AASM can contribute to the PAC by completing and faxing the form below to (507) 287-6008 or visit our website at [www.aasmnet.org/aasm/pac/contribution.asp](http://www.aasmnet.org/aasm/pac/contribution.asp)

CUT ALONG DOTTED LINE

## MAKE YOUR CONTRIBUTION TODAY

The American Academy of Sleep Medicine Political Action Committee needs your assistance in continuing its efforts to educate Congress in supporting the advancement of Sleep Medicine.

\$50    \$100    \$250    \$500    Other (you are free to contribute as much or as little as you wish)\*

VISA    MasterCard    American Express    Cash    Check (checks must be from a personal account)

CC# \_\_\_\_\_ Exp. \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature \_\_\_\_\_ Name on Card \_\_\_\_\_

**The following information will be used to identify your Congressional District**

Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone \_\_\_\_\_ / \_\_\_\_\_ FAX \_\_\_\_\_ / \_\_\_\_\_ E-mail \_\_\_\_\_

**Please detach this portion and fax to (507) 287-6008**

\*The amounts listed are simply suggestions; feel free to contribute as much or as little as you wish.

The amount of your contribution or decision not to contribute will not benefit or disadvantage your status with the AASM in any way.  
Contributions are not deductible for Federal Income tax purposes as charitable contributions.

# 2001 Sleep Medicine & Polysomnography

Submitted by: Edward J. Morgan, MD, Ph.D. and Carol Yoshimura, RRT, RPSGT

In October 2001 a Sleeping Dragon was awakened in the People's Republic of China to help those in that vast country who suffer from Sleep Disorders. The 2001 Sleep Medicine & Polysomnography Technology Course in Beijing was held between October 17 - 26, 2001. This was the first formal and comprehensive training course in Sleep Medicine and Polysomnography Technology to be given in China. It was designed to allow participants to open new sleep laboratories and to train people to staff them. Approximately 100 registrants attended lecture sessions that were held in

the Beijing Xinqiao Hotel Conference Hall and the Tongren Hospital Auditorium. Lecturers invited were from the United States, Hong Kong, Japan and China.

The physicians and nurses who attended this course were from various cities throughout China, including Hong Kong and Macao and had diverse medical specialties including otolaryngology, neurology, pediatrics, pulmonology, cardiology, and psychiatry.

The American Academy of Sleep Medicine made a generous contribution of its educational materials that were donated to the Tongren Hospital Sleep Disorders Laboratory and were also used for door prizes

during the course. Edward J. Morgan, MD, Ph.D. (a member of the AASM International Affairs Committee), made a formal presentation of the AASM materials to the Tongren Hospital Sleep Disorders Laboratory to Han Demin, MD, Ph.D., President of the Tongren Hospital on the first day of this course (see picture below).

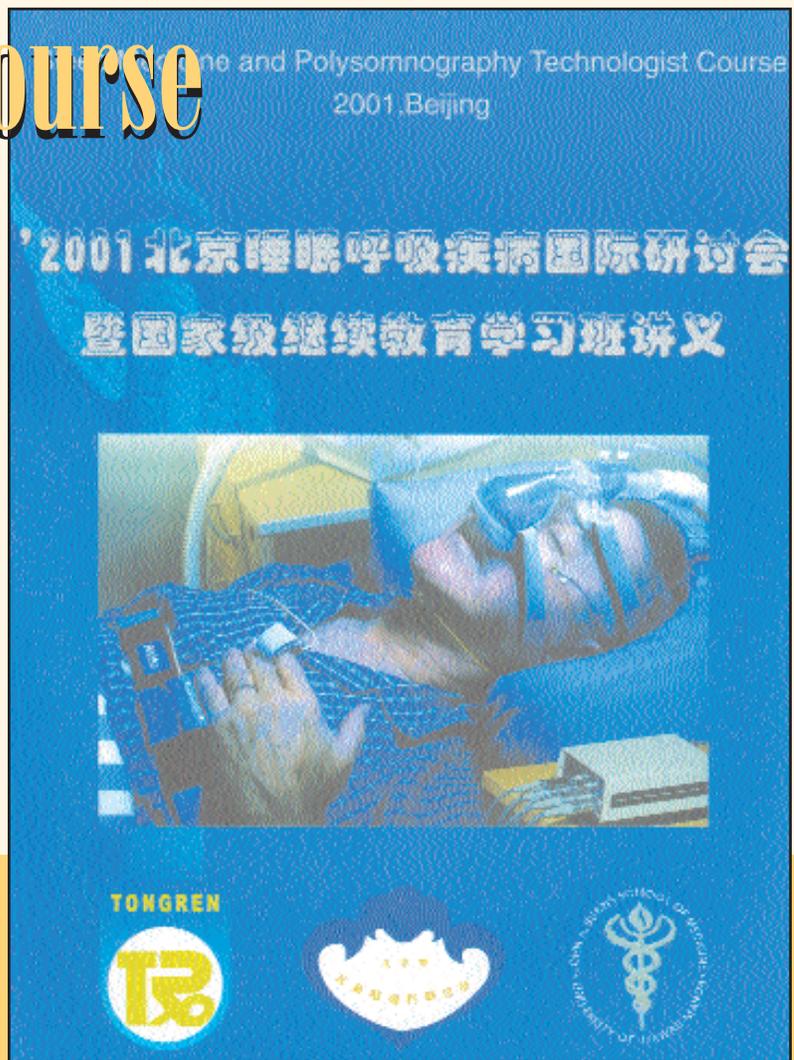
The course was divided into two sections. Level One, a 3-Day course, included topics in sleep medicine such as The Role of Homecare Providers in Sleep Medicine, Sleep Disorders in China, Overview of Sleep Disorders Medicine, Sleep Related Breathing Disorders, Insomnia / Sleep Hygiene / Circadian Rhythm Disorders, Restless Legs Syndrome / Periodic Limb

Edward J. Morgan, MD, PhD (a member of the AASM International Affairs Committee), made a formal presentation of the AASM materials to the Tongren Hospital Sleep Disorders Laboratory to Han Demin, MD, PhD, President of the Tongren Hospital on the first day of this course.



## Beijing, People's Republic of China

# Polysomnography Technology Course



cover of technologist course book

Movement Disorder, Parasomnias, Sleep Apnea: Medical Disorders including Cardiovascular Disease, Sleep and Mental Illness, Surgical Options for the Treatment of Sleep Related Breathing Disorders, Narcolepsy, and Neonatal and Pediatric Sleep Disorders.

Level Two was a 5-day course that was held immediately after Level One and attendance was limited to 40 registrants. It focused on topics in polysomnography Technology and included hands-on workshops. Topics for the lectures given during Level Two included: The International 10-20 Electrode Placement System, Components of the Polysomnogram / Equipment in the Sleep Laboratory / EOG, EMG and ECG Electrode Placement and Application, Scoring EEG Arousals, Respiratory Events and Periodic Limb Movements, Artifact Recognition and Elimination, NCPAP and Bi-Level Interface Selection and Fitting, and Principles and Application of NIPPV.

sleep medicine is a field that is advancing extremely rapidly in China. New and modern sleep laboratories have opened recently and are also being constructed.

One example is the Tongren Hospital Sleep Disorders Laboratory, a 5-bed sleep laboratory that has been open for approximately one year. It is equipped with state-of-the-art digital data acquisition and scoring equipment which include PCMCIA readers, CD-W, and CD-ROM. The Beijing Childrens' Hospital is currently planning its Pediatric Sleep Laboratory, which will be housed in a new building that is currently under construction on its campus. It will also be equipped with the most current polysomnographic equipment.

However, although the equipment may be current and state-of-the-art, there is still a great need for qualified physicians and trained sleep technologists to direct and staff these sleep laboratories. The 2001 Sleep Medicine & Polysomnography

Course was a good start toward achieving this goal. Virtually everyone who attended this course made it clear that it was the best medical training seminar of any kind ever held in China. Due to its great success, currently there are plans to hold a similar training course in 2002.

# AASM Accreditation Continues to be the Gold Standard for Developing Sleep Programs

By Donna Arand,  
PhD, Chair, Accreditation Committee

The American Academy of Sleep Medicine (AASM) has been accrediting sleep disorders programs for over 30 years.

The accreditation process was initiated by the early pioneers in sleep to help educate developing programs and set standards for the operation of sleep disorders programs. While accreditation was the primary role of the Academy, other needs were identified over the years and the AASM expanded its role to meet these needs. The AASM developed sleep boards, fellowship training programs and clinical practice parameters based on scientific research. In addition, the AASM is involved in fostering research partly through the *SLEEP* journal, as well as promoting public awareness of sleep disorders through national organizations and providing guidance for public policy. This growth has made the AASM a multifaceted organization with accreditation and other activities being coordinated and mutually enhanced to further the field. The AASM's efforts have been successful, and it is now the nationally recognized organization and leader in sleep disorders medicine.

Accreditation remains a very important part of the AASM. Currently there are 566 AASM accredited sleep disorders programs involving various physician specialties. The pursuit of AASM accreditation continues to be the gold standard for developing programs. A primary reason is that the AASM sets high standards that translate into quality patient care. This is reflected in the fact that, in many states, most third party payers require that sleep studies be performed at an AASM accredited facility for reimbursement. The AASM sets requirements for processes and procedures, as well as for personnel. The standards are developed by sleep specialists, whose knowledge enables them to tailor the requirements for the unique evaluation of sleep disorders patients. Moreover, sleep special-

ists who have a thorough understanding of the operation of sleep disorders programs perform the evaluation of sleep programs. Having sleep specialists involved in the accreditation process helps assure relevant standards, effective evaluation of programs, and quality of AASM accreditation.

In addition to the involvement of sleep experts, the AASM Standards for Accreditation have become increasingly based on scientific data. The Standards of Practice Committee, within the AASM, reviews and analyzes published data on various topics and generates clinical practice parameters. These guidelines are used as the basis for many accreditation requirements. As these reviews are updated, the Standards for Accreditation change to keep them current and relevant. This is ultimately reflected in the operations of sleep centers, which also makes them state-of-the-art. This is a necessity for maintaining high quality.

Another essential component to assure quality in AASM accredited programs is the requirement that a Diplomate of the American Board of Sleep Medicine (ABSM) be on staff. The ABSM Diplomate has a specific role in the evaluation of every patient. Requiring experienced sleep physicians to be on staff acknowledges the fact that sleep disorders medicine requires special education and training. This may be the most challenging requirement for programs seeking AASM accreditation. The AASM is the only accrediting body for sleep programs that requires such certification. Consequently, programs may seek accreditation through other means; however, the lack of a professional on staff with adequate training in the field severely limits the quality of a program.

While the AASM accreditation process is aimed at setting the standard for quality, it also has many other advantages. The accreditation process is not difficult for most programs. The new standards permit self-assessment of compliance with the requirements for accreditation, allow-

ing programs to identify deficiencies before the site visit. The \$3000 accreditation fee is considerably less than other accrediting bodies. A 5-year AASM accreditation cycle, as opposed to the typical three-year cycle, decreases the burden of accreditation preparation for sleep disorders programs.

Recently, there have been other organizations, which have promoted their own accreditation of sleep programs. These organizations do not require the same level of expertise in sleep medicine as the AASM. AASM sleep specialists are involved at all levels of the accreditation process. They also reflect an understanding of a new medical field. Accreditation is not an industry for the AASM but a single operation tailored for the specific purpose of setting standards for sleep disorders programs. The involvement of sleep experts and a scientific foundation for patient care are the most effective ways in which to set the standards for quality in sleep medicine. The AASM has effectively met this challenge.

The increased awareness of sleep disorders among physicians and the public will result in more patients with sleep disorders seeking care. With greater demand there will likely be more sleep disorders clinics erupting, with little regard for standards or quality. The need for quality programs will become extremely important. Patients and third party payers will look for evidence of quality to get the most value from their health care dollars. The AASM has a long history of a recognized formal accreditation process for the field that helps assure quality sleep programs. This will continue to be the goal of AASM accreditation. No other organization has more experience in the area of sleep disorders medicine. AASM accreditation is a symbol of excellence in the community. As with any medical specialty, national board certification of individuals and accreditation of programs is highly regarded. Consequently, AASM accreditation of sleep disorders programs will continue as the recognized leader.

# EVIDENCE-BASED MEDICINE: Is it here to stay?

By Michael Littner, M.D., Chair, Standards of Practice Committee, AASM

**E**vidence-based medicine is a process that has evolved as the need for objective practice recommendations has become necessary in an era with an abundance of literature of varying quality. Reinforcing the need for an objective process is the intense scrutiny by forces within and without the profession of medicine. This article will describe the process that the AASM uses.

The Standards of Practice Committee (SPC) of the AASM first published a position paper on MSLT in 1992 and has subsequently published 12 sets of clinical recommendations (called practice parameters) with one currently in press. The SPC has also published recent updates of two of the previous 12 practice parameter papers. There are several methods to produce clinical recommendations. A common, weaker evidence-based approach, is the “consensus conference” with a resulting published list of recommendations or guidelines for clinical practice. However, this is open to concern that the evidence used to produce the recommendations was not representative of the practice as a whole. A second approach, used exclusively by the SPC, is to pursue an evidence-based process producing an outcome that is predominantly determined by an unbiased evaluation of all of the evidence.

A topic is selected and approved by the Board of Directors of the AASM. The topic may be chosen in response to a request from the Board of Directors, from a perceived need from the diverse group of members of the SPC, or from inquiries to the AASM. Next, a set of questions related to the topic is posed by the SPC, a systematic search and review of the literature is performed generally by content experts. The available peer-reviewed literature is reduced to literature relevant to the questions by a pre-selected set of criteria. The content experts are generally volunteers who are not members of the SPC and who are often organized as a task force; the SPC members act as process advisors to guide the content experts. At this point, the information is extracted from each article into a database and rated according to currently accepted standards for level (measure of quality and lack of bias) and grade (measure of likelihood that the conclusions of the article are correct based on the level).

Once the above process is completed, the database is organized into evidence tables that briefly summarize the content and level of evidence of each article. The evidence is analyzed

including strengths and weaknesses to address the questions posed. The analysis is reported to the SPC. This completes the evidence review process.

Next, the evidence and analysis from content experts is evaluated by the SPC and practice parameters that address the original questions are produced by the SPC according to level and grade of evidence. In general, the analysis from the content experts and the practice parameters are published in *SLEEP* as companion articles authored by the content experts and the SPC, respectively. The SPC generally reports each practice parameter as a standard, guideline or option to reflect from a high degree to a low degree of certainty of how strongly the parameter should be considered as a preferred approach to the clinical question.

Although the process of gathering, selecting and grading the literature is evidence-based, there is an element of consensus that occurs at each step. For example, the criteria used to determine if an article is relevant may be obvious or may require a consensus. Eventually, when the evidence is evaluated there may well be a consensus as to how to interpret the results. However, the entire available literature will be catalogued, the inclusion and exclusion criteria will be available, the grading system that was used will be presented and the rationale for the conclusions will be detailed. A party outside of the evidence-based medicine process could reproduce the same evidence review result and practice parameters. It is possible that an outside party may question the process and conclusions. However, since all relevant evidence was highly likely to be included, concerns should be based on analysis, not content.

Evidence-based medicine has a number of strengths and weaknesses. The strengths are that bias is reduced, the process is reproducible, the rationale for the parameters is apparent, and there is a high degree of certainty that literature, both supportive and not supportive, has been included. For these reasons, the parameters are likely to be accepted as objective by potential consumers such as practitioners. A caveat is that parameters are not designed to supplant individual clinical judgment or to encompass every possible situation. Although an exact percentage of cases to which each set of parameters apply is difficult to determine, it should be a solid majority, particularly if the parameter is a standard or guideline. However, application of parameters should be based on each case’s individual circumstances. Alternative approaches to a given case may be warranted depending on the justification.

However, the process is long and potentially cumbersome. The cost is high either in dollars from contracting out part of the process (e.g., data extraction) or in man-hours from volunteers, (the approach used by the SPC), who commit to performing the tasks. Fortunately, volunteers have given generously of their time, for which the AASM is extremely grateful. Often, outside statistical experts are required to help analyze the information, potentially further extending the process. Not to be underestimated is the time and effort that the AASM staff devotes to the process. The staff spends time learning and applying the supporting skills involved such as literature searches, retrieving and copying literature, arranging conference calls, constructing evidence tables from the database, and ensuring that the task forces and SPC are current in their efforts. Because of the lapse in time between the approval and publication, recent information or technology may not be included in the published parameters. An important question may have inadequate literature to support a parameter and the parameter can only be produced by consensus after reviewing all of the available evidence. The parameters will eventually become dated and updating the parameters may take time away from newer projects. Finally, there is currently no readily available mechanism for the AASM to determine if the parameters are being implemented, and if implemented, actually improve clinical outcomes.

Producing parameters provides practical, credible guidance for busy practitioners. In addition, organizations such as HMOs and government agencies that make health care decisions generally require guidance that is beyond opinion and of high quality and credibility.

The title of this article asks if evidence-based medicine is here to stay. The answer is, for better or worse, yes. Perhaps, like democracy, it is a cumbersome system that is better than anything else available for the purpose for which it is used. Evidence-based parameters are not the exclusive method to guide clinical practice and should not be used as a crutch or a substitute for individual judgment and skill. Like most other aspects of medicine, the parameters need to be used judiciously with appropriate respect and skepticism. However, the process substantially raises the bar for rejecting or modifying the resultant parameters for the conduct of clinical practice. While some may look upon evidence-based medicine as “cook-book” medicine, it should be remembered the world’s best chefs base their recipes on solid evidence-based principles of the culinary arts and the rest of us buy their cook-books if we wish to emulate them!

# Viewpoint

## History of the Mayo Sleep Disorders Center

*by John W. Shepard, Jr., MD, AASM President; Cameron D. Harris, RPSGT; Peter J. Hauri, PhD; Lois E. Krahn, MD;*

Long before sleep centers were ever conceived, narcolepsy was a topic of interest to the Department of Neurology at Mayo Clinic. In 1934, Daniels published his landmark paper on the disorder. Dr Bob Yoss became the first "narcoleptologist", coining the term "narcoleptic tetrad" and pioneering the use of methylphenidate in the late 1940s and 1950s. He worked closely with the ophthalmologists in developing pupillometry for the assessment of hypersomnolence but was not involved with the development of the sleep disorders center.

Interest in the evaluation of sleep apnea at the Mayo Clinic began in the early 70's when patients scheduled for pulmonary function testing were observed to fall asleep in the waiting room, stop breathing and awaken with a loud snort. The earliest documented study was performed in the Special Pulmonary Evaluation Lab in 1973. It consisted of placing the patient in a chair wearing a bias-flow mask to detect airflow and a Waters oximeter to measure changes in oxyhemoglobin saturation. Sleep state was monitored by behavioral observation. Subsequently, a cot was used to provide a more soporific environment with the addition of an esophageal balloon to measure respiratory effort and a radial artery catheter to measure blood pressure and draw arterial blood for gas analysis. In 1975, EEG monitoring was added and formal sleep staging begun. These studies were done during the daytime under the supervision of Drs. Phil Westbrook, Joe Rodarte, Bob Hyatt, and Bruce Staats from

the Pulmonary Division and Frank Sharbrough from Neurology.

In 1979 Dr Kerry Olsen used the sleep lab for the first formal research protocol. He investigated the effects of experimental nasal occlusion on sleep disordered breathing and initiated the overnight recording of sleep. The first MSLT study was performed in 1982 and by 1983 nasal CPAP therapy was provided by fabricating customized silicone masks and using a Spencer blower with variable tubing resistors and bias flow to achieve the desired pressure.

In October 1983, after three years of dedicated work on the part of Dr. Westbrook, the Mayo Sleep Disorders Center began operation as a multidisciplinary program located at St Mary's Hospital. With the clinic and five bed lab on the same site, the Center was staffed by Phil Westbrook (pulmonary), Bruce Krueger (Neurology) and Jarrett Richardson plus Paul Fredrickson from Psychiatry. From its inception, Mr. Cameron Harris has proved invaluable in developing diagnostic techniques, training polysomnographic technicians and coordinating the activities of the Center. At that time, no one was certain of the economic viability of the SDC and it was simply placed under the financial and administrative control of the Division of Pulmonary and Critical Care Medicine where the program had primarily originated. In fact, nocturnal penile tumescent (NPT) studies played an important role in the early financial viability of the SDC, an activity that has subsequently gone limp.

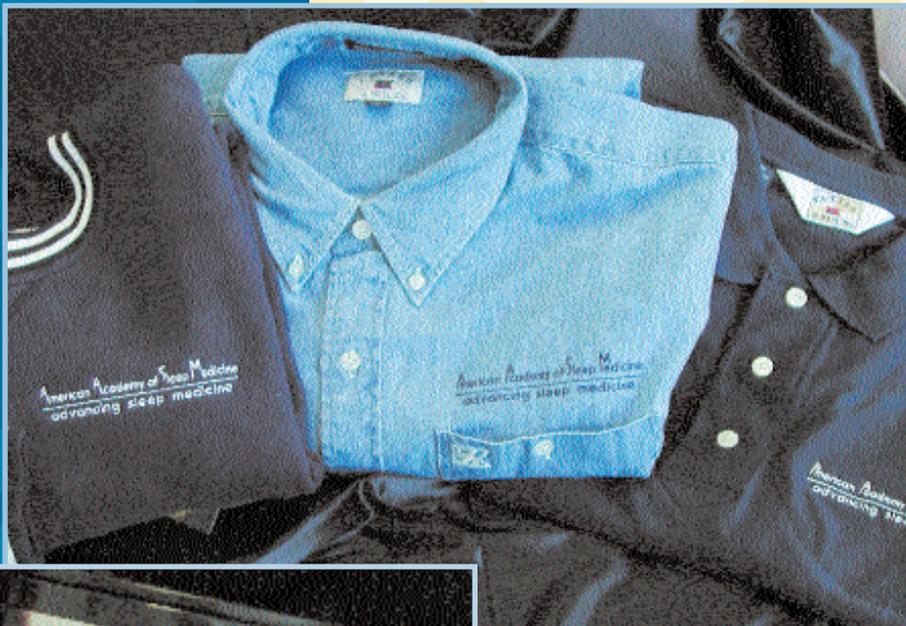
Two years after being accredited by the American Sleep Disorders Association (ASDA) in 1984, the Sleep Center moved into an eight bed facility located in the Colonial Building adjacent to Rochester

VIEWPOINT CONTINUED ON PAGE 33

# Looking for something new for casual Fridays?

Every dollar spent on merchandise goes to the Sleep Medicine Education & Research Foundation

You can find the answer while supporting the Foundation with AASM Apparel!



The AASM polos, denims and sweatshirts are professional, yet comfortable for your work environment.

These products also make great gift ideas for incoming employees or all staff uniforms.



Other great gifts include mugs, office accessories, key chains, hats, ties, lapel pins, and much more!

Order yours today by visiting the AASM website at [www.aasmnet.org](http://www.aasmnet.org) and make your casual Fridays even better!

# NEW

## AASM ACCREDITED

### SLEEP DISORDER CENTERS AND LABORATORIES

Breathing Related Sleep Disorder Center of MMC  
Marshall Medical Center South  
11491 US Highway 431, Suite E  
PO Box 758  
Boaz, AL 35957  
Accredited Center\*

CARITAS Sleep Disorders Center  
CARITAS Medical Center  
1850 Bluegrass Avenue  
Louisville, KY 40215-1199  
Accredited Center

Gulf Coast Sleep Laboratory  
Gulf Coast Medical Center (Tenet)  
180 B Debuys Road, Suite 103  
Biloxi, MS 39531  
Accredited Laboratory

Janice L. Miles, D.O. Pulmonary and Sleep Medicine Sleep Lab  
3501 Main Street  
Moss Point, MS 39563  
Accredited Laboratory

Minnesota Sleep Institute, Golden Valley  
Kindred Hospital  
4101 Golden Valley Road  
Golden Valley, MN 55443  
Accredited Center

North Shore Sleep Center  
North Shore Medical Center  
81 Highland Avenue  
Salem, MA 01970  
Accredited Center

Opelousas General Hospital Sleep Disorders Center  
Opelousas General Hospital  
539 East Prudhomme Street  
Opelousas, LA 70570  
Accredited Center

Provena Sleep Disorders Center  
Provena St. Joseph Medical Center  
300 Barney Drive, Suite C  
Joliet, IL 60435  
Accredited Center

Sleep Apnea Center  
Glenwood Regional Medical Center  
305 McMillan Road  
PO Box 35805  
West Monroe, LA 71294-5808  
Accredited Laboratory

Sleep Disorders and Neurology Clinic  
4725 Village Plaza Loop, Suite 101  
Eugene, OR 97401  
Accredited Center

Sleep Disorders Center of London PLLC  
1370 West Fifth Street, Suite One  
London, KY 40741  
Accredited Center

SleepMed of Central Georgia at Dublin  
770 Hemlock Street  
PO Box 1035  
Macon, GA 31208-1035  
Accredited Center Satellite\*

Southwestern Indiana Sleep Disorders Lab  
445 Cross Pointe Boulevard, Suite 230  
Evansville, IN 47715  
Accredited Center

Temple University Health System Sleep Disorders Center  
at Jeanes Hospital  
7600 Central Avenue  
Philadelphia, PA 19111  
Accredited Center Satellite\*

The Sleep Center at Jackson County  
Jackson County Hospital and Nursing Home  
380 Woods Cove Road  
PO Box 1050  
Scottsboro, AL 35768  
Accredited Center

The Washington Hospital Sleep Center  
The Washington Hospital  
155 Wilson Avenue  
Washington, PA 15301  
Accredited Center

Wooster Community Hospital Sleep Disorders Center  
Wooster Community Hospital  
1761 Beall Avenue  
Wooster, OH 44691  
Accredited Center

\*mailing address

# Fellowship Training: ACGME Recognition

For several years the AASM has worked with the American Board of Sleep Medicine (ABSM) in an effort to gain recognition of the ABSM by the American Board of Medical Specialties. One of the main obstacles has been the lack of AASM accredited training programs. The Academy is pleased to announce there has been steady increases in accredited programs over the past two years, however more accredited programs are needed.

Recently John Shepard, M.D. met with Marvin Dunn, M.D., Director of Residency Review Committee Activities for the Accredited Council for Graduate Medical Education (ACGME), along with Jerry Barrett, AASM Executive Director and Michael Silber, M.B.,Ch.B., President of the ABSM to discuss ACGME recognition. As part of the meeting Dr. Dunn was briefed on the history of the AASM and ABSM. In addition, Drs. Shepard and Silber presented an evolution of the science that has driven our field. As a result Dr. Dunn strongly encouraged the AASM to submit an application for ACGME Accreditation as a stand-alone specialty. This is the most encouraging sign the Academy could have hoped to receive.

The Executive Committee has discussed this and has begun the application process. The number of sleep fellowship programs accredited by the AASM will affect acceptance of this application.

**The Academy cannot emphasize strongly enough the importance of increasing the training programs applying for AASM Accreditation and the significant impact on the future of the field.**

If the Academy's application is approved by ACGME the benefits to AASM-accredited fellowship training programs could include potential funding through the existing GME funding, acknowledgement of sleep medicine as a specialty and a potential increase in reimbursement and research funding. This will also open the door for improved relations between hospitals and sleep laboratories.

The Fellowship Training Committee of the AASM has streamlined the fellowship training application process to ensure timely and constructive review of program applications. Several benefits are available for AASM-accredited fellowship training programs. The committee members and national office staff are available to answer any questions you may have regarding this process.

If your fellowship-training program is presently affiliated with an AASM-accredited sleep center or laboratory, you are eligible to submit an application immediately. If you are not associated with an AASM-accredited center or laboratory at this time, and would like to seek accreditation status, the AASM Standards for Accreditation are available on the Academy web site at

## VIEWPOINT CONTINUED FROM PAGE 30

Methodist Hospital. In 1988, Drs. Peter Hauri and John Shepard joined the medical staff and research activity accelerated. The following year Dr. Westbrook announced that 22 Minnesota winters were enough and returned to Southern California. Despite Phil's exodus, the Sleep Center continued to grow at close to a 15% annual rate. Dr. Hauri started a one year fellowship program in sleep medicine in 1990 and recruited Dr. Donn Dexter as our first fellow. Dr. Michael Silber joined the consultant staff in 1991 adding valuable neurological expertise. In September 1997 the Sleep Center was relocated into Rochester Methodist Hospital's Eisenberg building. The move to this beautiful new 12 bed facility was completed over one weekend without missing a single study thanks to the dedication and coordination skills of Mr. Cameron Harris. Following Dr. Hauri's semi-retirement in 1999, Dr. Lois Krahn assumed his position as administrative director of both the SDC and fellowship program. Since its inception, ten fellows have graduated from the program and we currently have three fellows in training. In 2000 Dr. Suresh Kotogal joined the medical staff adding expertise in the area of pediatric sleep.

At the present time, the Mayo SDC offers a full range of sleep services and has over 9,000 patient visits per year. The staff includes five pulmonologists, three neurologists (including one pediatric neurologist), four psychiatrists, one psychologist, three nurses and three fellows in sleep medicine. Active research programs include studies of narcolepsy, the management of sleep apnea and REM sleep behavior disorder.

However, since moving to the current facility, the growth of the SDC has slowed, limited by space and staffing issues. With no room to expand bed capacity and limitations placed on physician availability, the growth in medical staff and polysomnographic studies has increased by only one and two percent respectively between September 1997 and September 2001. This has occurred despite a tremendous growth in demand for sleep services. While multiple reasons can be cited for this shortfall, the inability of the Sleep Center to hire the consultant staff needed to meet patient demand has been a stumbling block. Currently, there is significant debate within the medical staff as to whether or not the future of the Mayo SDC is best served by remaining a part of the Division of Pulmonary and Critical Care Medicine or attempting to become an independent Division, Department or Center.

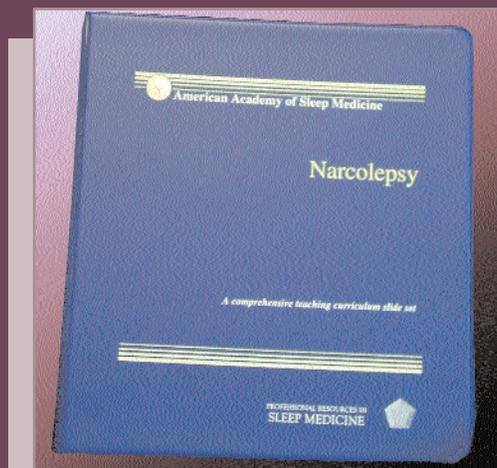
All of us practicing sleep medicine need to ask ourselves, which administrative structure offers the best model for the delivery of patient care and conduct of sleep research in the future.

[www.aasmnet.org](http://www.aasmnet.org). Specific questions regarding the application process can be directed to the Accreditation Department.

The leadership of the Academy encourages you to take advantage of this opportunity for the benefit of your program and the field. A copy of the Fellowship Training Program Guidelines and application can be found on the web at [www.aasmnet.org](http://www.aasmnet.org) under "Fellowship." If you have questions or require clarification, please contact Charlene Wibben, Senior Director of Administration and Special Services at 507-285-4374 or email at [cwibben@aasmnet.org](mailto:cwibben@aasmnet.org).

# Slide Sets on CD-ROM

Take advantage of this great new platform!  
The Narcolepsy and Sleep Apnea: Diagnosis &  
Treatment Slide Sets are now available on CD-ROM



Narcolepsy Slide Set CD-ROM: \$175.00 (AASM Member) \$350.00 (Non-member)  
Sleep Apnea: Diagnosis & Treatment Slide Set CD-ROM: \$195.00 (AASM Member) \$390.00 (Non-member)

To purchase your copy today, fill out the order form on page 37-38 or visit the AASM website at [www.aasmnet.org](http://www.aasmnet.org)

## Elimination of Satellite Accreditation

Effective January 1, 2002, the American Academy of Sleep Medicine will no longer offer accreditation of satellite centers or laboratories. Following review of survey data obtained from accredited programs, the Board of Directors, at its November meeting, eliminated this level of accreditation. Currently accredited satellites will continue their accreditation status until expiration, at which time they may apply for reaccreditation as a center or laboratory. Satellite applications in progress prior to January 1, 2002 will still be processed as satellites if the program chooses.

Satellite accreditation status was originally established to simplify the accreditation application process if accredited programs opened an identical program in another location. The intent was that there would be a reduced application size and decreased application fees when the satellite and parent facility were accredited at the same time. However, in most cases, the application was not smaller and the majority of satellite programs were site visited independently of the parent site since they developed after the parent was established, thus there were no cost savings. As a result, the majority of the 38 currently accredited satellite programs did not receive any additional benefits from satellite status.

Satellite facilities also had an additional burden of meeting independent facility standards, as well as requirements for satellites. The satellite requirements were to ensure that the satellite facility was the "same" program as the parent facility except in a different location. Since, satellite facilities were required to meet the same standards as the parent program, they already qualified for inde-

pendent center or laboratory accreditation. However, the added requirements imposed added restrictions. Specifically, satellites were required to have the same medical director, administrative structure, name, professional and technical staff, and associated physicians as the parent program. Additionally, the professional and technical staff was required to rotate to the parent facility. Finally, the satellite could not continue being accredited if the parent program terminated or lost its accreditation.

These additional requirements resulted in problems for existing satellites when changes in professional staff or ownership affected either the parent or satellite, but not both. While the independent facility could simply inform the national office of such changes and, if approved, could continue its accreditation, satellites did not have this option if the change did not include the parent program. The satellite's accreditation was suspended or terminated. This seemed unfair since the satellite met the same standards as an independent facility when they became accredited, in addition to meeting the requirements defining a satellite. Major changes at satellites, which were not anticipated at the time of satellite application, could suddenly result in loss of accreditation. This situation could have been avoided if application for independent accreditation had been made initially.

As the number of accreditation problems for satellites increased, it became clear that satellite accreditation status was more of a encumbrance than an advantage for many facilities. Therefore, it seemed reasonable to eliminate satellite accreditation. Doing so effectively gives all programs that meet the standards the same ability to make major changes

and maintain their accreditation status. This decision will significantly benefit currently accredited satellites.

## New Accreditation Product—Reference Manual

The Accreditation Committee of the American Academy of Sleep Medicine has completed a new product, which will become available for purchase during the first quarter of 2002. The Reference Manual for Policies, Procedures, Documentation and Reporting is intended for utilization by centers and laboratories as a guide to assist in the development of a Policies and Procedures Manual. The templates and protocols contained in this manual are suggested only, and may be used in whole or in part. The use of these specific documents is not required for accreditation by the AASM.

## Reminder to Submit Application

AASM accredited centers and laboratories that are up for reaccreditation in 2002 are encouraged to submit their applications by their respective submission deadline dates. Please note that the deadline for submissions has been changed from eight months to six months prior to expiration date, effective January 1, 2002. Those facilities that do not meet the six month deadline will be assessed a \$500 late fee, unless an extension is requested in advance.

# National Sleep Research Plan to be Revised

The National Plan for Sleep Disorders Research, first published by the National Institutes of Health in 1996, is to be revised. This effort will involve assessing the success of the previous plan and developing an updated plan for the next few years. To accomplish this, Dr. Carl Hunt, the recently appointed Director of the National Center for Sleep Disorders Research, has put together a multidisciplinary task force. Dr. Hunt is a former chairperson of the Department of Pediatrics at the Medical College of Ohio and did active research in the pathophysiology of Sudden Infant Death Syndrome (SIDS).

The members of the task force are [with major assigned areas (areas of expertise)]:

- \* Thomas Balkin:  
Performance and Sleep.
- \* Gene Block:  
Circadian Biology  
(basic, applied, clinical).
- \* Dan Buysse:  
Insomnia, Sleep in  
Psychiatric Disease
- \* David Dinges:  
Sleep Deprivation (all areas:  
neurocognitive and physiologic)
- \* David Gozal:  
Pediatric Sleep Apnea,  
Neurobiology of Respiration,  
Intermittent Hypoxia, Informatics  
and Sleep, Neurocognitive  
Sequelae
- \* Steve Henriksen:  
Sleep Neurobiology, Sleep  
Pharmacology/Pharmacogenetics,  
Including Drugs & Alcohol.
- \* Hannah Kinney:  
Neuropathology of Sleep  
Disorders (expert in  
neuropathology of SIDS)

- \* Carol Landis:  
Sleep and Fibromyalgia, Restless  
Leg Syndrome/Periodic Limb  
Movement Disorder.
- \* Emmanuel Mignot:  
Genetics of Sleep Disorders,  
Sleep Phenotyping, Narcolepsy  
(basic and clinical).
- \* Judith Owens:  
Pediatric Sleep Disorders  
(non-respiratory), Education and  
Sleep (all areas: public,  
professional, etc.).
- \* Jerry Siegel:  
Sleep Neurobiology,  
Sleep in Neurologic Disease.
- \* Esther Sternberg:  
Sleep and Immunology, Sleep  
and the Endocrine System.
- \* Debra Weese-Mayer:  
Genetic and Clinical Disorders  
in Autonomic Control of  
Breathing (including  
Central Hypoventilation  
Syndrome), SIDS & ALTE,  
Infant Sleep
- \* David White (Chair):  
Adult Sleep and Respiration  
(basic, applied, epidemiology and  
outcomes).

Cliff Saper  
(Chair of Neurology at Harvard) is a  
consultant to the task force.

The Research Committee of the American Academy of Sleep Medicine is seeking input from members of the Committee since we intend to provide input to the process. The input from the Committee will be published in a subsequent newsletter. Members of the Academy should feel free to input directly to the members of the NIH task force (see above) or members of the Research Committee.

The current members of the  
**Research Committee** are:

Richard Chemelli  
Steven Henriksen  
Beth Malow  
Eric Nofzinger  
Allan Pack (Chair)  
Susan Redline  
Mark Sanders  
Aaron Sher  
Michael Vitiello  
Edward Weaver  
James Wyatt  
Irina Zhdanova

## CALENDAR OF EVENTS

Life of the Sleepy Person V Conference:  
 New Perspectives on Disorders of Excessive Sleepiness  
 Center for Narcolepsy Research,  
 University of Illinois at Chicago  
 March 7-8, 2002  
 Chicago Marriott O'Hare, Chicago, IL  
 Events: Support group meeting in PM of March 7;  
 next day speakers include Drs. Emmanuel Mignot, Patricia Mer-  
 cer and Roza Hayduk, and Mr. Barry Taylor, Attorney  
 For more information: Visit [www.uic.edu/depts/cnr](http://www.uic.edu/depts/cnr) or contact  
 the center at 312.996.5176 or email: [narcolep@listser.uic.edu](mailto:narcolep@listser.uic.edu).

## POSITIONS AVAILABLE

**SLEEP SPECIALIST**—The University Medicine Foundation, Inc., the practice plan for the Department of Medicine at Brown Medical School, is seeking an Associate Director for the Sleep Disorders Center of Lifespan Hospitals. This individual will join the Division of Pulmonary and Critical Care Medicine at Rhode Island Hospital. The successful candidate must qualify for a full-time medical faculty position at the rank(s) of Assistant or Associate Professor in the Department of Medicine at Brown Medical School. Minimum requirements include board certification in internal medicine and pulmonary medicine and board certification/eligibility in sleep medicine. Clinical experience in sleep medicine and competence in clinical polysomnography is required as well as demonstrated interest and productivity in sleep-related research. The University Medicine Foundation, Inc. is an EEO/AA employer and encourages applications from minorities, women and protected persons. Review of applications will begin immediately and continue until the position is filled or the search is closed. Send CV to Richard P. Millman, M.D., Search Chairperson, Sleep Disorders Center of Lifespan Hospital, 593 Eddy Street, Providence, RI 02903.

**POLYSOMNOGRAPHIC TECHNOLOGIST**—The International Institute of Sleep is one of the nation's largest and fastest growing companies that specializes in sleep disorders testing. We are seeking motivated, dynamic, and flexible PSG technologists and managers to work with our growing organization. The qualified candidates will have sleep medicine experience with responsibility in direct patient care performing PSG's, MSLT's, MWT's, and titrating CPAP/BiPAP, as well as data analysis and troubleshooting. We welcome opportunities to provide training to individuals possessing Respiratory Therapy, EEG, and/or other medical related experience. We offer excellent starting salaries, plus bonuses, medical benefits, and excellent opportunities for growth and advancement. Fax resumes to (954) 426-8744.

**SLEEP MANAGER AND SLEEP TECHS**—Harrison Hospital, a 297 bed acute care facility, located in Bremerton, WA is a quick ferry ride from Seattle through beautiful Rich Passage in Puget Sound. Bremerton has views of the Seattle cityscape and the Cascade and Olympic mountain ranges. Our city's combination of unique attributes has earned us the recognition of The Most Liveable and The Best Quality of Life by national publications in recent years.

We seek the following professionals:

**Sleep Manager:** This leadership position is responsible for overall technical, clinical and administrative management in busy new Sleep Center. Requirements: Registered Polysomnography Tech, Certified EEG Tech or Resp Care Practitioner plus minimum of 3 years supervisory experience in Sleep Medicine.

**Sleep Techs:** Successful candidates will be registered RPSGT or RRT with at least 2 yrs exp performing and scoring studies. Prepping patients for sleep studies, application of CPAP and BIPAP, titrating CPAP and O2.

Applications available on-line: [www.harrisonhospital.org](http://www.harrisonhospital.org)  
 HMH Human Resources, 2520 Cherry Avenue, Bremerton, WA 98310, Phone: (360)792-6720. Fax: (360)792-6724,  
 E-Mail [suescriven@hmh.westsound.net](mailto:suescriven@hmh.westsound.net). EOE.

**PEDIATRIC PULMONARY SPECIALIST**—The Sleep Medicine Institute at Swedish Medical Center invites applications for a Pediatric Pulmonary Specialist trained in Sleep Medicine. This full-time position has been created due to expansion of the clinic's pediatric specialty services and will add to a staff of three ABSM accredited sleep physicians, two nurse practitioners and a large pediatric multi-specialty group. The Sleep Medicine Institute operates 14 sleep testing beds. Responsibilities will include medical direction of the pediatric sleep medicine clinic, diagnosis and treatment of patients with sleep problems and sleep related breathing disturbances, and establishment of medical standards of the use of CPAP and Bi-PAP on children. A general pulmonary practice component is available with the pediatric group. The ideal candidate will be personable, energetic and demonstrate a desire to promote pediatric specialty services within the community. Successful applicant will be BC/BE in Pediatric Pulmonary Medicine and BC/BE in Sleep Medicine. Excellent salary and benefits. For more information, please contact Jacqueline Carie, Physician Recruiter at (206) 215-2454. Fax your CV in confidence to (206) 215-2975 or email [jacqueline.carie@swedish.org](mailto:jacqueline.carie@swedish.org).

**TWO POSTDOCTORAL POSITIONS IN HUMAN SLEEP AND CHRONOBIOLOGY**—Competitive salary and infrastructure support for a minimum of two years. Candidates must be able to develop and carry out individual research projects that will lead

to independent extramural funding. The laboratory conducts research related to human circadian rhythms with a broad focus on clarifying the differential contributions of environmental, behavioral, and physiological factors in the regulation of sleep and biological rhythms. Send CV, statement of research interests/goals and the names of 3 references to: Scott S. Campbell, PhD, Professor, Department of Psychiatry, Weill Medical College of Cornell University, 21 Bloomingdale Road, White Plains, NY, 10605; e-mail: sscampb@med.cornell.edu

BC/BE SLEEP SPECIALIST; ATLANTA, GEORGIA—Successful sleep medicine practice seeking a BC/BE sleep specialist. The position is open to physicians and Ph.D. clinical psychologists. This progressive practice operating two sleep centers offers a competitive salary and benefits package. Fax CV to 404-499-0531 or e-mail pssconnie@earthlink.net.

SLEEP/NEURO TECHS—Cleveland Clinic Hospital has opportunities for enthusiastic professionals who believe, as we do, that maintaining excellence takes constant attention and diligence. Join us at our new Weston Hospital. Full-time and per diem opportunities are currently available for Sleep/Neuro Techs with previous experience. Opened in July 2, 2001, this 150-bed hospital was built through a partnership between Tenet HealthSystem and Cleveland Clinic Florida. While Tenet manages and operates the hospital, Cleveland Clinic Florida oversees all aspects of clinical and medical care. For consideration, please forward resume to Human Resources, Cleveland Clinic Hospital, 3100 Weston Road, Weston, FL 33331. Fax (954) 689-5128. EOE/Drug Free Workplace.

SLEEP MEDICINE PHYSICIAN OPPORTUNITY; COLUMBUS, OHIO—Full-time BE/BC Sleep Medicine Physician to join three Board Certified Sleep Specialists in practice of the full spectrum of sleep medicine. The Sleep Disorder Center is located on the Riverside Methodist Hospital campus with satellite locations in east Columbus, Grove City and Dublin. A combined bed capacity of 20 beds all four centers. Interested candidates contact Julie Hotchkiss; Grant/Riverside Methodist Hospitals, 800-368-7548; fax: (614)-566-3646; e-mail hotchkj@ohiohealth.com.

## SLEEP FELLOWSHIP

FELLOWSHIP IN SLEEP DISORDERS MEDICINE—The Henry Ford Hospital Sleep Disorders and Research Center is offering a 1-year fellowship in Sleep Disorders Medicine starting July 1, 2002. This full time AASM accredited position involves training in diagnosis and treatment of sleep disordered patients. The Sleep Clinic at Henry Ford Hospital evaluates approximately 900 new patients yearly. The position also includes exposure to research programs in sleep-related breathing disorders, narcolepsy, chronic insomnia, and the pharmacology of sleep. Candidates must be board eligible in psychiatry, neurology, or internal medicine. Send

inquiries and CV to David Hudgel, M.D., Henry Ford Hospital Sleep Center, 2799 West Grand Blvd, CFP3, Detroit, MI, 48202-2691.

## ANNOUNCEMENT

FOR SALE—

- ◆ 2 Alice 3 high performance (SVGA) sleep acquisition and analysis systems
  - ◆ 1 Alice 4 acquisition system
  - ◆ 1 Sims BCI end tidal carbon dioxide sensor with airway adaptor
  - ◆ 1 Infra-red TV camera monitor for 2 patients
  - ◆ A turnkey system for a two-bed sleep laboratory, ready to use
- Excellent prices available on this equipment!

For more information contact:

Wallace Mendelson, M.D.  
The University of Chicago  
Psychiatry Dept. MC3077  
5841 S. Maryland Ave.  
Chicago, IL 60637  
Phone Number: (773) 834-0742

## Do you qualify to offer AASM-sponsored CME credit?

In November 1997, the American Academy of Sleep Medicine was awarded full accreditation by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians. Since that time, the AASM CME Committee has worked to establish guidelines and procedures to enter into joint sponsorship agreements with organizations not accredited to sponsor CME educational activities. At this time, the Committee is pleased to announce its intent to accept applications from AASM accredited member centers and laboratories and other entities for joint sponsorship with the AASM.

If you are interested in offering CME credit for physician educational activities, please contact Jennifer Markkanen at the AASM National Office by phone at (507) 287-6006, or by e-mail at [jmarkkanen@aasmnet.org](mailto:jmarkkanen@aasmnet.org) for additional information and an application for CME credit.

Thank You to this Issue's Advertisers

Ambulatory Monitoring

Astro-Med

Compumedics

MSNI

NTS

Respironics

ResMed

School of Sleep Medicine

Sleep Sciences