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COURT OF APPEALS
DIVISION I
OF THE STATE OF WASHINGTON

NO. 70819-8

PAUL WILKINSON

Appellant/Plaintiff,

v.

AUBURN REGIONAL MEDICAL CENTER, UNIVERSAL HEALTH
SERVICES, DR. DANIEL CLERC, TRACY RADCLIFF, MELISSA
POLANSKY,

Respondents /Defendants.

Appellant Paul Wilkinson's Opening Brief

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Assignments of Error

No. 1 The trial court erred in granting summary judgment on August 9, 2013, and dismissing Paul Wilkinson's discrimination complaint under Washington Laws Against Discrimination (WLAD).

No. 2 The trial court erred in granting summary judgment on August 9, 2013, and dismissing Paul Wilkinson's retaliation complaint under the National Labor Relations Act (NLRA).

No. 3 The trial court failed to enter a judgment concerning the implied contract between Wilkinson and ARMC exclusive of the collective bargaining agreement with UFCW local 21.

Issues Pertaining to Assignments of Error

No. 1 Was the plaintiff terminated for violations of Policy and Procedure or was it a pretext and he was instead terminated in retaliation for his union activities? Assignment of Error 1

No. 2 Was the plaintiff terminated for violations of Policy and Procedure or was it a pretext and he was instead terminated because of his sex? Assignment of Error 2

No. 3 Were there issues of material fact that preclude summary judgment? Assignments of Error 1, 2

No. 4 Did the defendants control of the material facts in this case? Assignments of Error 1, 2

No. 5 Is there an implied contract between Wilkinson and ARMC exclusive of the collective bargaining agreement between ARMC and UFCW Local 21? Assignments of Error 3

No. 6 Did the court abuse its discretionary power by not considering the journal of Paul Wilkinson as evidence and allowing the unsworn statements of Dr. Daniel Clerc and Dr. Morris Chang as evidence during the summary judgment? Assignments of Error 1,2

Statement of the Case

Paul Wilkinson was employed by Auburn Regional Medical Center (ARMC) for approximately five years. During this time ARMC was owned and operated by Universal Health Services (UHS). Wilkinson was under the direct supervision of his lead, Melissa Polansky, and his Department Manager, Tracy Radcliff. Wilkinson performed sleep studies with direct outpatient care at the ARMC sleep center. The Medical Director for the ARMC sleep center was Dr. Morris Chang during Wilkinson's time there. Dr. Daniel Clerc served as a doctor under the supervision of Dr. Chang while learning to be a sleep specialist at the ARMC sleep center.

From November 2005 to April 2009, Paul Wilkinson was subjected to one disciplinary action. It was for four absences in a rolling calendar year. In April 2009, Paul Wilkinson was accused by his supervisor, Melissa Polansky, of not calling in as sick for one of his shifts in violation of the union contract and of not providing a doctor's note on his return to work (CP pg 267,268). He went to his Department Manager, Tracy Radcliff, and Human Resources Director, Jim Morris, to have the

matter expunged but they refused to remove the absence. Wilkinson then engaged UFCW local 21 to grieve the matter. An agreement with the union was made to have the disciplinary action removed in its entirety (CP pg 269), but it was still left in Wilkinson's personnel file.

In May, 2009 Wilkinson again called in sick. When he attended the staff meeting on May 6, 2009 his sore throat was so obvious that Dr. Dan Clerc grabbed him by the throat to try and "heal" him. Polansky yelled at him during this meeting, telling him to keep comments to himself and interrupted him when he tried to talk (CP pg 83-86, 78-82, 1).

Wilkinson had called in sick for symptoms of Swine Flu. Polansky put forward a disciplinary action accusing Wilkinson of absenteeism (CP 270). Administration of ARMC had stipulated in a hospital wide document that all personnel exhibiting symptoms of this disease would not be subject to punitive action for calling in sick (CP pg 263,264).

Wilkinson asked that Radcliff remove the absence. She refused. The absence was only removed when Wilkinson again engaged the union. In May 2009 and June 2009, Wilkinson approached his supervisor, Polansky about various deficiencies in the sleep lab regarding the union contract requirements (CP pg 168). She responded that she did not need to know the union contract. When Wilkinson and David Ilagan engaged the union contract by requesting the hours of a female per diem, Lulit Gualu, to

make up for hours they had lost due to low census duty (LCD), they were refused the hours by Polansky. Polansky then established a 0.6 permanent position for Gualu (CR pg 37-41). The 0.6 position was not posted in the sleep lab per union contract. There was also an ongoing issue with keeping the fulltime employees employed during this period of time. There was also an expected greater drop in hours due to the sleep lab reducing its available beds by a third for at least the next six months while it transitioned to a new sleep center at another location. The 0.6 position was refused by Gualu and it was then closed. No other applicants were interviewed. When David Ilagan put in a request for all hours as he was required by union contract, Melissa Polansky asked him twice over the next week if he wanted to quit (CP pg 78-82).

In June 2009, Radcliff accused Wilkinson of insubordination, but failed to bring forward a formal disciplinary action, for not signing a blank sheet of paper under a post-it note written by Polansky requesting a schedule change (CP pg 237). Wilkinson had rewritten the note and submitted it to both Polansky and Radcliff instead.

In July, Wilkinson was written up for an absence (CP pg 257).

In August 2009, Wilkinson was again yelled at first by Barbara Rooney, sleep technician, and then again by Polansky for working at different terminals than he had for the past month. Polansky told him to

remove all his equipment and move to the other rooms so that Rooney could work in the rooms she wanted to work in that night. Polansky hangs up on Wilkinson when he tried to respond (CP pg 10). No P/P existed regarding work stations and Wilkinson had a habit of familiarizing himself with all the workstations and rooms at any sleep lab he ever worked at. Two days later, Barbara Rooney was terminated from ARMC after not showing up to work for the third time without explanation. Barbara Rooney had multiple complaints from other employees about her sleeping on the job and harassing other employees, but was never disciplined by Polansky or Radcliff (CP pg 78-86, 10). Barbara Rooney also had an issue showing up to the required 90% mandatory staff meetings (CP pg 182, 183) and was never disciplined by Polansky or Radcliff (CP pg 78-86)

In September, 2009 Wilkinson was disciplined for insubordination for going into overtime without prior approval by his immediate supervisor, Polansky (CP pg 258). The plaintiff was never ordered to leave by the acting lead, Carrie Olsen (CP pg 11, 259-261) and he was trying to give time that had been paid for by staying (CP pg 250, 251). Wilkinson was the only one ever disciplined even though other employees of the sleep center did not seek prior approval. Wilkinson sought his personnel and financial records for the first time in September, 2009 and

complains of the harassment and retaliation he is experiencing from Polansky and Radcliff (CP pg 35, 36). He requested a copy of his personnel file per ARMC policy and procedure (CP pg 74) and was told to obtain a subpoena if he wanted them (CP pg 13). He asked for his financial records under Washington state law several times and was ignored (CP pg 111-113, 117). Wilkinson filed a charge against Jim Moore with Labor and Industries and was told he would have to sue for the records (CP pg 114, 115).

In October, 2009, Wilkinson was suspended for absenteeism and a pattern of behavior for calling in sick when denied vacation time (CP pg 73). After being grieved by the union the suspension was reversed (CP pg 105, 11-13). There was no pattern of behavior and the absenteeism was within the policies of ARMC.

In November 2009, Wilkinson again requested his financial records from Jim Moore, Human Resources Director. (Ex 5).

December, 2009, Gualu was cited for violation of the Policy and Procedure by Dr. Morris Chang, Auburn Regional Medical Center, sleep lab medical director. It was not brought forward for disciplinary action by Polansky or Radcliff (CP pg 14, 17). Wilkinson tried to get his personnel file changed because it was inaccurate (CP pg 132) under union contract (CP pg 129). HR Director, James Moore, never responded.

In January, 2010, Wilkinson was accused of not clocking in for a scheduled shift (CP pg 255). His union representative, Erin Adamson, refused to put the grievance forward citing that this was just the first one. Adamson starts to look closer at the Sleep Center's adherence to the union contract after complaints are made by Wilkinson. Wilkinson was also disciplined for not getting approval for overtime (CP pg 239). The medical necessity of the situation was explained to Tracy Radcliff by the plaintiff and guidance was requested (CP pg 240). None was given. The protocol for the sleep center states that an 8 hour study should be run every time (CP pg 148), truncating the study would have violated P/P. Also in January, 2010, Wilkinson was given a highly negative personnel review that labeled him as "incompetent" with a 58% score (40%-60% =requires improvement) (CP pg 150-173). This personnel review received the lowest marks, unsatisfactory or requires improvement, regarding attitude and communications and the highest marks regarding his knowledge of sleep disorders, sleep procedures, and education of patients; exceeding requirements. Frequent communications are documented in the exhibits presented at summary judgment. For Polansky and Radcliff to claim that Wilkinson does not communicate often or well is unreasonable. Wilkinson is required to attend a Service Excellence class to improve his scores (CP pg 178,179). The class is cancelled and he is not required to

attend another and is complimented by Radcliff on his improvement in the necessary areas of attitude and communications.

In March, 2010, Wilkinson is disciplined for not starting a patient on CPAP therapy for a mandatory split in March, 2010. Wilkinson did not grieve the action.

In July, 2010, Wilkinson was disciplined for starting a patient on ASV during a study (CP pg 242). Wilkinson does not grieve the action, but stipulates that there is no protocol for ASV use at the lab (Ex 9) and the last time it was mentioned was over a year ago during a staff meeting (CP pg 241). According to Exhibit 77, the ASV modality does not even start until the patient's breath rate is below the level set by the technologist (CP pg 98, 99). At no time during the study did the patient's breathe rate fall to a level that would trigger the ASV modality; so the patient was never on ASV. Wilkinson writes a letter to Radcliff offering to rewrite and update the Policy and Procedure of the lab to bring it into line with the AASM (American Academy of Sleep Medicine) Manual for the Scoring of Sleep and Associated Events based on the Practice Parameters of the AASM and Dr. Chang's (Medical Director) views regarding the care of patients at the ARMC Sleep Center. Wilkinson is rebuked by Radcliff for his offer of help.

In August, 2010, the Policy and Procedure of the Sleep Center at ARMC is updated after eight years by Polansky (Ex 9, CP pg 126, 127, ARMC000140). Polansky fails to inform the technicians under her supervision of the changes. It includes a new ASV P/P written into it. Wilkinson discovers the changes in late September, 2010 and informs the other technicians (CP pg 27). Wilkinson shows examples every week for the months of July and August that female employees are not following Policy/Procedure regarding the sterilizing of equipment to Polansky (CP pg 95-103, 107). Polansky disciplines no one for these violations. Anthony Dauley, sleep technician, informs Wilkinson that he went into overtime in August, 2010 and was not disciplined or questioned for not informing Polansky or Radcliff (CP pg 20). Wilkinson is disciplined for insubordination in August, 2010 for moving a recliner from one room to another (CP pg 233). Wilkinson had a conversation with Polansky over the phone about the recliner. He is again yelled at (CP pg 20-22). The disciplinary action is removed (CP pg 220).

In September, 2010, Wilkinson is disciplined four times for violations of the Policy and Procedure of Sleep Center at ARMC, which is an accredited by the AASM (American Academy of Sleep Medicine) (CP pg 184) as a sleep lab meeting their standards. Most of the actions are sponsored by Dr. Daniel Clerc. Dr. Clerc left the employ of ARMC by

January 2011. Wilkinson presents evidence that P/P was not violated by him during various Step meetings with ARMC HR director, Charmion Patton and Department manager, Tracy Radcliff. Wilkinson shows that ASV P/P does not exist until the P/P rewrite in August, 2010 (Ex 9, CP pg 226, 227), the only reference to it is made at a staff meeting a year before Wilkinson used it (CP pg 241). It was not formalized into the Sleep Center P/P until 15 months later. Exhibit 35 says that Wilkinson violated P/P by not increasing for snores (CP pg 224). According to the AASM parameters (Ex 8, pg. 165, 4.3.2.5) the snoring must be “loud and unambiguous for at least 3 minutes.” Only the technician/investigator can gauge snores because sound is not recorded during the sleep study and only the technician/investigator has an external microphone to listen to. Wilkinson followed the P/P and increased the pressure when he thought he heard snoring. Wilkinson is accused of starting the patient on 8/5 H2O instead of 8/6 cm/H2O and starting the patient on BIPAP when it was not ordered (CP pg 223). Discussions between Tracy Radcliff and the doctors made this disciplinary action “irrelevant” (CP pg 219). Wilkinson is accused of not starting a patient on CPAP soon enough in their study and this lead to patient dissatisfaction. Patients rate Wilkinson and the sleep center as “excellent”. It also accused Wilkinson of using an alternate mask than the one that was on the homecare order, not the sleep study order.

The sleep study order is the one given to the sleep technician, the home care order is for the home care technician. Patients are often started late in a study when they have severe apnea because the lack of breathing wakes them too frequently for them to meet the “sleep” duration required by the P/P. Split night studies sometimes require a new study with a full night of titration or testing of pressures because there simply is not enough time to titrate the patient well in the short period of time after a patient qualifies for a split night study (CP pg 27). Wilkinson is accused of switching a patient to BIPAP contrary to protocol (CP pg 235). The patient was switched to BIPAP for oxygen saturation issues according to the sleep center P/P for inadequate oxygen saturations. “Increase the IPAP pressure until the hypopneas are resolved and adequate oxygen saturations have been reached.” (Ex 9, pg.3). “Titration of alveolar hypoventilation requires using patient tolerance and adequate oxygen saturation for levels of pressure.” (Ex 9, pg.3). The patient was set at a proper EPAP and IPAP pressure according to BIPAP/CPAP P/P. “When initiating BiPAP set the EPAP or around the pressure where apneas were eliminated, IPAP should be set minimum 3 cmh₂o above the EPAP for obstructive sleep apnea.” (Ex 9, pg.3). The doctor had also been consulted about this during the study per P/P, “The patients oxygen saturation remains below 88% after a therapeutic level of CPAP/BiPAP has been reached” (ARMC000140) and

had not questioned it (CP pg 28, 229, 230, 236, 237). Dr. Chang recommended that the patient be titrated on BIPAP with a differential of only 5 cm/H₂O above the EPAP for the patient's oxygen saturations. The P/P also states, "If the patient is absolutely not sleeping with CPAP then BiPAP may be tried." (CP pg 227). The disciplinary actions that led to Wilkinson's termination in October, 2010 are disproven by the P/P and the parameters of the AASM during the grievance Step meetings with Charmion Patton and Tracy Radcliff. Wilkinson is still terminated.

Wilkinson files a complaint with the National Labor Relations Board (NLRB) and the Human Rights Commission (HRC). The HRC files in parallel with the Equal Employment Opportunity Commission (EEOC). They all refuse to take any action.

In April, 2011, Wilkinson received a copy of his financial records and personnel file after promising to sue for them. The file contains no redactions of patient information. Wilkinson is no longer employed in the medical profession and is not bound by HIPAA (Health Insurance Portability and Accountability Act).

In May 2012, an arbitrator determined that Wilkinson should be given a reasonable amount of time to correct his behavior, since this was not done in October 2010, before he was terminated. Wilkinson is terminated again after working for five nights. Wilkinson worked three

nights alone without supervision after not working for ARMC for 20 months. Wilkinson was not given a copy of the new Policy/Procedure of the Sleep Center, as he requested in the initial meeting with Jerry Hudson, Radcliff, and Polansky (CP pg 30). Wilkinson is told by Polansky to follow the parameters of the AASM at that meeting. Multicare agrees to buy ARMC from UHS in May 2012 with a full transfer occurring on September 30, 2012 (Declaration of Jerry Mason Hudson, pg 2, para 3).

In June, 2012, Wilkinson was terminated again for violations of the P/P and the doctor's orders and of coming to a mandatory staff meeting late (CP pg 216). The policy and procedure for mandatory staff meetings (CP pg 182, 183) do not address tardiness to staff meetings at all. There was no cause to discipline him for this matter and it was removed. Wilkinson was accused of rolling a patient with back pain onto his back against doctor's orders. The patient was never forced to sleep in any position, it was his choice. "Test laterally" on a doctor's order (CP pg 207) means to try and get the patient to sleep laterally as much as possible (CP pg 33, 78-86) this was done for 89% of the study. Wilkinson was accused of not informing a patient about a full face mask option. The patient was contacted six days after his study (CP pg 205). Individuals with sleep apnea are known to suffer from depression, inability to concentrate, and a lack of memory (CP pg 203). The patient described

using nasal pillows on his last study, but the prior technician, Alisha, had noted a mask that surrounds the nose (CP pg 191-193), and did not note showing a FFM option to the patient. Alisha was not disciplined for this violation of P/P. Wilkinson never noted that the patient was uncomfortable with the chinstrap. Normal established habit for Wilkinson is to offer a FFM if there is a complaint about a chinstrap and to note it in the tech notes. Dr. Chang has said on multiple occasions to use a FFM only under specific circumstances (CP pg 215, 221, 222). Union representative, Charles Primm, and Wilkinson both requested a look at the video at Step II meeting and well before the Step III meeting. Mr. Hudson said it would be too difficult for them to have a look at (Ex 2). There are six terminals to call the video up on and only two are ever used for scoring during the day (CP pg 177). Wilkinson asked for the video because he has an established habit of giving a standardized CPAP inservice which discusses the use of a chinstrap and a full face mask. Wilkinson makes a certain motion with his hands when he gives the inservice that describes where the mask fits on the face and where the chinstrap fits around the head. Wilkinson has given the same speech to literally thousands of patients over his fourteen years as a sleep technologist and always described a full face mask to all of his patients during his CPAP inservice; whether they use it or not (Ex 2). These motions were described to both

Jerry Hudson and Tracy Radcliff. The video has since been destroyed by the defendants. Wilkinson was accused of not increasing a patient early enough in a study and not leaving him on the final pressure long enough. The patient's apnea hypopnea index (AHI), was under 5 (CP pg 185) which is considered an optimal titration according to the AASM (Ex 8, pg. 157, pg. 162, Figure 2). There was no reason for a pressure increase for respiratory events or snores. Wilkinson followed the P/P, "After all respiratory events have disappeared, one may consider increasing pressure by 1 or 2 for arousals if arousals are not due to high pressures." (CP pg 227). The P/P of the sleep center requires a patient be on a "pressure for at least 20 minutes" and the technician is warned, "Do not increase pressure for one or two events." (CP pg 227). The practice parameters of the AASM (Ex 8, pg. 162, 4.2.2.1) only require 5 minutes. Dr. Nicole Phillips recommends the last pressure Wilkinson had the patient on; and the patient feels he slept better than he did at home and is willing to use the CPAP therapy (CP pg 185). Wilkinson presents his information to ARMC HR director, Jerry Mason and Department manager, Tracy Radcliff during union Step meetings and he is still terminated. Wilkinson is denied a position at Multicare because of his recent termination by ARMC for violations of the P/P. Arbitration is still

pending on the matter. Wilkinson is replaced by a female technician named Alisha that was displaced when Wilkinson was reinstated.

ARGUMENT

STANDARD OF REVIEW-C.R. 56 MOTIONS

This court held in **Ramirez v. Whatcom Counseling and Psychiatric Clinic**, 151 Wash.App 1007 (2009) that:

“We review an order of summary judgment de novo, engaging the same inquiry as the trial court. *Dumont v. City of Seattle*, 148 Wash.App. 850, 200 P.3d 764, (2009) (citing *Sellsted v. Wash. Mut. Sav. Bank*, 69 Wash.App 852, 857, 851 P.2d 716 (1993) overruled on other grounds by *Mackay v. Acorn Custom Cabinetry, Inc.*, 127 Wash.2d 302, 898 P.2d 284 (1995)). Summary judgment is appropriate in the moving party demonstrates the absence of any genuine issue of material fact and that it is entitled to judgment as a matter of law. . *Dumont*, 148 Wash.App. at 860-861 P.3d 764, (citing *Sellsted*, 69 Wash.App 852, 857, 851 P.2d 716). Summary judgment is also proper if reasonable persons could reach only one conclusion. *Dumont*, 148 Wash.App. at 861 P.3d 764, (citing *Korlund v. Dyncorp Tri-Cities Servs., Inc.*, 156 Wash.2d 168,177,125 P.3d 119 (2005))”

RCW 4.44.080 - Questions of law to be decided by court. All questions of law including the admissibility of testimony, the facts preliminary to such admission, and the construction of statutes and other writings, and other rules of evidence, are to be decided by the court, and all discussions of law addressed to it.

RCW 4.44.090 - Questions of fact for jury.

All questions of fact other than those mentioned in **RCW 4.44.080**, shall be decided by the jury, and all evidence thereon addressed to them.

RCW 4.40.060 - Trial of certain issues of fact — Jury.
An issue of fact, in an action for the recovery of money only, or of specific real or personal property shall be tried by a jury, unless a jury is waived, as provided by law, or a reference ordered, as provided by statute relating to referees.

Summary judgment should not have been granted because issues of material facts exist. ARMC alleges that Wilkinson was terminated for violations of Policy/Procedure (P/P). Wilkinson shows that the written Policies/Procedures contradict this conclusion. Wilkinson was disciplined for starting a patient on ASV modality without a doctor's order (CP pg 242). ASV P/P does not exist until the P/P rewrite in August, 2010 (CP pg 228), the only reference to it is made at a staff meeting a year before Wilkinson used it (CP pg 241). It is unreasonable to expect that anyone would remember from that far back. It would also indicate that the change was a suggestion, since it was not formalized into the Sleep Center P/P until 15 months later. Wilkinson allegedly violated P/P by not increasing for snores (CP pg 224). According to the AASM parameters (Ex 8, pg. 165, 4.3.2.5) the snoring must be "loud and unambiguous for at least 3 minutes." Only the technician/investigator can gauge snores because sound is not recorded during the sleep study and only the

technician/investigator has an external microphone to listen to. Wilkinson followed the P/P and increased the pressure when he thought he heard snoring. Wilkinson allegedly started the patient on 8/5 H₂O instead of 8/6 cm/H₂O and started the patient on BIPAP when it was not ordered (CP pg 223). Discussions between Tracy Radcliff and the doctors make this disciplinary action “irrelevant” (CP pg 219). Wilkinson allegedly did not start a patient on CPAP soon enough in their study and this led to patient dissatisfaction (CP pg 225). No indication of “patient dissatisfaction” was presented by the defense. It also alleges that Wilkinson used an alternate mask than the one that was on the homecare order. The homecare order is for homecare, not the sleep study. If the doctor wanted the patient on a particular mask during the sleep study it would have been stated on the sleep study order; it was not. Wilkinson allegedly switched a patient to BIPAP contrary to P/P (CP pg 235). The patient was switched to BIPAP for oxygen saturation issues according to the sleep center P/P for inadequate oxygen saturations. “Increase the IPAP pressure until the hypopneas are resolved and adequate oxygen saturations have been reached.” (Ex 9, pg.3). “Titration of alveolar hypoventilation requires using patient tolerance and adequate oxygen saturation for levels of pressure.” (Ex 9, pg.3, 228-232, 237). The patient was set at a proper EPAP and IPAP pressure according to BIPAP/CPAP P/P. “When

initiating BiPAP set the EPAP or around the pressure where apneas were eliminated, IPAP should be set minimum 3 cmh₂o above the EPAP for obstructive sleep apnea.” (Ex 9, pg.3). Dr. Chang had also been consulted about this during the study per P/P, “The patients oxygen saturation remains below 88% after a therapeutic level of CPAP/BiPAP has been reached” (ARMC000140) and had not questioned it (CP pg 229, 230). Dr. Chang actually recommended that the patient be titrated on BIPAP with a differential of only 5 cm/H₂O above the EPAP for the patient’s oxygen saturations. The P/P also states, “If the patient is absolutely not sleeping with CPAP then BiPAP may be tried.” (CP pg 227). This gives the sleep technician a great deal of latitude when adjusting the pressures for a patient or deciding whether to use CPAP or BiPAP. A doctor cannot reasonably expect the technician to guess that the doctor would want the technician to do something different than what is outlined in the P/P and the parameters set down by the AASM. The majority of disciplinary actions that led to Wilkinson’s termination in October, 2010 were a pretext for discrimination and/or retaliation since they contradict standing P/P and the parameters of the AASM. There is only one time when the material facts are not disputed in the disciplinary actions involving violations of P/P or doctor’s orders. Therefore, summary judgment is not appropriate

since matters facts are in question and a jury is necessary to determine if the terminations were merely a pretext for discrimination and retaliation.

“Just cause” is defined in **Baldwin v. Sisters of Providence in Washington, Inc.**, 112,127, 139, 769 P.2d 298 (1989), and expounded upon by the Supreme Court as a fair and honest cause or reason, regulated by good faith on the part of the party exercising the power. We further hold a discharge for “just cause” is one which is based facts (1) supported by substantial evidence and (2) reasonably believed by the employer to be true.” In **Gaglidari v Denny’s Restaurants, Inc.**, Judge Brachtenbach’s concurrence amplifies the meaning of “good faith”

good faith “means that an employer should conduct an objectively reasonable investigation to ascertain the facts. It means that the facts must lead a reasonable person to the conclusion that the employee was guilty of committing the prohibited act or not doing the omitted act. It means the employee should be told of the grounds for discharge and be given a reasonable opportunity to dispute the alleged acts or omission. If after taking these steps, the employer reasonably concludes that the stated grounds exists, the termination is not a wrongful discharge”

An arbitrator determined in May 2012, that Wilkinson was not terminated for “just cause” and should be given a reasonable amount of time to correct his behavior, since this was not done in October 2010, before he was terminated. Wilkinson was denied a copy of the new P/P, was not supervised for three of the five nights he worked, and only worked five

nights before again being terminated in June 2012. Five nights supervised with a copy of the P/P would have been an unreasonable amount of time for anyone to correctly do a job he/she had been absent from for over 20 months. Wilkinson again establishes that the P/P and the practice parameters of the AASM support his case against termination during the union's Step meetings process. Wilkinson provides the affidavits of Sarin Plork and David Iligan, former sleep technicians of ARMC, that corroborate a routine practice of the sleep lab regarding doctor's orders for patient sleeping positions during summary judgment. According to **RULE ER 406, HABIT; ROUTINE PRACTICE**

Evidence of the habit of a person or of the routine practice of an organization, whether corroborated or not and regardless of the presence of eyewitnesses, is relevant to prove that the conduct of the person or organization on a particular occasion was in conformity with the habit or routine practice.

ARMC goes so far as to refuse to let Wilkinson or his union representative view a video (Ex 2), and then destroy it, that would have exonerated Wilkinson completely from one of the disciplinary action involving a patient who was allegedly not offered a full face mask in lieu of a chinstrap. The patient was contacted six days after his study (CP pg 205). Individuals with sleep apnea are known to suffer from depression, inability to concentrate, and a lack of memory (CP pg 189, 193-204). The

patient described using nasal pillows on his last study, but the prior technician, Alisha, had noted a mask that surrounds the nose (CP pg 190-192). Wilkinson never noted that the patient was uncomfortable with the chinstrap. Habit for Wilkinson is to offer a FFM if there is a complaint about a chinstrap and to note it in the tech notes. Wilkinson was never told the chinstrap was uncomfortable by the patient, so it was not noted. Wilkinson allegedly did not increase a patient's CPAP pressure even though he was having respiratory events, snores, and arousals (CP pg 217). Wilkinson increased the pressure, but for too short a period according to the patient's doctor, Dr. Nicole Philips. The patient's apnea hypopnea index (AHI), was under 5 (CP pg 247) which is considered an optimal titration according to the AASM (Ex 8, pg. 157, pg. 162, Figure 2). Since snoring has already been addressed early in the brief, I refer you back to that information. There was no reason for a pressure increase for respiratory events or snores. The patient was increased 34 minutes before the study was stopped for arousals (CP pg 249) and showed no improvement in his arousals. The policy and procedure of the sleep center requires a patient be on a pressure for only 20 minutes (CP pg 227). The practice parameters of the AASM (Ex 8, pg. 162, 4.2.2.1) only require 5 minutes. It was also alleged that Wilkinson showed up to a mandatory staff meeting late. The P/P for mandatory staff meetings (CP pg 182, 183)

did not address tardiness to staff meetings at all. There was no cause to discipline him for this matter and it was removed. There is no “just cause” for either termination as an investigation in “good faith” was not done the first or the second time. Substantial evidence exists that contradicts the alleged violations of P/P reported by the doctors, Polansky, and Radcliff that would lead a reasonable person to conclude that Wilkinson did not violate the P/P and so his multiple terminations are simply pretext.

Summary judgment should be granted only if reasonable persons could reach but one conclusion after considering the evidence presented in the light most favorable to the nonmoving party, **Marincovich v. Tarabochia**, 114 Wash. 2d 271, 274, 787 P.2d 562 (1990). The defense presents no evidence but hearsay statements since the P/P and the practice parameters of the AASM do not support the disciplinary actions used as a basis to terminate Wilkinson. Judge Schapira reduces the P/P and the parameters of the AASM to merely “science”. They are rules. The parameters of the AASM form the basis of how the personnel in a sleep lab accredited by the AASM must act since by definition “accreditation” denotes certain standards that must be maintained by following specific rules. The P/P of the ARMC sleep lab are the rules set down by the Medical Director, Dr. Chang that every sleep technician must follow. Wilkinson should never have been disciplined for following the rules.

Judge Schapira says, “It is not okay to treat people badly, but it is not illegal to treat people in a way that leaves them unhappy with the end of their employment.” (RP pg. 122, line 12-14). There are laws against harassment, discrimination, and retaliation by employers against employees. Judge Schapira denies that any of this occurred simply because ARMC says it did not occur. Without substantial supporting evidence, ARMC’s denials of wrongdoing should fall on deaf ears since it does not meet the “just cause” standard as defined in **Baldwin v. Sisters of Providence in Washington, Inc.**, 112,127, 139, 769 P.2d 298 (1989)

Washington laws against discrimination (WLAD), prohibits discrimination by employers based on sex. A prima facie case of sex discrimination must have four elements. First, it must be unwelcome. Wilkinson established this with multiple complaints to Human Resources, Radcliff, and the HRC. Second, the harassment must be because of sex. Polansky wanted a female staff member on each shift (CP pg 83-86) though male employees had been performing well for years with female patients. Wilkinson is male in a subordinate position to Radcliff and Polansky, who are female. Several incidents have been presented in the evidence where male employees, especially Wilkinson, were treated to a different standard than female employees. Wilkinson is late to a mandatory meeting, he is disciplined (CP pg 216). Barbara Rooney does

not show up for multiple mandatory meetings, she is not disciplined (CP pg 35,36). Wilkinson violates P/P for not starting a mandatory split, he is disciplined. Gualu violates P/P by starting a patient on supplemental oxygen before using BiPAP or consulting the doctor oncall, she is not disciplined (CP pg 202). Carrie Olsen and Alisha violate P/P and did not clean and sterilize equipment for over two months; both females are not disciplined (CP pg 95-106). Wilkinson leaves a patient on a pressure for over 20 minutes, following P/P; he is disciplined (CP pg 188). Females leave a patient on a pressure for under the mandatory 20 minutes, and they are not disciplined. Wilkinson is disciplined for not offering a full face mask (FFM) to a patient, but Alisha, a female technologist, is not disciplined when she fails to even give the same patient any documented mask options beyond a nasal mask (CP pg 190-192).

The majority of the disciplinary actions regarding P/P violations by Wilkinson were based on complaints made by Dr. Clerc whose credibility is in question. The affidavit of David Iligan outlines an incident in which he was forced to falsify a patient's medical file by Dr. Clerc. This is further supported by Wilkinson's journal entries. **RULE ER 405, METHODS OF PROVING CHARACTER**, states:

(a) Reputation. In all cases in which evidence of character or a trait of character of a person is admissible, proof may be made by testimony as to reputation. On cross

examination, inquiry is allowable into relevant specific instances of conduct.

(b) Specific Instances of Conduct. In cases in which character or a trait of character of a person is an essential element of a charge, claim, or defense, proof may also be made of specific instances of that person's conduct.

Dr. Clerc was not directly involved in the discrimination, but without his support the disciplinary actions would not have started. He being male does not exonerate Radcliff and Polansky from wrongdoing as Judge Schapira believes. Radcliff stated in her Declaration, pg. 2, P 6. "In November 2005, I hired Paul Wilkinson to work as a Sleep Technician. With review and approval from Human Resources, I also made the decision to terminate Mr. Wilkinson's employment". She is responsible for the hiring and terminating of personnel at ARMC sleep center. Disciplinary actions must then go through her if a sleep technician is to be terminated, not the doctors. "While I managed the Sleep Center, I relied upon a department lead, Melissa Polansky, due to her expertise and knowledge.", Declaration of Tracy Radcliff, pg 2, P 3. Radcliff relied on Polansky, but does not refer to the written P/P of the sleep center, or the practice parameters of the AASM. Since the sleep center at ARMC is accredited by the AASM and the P/P is established by the Medical Director, Dr. Chang, Radcliff should rely on this objective evidence, rather than the subjective evidence given by an individual. As the one

responsible for conducting an investigation in “good faith” Radcliff must be reasonable and objective. She is neither. Radcliff disregards the P/P. Radcliff disregards the practice parameters of the AASM. Radcliff stated in her Declaration, pg. 2, P 6, “Over time, Mr. Wilkinson began aggressively resisting Ms. Polansky’s work instructions and disciplinary efforts because he believed that he knew more than she did.” Rather than question why an exceedingly competent employee, (Ex 3, CP pg 150) such as Wilkinson, would suddenly start to require frequent disciplining by Polansky, Radcliff continues to terminate Wilkinson not once but twice for violations of P/P that do not exist. All the disciplinary actions written by Radcliff and Polansky are merely pretext; their real reason for terminating Wilkinson must be determined by a jury since material facts are in dispute. Third, the harassment must affect the terms and conditions of employment. Wilkinson was terminated twice. The second time so that ARMC could rehire Alisha, a female employee displaced by Wilkinson’s reinstatement before Multicare took over the hospital on September 30, 2012. And fourth, the harassment must be imputable to the employer. Radcliff is the department manager, Polansky is the supervisor, James Moore, HR director, Jerry Hudson, HR director, and Charmion Patton, HR director at ARMC. **Glasgow v. Georgia-Pacific Corp.** 103 Wash.2d 401, 406-407, 693 P.2d 708 (1985). The Plaintiff established all four elements

with his journal alone (Ex 2, CP pg 9-34). If he has not, it is generally a factual question for a jury to decide if working conditions have risen to an intolerable level. **Sneed**, 80 Wash. App at 849-50, 912 P.2d 1035. So this alone precludes summary judgment.

The defense has established few material facts that establish a foundation for their case. The statements made by Jerry Hudson in his affidavit are not “material facts”, **Grimwood v. Puget Sound**, 110 Wn.2d 355, 359-360 (1988), because he was not present or even employed at ARMC until 2011 and he is not an expert witness. He was not at the staff meeting Wilkinson was late to and all statements made to him are simply hearsay. **RULE ER 602, LACK OF PERSONAL KNOWLEDGE** states:

A witness may not testify to a matter unless evidence is introduced sufficient to support a finding that the witness has personal knowledge of the matter. Evidence to prove personal knowledge may, but need not, consist of the witness' own testimony. This rule is subject to the provisions of rule 703, relating to opinion testimony by expert witnesses.

The defendants supply evidence of negative outcomes for the patients that were under Wilkinson’s care in only one instance; the same one Wilkinson did not grieve. If his violations of P/P were so egregious as to warrant termination, then the negative outcomes from the patients studied should have warranted a new sleep study every time. In the case of the patient that received the ASV modality, it was clear that another titration would

be beneficial simply for the lack of sleep exhibited by the patient and again no P/P existed concerning the use of ASV modality. The defendants do not stipulate where the P/P was violated in the disciplinary actions against Wilkinson because they cannot. Defendants simply rely on statements made by individuals without any supporting evidence from the P/P. The defendants do not provide any material evidence that investigations were ever done regarding Wilkinson's complaints of harassment, discrimination, and retaliation that he made to Human Resources directors James Moore, Charmion Patton, or Jerry Hudson (CP pg 35-36, CP pg 91-94). The defendants do not refute the fact that Dr. Clerc is the type of person to force someone to cover up his own wrongdoing by lying. The defense does not refute that Dr. Chang swore during the first arbitration that one of the disciplinary actions attributed to him was not one he sponsored. The defendants' attorneys have claimed that they never received a request for records that Wilkinson states was sent. Defendants' attorneys failed to provide the records requested in another instance within the 30 day period allotted by the court. Defendants have destroyed a video that was both pertinent to this case and an arbitration hearing to be held at a later date. The defendants have at every turn maintained control of the material facts in this case. This in and of itself warrants a denial of summary judgment.

“We have specific statutes. I understand you haven't taken depositions yet, but nevertheless your diary about what you think is in other people's minds or what motivates people is not how we are able to decide this case. That's not the evidence I would present – allow to be presented to the jury. You don't know what's in their mind -- of course they don't know, necessarily, what is in your mind.” as Judge Schapira informs (RP report, pg 122). But that is exactly a question for a jury not a judge. It is a matter of material facts not of the law. Only a jury may deduce what the defendants or plaintiffs are thinking by their behaviors. Disparate treatment infers discrimination and/or retaliation. Radcliff and Polansky clearly show a pattern of behavior here that is hard to deny. Polansky yelled at Wilkinson several times and refused to let him speak on various occasions. Polansky did this in front of other staff without provocation of any sort (CP pg 9, 78-86). Polansky and Radcliff accuse Wilkinson of abusing the use of sick time and then suspend him (CP pg 262). This decision is later reversed and removed (CP pg 105). Then he is accused of insubordination multiple times when no direct order is ever given. Then finally he is accused of violations of P/P. No part of the P/P is violated that Radcliff or Polansky can point to, but he is still summarily terminated. Radcliff writes a negative review of Wilkinson, but provides no supporting evidence for it when it is requested by Wilkinson

(Declaration of Tracy Radcliff, ARMC Ex 9). In the same document, Wilkinson asks, “How can we score a 5 out of 5 in any one of the sections of our evaluations? I have done the best I can over a very difficult year, but it is apparently not good enough for you or Melissa. Please tell me what I can do because I can think of nothing else.” (CP pg 168). There is no evidence that Radcliff was ever forthcoming with any sort of guidance for Wilkinson. Judge Schapira denies that this is a pattern. She goes so far as to say that the journal of Wilkinson is inadmissible as evidence “That's not the evidence I would present – allow to be presented to the jury.”. Quoting *Argo*, 452 F.3d at 1199; *cf. Fraser v. Goodale*, 342 F.3d 1032, 1036 (9th Cir. 2003) “[W]e need not decide whether the diary [submitted to oppose summary judgment] itself is admissible. It would be sufficient if the contents of the diary are admissible at trial, even the diary itself may be inadmissible. At the summary judgment stage, we do not focus on the admissibility of the evidence’s form. We instead focus on the admissibility of its contents.”. The contents of the diary are mere recitations of events within Fraser’s personal knowledge and, depending on the circumstances, could be admitted into evidence at trial in a variety of ways. Fraser could testify to all the relevant portions of the diary from her personal knowledge. **FED. R. EVID. 602**. If she forgets the exact dates or the details of the event, she may be able to use the diary to refresh her

recollection. **FED. R. EVID. 612**. Indeed, even inadmissible evidence may be used to refresh a witness's recollection. **United States v. Frederick**, 78 F.3d 1370, 1376 (9th Cir. 1996); **United States v. Weller**, 238 F.3d 1215, 1221 (10th Cir. 2001); **United States v. Muhammad**, 120 F.3d 688, 699 (7th Cir. 1997). If the diary fails to refresh her recollection, she might still be able to read the diary into evidence as a recorded recollection under **FED. R. EVID. 803(5)**. **Fraser**, 342 F.3d at 1037. (citing **Block v. City of Los Angeles**, 253 F.3d 410, 418–19 (9th Cir. 2001); **Fed. Deposit Ins. Corp. v. N.H. Ins. Co.**, 953 F.2d 478, 485 (9th Cir. 1991)). Yet she readily accepts statements allegedly made by the doctors as evidence though the court has no proof that these are actual statements from them and they do not meet the requirements for material evidence outlined in **Baldwin v. Sisters of Providence in Wash. Inc.**, 112 Wash.2d 127, 132, 769 P.2d 298 (1989). **Rule ER 602** of the Washington state courts closely follows **FED. R. EVID. 602**.

A witness may not testify to a matter unless evidence is introduced sufficient to support a finding that the witness has personal knowledge of the matter. Evidence to prove personal knowledge may, but need not, consist of the witness' own testimony. This rule is subject to the provisions of rule 703, relating to opinion testimony by expert witnesses.

Judge Schapira even has the rare opportunity of swearing in Wilkinson to ascertain the honesty of the statements he makes in his journal, but fails to do so.

Under the National Labor Relations Act, it is illegal to retaliate against a union employee for engaging in concerted activities for the purpose of collective bargaining or other mutual aid or protection. Wilkinson reported violations of the union contract to UFCW Local 21 and fought nearly every disciplinary action, with the union after April 2009. Polansky, Radcliff, Jim Moore, Charmion Patton, and Jerry Hudson continued to write and support disciplinary actions against Wilkinson, not allow him to produce evidence against the actions, and withheld evidence that the plaintiff relied on to defend himself against the actions. They held his financial records after he made multiple requests for them and refused to allow him to copy or change his personnel file after repeated requests for them. Wilkinson was held to a different standard than other employees and retaliated against once he enlists the union's aid. When Wilkinson and Illigan requested the hours of Gualu, Polansky forms a 0.6 position to reduce their hours. Illigan is also asked by Polansky if he wants to quit. Wilkinson also asked that the union representative look into the validity of Polansky's claims that Wilkinson and Illigan could not take Gualu's hours and her per diem status.

Wilkinson is disciplined for going into overtime without supervisor approval, Dauley is not disciplined for the same. Only one disciplinary action was leveled against Wilkinson before he engaged the union in April, 2009. Fourteen disciplinary actions were leveled against Wilkinson after he engaged the union in April, 2009, till his termination in 2010. Wilkinson was terminated after only five nights of work after being reinstated in May 2012 with four more disciplinary actions. Again the defense provides no evidence beyond the unsworn statements made by doctors at the sleep center to support their case that Wilkinson actually violated P/P. Wilkinson provided the P/P of the lab, the practice parameters of the AASM, his technician notes and the affidavits of two other former sleep technicians to show that he neither violated P/P or the doctor's orders. Judge Schapira seems to think that doctors are incapable of mistakes and disregards the evidence. "we don't have the evidence that when a doctor says, This is what I wanted and you don't do it—that that's wrong for there to be discipline connected with that." (RP P109, lines 2-5).

The sleep doctors are employees of ARMC and UHS. A complaint from them is handled in the same manner as any other employee complaint against another employee. Any reasonable and objective investigation conducted in "good faith" as outlined in **Baldwin v. Sisters**

of Providence in Washington, Inc. and Gaglihari v Denny's

Restaurants, Inc. done by Polansky, Radcliff, Jim Moore, Charmion Patton, or Jerry Hudson would have shown that the doctors were mistaken about Wilkinson violating the written P/P of the lab or the parameters of the AASM. From the 2009 personnel review of Wilkinson we find that Radcliff and Polansky rate him highly for his expertise in sleep and patient education. After making several complaints to Human Resources about discrimination, harassment, bullying, and retaliation from Polansky and Radcliff; after engaging the union multiple times to address deficiencies in the sleep; and after showing disparate treatment between males and females at the sleep lab, Wilkinson is now seen as incompetent. Frequent communications are documented in the Exhibits presented at summary judgment. For Polansky and Radcliff to claim that Wilkinson does not communicate often or well is unreasonable.

Section 301 puts the Collective Bargaining Agreement (CBA) first. In this case the CBA does not specify what policies and procedures the employer may institute or how an employer will conduct investigations, how it will discipline employees, or even if an employer is obligated to do any of those things. Does then the employee rely solely on the CBA? No. An employee must then rely on the implied contract that exists between the employer and employee for those things not covered in the CBA. A

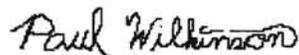
jury must determine if this contract exists and if damages can be collected for violations of that contract.

CONCLUSION

The Appellant submits that there were errors of law made by the trial court. After reviewing the foregoing and the evidence it is my hope and wish that the Court of Appeals reverse the summary judgment the trial court granted the defendants on August 9, 2013, concerning discrimination under WLAD and retaliation under the NLRA and order that the case go forward to trial. It is also my hope that the Appellate Court will correct the trial court failure to enter a judgment concerning the implied contract between Wilkinson and ARMC exclusive of the collective bargaining agreement with UFCW local 21 and send it back to the trial court or enter a judgment concerning the matter.

Dated on February 10, 2014

Respectfully submitted,



Paul Wilkinson, Pro Se
Appellant /Plaintiff

DECLARATION OF SERVICE

The undersigned declares under penalty of perjury under the laws of the State of Washington that on this day, I sent a copy to the following:

Catharine Morisset

Attorney at Law

Jackson Lewis LLP

520 Pike Street, Suite 2300

Seattle, WA 98101-4099

Dated on February 10, 2014

Paul Wilkinson

Paul Wilkinson, Pro Se
3041 Mills Park Dr, Apt 44
Rancho Cordova, CA 95670
425-427-5183
rasdp@hotmail.com

FILED
COURT OF APPEALS DIV I
STATE OF WASHINGTON
2014 FEB 11 AM 8:32

Exhibit 1
16 pages

SUPERIOR COURT OF WASHINGTON FOR King COUNTY

Paul Wilkinson Plaintiff,

No. 12-2-29262-1 KNT
Consolidated with Case No. 12-2-21215-0
SUMMONS BY PERSONAL SERVICE

Vs.
Auburn Regional Medical
Center, Universal Health Services,
Inc., Drs Daniel Clero,
Melissa Polansky, Defendant,
Tracy Radcliffe

The State of Washington to:
Defendant Melissa Polansky
Address 16108 87th Avenue Ct. E., Puyallup WA 98375

1. A lawsuit has been started against you in the above entitled court by the plaintiff.
2. Plaintiff's claim is stated in the written complaint, a copy of which is served upon you with this summons.
3. In order to defend against this lawsuit, you must respond to the complaint by stating your defense in writing, and serve a copy upon the undersigned person.
 within 20 days (if service is made on you within the State of Washington), or
 within 60 days (if service is made on you outside the State of Washington), after the date of service on you of this summons, excluding the day of service, or a default judgment may be entered against you without notice. A default judgment is one where the plaintiff may be entitled to what is asked for because you have not responded.
4. If you serve a notice of appearance on the undersigned person you are entitled to notice before a default judgment may be entered.
5. If not previously filed, you may demand that the plaintiff file this lawsuit with the court. If you do so your demand must be in writing and must be served upon the undersigned person. Within 14 days after you serve your demand, the plaintiff must file this lawsuit with the court, or the service on you of this summons and complaint will be void.
6. If you wish to seek the advice of a lawyer in this matter, you should do so promptly so that your written response, if any, may be served on time.

7. This summons is issued pursuant to Rule 4 of the Civil rules for Superior Court of the State of Washington.

Dated: June 4, 2013

Paul Wilkinson, Pro Se

Signature:

Paul Wilkinson

(type name)

3600 Dana Dr, Apt 360
Rancho Cordova, CA 95670

Address

SUPERIOR COURT OF WASHINGTON FOR King COUNTY

Paul Wilkinson Plaintiff,

Vs.
Auburn Regional Medical
Center, Universal Health Services
Inc, Dr. Daniel (Clerc),
Melissa Polansky, Defendant,
Tracy Radcliff

No. 12-2-29262-1 KNT
Consolidated with Case No. 12-2-31215-0
SUMMONS BY PERSONAL SERVICE

The State of Washington to:

Defendant Tracy Radcliff

Address 1012 7th Avenue NW, Puyallup, WA 98371

1. A lawsuit has been started against you in the above entitled court by the plaintiff.
2. Plaintiff's claim is stated in the written complaint, a copy of which is served upon you with this summons.
3. In order to defend against this lawsuit, you must respond to the complaint by stating your defense in writing, and serve a copy upon the undersigned person.
 within 20 days (if service is made on you within the State of Washington), or
 within 60 days (if service is made on you outside the State of Washington), after the date of service on you of this summons, excluding the day of service, or a default judgment may be entered against you without notice. A default judgment is one where the plaintiff may be entitled to what is asked for because you have not responded.
4. If you serve a notice of appearance on the undersigned person you are entitled to notice before a default judgment may be entered.
5. If not previously filed, you may demand that the plaintiff file this lawsuit with the court. If you do so your demand must be in writing and must be served upon the undersigned person. Within 14 days after you serve your demand, the plaintiff must file this lawsuit with the court, or the service on you of this summons and complaint will be void.
6. If you wish to seek the advice of a lawyer in this matter, you should do so promptly so that your written response, if any, may be served on time.

7. This summons is issued pursuant to Rule 4 of the Civil rules for Superior Court of the State of Washington.

Dated: June 4, 2013

Paul Wilkinson

Signature:

Paul Wilkinson

(type name)

3600 Santa Dr, Apt 378
Rancho Cordova, CA 95670

Address

SUPERIOR COURT OF WASHINGTON FOR King COUNTY

Paul Wilkinson Plaintiff,

No. 12-2-29262-1 KNT
Consolidated with Case No 12-2-31215-0
SUMMONS BY PERSONAL SERVICE

Vs.
Auburn Regional Medical
Center, Universal Health
Services, Inc., Dr. Daniel Clerc
Melissa Polansky, Defendant,
Tracy Radcliffe

The State of Washington to:

Defendant Dr. Daniel Clerc,

Address 5814 Olive Ave SE, Auburn, WA 98092

1. A lawsuit has been started against you in the above entitled court by the plaintiff.
2. Plaintiff's claim is stated in the written complaint, a copy of which is served upon you with this summons.
3. In order to defend against this lawsuit, you must respond to the complaint by stating your defense in writing, and serve a copy upon the undersigned person.
 within 20 days (if service is made on you within the State of Washington), or
 within 60 days (if service is made on you outside the State of Washington), after the date of service on you of this summons, excluding the day of service, or a default judgment may be entered against you without notice. A default judgment is one where the plaintiff may be entitled to what is asked for because you have not responded.
4. If you serve a notice of appearance on the undersigned person you are entitled to notice before a default judgment may be entered.
5. If not previously filed, you may demand that the plaintiff file this lawsuit with the court. If you do so your demand must be in writing and must be served upon the undersigned person. Within 14 days after you serve your demand, the plaintiff must file this lawsuit with the court, or the service on you of this summons and complaint will be void.
6. If you wish to seek the advice of a lawyer in this matter, you should do so promptly so that your written response, if any, may be served on time.

7. This summons is issued pursuant to Rule 4 of the Civil rules for Superior Court of the State of Washington.

Dated: June 4, 2013

Paul Wilkinson, Pro Se
Signature:

Paul Wilkinson
(type name)
3600 Data Dr, Apt 378
Rancho, Cordova, CA 95670
Address

SUPERIOR COURT OF WASHINGTON FOR King COUNTY

Paul Wilkinson Plaintiff,

Vs.

Amburn Regional Medical
Center, Universal Health
Services, Inc., Defendant,
Dr. Daniel Clark, Tracy Radloff,
Melissa Palansky

No. 12-2-29262-1 KNT
Consolidated with Case No. 12-2-3215-0
SUMMONS BY PERSONAL SERVICE

The State of Washington to:

Defendant Amburn Regional Medical Center, Universal Health Services, Inc.
Address 520 Pike Street, Suite 2300, Seattle, WA 98101

1. A lawsuit has been started against you in the above entitled court by the plaintiff.
2. Plaintiff's claim is stated in the written complaint, a copy of which is served upon you with this summons.
3. In order to defend against this lawsuit, you must respond to the complaint by stating your defense in writing, and serve a copy upon the undersigned person.
 within 20 days (if service is made on you within the State of Washington), or
 within 60 days (if service is made on you outside the State of Washington), after the date of service on you of this summons, excluding the day of service, or a default judgment may be entered against you without notice. A default judgment is one where the plaintiff may be entitled to what is asked for because you have not responded.
4. If you serve a notice of appearance on the undersigned person you are entitled to notice before a default judgment may be entered.
5. If not previously filed, you may demand that the plaintiff file this lawsuit with the court. If you do so your demand must be in writing and must be served upon the undersigned person. Within 14 days after you serve your demand, the plaintiff must file this lawsuit with the court, or the service on you of this summons and complaint will be void.
6. If you wish to seek the advice of a lawyer in this matter, you should do so promptly so that your written response, if any, may be served on time.

7. This summons is issued pursuant to Rule 4 of the Civil rules for Superior Court of the State of Washington.

Dated: June 4, 2013

Paul Wilkinson, Pro Se
Signature:

Paul Wilkinson
(type name)
8136 3600 Data Dr, Apt 378
Rancho Cordova, CA 95670
Address

**Superior Court of Washington
County of King**

In re:

Paul Wilkinson

Petitioner,

And

Auburn Regional Medical Center, Universal
Health Services

Respondent.

No. 12-2-29262-1 KNT
Consolidated with Case No. 12-2-31215-0
**Return of Service
(Optional Use)
(RTS)**

I Declare:

1. I am over the age of 18 years, and I am not a party to this action.

2. I served the following documents to (name) T.J. ELSTON:

- summons, a copy of which is attached
- petition in this action
- proposed parenting plan or residential schedule
- proposed child support order
- proposed child support worksheets
- sealed financial source documents cover sheet and financial documents
- financial declaration
- Notice Re: Dependent of a Person in Military Service
- notice of hearing for _____
- motion for temporary order _____
- motion for and ex parte order _____
- motion for and order to show cause re: _____
- declarations of _____
- temporary order _____
- other: _____

FRONT DESK
OF LAW OFFICE

3. The date, time and place of service were (if by mail refer to Paragraph 4 below):

Date: 6-14-13 Time: 2:39 a.m./p.m. (p.m.)

Address: 520 PIKE STREET #2300
SEATTLE, WA

4. Service was made:
- by delivery to the person named in paragraph 2 above.
 - by delivery to (name) _____, a person of suitable age and discretion residing at the respondent's usual abode.
 - by publication as provided in RCW 4.28.100. (File Affidavit of Publication separately.)
 - (check this box only if there is a court order authorizing service by mail) by mailing two copies postage prepaid to the person named in the order entered by the court on (date) _____. One copy was mailed by ordinary first class mail, the other copy was sent by certified mail return receipt requested. (Tape return receipt below.) The copies were mailed on (date) _____.
 - (check this box only if there is a statute authorizing service by mail) by mailing a copy postage prepaid to the person requiring service by any form of mail requiring return receipt. (Tape return receipt below.) The copy was mailed on (date) _____.

5. Service of Notice on Dependent of a Person in Military Service.
- The Notice to Dependent of Person in Military Service was served on mailed by first class mail on (date) _____.
 - Other: _____

6. Other: _____

I declare under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

Signed at (city) SEATTLE, (state) WA on (date) 6-14-13

Georgia Berry GEORGIA BERRY
Signature Print or Type Name

Fees:
Service \$25.00
Mileage _____
Total _____

(Tape Return Receipt here, if service was by mail.)

**Superior Court of Washington
County of King**

In re:

Paul Wilkinson

Petitioner,

And

Daniel Clerc, MD

Respondent.

No. 12-2-29262-1 KNT
Consolidated with Case No 12-2-31215-0
**Return of Service
(Optional Use)
(RTS)**

I Declare:

1. I am over the age of 18 years, and I am not a party to this action.

2. I served the following documents to (name) MARY KNUTSON:

- summons, a copy of which is attached
- petition in this action
- proposed parenting plan or residential schedule
- proposed child support order
- proposed child support worksheets
- sealed financial source documents cover sheet and financial documents
- financial declaration
- Notice Re: Dependent of a Person in Military Service
- notice of hearing for _____
- motion for temporary order
- motion for and ex parte order
- motion for and order to show cause re: _____
- declarations of _____
- temporary order
- other:

NURSING SUPERVISOR
ON BEHALF OF
DANIEL CLERC
AT OFFICE

3. The date, time and place of service were (if by mail refer to Paragraph 4 below):

Date: 6/14/13 Time: 1:00 a.m./(p.m.)

Address: 3021 GRIFFIN AVE
ENUMCLAW, WA 98022

4. Service was made:
- by delivery to the person named in paragraph 2 above.
 - by delivery to (name) _____, a person of suitable age and discretion residing at the respondent's usual abode.
 - by publication as provided in RCW 4.28.100. (File Affidavit of Publication separately.)
 - (check this box only if there is a court order authorizing service by mail) by mailing two copies postage prepaid to the person named in the order entered by the court on (date) _____. One copy was mailed by ordinary first class mail, the other copy was sent by certified mail return receipt requested. (Tape return receipt below.) The copies were mailed on (date) _____.
 - (check this box only if there is a statute authorizing service by mail) by mailing a copy postage prepaid to the person requiring service by any form of mail requiring return receipt. (Tape return receipt below.) The copy was mailed on (date) _____.

5. Service of Notice on Dependent of a Person in Military Service.
- The Notice to Dependent of Person in Military Service was served on mailed by first class mail on (date) _____.
 - Other: _____

6. Other: _____

I declare under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

Signed at (city) ENUMCLAW, (state) WA on (date) 6/14^{MLB}/13

Georgia Berry GEORGIA BERRY
 Signature Print or Type Name

Fees:
 Service \$ 25-
 Mileage _____
 Total _____

(Tape Return Receipt here, if service was by mail.)

File the original Return of Service with the clerk. Provide a copy to the law enforcement agency where protected person resides if the documents served include a restraining order signed by the court.

**Superior Court of Washington
County of King**

In re:

Paul Wilkinson

Petitioner,

And

Melissa Polansky

Respondent.

No. 12-2-29262-1 KNT
Consolidated with Case No. 12-2-3215-0
**Return of Service
(Optional Use)
(RTS)**

I Declare:

1. I am over the age of 18 years, and I am not a party to this action.

2. I served the following documents to (name) MELISSA POLANSKY:

- summons, a copy of which is attached
- petition in this action
- proposed parenting plan or residential schedule
- proposed child support order
- proposed child support worksheets
- sealed financial source documents cover sheet and financial documents
- financial declaration
- Notice Re: Dependent of a Person in Military Service
- notice of hearing for _____
- motion for temporary order
- motion for and ex parte order
- motion for and order to show cause re: _____
- declarations of _____
- temporary order
- other:

3. The date, time and place of service were (if by mail refer to Paragraph 4 below):

Date: 6-14-13 Time: 1:34 a.m./p.m. (p.m.)

Address: 202 N DIVISION ST
AUBURN, WA

4. Service was made:
- by delivery to the person named in paragraph 2 above.
 - by delivery to (name) _____, a person of suitable age and discretion residing at the respondent's usual abode.
 - by publication as provided in RCW 4.28.100. (File Affidavit of Publication separately.)
 - (check this box only if there is a court order authorizing service by mail) by mailing two copies postage prepaid to the person named in the order entered by the court on (date) _____. One copy was mailed by ordinary first class mail, the other copy was sent by certified mail return receipt requested. (Tape return receipt below.) The copies were mailed on (date) _____.
 - (check this box only if there is a statute authorizing service by mail) by mailing a copy postage prepaid to the person requiring service by any form of mail requiring return receipt. (Tape return receipt below.) The copy was mailed on (date) _____.

5. Service of Notice on Dependent of a Person in Military Service.
- The Notice to Dependent of Person in Military Service was served on mailed by first class mail on (date) _____.
 - Other: _____

6. Other: _____

I declare under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

Signed at (city) AUBURN, (state) WA on (date) 6-14-13.

Georgia Berry GEORGIA BERRY
Signature Print or Type Name

Fees:
Service \$25-
Mileage _____
Total _____

(Tape Return Receipt here, if service was by mail.)

File the original Return of Service with the clerk. Provide a copy to the law enforcement agency where protected person resides if the documents served include a restraining order signed by the court.

**Superior Court of Washington
County of King**

In re:

Paul Wilkinson

Petitioner,

And

Tracy Radcliff

Respondent.

No. 12-2-29262-1 KNT
Consolidated with Case No. 12-2-31215-0

**Return of Service
(Optional Use)
(RTS)**

I Declare:

1. I am over the age of 18 years, and I am not a party to this action.
2. I served the following documents to (name) TRACY RADCLIFF :
 - summons, a copy of which is attached
 - petition in this action
 - proposed parenting plan or residential schedule
 - proposed child support order
 - proposed child support worksheets
 - sealed financial source documents cover sheet and financial documents
 - financial declaration
 - Notice Re: Dependent of a Person in Military Service
 - notice of hearing for _____
 - motion for temporary order _____
 - motion for and ex parte order _____
 - motion for and order to show cause re: _____
 - declarations of _____
 - temporary order _____
 - other: _____

3. The date, time and place of service were (if by mail refer to Paragraph 4 below):

Date: 6-14-13 Time: 1:39 a.m./(p.m.)

Address: 202 N DIVISION ST
AUBURN, WA

4. Service was made:

- by delivery to the person named in paragraph 2 above.
 by delivery to (name) _____, a person of suitable age and discretion residing at the respondent's usual abode.
 by publication as provided in RCW 4.28.100. (File Affidavit of Publication separately.)
 (check this box only if there is a court order authorizing service by mail) by mailing two copies postage prepaid to the person named in the order entered by the court on (date) _____. One copy was mailed by ordinary first class mail, the other copy was sent by certified mail return receipt requested. (Tape return receipt below.) The copies were mailed on (date) _____.
 (check this box only if there is a statute authorizing service by mail) by mailing a copy postage prepaid to the person requiring service by any form of mail requiring return receipt. (Tape return receipt below.) The copy was mailed on (date) _____.

5. Service of Notice on Dependent of a Person in Military Service.

- The Notice to Dependent of Person in Military Service was served on mailed by first class mail on (date) _____.
 Other:

6. Other:

I declare under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

Signed at (city) AUBURN, (state) WA on (date) 6-14-13.

Georgia Berry
Signature

GEORGIA BERRY
Print or Type Name

Fees:
Service \$25-
Mileage _____
Total _____

(Tape Return Receipt here, if service was by mail.)

File the original Return of Service with the clerk. Provide a copy to the law enforcement agency where protected person resides if the documents served include a restraining order signed by the court.

Return of Service (RTS) - Page 2 of 2

WPF DRPSCU 01.0250 (6/2010) - CR 4(g), RCW 4.28.080(15)

patient. I said this is completely about this patient. In medicine, if a patient had a broken leg and a bleeding carotid artery, I would staunch the wound first so the patient did not die. This patient had severe apnea on his back which could cause a stroke or a heart attack or a backache. Which should I be more concerned about? I should treat for the stroke and the heart attack first, the back ache is a distant third. The patient was worse on his back, I would not be a good technician if I did not get an accurate titration of the patient on his back in REM, when he sleeps on his back naturally. Mr. Primm said to bring it back around, when the doctor in the past had ordered a study in a particular like supine he always meant at least supine, not only supine. Mrs. Radcliff said that if there had been a question on my part about the orders that I should have contacted the doctors, they are always available.

Mr. Primm moved on to the next write up about me not offering a FFM to a patient. Mr. Hudson said that the doctor contacted the patient when he said he would not use CPAP. The patient said that he would not use a chinstrap and that I never offered a FFM for him to use during the study. Mr. Hudson said the video had been reviewed and it showed that I did not offer a FFM to the patient during the CPAP inservice or at any the during the study. And because of the issues with seeing the video, it was in another building and we had not made prior arrangements, we could not look at that ourselves. I asked if it showed me making the motion (I made the motion with my hands) during the in service? Mrs. Radcliff said my back was to the camera. I found that strange since the patient was sitting on the bed when I showed him the masks. That means the camera was over my right shoulder when I was giving the inservice. I explained that when I give an inservice I explain how all the three different types of masks fit. Nasal pillows makes a seal on the nares, a classic nasal mask surrounds the nose only, and an FFM fits from between the eyes to the chin and covers the mouth completely. I know I do it because I have a "Spiel". All techs have a spiel so that they cover the material and know how long it will take them to complete certain tasks. I say the same thing over and over, I change it very little. But describing the masks I always do, it is fundamental to a CPAP inservice. The CPAP inservice sheet would show why I used the masks I used and why a patient refused a mask. I reiterated that the patient never complained to me about the chinstrap keeping him awake. If he had I would have suggested a FFM even if he was claustrophobic. Also a patient on this low a pressure could use a wedge, which I have seen take up to 6 cm/H₂O off the pressure needed to titrate the patient. Or he could use a jaw thrust device which has been used to treat patients with mild or moderate sleep apnea.

The third write up involved a patient that had been on 5 cm/H₂O for all but the last 30 minutes of his study. Then he was increased to 6 cm/H₂O. Mr. Hudson said that since I stated at the last meeting I believed the study had been misscored, a board certified physician had reviewed the study and said that the scoring was correct. Mr. Primm felt that this was a little too technical for him and said he would let me explain. I said that at the first meeting we had before I came back to work, I asked for a copy of the PnP. Melissa Polansky said a copy was available in the lab and if I just followed AASM guidelines I would be fine, anyway. But Mrs. Polansky has a sign on her desk that says not to touch anything on her desk without her permission and the PnP notebook is on her desk. Tracy said that the protocol is above her desk on a shelf and I could easily get it whenever I needed it. I did not correct her, but the note Mrs. Polansky wrote actually hangs from that shelf. I explained that the guidelines established by the AASM specifically stated that the patient "may be increased if there is 3 minutes of loud and unambiguous snoring for patients \geq 12 years old." Also a question about snoring was answered by the AASM saying that there was no real accurate way to measure snores. There really is not. Only the technician listening in on a room microphone has any way of knowing if a snore is real or artifact and how loud it is. It is purely a subjective measure.

I stated that according to that any scoring of snores later after the study was over was pure guess on the scoring technician's part. Simply Monday morning quarterbacking. Mr. Hudson pointed out that there were respiratory events and the AASM requires no events, no spontaneous arousals and no snores for an optimal study. Why did I not increase the pressure, since the patient was having events? I said that the patient did not have the required amount to be considered abnormal. He said he was having events and arousals I should have increased him. I said I did. He said but not till the end of the study and then only for thirty minutes. I said that as I had said at the last meeting I waited until his last REM to see if he would do enough that I could increase his pressure. He said I did not increase his pressure until after the patient's last REM. I explained to Mr. Primm that I hoped to finagle the patient into dropping back into REM by increasing his pressure. I had been able to in the past. I also explained to everyone that he had been on 6 cm/H₂O and showed no improvement that I could see in his arousability according to the chart that we were looking at. He looked just as bad at 5cm/H₂O. Mrs. Radcliff asked why I did not increase him to 7 cm/H₂O then. I said if 6 cm/H₂O did not help, why would 7 cm/H₂O? Mrs. Radcliff asked why I did not increase him sooner. I said because I really had no cause to. It is standing procedure in the lab not to leave a patient at 5 cm/H₂O for the entire study, Dr. Chang does not like it. Mrs. Radcliff asked why only 30 minutes? I stated that according to PnP we were to leave a patient on a pressure for 20 minutes. AASM requires 10 minutes. Dr. Chang has said in several meetings to decrease it to as low as 5 minutes if the patient is very severe. I left the patient on for 30 minutes. If the doctor is uncomfortable making a determination within that time period then they must let the technicians know by changing the protocol in the PnP. Also the doctor can prescribe any pressure they feel is appropriate. I have seen doctors increase pressures at least 2 cm/H₂O without having those pressures shown in a sleep study. Also a patient on this low a pressure could have their apnea addressed with a wedge or oral jaw thrust device instead of CPAP. Mr. Hudson pointed out that the patient had many arousals during the night, why did I not increase for them. I stated they were spontaneous or idiopathic not respiratory related. They could have been caused by the pressure being too high, the patient was wearing a mask, the room was too cold, the bed was not his, the train woke him, he did not have his favorite stuffed animal, or he did not take a sleep aid he normally takes. There are many reasons why he could have been waking up beyond his pressure being too low. Only a few of those arousals were respiratory related. Mr. Primm clarified by saying, "So you are saying that the patient did not reach the necessary threshold to require a pressure increase." I said there were simply not enough events per hour to say that this patient was anything but normal. Mr. Hudson again asked about why I did not increase for the arousals as the AASM requires for an optimal titration. I asked if he truly believed that every CPAP titration coming out of the Sleep Center was optimal? If that was every tech was required to accomplish, then every tech working there should have been written up multiple times. I referred him to the AASM definitions for a good titration and an adequate titration. This study more than met those parameters. Mr. Primm asked if all patients were like this one. I said no. Most of the patients are horrible. They have ignored their problem for so many years that it takes a lot of pressure to keep their airway open.

Mr. Primm asked again about obtaining the information we had requested last week. Mr. Hudson stated he would not obtain any statements from the doctors or the patients. He said that the video was too difficult to set up a time for. He asked what an FFM was. I said it stands for Full Face Mask. I said there was a page in the tech log from around August September of 2009, maybe June. I was not really sure. That Dr. Chang had said not to give FFMs to patients right at the start of the study because he would rather not use them.

to the patient before the study started. I make certain movements with my hands when I do the explanation. They would be on the video file. I started with the easiest one. I reiterated that I left an hour and half before the meeting was to start at 7:15am. I did not know why traffic was so bad on 167. I did not know if it was from a prior accident or it was always this way. Usually I work a Sunday, Monday, Tuesday shift and I am there on Wednesday morning when the meetings are scheduled. This is the first time that I have had to travel 167 to make a meeting that early. I had no idea that traffic was that bad. I also stated I was only 20 minutes late, arriving by 7:35am, not 30 minutes. The time clock has been removed from our department so we have to note what time we come in so that we can write it down on our exception sheet so we get paid properly. I was there for at least 30 minutes of the meeting.

I talked about the patient who did not receive a FFM recommendation. I said that the CPAP inservice paperwork and the video would help with that. I also said that there were other methods of treatment such as a jaw thrust device or a wedge to elevate the patient that would probably take care of the patient's apnea. CPAP was not the only answer. The idea that a sleep doctor would be "alarmed" because a patient would not use CPAP shows a lack of experience on the doctors part. I pointed out that the patient who was gotten up early without explanation actually slept nearly 8 hrs. That is a normal nights sleep so no explanation was needed. I explained that in sleep there was no such thing as "snort arousals" only snores. The numbers for arousals associated with snores were well below normal and the AHI was well below normal. Even together they were within the normal range. There was no reason to change the pressure, except for the fact that Dr. Chang hates it when a patient stays on one pressure all night long and wants to see at least one other pressure by the end of the study. So it is standard for a technician to increase one or two cm/H₂O for little or no reason even though it is not in the pnp. Mr. Hudson said that the doctor had some concern that I might be asleep and that is why I did not increase the patient until later in the study. I asked then was the doctor concerned that the day tech was also asleep when they scored the study? Because the day tech's score of the study was the same as my own conclusions. He asked why I waited so late to increase. I explained that I have had many experiences where a patient has cruised on a pressure most of the night and seems fine till they get to their last REM cycle just before they wake up and the whole titration goes down the drain. I was just waiting for that last REM. Mrs. Radcliff asked why did I wait so late when I might have been able to decrease the patient's arousability with a pressure increase. I told her I was not God. The patient could have been waking up because the pressure was too high. Why did I not decrease the pressure and see if that helped? I also indicated that this patient could probably have been better off with a wedge or jaw thrust device. Those might have decreased his arousals. He could have woken up because of the train, the mask, the new sleeping situation, anything really. Most of his arousals were not respiratory related according to the data.

Mr. Hudson seemed to be sweating at points. I do not know why, it was freezing in that room.

8/23/12- Charles Primm called and said that ARMC asked for more time so that they could talk to one more person regarding my termination. They will make their decision tomorrow. I asked him if he got a copy of the CPAP inservice sheet for that one patient. He did not know what I was talking about so I had to remind him. He said he would look into it. I said that it seemed strange to me at our last meeting that they did not have any written statements from the doctors. He asked why. I said that normally if doctors wanted someone written up they furnished a statement as to why they should be written up. That had not happened. I told

him he also promised me a copy of everything, but I had not gotten anything yet. He said again he would get a copy for me. He said it was good that they were talking to someone else still. That meant that they may come back with a decision to reinstate me. He usually allowed them the extra time because of that possibility. I said if they did not come back with a decision in our favor we needed to make an appointment quickly for the Step 3 meeting because we are running out of time and we need to move things along.

8/27/12- I messaged Mr. Primm and asked what the Step 2 decision was reached regarding my termination. I also called Jody Smith from Multicare and left a messaging asking what was the progress on my records request.

8/28/12- I called Mr. Primm and left a message asking what the Step 2 decision was.

8/29/12- Mr. Primm finally called. He said he made a mistake and he had actually promised to give them until today to reach a decision. He said he would email the decision to me. I asked again about a copy of all the documentation he had gotten from ARMC. He said he would email it to me and asked for my email. I told him again that these delaying tactics were used last time and then ARMC used them as a basis to try and get the arbitration thrown out. He said he was aware of that, but when the employer asks for more time then he is inclined to give it when they say they want to interview more witnesses. I told him he should not do it anymore. ARMC is just stalling.

I responded to the email Mr. Primm's email, which included ARMC's response to the Step 2 meeting. He wanted me to respond to their assertions and write down whatever evidence I thought we should request. I did. He still did not send me copies of the paperwork he still has.

8/30/12- I called Jody Smith again at Multicare and asked her to please call me about the progress on my records request.

9/5/12- I got a call from Multicare. Mrs. Smith said that she had not received my request in the email, but had gone forward with the records request. She said they burn the records 7 years after the person leaves Multicare. I was hired on 1/17/2000 and terminated 3/31/2000. She has no idea why. She said she would talk to people in the Sleep Center to see if anyone remembered me. I said there was not much chance of that since I only worked for a couple of months. What bothered me the most is that I had apparently lied on my job applications since then. I also pointed out that I only worked for two months; is it possible a mistake in record keeping happened? If I had been fired I would have fought it like I am doing at Auburn. I asked what could I do to clear my name. She said it was possible to petition a review, but once Multicare takes over at Auburn they would have to consider the evidence in my file there when making a decision. First I would have to be reinstated at Auburn. I would petition for a review.

9/6/12- I met with Mr. Primm, Mrs. Radcliff, and Mr. Hudson today at 1pm at ARMC. Mr. Hudson had been flooded out of his office and so we met in the Administrative conference room down the hall a little. Mr. Hudson explained the situation and then turned down the temp some more. Mrs. Radcliff said, "Oh, please no Hudson." Last time it was ice cold in his office when we met. Mr. Primm asked, since he was new to ARMC, if it was normal to not only have Mr. Hudson for the Step 2 meeting, but also the Step 3 meeting. Mr Hudson stated that that is

the way it was done at ARMC. Mr. Primm asked if Mr. Hudson was able to get any of the information we had requested last week. Mr. Hudson said that he did not have any written statements from the doctors or the patient. The reports had been passed to him and that was good enough. The video was unobtainable because it could only be viewed on the sleep lab computers and they were in use. This was a blatant lie or just lack of knowledge on his part. There are six computers and one scorer, sometimes two, that means that at least four computers can be used to call up the video at any time. I asked about the CPAP inservice sheet that we had requested at the end of the Step 2 meeting four weeks ago. He said he did not have that. Mr. Primm stated that we needed it. I pointed out that it should not be too hard to make a copy from the patient's file. I pointed out that if I had noted why the patient did not like a particular mask, that would be the place to find it. I did it so that the technician following me would know the complaints that a patient made about a particular mask and not use or maybe use it instead of a the patient's first choice. Mr. Primm asked for clarification on how the CPAP inservice sheet was set up. Mrs. Radcliff tried to brush it off as unimportant. I explained how the sheet was set up. Mr. Primm started to talk about the first write up explaining my point of view that in the past when a doctor has requested a particular position on an order, he has usually meant that we should study that patient in "at least" that position, not "only" that position. Usually the request is for the supine position and it is uncommon for a request like that. Mr. Hudson reiterated that the doctors consultation notes were very clear that the patient should not be study in the supine position. I responded at that point that the when I read the consultation notes, I assumed that the doctor was not sleeping with the patient. Mr. Hudson interrupted me before I could continue. He asked in a loud and aggressive manner if I was insinuating that the doctor had some sort of sexual relationship with the patient. If there was some boundary that had been crossed improperly by the doctor and that is why he did not agree with my assessment of the patient. He kept on until I interrupted him and asked what was he going on about, I had just made a logic conclusion that the doctor had not been sleeping with the patient because...Mr. Hudson interrupted me again and got very angry that I would even suggest that a doctor at ARMC would do something like that. I said that if Mr. Hudson was going to interrupt me and not let me finish a statement then he should just do all the talking and we would sit and listen till he was done, but..... Mr. Primm interrupted as this point because Mr. Hudson was getting very angry and loud. He suggested that Mr. Hudson let me finish my statement and pleaded for calm. I started again. "as I was saying, I made the assumption that the doctor was not sleeping with the patient for the last ten years, so could not... just because someone is sleeping with someone else, what makes you (Mr.Hudson) think that they are having sex with that person?" He did not answer. Mr. Primm said,"Paul". I continued. "Since the doctor was not monitoring the patient's sleep, then the statement in the notes is from the patient's report to the doctor. Patient's say many things that are untrue when we monitor their sleep, mostly because they do not know, they are asleep." Tracy said the patient had multiple back surgeries and so probably experienced a great deal of pain sleeping on his back. I said maybe the back surgeries alleviated his pain like they were supposed to. I said he naturally rolled to his back by himself and slept there before I made any attempt to ask him to roll over so apparently the statement was false, he does sleep on his back. Because he does it was medically necessary for me to titrate him in that position. Mr. Hudson said that it was unnecessary for me to do that, it caused the patient great pain, and the doctor specifically said in his order for me not to do it. I substituted my judgment for the doctor's and superseded her orders. I said it was "his" orders that I at least test the patient on laterally, on his right and left side, I did that. If I were in the ER....Mr. Hudson interrupted me again. He said he did not want to hear some analogy that did not have anything to do with this particular



*Exhibit 3
5 part*

DUTIES, RESPONSIBILITIES & STANDARDS (Essential Functions):

Name:	Paul Wilkinson, RPSGT (per diem)		
Hire Date:	1/12/2009	Last Evaluation Date:	90 day review
Current Date:	04/20/2010	Next Evaluation Date:	1/12/2011

Ratings:

- 5 = Significantly above expectations.
- 4 = Above expectations.
- 3 = Meets expectations.
- 2 = Below expectations.
- 1 = Significantly below expectations.

PAUL COPY

1. Harrison Medical Center Standards

Harrison firmly believes that an engaged workforce results in higher customer service, lower turn-over, reduced absences a safe environment, and lower costs. Therefore, we measure engagement of people living our missions "we make a positive difference in people's lives through exceptional medical care." This is demonstrated by behaviors that reflect our core values.

EMPATHY		
Rating	Standard	Comments
<input checked="" type="checkbox"/> 5 <input checked="" type="checkbox"/> 4 <input checked="" type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1	Exhibits compassionate understanding of others needs, practices active kindness, and establishes and nurtures trusting relationships.	Paul seems very committed to the well being of his patients, practices active kindness and understands the principles of AIDET. As a per diem tech he shows a good level of acting like an owner with his participation.
INNOVATION		
<input type="checkbox"/> 5 <input checked="" type="checkbox"/> 4 <input checked="" type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1	Consistently identifies ways to improve processes, systems, and outcomes for patients and other customers	During staff meetings and the yearly educational day Paul offers creative solutions to our operational challenges from his unique background and previous work history.
ACCOUNTABILITY		
<input checked="" type="checkbox"/> 5 <input checked="" type="checkbox"/> 4 <input checked="" type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1	Demonstration of personal accountability for making and keeping promises to patients and to each other that are consistent with our mission and values.	Paul is dependable and communicates clearly and with proper notification when he needs off. He has jumped in and provided coverage relief to fill empty shift. Paul demonstrates a level of consistency and dedication by showing up for staff meetings when he lives in Auburn.

2. Service Excellence Standards

These core values are further measured by employees embracing and participating in our Service Excellence Standards, which are:

SERVICE EXCELLENCE		
Rating	Standard	Comments
<input checked="" type="checkbox"/> 5 <input type="checkbox"/> 4 <input checked="" type="checkbox"/> 3	Behaves like an owner of Harrison Medical Center. Takes care of the customer Recognizes and rewards.	Because of Paul's tenure as a registered sleep tech we are confident that he is providing a high

<input type="checkbox"/> 2 <input type="checkbox"/> 1	Learns and uses key words at key times. Contributes to and creates a welcoming environment. Participates in service rescue.	level of service excellence by taking care of the patients. His survey results display remarks like "he made feel comfortable in every way," " he educated me about the many different sleep disorders" We are thankful for his commitment to our labs' success understanding that he live so far away.
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3. **Positions Standards:** Includes all significant expectations and tasks that contribute to the Harrison mission and core values.

Measured by supervisor observation, peer review, and other feedback processes as indicated		
Rating	Position/Standard	Comments
<input checked="" type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1	<p>Age Appropriate Care Competency:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Infants 0 to 1 year of age <input type="checkbox"/> Pediatric 2 to 12 years of age <input type="checkbox"/> Adolescent 13 to 18 years of age <input type="checkbox"/> Adult 19 to 65 years of age <input type="checkbox"/> Geriatric Patient Over 65 years of age <p>Delivers patient care appropriate to age of patients cared for/served. Obtains and interprets information in terms of patient needs. Applies knowledge of growth and development appropriate for the age groups cared for/served. Understands the range of educational treatment needs of the patients cared for/served in the specific age groups. Has met annual in-service requirement for education case studies regarding age appropriate care for the patients in the specified age groups.</p>	<p>Paul meets all requirements set out by our policies and procedures.</p>
<input checked="" type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1	<p>Demonstrates competence in the administration of Polysomnography regimens, including preparation of patient for recording and preparation of equipment for recording session. Independently performs CPAP demonstrations before each study. Loads appropriate montage and patient information. Performs machine and bio calibrations. Corrects artifact in bio-calibrations before continuing study.</p>	<p>Paul meets all the basic requirements for pre-testing duties and CPAP demonstrations. Dave has met his core competencies outlined by hospital requirements.</p>
<input type="checkbox"/> 5 <input checked="" type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1	<p>Demonstrates technical knowledge of Polysomnographic requirements and its application to patient care. Monitors study correcting and adjusting to record within acceptable standards. Keeps an accurate record of events. Identifies when MSLT vs. Split-procedure should be implemented. 5: Consistently provides thorough technician notes above and beyond the necessary format demonstrating above average critical thinking skills.</p>	<p>Paul is consistent with all the appropriate documentation processes.</p>
<input type="checkbox"/> 5 <input checked="" type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1	<p>Demonstrates hospital and unit specific clinical competencies. Successfully completes annual skills checklist within specified timeframe. 5: Provides staff education in clinical specialty. Is seen as a clinical expert by peer reviews. Assists in verification of skill competency with completion of annual skills checklist.</p>	<p>Paul meets sleep center clinical competencies.</p>
<input type="checkbox"/> 5 <input checked="" type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1	<p>Provides required calibration and maintenance of equipment. Troubleshoots equipment problems and corrects problems according to department policy. 5: shows the highest level of skill and ingenuity in creating clear Polysomnograms as demonstrated by specific recordings.</p>	<p>Paul does understand how to troubleshoot most issues with out supervision. We appreciate his technical abilities and his knowledge of the inner workings of the calibration system.</p>
<input checked="" type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1	<p>Performs day time study procedures including MSLT's and MWT's, as well as full hook-up polysomnography testing procedures.</p>	<p>N/A</p>
<input type="checkbox"/> 5 <input checked="" type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1	<p>Performs analysis of polysomnographic records, including sleep staging, arousal, respiratory disturbance, upper airway resistance, cardiac abnormalities and periodic leg movement. Documents and addresses artifact in less than 10 minutes from first occurrence. Can ID and remedy common artifacts. 5: Rectifies complex hardware/software issues during collection or analysis by using own initiative to contact technical support.</p>	<p>Paul has shown consistently over the last year his ability to stage accurately and and formulate correct AHI's. Paul can identifies and correct artifact. Paul understands cardiac arrhythmia's, PLM's and clearly notes them in his studies.</p>

Measured by supervisor observation, peer review, and other feedback processes as indicated		
Rating	Position/Standard	Comments
<input type="checkbox"/> 5 <input checked="" type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1	Shows progressive increase in quality of scoring records in line with Medical Directorship as demonstrated by Scorer inter-reliability QAs . 5: Ongoing Acquisition QAs demonstrates desire for excellence in scoring records.	Paul will participate in the departments on going scoring sessions with the lead technologist to enhance his knowledge and practice. We are confident that Paul has the skills already to progress in our goal of every technologist scoring independently.
<input type="checkbox"/> 5 <input checked="" type="checkbox"/> 4 <input checked="" type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1	Orients nasal CPAP patient to the CPAP testing procedure as well as to the equipment that will be used in testing and at home. 5: Shows the highest level of customer service and empathy, reduces patient complaint by resolving issues during the study as demonstrated by decreased # of desensitizations	Paul is excellent at performing CPAP Titrations. He has a great ability in finding the right pressure according to policy.
<input type="checkbox"/> 5 <input checked="" type="checkbox"/> 4 <input checked="" type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1	Demonstrates complete understanding of Departmental Policies. Seeks direction from Sleep Coordinator or Medical Director when necessary. 5: functions as a mentor and leader on their shift.	Paul demonstrates his ability to implement the current policies and procedures effectively and helps other technologists.
<input type="checkbox"/> 5 <input type="checkbox"/> 4 <input checked="" type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1	Identify and implement use of Urgent Fax Form 1 and Urgent Fax Form 2 for patients who meet Sleep Center's severe criteria and fax form to referring physician. Communicate pertinent information to DME to ensure immediate set-up of equipment.	Paul meets this requirement and knows how to document and communicate it appropriately.

4. DISCLAIMER STATEMENT

The above statements are intended to describe the general nature and level of work being performed. They are not intended to be an exhaustive list of all responsibilities, duties, and skills required of personnel so classified.

Scoring Summary

Check one of the following summary statements:

5	Performance excels in virtually all aspects of the job. Performance is clearly recognizable as being consistently distinguished, far exceeding all expectations or required job standards. Demonstrates a very high degree of expertise and serves as a model of excellence or mentor to other employees. This level of performance merits special recognition and opportunities for particularly challenging assignments. Quality of work is superior. No corrective actions.
<input checked="" type="checkbox"/> 4.15	Performance clearly and consistently exceeds the criteria and standards. Performance is above the level expected in fulfilling job requirements and achieving goals and objectives. Demonstrates unusual proficiency in performing the difficult and complex aspects of the job. Initiates and completes other projects in addition to objectives. Quality of work is excellent. No corrective actions.
3	Performance consistently meets the criteria and standards of job performance for nearly all aspects of the job. Performance is steady, reliable and is maintained with a minimum of supervision. Accomplishes goals and objectives as well as meets all required job standards. Performance is fully acceptable. No written corrective actions but may have verbal.
2	Performance usually meets the normal requirements in most job areas but does not meet standards in several key areas. Performance at this level requires some improvement in order to be considered competent. Improvement is necessary in accord with the goals stated above to avoid performance falling to an unacceptable level. No written corrective actions.
1	Performance falls substantially short of the criteria and standards of job performance. Performance frequently fails to meet minimum requirements and objectives. Work is clearly below the level of acceptability. Substantial improvement is necessary, in accord with the goals for improvement stated above or as delineated in the attached improvement plan, to avoid termination. No corrective action above one written warning.
	New to the position. The level of contribution prevents proper appraisal due to lack of experience; focus is on timely future development.

Summary of Co-worker Evaluations	

Manager's Overall Comments:	Being a Registered Sleep Technologist with years of experience in the field, Paul displays on all levels a highly competent knowledge and practice of the fundamentals of Sleep medicine. His ethical standards are clearly visible in his actual care of patients and his application of clinical principles.
Strengths:	Intelligent, caring, good sense of humor, comforting to patients, team oriented, willing to learn.
Improvements related to last year's goals	NA

Goals for improvement in the coming year (each "2" rating **must** have a goal for improvement):

Paul will be staging and scoring at an 85% accuracy rate.
Paul will adhere more closely to the Harrison policies and procedures rather than relying on experience from other labs
Paul will complete his core competencies

Development Plan

Employee Comments: _____

Employee Signature: Paul W. [Signature] Date: 5/25/10

***Note: If the employee refuses to sign, the supervisor will so indicate on this page.**

Evaluator Signature: [Signature] Date: 5/25/2010

Reviewer Signature: _____ Date: _____

Dear Jim Moore,

Ex 21000 -

I am requesting my personnel file and my financial records (pay) for the last 3 yrs. I would like this back dated to 9/09 when I verbally made a request for these records. According to Washington State Law you must provide me these records within a reasonable amount of time. ~~A month~~ More than a month has passed already.

Thank You,

Paul Wilkinse

11/3/9

SPECIAL ARTICLE

Clinical Guidelines for the Manual Titration of Positive Airway Pressure in Patients with Obstructive Sleep Apnea

Positive Airway Pressure Titration Task Force of the American Academy of Sleep Medicine

Task Force Members: Clete A. Kushida, M.D., Ph.D., RPSGT (Chair)¹; Alejandro Chediak, M.D. (Vice-Chair)²; Richard B. Berry, M.D.³; Lee K. Brown, M.D.⁴; David Gozal, M.D.⁵; Conrad Iber, M.D.⁶; Sairam Parthasarathy, M.D.⁷; Stuart F. Quan, M.D.⁸; James A. Rowley, M.D.⁹

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Summary: Positive airway pressure (PAP) devices are used to treat patients with sleep related breathing disorders (SRBDs), including obstructive sleep apnea (OSA). After a patient is diagnosed with OSA, the current standard of practice involves performing attended polysomnography (PSG), during which positive airway pressure is adjusted throughout the recording period to determine the optimal pressure for maintaining upper airway patency. Continuous positive airway pressure (CPAP) and bilevel positive airway pressure (BPAP) represent the two forms of PAP that are manually titrated during PSG to determine the single fixed pressure of CPAP or the fixed inspiratory and expiratory positive airway pressures (IPAP and EPAP, respectively) of BPAP for subsequent nightly usage. A PAP Titration Task Force of the American Academy of Sleep Medicine reviewed the available literature. Based on this review, the Task Force developed these recommendations for conducting CPAP and BPAP titrations. Major recommendations are as follows: (1) All potential PAP titration candidates should receive adequate PAP education, hands-on demonstration, careful mask fitting, and acclimatization prior to titration. (2) CPAP (IPAP and/or EPAP for patients on BPAP) should be increased until the following obstructive respiratory events are eliminated (no specific order) or the recommended maximum CPAP (IPAP for patients on BPAP) is reached: apneas, hypopneas, respiratory effort-related arousals (RERAs), and snoring. (3) The recommended minimum starting CPAP should be 4 cm H₂O for pediatric and adult patients, and the recommended minimum starting IPAP and EPAP should be 8 cm H₂O and 4 cm H₂O, respectively, for pediatric and adult patients on

BPAP. (4) The recommended maximum CPAP should be 15 cm H₂O (or recommended maximum IPAP of 20 cm H₂O if on BPAP) for patients <12 years, and 20 cm H₂O (or recommended maximum IPAP of 30 cm H₂O if on BPAP) for patients ≥12 years. (5) The recommended minimum IPAP-EPAP differential is 4 cm H₂O and the recommended maximum IPAP-EPAP differential is 10 cm H₂O (6) CPAP (IPAP and/or EPAP for patients on BPAP depending on the type of event) should be increased by at least 1 cm H₂O with an interval no shorter than 5 min, with the goal of eliminating obstructive respiratory events. (7) CPAP (IPAP and EPAP for patients on BPAP) should be increased from any CPAP (or IPAP) level if at least 1 obstructive apnea is observed for patients <12 years, or if at least 2 obstructive apneas are observed for patients ≥12 years. (8) CPAP (IPAP for patients on BPAP) should be increased from any CPAP (or IPAP) level if at least 1 hypopnea is observed for patients <12 years, or if at least 3 hypopneas are observed for patients ≥12 years. (9) CPAP (IPAP for patients on BPAP) should be increased from any CPAP (or IPAP) level if at least 3 RERAs are observed for patients <12 years, or if at least 5 RERAs are observed for patients ≥12 years. (10) CPAP (IPAP for patients on BPAP) may be increased from any CPAP (or IPAP) level if at least 1 min of loud or unambiguous snoring is observed for patients <12 years, or if at least 3 min of loud or unambiguous snoring are observed for patients ≥12 years. (11) The titration algorithm for split-night CPAP or BPAP titration studies should be identical to that of full-night CPAP or BPAP titration studies, respectively. (12) If the patient is uncomfortable or intolerant of high pressures on CPAP, the patient may be tried on BPAP. If there are continued obstructive respiratory events at 15 cm H₂O of CPAP during the titration study, the patient may be switched to BPAP. (13) The pressure of CPAP or BPAP selected for patient use following the titration study should reflect control of the patient's obstructive respiration by a low (preferably <5 per hour) respiratory disturbance index (RDI) at the selected pressure, a minimum sea level SpO₂ above 90% at the pressure, and with a leak within acceptable parameters at the pressure. (14) An optimal titration reduces RDI <5 for at least a 15-min duration and should include supine REM sleep at the selected pressure that is not continually interrupted by spontaneous arousals

Disclosure Statement

This was not an industry supported study. The authors have indicated no financial conflicts of interest.

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or awakenings. (15) A good titration reduces RDI ≤ 10 or by 50% if the baseline RDI < 15 and should include supine REM sleep that is not continually interrupted by spontaneous arousals or awakenings at the selected pressure. (16) An adequate titration does not reduce the RDI ≤ 10 but reduces the RDI by 75% from baseline (especially in severe OSA patients), or one in which the titration grading criteria for optimal or good are met with the exception that supine REM sleep did not occur at the selected pressure. (17) An unacceptable titration is one that does not meet any one of the above grades. (18) A repeat PAP titration study should be considered if the initial titration does not achieve a grade of optimal or good and, if it is a split-night PSG study, it fails to

meet AASM criteria (i.e., titration duration should be > 3 hr).

Keywords: PAP; titration; continuous positive airway pressure; CPAP; bilevel positive airway pressure; BPAP; obstructive sleep apnea; sleep related breathing disorder; sleep disordered breathing

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1.0 INTRODUCTION

Positive airway pressure (PAP) is a standard treatment for patients with obstructive sleep apnea (OSA), a sleep related breathing disorder characterized by full or partial occlusion of the upper airway during sleep. Standard sleep medicine practice involves manual pressure adjustment by a sleep technologist during attended laboratory polysomnography (PSG) to eliminate obstructive respiratory-related events (apneas, hypopneas, respiratory effort-related arousals [RERAs], and snoring). A PAP delivery system consists of three main components: a PAP device; a nasal, oral, or oronasal interface (i.e., nasal mask, nasal pillows, full-face mask) held snug to the face by headgear; and a flexible hose that connects the device to the interface. A PAP device is basically an air pump (fan-driven or turbine system) that draws in external, filtered air and delivers pressurized airflow, which is adjustable by varying the pressure valve diameter or fan/turbine speed. PAP devices are divided into four basic types depending on their pressure delivery system: (1) continuous positive airway pressure (CPAP), which delivers a single, fixed pressure to the patient during the night; (2) bilevel positive airway pressure (BPAP), which delivers a higher inspiratory PAP (IPAP) than expiratory PAP (EPAP); (3) auto-titrating positive airway pressure (APAP), which automatically increases CPAP or BPAP (IPAP/EPAP) as needed to maintain airway patency and then decreases the pressure if no abnormal respiratory events are detected within a set period of time; and (4) adaptive servoventilation (ASV), which uses a servocontroller that automatically adjusts pressure by breath-by-breath analysis to maintain a steady minute ventilation especially in heart failure patients with central sleep apnea and/or Cheyne-Stokes respiration.

A 2004 national survey of 196 board certified sleep physicians regarding APAP device prescriptions based upon point-prevalence estimates revealed that only 4% of PAP devices prescribed were APAP and that 30% of board certified sleep physicians reported having never prescribed APAP devices.¹ As more validation and reliability studies in diverse settings are being conducted, it is assumed that sleep medicine specialists are gradually becoming more accepting of the use of APAP devices.²⁻⁴ Nevertheless, manual titration of CPAP or BPAP is currently the gold standard for selection of the optimal (effective) pressure for CPAP and BPAP (IPAP/EPAP), respectively, and the goal of this report was to develop recommendations that reflect current knowledge and practice of this procedure.

The American Academy of Sleep Medicine (AASM) has published practice parameters on the indications for PSG^{5,6} (i.e.,

the utility of PSG for the diagnosis of sleep-related breathing disorders) and on the indications for CPAP and BPAP in the treatment of airway obstruction in OSA.⁷ Lastly, in 2007, the AASM published a new scoring manual that defines the abnormal respiratory events (e.g., apneas, hypopneas, RERAs), which are used for PAP titration.⁸ The present recommendations add to but do not modify any of these previously published guidelines and definitions.

2.0 METHODS

The AASM Board of Directors approved the development of PAP titration recommendations in April 2007, and approved the appointments of Task Force members in July 2007. An initial literature search was conducted by Drs. Alejandro Chediak and Vincenzo Novara on November 27, 2006 using the key words: CPAP initiation, CPAP titration, CPAP adjustment, PAP titration, bilevel positive pressure titration, bi-level pressure titration, BiPAP titration, and BiPAP adjustment. This search yielded 372 results, of which 26 relevant abstracts and articles were obtained and reviewed. Supplemental literature searches were conducted on June 29, 2007 and December 5, 2007 using the same key words as in the original search; an additional literature search was conducted on November 30, 2007 using the same key words plus the key word: children. These supplemental searches yielded an additional 82 results, of which 7 additional relevant articles were obtained and reviewed. All literature searches were computer-based using PubMed. The objective was to identify all studies that described PAP titration protocols and that were published in English from 1968 up to the date of the searches. Twenty-two additional relevant publications were obtained after reviewing the bibliographies of the publications collected through the original and supplemental searches. Lastly, the Task Force also reviewed PAP titration protocols developed by industry for background information; however, these protocols were not used to support the recommendations.

All relevant publications were assigned an evidence level based on the classification shown in Table 1.

Potential recommendations reflected evidence for reliability and validity as assessed by the Task Force following literature review, or comprised uncertainties in the literature that needed resolution by consensus. The Rand/UCLA Appropriateness Method¹⁰ was selected as the consensus process for use by the Task Force given its use by the AASM Standards of Practice Committee (SPC) and the AASM Scoring Manual Task Forces, and also because the relative paucity of evidence warranted

Table 1—AASM Classification of Evidence

Evidence Levels	Study Design
I	Randomized well-designed trials with low alpha and beta error*
II	Randomized trials with high alpha and beta error*
III	Nonrandomized concurrently controlled studies
IV	Nonrandomized historically controlled studies
V	Case series

Adapted from Sackett⁹

*Alpha error refers to the probability (generally set at 95% or greater) that a significant outcome (e.g., $p < 0.05$) is not a result of chance occurrence. Beta error refers to the probability (generally set at 80% to 90% or greater) that a nonsignificant result (e.g., $p > 0.05$) is the correct conclusion of the study or studies. The estimation of beta error is generally the result of a power analysis. The power analysis includes a sample size analysis to project the size of the study population necessary to ensure that significant differences will be observed if actually present.

a formal consensus process. The first conference call of the Task Force was held on July 23, 2007 to discuss the consensus process and to develop a ballot comprised of possible recommendations. In order to encourage single recommendations, the ballots were constructed when possible to address mutually exclusive options. For balloting, the possible recommendations were rated on a 9-point scale for appropriateness and a 4-letter rank for specifying a judgment regarding whether the decision was being made on evidence vs. opinion. The "classic" definition of agreement was assessed using definitions from the RAND manual:

- Agreement for or against: No more than 2 Task Force members rate the indication outside the 3-point region (1-3, 4-6, 7-9) containing the median.
- Disagreement: At least 3 Task Force members rate the indication in the 1-3 region, and at least 3 Task Force members rate it in the 7-9 region.
- Indeterminate: Criteria are not met for agreement or disagreement.

The first round ballot was distributed to the Task Force on August 6, 2007 and was completed by September 1, 2007; Task Force members completed this round of voting individually without discussion. The first round ballot results were distributed to the Task Force on September 14, 2007. A conference call for the second round of voting was held on September 24, 2007, at which time there was discussion of the recommendations and the results of the first vote; consensus was achieved on all recommendations during this second round of voting. The recommendations in section 4.0 were developed based on the voting results and were subsequently reviewed by two outside reviewers, the Chair of the AASM Standards of Practice Committee, and the AASM Board of Directors. The Executive Committee of the AASM Board of Directors approved these recommendations on February 8, 2008.

All members of the Task Force and the Board of Directors completed detailed conflict-of-interest statements; none had Level 1 conflicts in the scope of their roles. Most participants

Table 2—AASM Levels of Recommendations

Term	Definition
Standard	This is a generally accepted patient care strategy that reflects a high degree of clinical certainty. The term standard generally implies the use of level I evidence that directly addresses the clinical issue, or overwhelming level II evidence.
Guideline	This is a patient care strategy that reflects a moderate degree of clinical certainty. The term guideline implies the use of level II evidence or a consensus of level III evidence.
Option	Recommendation with less evidence than guideline for which agreement was reached in a standardized consensus process based on available information.

Adapted from Eddy¹¹ and Iber et al.⁸

in the development of this report are directors or members of sleep disorders centers, and many have substantial experience with PAP titration. These recommendations should not be considered inclusive of all proper methods of care or exclusive of other methods of care reasonably directed to obtaining the same results. The ultimate judgment regarding the propriety of any specific care must be made by the clinician in light of the individual circumstances presented by the patient and the availability of diagnostic and treatment options and resources.

The AASM expects these recommendations to have a positive impact upon the practice of sleep medicine, patient treatment outcomes, and health care costs. These recommendations reflect the state of knowledge at publication and will be reviewed, updated, and revised as new information becomes available. It is important to note that the recommendations published in this report are not practice parameters, since the majority of these recommendations do not achieve the evidence level of typical practice parameters. Instead, all recommendations were developed using the consensus process and the evidence grading was used only to indicate the level of evidence available to support the recommendations. AASM levels of recommendations (Table 2) are indicated in parentheses after recommendations that are based on published practice parameters; those recommendations that were not based on published parameters are labeled as "(Consensus)."

3.0 BACKGROUND

The manual titration of positive airway pressure has been conducted for over a quarter of a century,¹² yet no standardized protocols exist for this procedure.¹³ A survey of accredited sleep centers reviewed titration protocols from 51 accredited centers and found that the procedures described for PAP titration varied widely among the centers; 22% of these centers did not have a written protocol.¹⁴ The lack of standardization results in clinicians and technologists from different sleep laboratories developing their own protocols¹⁵ or relying on protocols obtained from industry or other sleep laboratories. When a standardized protocol is implemented, the optimal pressure for CPAP can be reproducible; one study revealed a Spearman correlation coefficient of 0.89 for the optimal pressure selected for 2 consecutive CPAP titration nights in 50 patients with OSA.¹⁶

However, very few PAP titration protocols have been published in the literature, and there is a question as to what one would use or measure to advocate or support one particular protocol over another. Thus, the goal of this Task Force was the development of an evidence- and consensus-based standardized PAP titration protocol, with the underlying concept that a successful titration is one in which there is an optimized trade-off between increasing pressure to yield efficacy in elimination of respiratory events and decreasing pressure to minimize emergence of pressure-related side effects.¹⁷

The optimal pressure selected for an OSA patient during a PAP titration study is subject to interindividual variability, i.e., a pressure that controls the respiratory events of one patient may inadequately control those of another patient.¹⁸ There are several factors that have been identified as potentially influencing optimal pressure, such as rapid eye movement (REM) sleep amounts,¹⁹ the length of the soft palate,¹⁸ and the degree of respiratory effort.¹⁸ Additionally, one might reason that the level of optimal PAP is correlated with OSA severity and/or obesity; i.e., higher levels of PAP would be needed to control respiratory events in patients with severe OSA and/or those who are obese. However, this premise has not been consistently supported in the literature; although there are some studies demonstrating a good correlation between the level of optimal CPAP and the apnea-hypopnea index (AHI)^{20,21} or obesity,²¹ a significant correlation for optimal CPAP and AHI has been observed only in patients whose apneas are dependent on body position.²² Mathematical equations incorporating measures of OSA severity (AHI) and obesity (i.e., body mass index and neck circumference) have been developed to predict the optimal level of CPAP^{21,23,24} in order to theoretically achieve a higher rate of successful CPAP titrations by eliminating the need for multiple pressure changes at low pressure levels and to decrease the risk of insufficient time to perform an adequate titration study. However, two studies have independently failed to confirm the accuracy of these equations in predicting the prescribed CPAP level,²⁵⁻²⁷ prompting the authors of one of these studies to comment that this failure "reaffirms the need for a CPAP titration study to prescribe the optimal therapy to the patient."²⁵

Two types of PAP devices (CPAP and BPAP) are included in these titration recommendations, and BPAP as described in this report refers to BPAP set in spontaneous mode unless otherwise specified. Data regarding usefulness of other PAP device types or device features were not reviewed; although specific indications for adaptive servoventilation are discussed, a titration protocol for this device is not described since this type of ventilation was considered beyond the scope of this report. The recommendations in this report pertain only to nighttime PAP titration studies, although there is an emerging body of literature that indicates that diurnal and nocturnal titration results in comparable therapeutic pressures, equivalent resolution of sleep disordered breathing, and improvement in subjective sleepiness after 1-12 weeks of treatment, particularly for patients with severe OSA.²⁸⁻³⁰

This report uses the following terminology. Unless stated otherwise OSA is used synonymously with obstructive sleep apnea syndrome (OSAS), obstructive sleep apnea-hypopnea syndrome (OSAHS), and obstructive forms of either sleep disordered breathing (SDB) or sleep related breathing disorder

(SRBDs). Other SRBDs are not addressed except when relevant to adaptive servoventilation treatment. The respiratory disturbance index (RDI) refers to the total of apneas, hypopneas, and RERAs per hour of sleep, and for this report, this term is not synonymous with the AHI, which refers to the total of apneas and hypopneas per hour of sleep. Mild, moderate and severe OSA are defined according to following criteria in adults: mild, RDI 5 to ≤ 15 ; moderate, RDI 15 to 30; and severe, RDI >30 .³¹ In children <12 years of age: mild, RDI 1 to <5 ; moderate, RDI 5 to <10 ; and severe, RDI >10 .^{8,32-34}

4.0 RECOMMENDATIONS

The following are recommendations of the PAP Titration Task Force and the AASM Board of Directors. The scope of these PAP titration recommendations is restricted to adult (≥ 12 years) and pediatric (<12 years) patients with obstructive sleep apnea; these recommendations do not apply to patients with conditions such as neuromuscular disease or intrinsic lung disease. Summaries and evidence levels of published PAP titration protocols for adult and pediatric patients are listed in Tables 3a and 3b (see JCSM website: www.aasmnet.org/JCSM), respectively, and CPAP and BPAP titration algorithms for adult and pediatric patients during full- or split-night titration studies are depicted in Figures 1-4. The optimal setting for the titration of CPAP or BPAP is in an AASM-accredited sleep center or laboratory, with the titration protocol implemented by registered polysomnographic technologists and review of the titration study (including pressure selection) by a board certified sleep specialist. Additionally, the definitions, protocols, procedures, and indications for the diagnosis and management of OSA as specified in the AASM practice parameters for polysomnography⁵ and PAP,⁷ and the AASM Manual for the Scoring of Sleep and Associated Events⁸ (i.e., respiratory rules) should be followed. It is understood that the recommendations for minimum and maximum PAP may be constrained by the specific PAP device used during the titration protocol. Lastly, the expectation of the Task Force is that these recommendations should not be followed in a "cookbook" manner; instead, sleep technologists and clinicians should combine their experience and judgment with the application of these recommendations to attain the best possible titration in any given patient.

4.1 General Recommendations for Conducting PAP Titration Studies in Pediatric or Adult Patients with Obstructive Sleep Apnea

4.1.1 All Potential PAP Titration Candidates (Including Those Candidates Prior to a Diagnostic Study Where the Clinical Suspicion of OSA is High and a Split-Night Study is a Possibility) Should Receive Adequate PAP Education, Hands-On Demonstration, Careful Mask Fitting, and Acclimatization Prior to Titration (Standard).

This recommendation is based on Standard-Level Recommendation 4.3.4 ("The addition of a systematic educational program is indicated to improve PAP utilization") in the 2006 practice parameters for the use of PAP devices⁷ and consensus agreement by the PAP Titration Task Force. The Task Force recommends that

the indications, rationale for use, and side effects should be discussed in detail with the patient or caregiver preferably prior to the PAP titration study; parts and assembly, optional equipment, importance of daily/nightly use, adherence issues, necessity of cleaning the equipment, and implications of the purchase/rental of the equipment (when applicable) should be discussed in detail with the patient or caregiver, preferably following the PAP titration study. The patient should be carefully fitted for the interface (i.e., nasal mask, nasal pillows, full-face/oronasal mask) with the goals of maximizing comfort, compensating for significant nasal obstruction, and minimizing leak prior to the PAP titration. There should be several different types of PAP interfaces (i.e., nasal mask, nasal pillows, full-face/oronasal mask) and accessories (chinstrap, heated humidifier) available if the patient encounters problems (e.g., mouth leak, nasal congestion, or oronasal dryness) during the night. The patient should be acclimated to the PAP equipment (i.e., wearing the interface with the pressure on) prior to "lights off."³⁵ For pediatric patients, in addition to the above, pediatric interfaces should be available³⁶ and behavioral modification techniques may be implemented to increase the tolerability and potential adherence to PAP equipment,³⁷⁻³⁹ since children frequently have problems adjusting to PAP.

4.1.2 Recording the Airflow Signal Generated by the PAP Device or Estimating Airflow by Measurement of the Pressure Difference Between the Mask and the Outlet of the Machine Using a Pressure Transducer, with or without Square Root Transformation of the Signal, are Acceptable Methods for Detecting Apneas or Hypopneas (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force and Consensus-Level Respiratory Rule 1.B (i.e., a nasal air pressure transducer with or without square root transformation of the signal is the preferred sensor for detection of airflow for identification of a hypopnea during diagnostic [non-PAP] PSG) in the AASM Scoring Manual.⁸ However, during PAP titrations, the use of a standard nasal pressure sensor placed under the nares is problematic due to the difficulty in obtaining a good PAP mask seal since the tubing has to pass underneath the mask. Thus, estimation of airflow for detection of apneas or hypopneas by one of the two techniques specified above is acceptable; care should be exercised to ensure that the signal is accurately recorded. PAP devices designed for use in polysomnography generate a flow signal based on accurate flow sensors within the device and the majority also provide a signal reflecting an estimate of leak.

4.1.3 Nasal Airflow Obtained from a Thermistor or Thermocouple Placed Under the PAP Mask is not an Acceptable Method for Detecting Apneas or Hypopneas (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force. An oronasal thermal sensor is the preferred primary sensor to detect absence of airflow for identification of an apnea during diagnostic (non-PAP) PSG.⁸ However, it is not the preferred sensor to detect airflow for identification of a hypopnea (see Recommendation 4.1.2) and the placement of this sensor under a PAP mask for detection of airflow is not recommended.

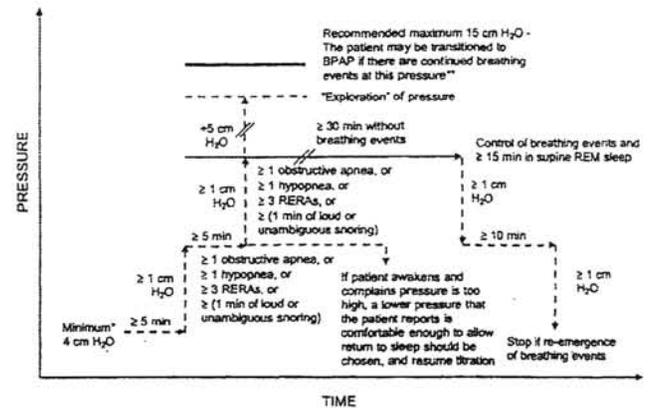


Figure 1—CPAP Titration Algorithm for Patients <12 years During Full- or Split-Night Titration Studies. Note: Upward titration at ≥ 1 -cm increments over ≥ 5 -min periods is continued according to the breathing events observed until ≥ 30 min without breathing events is achieved.

* A higher starting CPAP may be selected for patients with an elevated BMI and for retitration studies

** The patient should also be tried on BPAP if the patient is uncomfortable or intolerant of high CPAP

4.1.4 Respiratory Effort-Related Arousals May Be Estimated by Flattening of the Inspiratory Airflow Profile Associated with an Arousal When Airflow Changes Do Not Meet Criteria for apneas or Hypopneas (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force. As specified in the AASM Scoring Manual, a respiratory effort-related arousal (RERA) in adults is defined as a sequence of breaths lasting at least 10 sec characterized by increasing respiratory effort or flattening of the nasal pressure waveform leading to an arousal from sleep when the sequence of breaths does not meet criteria for an apnea or hypopnea.⁸ The scoring rules for pediatric RERAs when using a nasal pressure sensor requires a discernible fall in the amplitude of the signal from the sensor; a duration of at least 2 breath cycles; accompanying snoring, noisy breathing, elevation in the end-tidal CO_2 , transcutaneous CO_2 , or visual evidence of increased work of breathing; and termination by an arousal.⁸ The contour of inspiratory flow tracing from a PAP system can be used to infer the presence of elevated upper airway resistance and flow limitation,^{40,41} and this contour appears to be the simplest variable that best correlates with the lowest esophageal pressure during PAP titration.⁴² For the assessment of respiratory effort during PAP titration, esophageal manometry or nasal pressure plus inductance plethysmography can be used in pediatric and adult patients, although the former technique may be more problematic given partial occlusion of one of the nares and difficulty obtaining a good PAP mask seal with the esophageal catheter and poorer adherence in the pediatric population.

4.1.5 Sawtooth Patterns in the Unfiltered Airflow or Mask Pressure Tracings and/or Detection of Vibration by Piezoelectric Transducers or Microphones Applied to the Neck are Acceptable Methods for Detecting Snoring (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force. The output from most PAP de-

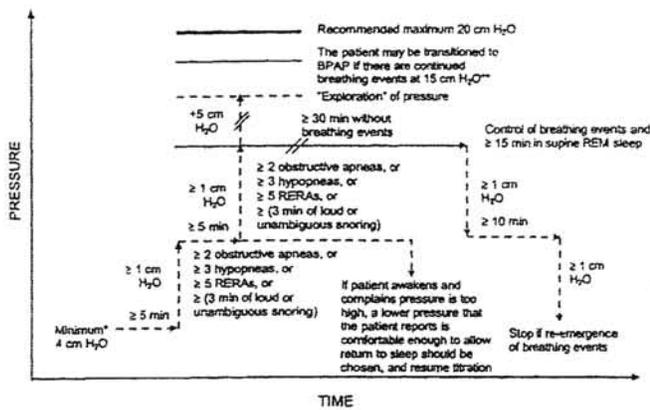


Figure 2—CPAP Titration Algorithm for Patients ≥ 12 years During Full- or Split-Night Titration Studies. Note: Upward titration at ≥ 1 -cm increments over ≥ 5 -min periods is continued according to the breathing events observed until ≥ 30 min without breathing events is achieved.

- * A higher starting CPAP may be selected for patients with an elevated BMI and for retitration studies
- ** The patient should also be tried on BPAP if the patient is uncomfortable or intolerant of high CPAP

vices while accurate for assessing airflow and flow limitation is often too filtered or undersampled to display snoring.

4.2 Recommendations for Conducting CPAP Titration Studies in Pediatric or Adult Patients with Obstructive Sleep Apnea

4.2.1 General Recommendations for CPAP Titration Studies

4.2.1.1 CPAP should be increased until the following obstructive respiratory events are eliminated (no specific order) or the recommended maximum CPAP is reached: apneas, hypopneas, RERAs, and snoring (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force and Guideline-Level evidence (3 level II studies,⁴³⁻⁴⁵ 2 level III studies,^{46,47} and 5 level V studies^{42,48-51}). The Task Force recommends that SaO₂ desaturation-resaturation events occurring without associated obstructive respiratory events should not be considered in the decision to increase CPAP in pediatric and adult patients.

4.2.1.2 The recommended minimum starting CPAP should be 4 cm H₂O in pediatric and adult patients (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force and Standard-Level evidence (1 level I study,⁵² 4 level II studies,^{44,45,53,54} 4 level III studies,^{16,47,55,56} 2 level IV studies,^{35,57} and 4 level V studies^{49,58-60}).

4.2.1.3 The recommended maximum CPAP should be 15 cm H₂O for patients <12 years and 20 cm H₂O for patients ≥ 12 years (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force and Option-Level evidence (1 level II study⁵³ [adult patients], 1 level III study⁶¹ [adult patients], 2 level

V studies^{40,62} [adult and pediatric patients]). If there are continued obstructive respiratory events at 15 cm H₂O of CPAP for either adult or pediatric patients during the titration study, the patient may be switched to BPAP (see Recommendation 4.3.1.1)

4.2.1.4 Methodology to determine CPAP a priori has insufficient evidence, although a higher starting CPAP may be selected for patients with an elevated body mass index and for retitration studies (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force and Option-Level evidence (1 level III study that found that the amount of CPAP pressure was correlated with body mass index at baseline [$p = 0.32$, $p < 0.001$]²⁰ and 1 level V study that indicates that body mass indices were significantly higher in patients who required higher CPAP levels to abolish their apnea²¹).

4.2.2 Full Night CPAP Titration Studies

4.2.2.1 CPAP should be increased by at least 1 cm H₂O with an interval no shorter than 5 min, with the goal of eliminating obstructive respiratory events (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force and Standard-Level evidence (2 level I studies,^{52,63} 7 level II studies,^{43,44,53,54,64-66} 8 level III studies,^{16,46,47,55,56,61,67,68} 5 level IV studies,^{25,35,57,69,70} 21 level V studies,^{18,21,24,42,48,49,51,59,60,62,71-81}). The studies reported pressure increments of 1-2.5 cm H₂O, and 11 of these studies^{16,25,26,42,43,52,55,56,59,74,77} specify a time duration ≥ 5 min. There are insufficient data to recommend increasing CPAP by increments of more than 2.5 cm H₂O.

4.2.2.2 CPAP should be increased (according to the criterion in Recommendation 4.2.2.1) if at least 1 obstructive apnea is observed for patients <12 years or if at least 2 obstructive apneas are observed for patients ≥ 12 years (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force. A lower pressure is required to treat apneas compared to the pressure required to treat other respiratory events.⁸²

4.2.2.3 CPAP should be increased (according to the criterion in Recommendation 4.2.2.1) if at least 1 hypopnea is observed for patients <12 years or if at least 3 hypopneas are observed for patients ≥ 12 years (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force.

4.2.2.4 CPAP should be increased (according to the criterion in Recommendation 4.2.2.1) if at least 3 RERAs are observed for patients <12 years or if at least 5 RERAs are observed for patients ≥ 12 years (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force.

4.2.2.5 CPAP may be increased (according to the criterion in Recommendation 4.2.2.1) if at least 1 min of loud or unambiguous snoring is observed for patients <12 years or if at least 3 min of loud or unambiguous snoring are observed for patients ≥ 12 years (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force. The utility of titrating CPAP to eliminate snoring was demonstrated in a limited study of non-apneic patients. Although a minority of these patients accepted CPAP use and their subsequent CPAP adherence was poor, 73% of these patients nevertheless reported improvement in their subjective daytime sleepiness after using CPAP for a six-month period.⁸³

4.2.2.6 "Exploration" of CPAP above the pressure at which control of abnormalities in respiratory parameters is achieved should not exceed 5 cm H₂O (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force. CPAP exploration does have utility; upper airway resistance can be four times normal despite selection of a pressure that eliminates apneas and hypopneas,⁴² and this residual high airway resistance can lead to repetitive arousals and insomnia.⁸⁴ Reduction of this resistance has been demonstrated by increasing pressure until esophageal pressure swings (if measured) or the shape of the inspiratory flow limitation curve are normalized,^{40,84,85} or by increasing pressure by 2 cm H₂O¹⁷ but no higher than by 5 cm H₂O.

4.2.2.7 If the patient awakens and complains that the pressure is too high, the pressure should be restarted at a lower pressure, chosen as one that the patient reports is comfortable enough to allow return to sleep (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force.

4.2.2.8 "Down" titration is not required but may be considered as an option (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force and Option-Level evidence (2 level III studies^{16,47}). A "down" titration is recommended due to the "hysteresis" phenomenon:⁴⁰ during upward titration the PAP level at which flow limitation disappears is 2-5 cm H₂O higher than the level at which it reappears during downward titration. If a "down" titration is implemented, the Task Force recommends at least one "up-down" CPAP titration (1 cycle) should be conducted during the night. It should be conducted when at least 30 min has elapsed without obstructive respiratory events. CPAP should be decreased by more than 1 cm H₂O with an interval no shorter than 10 min, until there is reemergence of obstructive respiratory events. There is also limited evidence that an "up-down-up" titration protocol should be considered.⁴⁹ One study with 85 OSA patients used a CPAP protocol in which the pressure was increased by 1 cm H₂O in a stepwise fashion until respiratory events disappeared (effective pressure 1, Peff₁); the pressure level was then decreased by increments of 1 cm H₂O until respiratory abnormalities reappeared. The pressure was re-

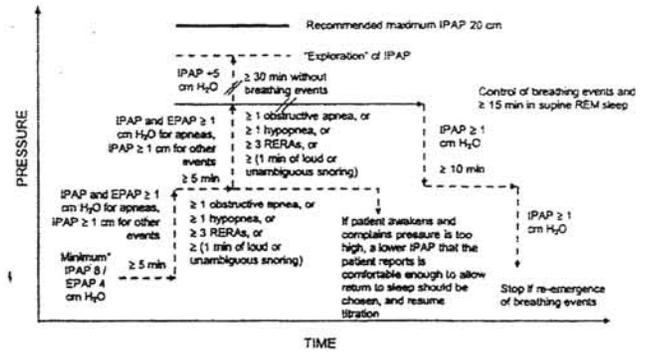


Figure 3—BPAP Titration Algorithm for Patients <12 years During Full- or Split-Night Titration Studies. Note: Upward titration of IPAP and EPAP ≥ 1 cm H₂O for apneas and IPAP ≥ 1 cm for other events over ≥ 5 -min periods is continued until ≥ 30 min without breathing events is achieved. A decrease in IPAP or setting BPAP in spontaneous-timed mode with backup rate may be helpful if treatment-emergent central apneas are observed.

* A higher starting IPAP and EPAP may be selected for patients with an elevated BMI and for retitration studies. When transitioning from CPAP to BPAP, the minimum starting EPAP should be set at 4 cm H₂O or the CPAP level at which obstructive apneas were eliminated. An optimal minimum IPAP-EPAP differential is 4 cm H₂O and an optimal maximum IPAP-EPAP differential is 10 cm H₂O.

increased by increments of 1 cm H₂O to normalize respiration (Peff₂). The pressure obtained after the "down" titration had to be re-increased in 79 patients due to snoring (n = 26), flow limitations associated with arousals (n = 32), obstructive hypopneas (n = 19), and obstructive apneas (n = 2). The Peff₂ level was significantly lower than Peff₁ with a mean difference of 0.6 (1.5) cm H₂O (95% confidence interval, 0.29-0.93).

4.2.3 Split-Night CPAP Titration Studies

4.2.3.1 The titration algorithm for split-night CPAP titration studies should be identical to that of full-night CPAP titration studies (Guideline).

This recommendation is based on Guideline-Level Recommendation 4.2.1 ("A full-night, attended polysomnography performed in the laboratory is the preferred approach for titration to determine optimal positive airway pressure; however, split-night, diagnostic-titration studies are usually adequate") in the 2006 practice parameters for the use of PAP devices⁷ and consensus agreement by the PAP Titration Task Force. Studies that have compared adequacy of prescribed pressure, CPAP adherence, and patient acceptance have found no significant differences for adult patients undergoing full-night vs. split-night CPAP titration studies,^{46,69,86-88} with the possible exception that pressures determined from split-night studies may be lower for patients with mild-to-moderate OSA who may not manifest the maximal severity of their condition during the first portion of the night.^{25,73} It may be prudent to increase CPAP at larger increments (i.e., 2 or 2.5 cm H₂O) given the shorter CPAP titration duration in split-night vs. full-night studies. Of note, there are

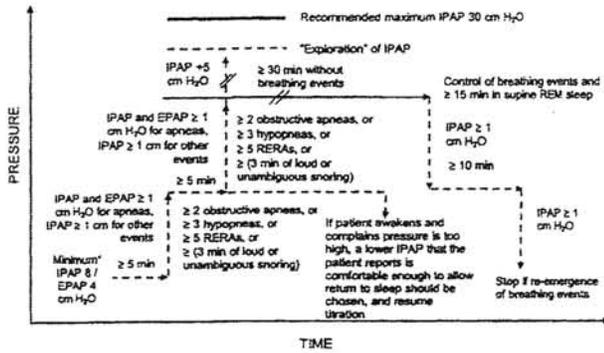


Figure 4—BPAP Titration Algorithm for Patients ≥ 12 years During Full- or Split-Night Titration Studies. Note: Upward titration of IPAP and EPAP ≥ 1 cm H₂O for apneas and IPAP ≥ 1 cm for other events over ≥ 5 -min periods is continued until ≥ 30 min without breathing events is achieved. A decrease in IPAP or setting BPAP in spontaneous-timed mode with backup rate may be helpful if treatment-emergent central apneas are observed.

* A higher starting IPAP and EPAP may be selected for patients with an elevated BMI and for retitration studies. When transitioning from CPAP to BPAP, the minimum starting EPAP should be set at 4 cm H₂O or the CPAP level at which obstructive apneas were eliminated. An optimal minimum IPAP-EPAP differential is 4 cm H₂O and an optimal maximum IPAP-EPAP differential is 10 cm H₂O.

insufficient data to make any recommendations for split-night CPAP titration studies in children <12 years.

4.3 Recommendations for Conducting Bilevel PAP (BPAP) Titration Studies in Pediatric or Adult Patients with Obstructive Sleep Apnea

4.3.1 General Recommendations for BPAP Titration Studies

4.3.1.1 If the patient is uncomfortable or intolerant of high pressures on CPAP, the patient may be tried on BPAP. If there are continued obstructive respiratory events at 15 cm H₂O of CPAP during the titration study, the patient may be switched to BPAP (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force and Option-Level evidence (1 level IV study⁴⁰ and 1 level V study⁶²). However, this recommendation does not imply that BPAP is more effective than CPAP at maintaining upper airway patency. Additionally, efforts should be made to explore why the patient is uncomfortable or intolerant of high pressures on CPAP and to remedy the situation before trying the patient on BPAP.

4.3.1.2 BPAP (IPAP and/or EPAP, depending on the type of obstructive respiratory event) should be increased until the following events are eliminated (no specific order) or the recommended maximum IPAP is reached: apneas, hypopneas, RERAs, and snoring (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force and Guideline-Level evidence (1

level I study⁵² and 1 level III study⁴⁶). The Task Force recommends that SaO₂ desaturation-resaturation events occurring without associated obstructive respiratory events should not be considered in the decision to increase IPAP and/or EPAP in pediatric and adult patients.

4.3.1.3 The recommended minimum starting IPAP and EPAP should be 8 cm H₂O and 4 cm H₂O, respectively, in pediatric and adult patients (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force and Guideline-Level evidence (1 level I study⁵² for the minimum starting EPAP in adult patients). In addition, when switching from CPAP to BPAP, the Task Force recommends that the minimum starting EPAP should be set at 4 cm H₂O or the CPAP level at which obstructive apneas were eliminated.

4.3.1.4 The recommended maximum IPAP should be 20 cm H₂O for patients <12 years or 30 cm H₂O for patients ≥ 12 years (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force. There is also evidence from the critical care literature indicating that an excess of 30 cm H₂O of upper airway pressure may increase the risk for barotrauma and other morbidities.^{89,90}

4.3.1.5 Methodology to determine IPAP or EPAP a priori has insufficient evidence, although a higher starting IPAP or EPAP may be selected for patients with an elevated BMI and for retitration studies (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force. As in the case of CPAP, a higher starting IPAP or EPAP may be needed for patients with an elevated BMI (see Recommendation 4.2.1.4).

4.3.1.6 The recommended minimum IPAP-EPAP differential is 4 cm H₂O and the recommended maximum IPAP-EPAP differential is 10 cm H₂O (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force and Guideline-Level evidence (1 level I study⁵² for the minimum IPAP-EPAP differential in adult patients).

4.3.2 Full-Night BPAP Titration Studies

4.3.2.1 IPAP and/or EPAP (depending on the type of obstructive respiratory event) should be increased by at least 1 cm H₂O apiece with an interval no shorter than 5 min, with the goal of eliminating obstructive respiratory events (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force and Guideline-Level evidence (1 level II study,⁵⁶ 1 level III study,⁴⁶ and 2 level V studies^{71,74}).

4.3.2.2 IPAP and EPAP should be increased (according to the criterion in Recommendation 4.3.2.1) if at least 1 obstructive apnea is observed for patients <12 years or if at least 2 obstructive apneas are observed for patients ≥12 years (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force. As in the case of CPAP, a lower pressure is required to treat apneas compared to the pressure required to treat other respiratory events (see Recommendation 4.2.2.2); however, there is 1 level II study⁵³ and 1 level V study⁷¹ that used increases in both IPAP and EPAP to eliminate apneas.

4.3.2.3 IPAP should be increased (according to the criterion in Recommendation 4.3.2.1) if at least 1 hypopnea is observed for patients <12 years or if at least 3 hypopneas are observed for patients ≥12 years (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force.

4.3.2.4 IPAP should be increased (according to the criterion in Recommendation 4.3.2.1) if at least 3 RERAs are observed for patients <12 years or if at least 5 RERAs are observed for patients ≥12 years (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force.

4.3.2.5 IPAP may be increased (according to the criterion in Recommendation 4.3.2.1) if at least 1 min of loud or unambiguous snoring is observed for patients <12 years or if at least 3 min of loud or unambiguous snoring are observed for patients ≥12 years (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force. As in the case of CPAP, the utility of titrating PAP to treat snoring may be reflected in improvement in patients' subjective daytime sleepiness (see Recommendation 4.2.2.5).

4.3.2.6 "Exploration" of IPAP above the pressure at which control of abnormalities in respiratory parameters is achieved should not exceed 5 cm H₂O (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force. As in the case of CPAP, IPAP exploration does have utility (see Recommendation 4.2.2.6).

4.3.2.7 If the patient awakens and complains that the pressure is too high, the pressure should be restarted at a lower IPAP, chosen as one that the patient reports is comfortable enough to allow return to sleep (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force.

4.3.2.8 A decrease in IPAP or setting BPAP in spontaneous-timed (ST) mode with backup rate may be helpful if treatment-emergent

central apneas (i.e., complex sleep apnea) are observed during the titration study (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force.

4.3.2.9 "Down" titration is not required but may be considered as an option (Consensus).

This recommendation and the following protocol is based on consensus agreement by the PAP Titration Task Force. As in the case of CPAP, a "down" titration is recommended for BPAP due to the "hysteresis" phenomenon⁴⁰ (see Recommendation 4.2.2.8). If a "down" titration is implemented, the Task Force recommends at least one "up-down" BPAP titration (1 cycle) should be conducted during the night. "Down" titration of IPAP and EPAP is conducted when at least 30 min has elapsed without obstructive respiratory events. IPAP should be decreased by at least 1 cm H₂O with an interval no shorter than 10 min, until there is reemergence of obstructive respiratory events. There is also limited evidence that an "up-down-up" titration protocol should be considered for CPAP⁴⁹ (see Recommendation 4.2.2.8); an "up-down-up" titration protocol should also be similarly considered for BPAP.

4.3.3 Split-Night BPAP Titration Studies

4.3.3.1 The titration algorithm for split-night BPAP titration studies should be identical to that of full-night BPAP titration studies (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force. A full-night, attended polysomnography performed in the laboratory is the preferred approach for titration to determine optimal positive airway pressure; however, split-night, diagnostic-titration studies are usually adequate (Recommendation 4.2.1 [Guideline] in the practice parameters for the use of CPAP and BPAP devices published in 2006).⁹¹ Unfortunately, studies comparing factors such as patient acceptance, adequacy of prescribed IPAP/EPAP, and adherence to BPAP for patients undergoing full-night vs. split-night BPAP titration studies do not exist. It may be prudent to increase IPAP and EPAP at larger increments (i.e., 2 or 2.5 cm H₂O) given the shorter BPAP titration duration in split-night vs. full-night studies. Of note, there are insufficient data to make any recommendations for split-night BPAP titration studies in children <12 years.

4.4 Important Considerations for PAP Titration Studies in Pediatric or Adult Patients with Obstructive Sleep Apnea

4.4.1 Acceptable PAP Titration Study

4.4.1.1 The CPAP or BPAP selected for patient use following the titration study should reflect control of the patient's obstructive respiration by a low (preferably <5 per hour) RDI at the selected pressure, a minimum sea level SpO₂ above 90% at the pressure, and with a leak within acceptable parameters at the pressure (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force. See Recommendation 4.4.3.2 for description of leak within acceptable parameters.

4.4.1.2 Grading system: An optimal titration reduces RDI <5 per hour for at least a 15-min duration and should include supine REM sleep at the selected pressure that is not continually interrupted by spontaneous arousals or awakenings (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force and the grading system proposed by Hirshkowitz and Sharafkhaneh.⁹¹

4.4.1.3 Grading system: A good titration reduces the overnight RDI ≤10 per hour or by 50% if the baseline RDI <15 per hour and should include supine REM sleep that is not continually interrupted by spontaneous arousals or awakenings at the selected pressure (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force and the grading system proposed by Hirshkowitz and Sharafkhaneh.⁹¹

4.4.1.4 Grading system: An adequate titration is one that does not reduce the overnight RDI ≤10 per hour but does reduce the RDI by 75% from baseline (especially in severe OSA patients), or one in which the titration grading criteria for optimal or good are met with the exception that supine REM sleep did not occur at the selected pressure (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force and the grading system proposed by Hirshkowitz and Sharafkhaneh.⁹¹

4.4.1.5 Grading system: An unacceptable titration is one that does not meet any one of the above grades (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force and the grading system proposed by Hirshkowitz and Sharafkhaneh.⁹¹

4.4.2 Repeat PAP Titration Study

4.4.2.1 A repeat PAP titration study should be considered if the initial titration does not achieve a grade of optimal or good and, if it is a split-night PSG study, it fails to meet AASM criteria (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force. As per split-night study criteria in the AASM practice parameters for the indications for PSG⁵: (a) an AHI of at least 40 is documented during a minimum of 2 hours of diagnostic PSG. Split-night studies may sometimes be considered at an AHI of 20 to 40, based on clinical judgment (e.g., if there are also repetitive long obstructions and major desaturations). However, at AHI values below 40, determination of CPAP pressure requirements, based on split-night studies, may be less accurate than in full-night calibrations. (b) CPAP titration is carried out for more than 3 hours (because respira-

tory events can worsen as the night progresses). (c) PSG documents that CPAP eliminates or nearly eliminates the respiratory events during REM and NREM sleep, including REM sleep with the patient in the supine position. (d) A second full night of PSG for CPAP titration is performed if the diagnosis of a SRBD is confirmed but criteria (b) and (c) are not met.

4.4.3 Leak and Comfort

4.4.3.1 PAP mask refit or readjustment should be performed whenever any significant unintentional leak is observed (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force. Leakage can occur in several forms. Intentional leak is the controlled leak from the port on mask interfaces that washes out CO₂ and prevents rebreathing. Unintentional leak is characterized as a “mouth leak” (i.e., pressurized air escaping via the mouth when a nasal mask is used) or “mask leak” between the mask and the face (i.e., pressurized air escaping between the mask and the face when a nasal mask or full-face/oronasal mask is used). Unintentional leak can be minimized by mask refit or readjustment, and, in the case of “mouth leak”, addition of a chinstrap to reduce mouth opening or switching to a full-face/oronasal mask may be beneficial.^{92,93} A study examining the effects of mask leak on the efficacy of BPAP therapy reported that the patients showed improved oxygenation, decreased arousal index, and increased REM sleep when this leak was minimized.⁹⁴

4.4.3.2 There is insufficient evidence for what constitutes a clinically significant leak given mask fit and other factors; however, in general, an unacceptable leak for PAP is one that is substantially higher than the leak recorded at a given pressure from a well-fitted, applied, and secured interface. The acceptable leak will always exceed the intentional leak, which depends on the applied pressure and interface type. The intentional leak vs. pressure relationship is usually supplied by the manufacturer of each interface (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force. The intentional leak of all interfaces increases as pressure increases. The exact amount of leak also varies with the type of interface. This makes identification of what constitutes an unacceptable leak value very difficult. Clinical judgment based on laboratory-specific criteria or the leak vs. pressure relationship supplied by the manufacturer for a given interface is recommended. A sudden increase in leak without a pressure change should alert the technologist to a possible increase in mask/mouth leak.

4.4.3.3 Pressure waveform modification technologies may improve patient comfort and adherence with PAP (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force. Complaints of a sensation of exhaling against a high pressure were reported by approximately 20% of patients receiving CPAP,⁹⁵ and it is possible that the pressure reduction during expiration on pressure-relief CPAP is

more comfortable for those patients who require a higher CPAP pressure. These new technologies have had limited testing but have potential utility in patient acceptance and utilization of PAP.^{43,58,96-99}

4.4.4 Positional and Sleep Stage Factors

4.4.4.1 Ideally, the patient should be recorded in supine REM sleep for at least 15 min at the designated optimal pressure during the PAP titration study. If the patient is in REM sleep but not in the supine position while at the designated optimal pressure, the patient may be awakened and instructed to lie in the supine position (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force. Optimal CPAP has been defined as the highest pressure obtained during REM sleep with the patient having slept in the supine position.⁵⁵ Since treatment-emergent central sleep apnea is more likely to occur in NREM sleep, it is also important to evaluate patients at the designated optimal pressure during NREM sleep.¹⁰⁰ There is evidence that the optimal CPAP level in the supine position is greater than 2 cm H₂O higher than the optimal CPAP needed while sleeping in the lateral position, both in REM and NREM sleep, in obese and nonobese subjects and in those younger and older than 60 years.⁵⁰ However, the decision to awaken the patient to obtain a PSG sample of supine REM must be carefully considered, since it is important that the patient be allowed to obtain adequate sleep during the titration study. This point may be supported by research demonstrating that an increase in sleep efficiency (SE) during CPAP titration compared to the diagnostic night was found to be the only significant predictor of objectively measured CPAP adherence after controlling for indices of OSA severity and sleep quality during the diagnostic night. Specifically, patients who had their SE increase used their machines an average of 2 hours more per night than those who did not have their SE increase.¹⁰¹

4.4.5 Supplemental Oxygen

4.4.5.1 Supplemental O₂ should be added during the PAP titration when, prior to the PAP titration, the patient's awake supine SpO₂ while breathing room air is ≤88%. Supplemental O₂ may also be added during the PAP titration when SpO₂ is ≤88% for ≥5 minutes in the absence of obstructive respiratory events. In both instances, supplemental O₂ should be introduced at 1 L/min and titrated upwards to achieve a target SpO₂ between 88% and 94% (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force. The above recommendation is made with the understanding that pulse oximetry can overestimate the actual arterial oxygen saturation in some circumstances and that the effective inspired oxygen concentration can fall if machine flow increases due to higher leak. A slightly higher goal than 88% (90%-94%) might be prudent in some circumstances.

4.4.5.2 The minimum starting O₂ rate should be 1 L/min (both pediatric and adult patients) (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force.

4.4.5.3 O₂ rate should be increased by 1 L/min, with an interval no shorter than 15 min, until SpO₂ is between 88% and 94% (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force. Similar to Recommendation 4.4.5.1, a slightly higher goal than 88% (90%-94%) might be prudent in some circumstances.

4.4.5.4 Optimally, supplemental O₂ should be connected to the PAP device outlet (using a T-connector) (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force. When O₂ is introduced directly into a PAP mask, the O₂ does not have time or space to mix well with the high flow coming from the tubing, which leads to highly variable O₂ concentrations inside the mask. However, when O₂ is introduced into the tubing near the PAP device rather than directly into the mask, more constant O₂ delivery to patients using PAP would be expected.¹⁰²

4.4.5.5 "Weaning" down of O₂ supplementation by employing BPAP or by further increasing IPAP (if BPAP was already instituted and if the patient tolerates the higher inspiratory pressures) can be attempted (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force. However, there is evidence from bench testing and limited human studies that measured O₂ concentration with supplemental O₂ is lower with higher CPAP, or in the case of BPAP, higher IPAP and EPAP levels, regardless of the difference between IPAP and EPAP levels.^{92,102} Anything that increases machine flow (room air) has the potential to reduce the effective O₂ concentration for a given supplemental O₂ flow.

4.4.6 Adaptive Servoventilation

4.4.6.1 Adaptive servoventilation may be considered if the patient is observed to have Cheyne-Stokes respiration or if treatment-emergent central sleep apnea (i.e., complex sleep apnea) during the titration study is not eliminated by down titration of pressure (Consensus).

This recommendation is based on consensus agreement by the PAP Titration Task Force. Adaptive servoventilation is a new therapy that provides an expiratory positive airway pressure and inspiratory pressure support which is servocontrolled, based on the detection of Cheyne-Stokes respiration,¹⁰³ with a backup respiratory rate. There is controversy as to what complex sleep apnea represents,^{104,105} but in one study, adaptive servoventilation has been shown to decrease respiratory events and improve objective sleep measures in patients with central sleep apnea/Cheyne-Stokes respiration, mixed sleep apnea, and complex sleep apnea.¹⁰⁶

4.4.7 Follow-up After the PAP Titration Study

4.4.7.1 PAP usage should be objectively monitored to help assure utilization (Standard).

This recommendation is based on consensus agreement by the PAP Titration Task Force, and is a slight modification of Standard-Level Recommendation 4.3.1 in the 2006 practice parameters for the use of PAP devices⁷; the current recommendation reflects objective monitoring of PAP (i.e., CPAP and BPAP), rather than only CPAP, usage.

4.4.7.2 Troubleshooting of problems encountered while on PAP, management of side effects, and methods to increase adherence should be a part of the close follow-up of the patient on PAP (Standard).

This recommendation is based on consensus agreement by the PAP Titration Task Force, and is a modification of Standard-Level Recommendation 4.4.1 ("Close follow-up for PAP usage and problems in patients with OSA by appropriately trained health care providers is indicated to establish effective utilization patterns and remediate problems, if needed. This is especially important during the first few weeks of PAP use.") in the 2006 practice parameters for the use of PAP devices.⁷ CPAP use is improved by contact with health care providers (either clinic physician appointment or specialist nurse home visit).¹⁰⁷ However, newer approaches may represent alternatives to current practices; the use of telemedicine support (i.e., Internet-based informational support and feedback for problems experienced with CPAP use) resulted in equivalent use, functional status, and patient satisfaction at 30 days compared to traditional follow-up care.¹⁰⁸ Skipping the use of CPAP for 2 or more nights within the first week of treatment signals potential nonadherence and highlights the need for close follow-up during this particularly vulnerable period of usage.¹⁰⁹ This is especially important since it is estimated that worldwide 5%-50% of OSA patients recommended for CPAP either reject or discontinue its use within the first week.¹¹⁰

5.0 FUTURE RESEARCH

Additional work is needed with respect to the following:

1. Further outcome studies comparing manual PAP titration studies vs. autotitrating PAP devices with respect to OSA severity and diverse patient populations.
2. Assessment of the reliability of selection of optimal pressure following PAP titration studies and the stability of the selected optimal pressure across successive PAP titration studies is needed.
3. Clinically significant thresholds for unintentional leak from the mouth or mask need to be identified.
4. Finally, advances in the technology for improving patient comfort and adherence to PAP devices are sorely needed.

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V. PROCEDURE:

Follow all preparation, patient set-up and testing procedures as stated in the Polysomnography Policy 736-1.08 as well as the following.

1. During Patient set-up, explain CPAP/BiPAP and encourage patient to ask questions.
2. Fit the patient with the proper type and size of mask.
3. Before starting the test, have the patient try on the mask and get used to the feel of the pressure. Check for proper fit and leaks during this time.
4. Before "lights out", explain that the pressure will be increased in small increments, by remote control throughout the night as the events are observed.
5. Encourage the patient to inform the technician of any difficulties or problems he/she may experience during the testing procedure.

Titration of Pressure:

1. Start all patients on CPAP, unless ordered otherwise by the physician.
2. Start at a pressure of 5 cmh₂o. Once patient falls asleep, watch for cyclical apneic episodes.
3. Titrate first for apneas then hypopneas, snoring desaturations and last arousals.
4. Increase pressure in 2 cmh₂o increments, in general, for apneas.
5. Increase pressure in 1 cmh₂o increments, in general, for hypopneas, snoring and arousals
6. After all respiratory events have disappeared, one may consider increasing pressure by 1 or 2 for arousals if arousals are not due to high pressures.
7. Do not increase pressure for at least 20 minutes. Cyclical events should be noted before increasing pressure. Do not increase pressure for on r two isolated events.
8. A chinstrap may be necessary if the patient breaths through his/her mouth.
9. Check for adequate oxygen saturations (>90%)
10. If an adequate pressure is obtained where no apnea or hypopneas are occurring but the saturations is below 88%, the physician should be notified for possible entrainment of oxygen. Oxygen may only be entrained with a physician's order.
11. The patient must be observed for adequate oxygen saturations (>90%) as well as central apneas. If central apneas are occurring, decrease the pressure by 2 or 3 cmh₂o for 30 minutes and gradually increase the pressure, observing for central apneas.

BiPAP Titration

1. For patients with OSA but in the absence of Obesity hypoventilation, neuromuscular disease, or CSAS, BiPAP should not be initiated until the patient is on at least 15 cmh₂o of CPAP. Do not place patient on BiPAP for arousals alone. It is difficult to determine the exact cause of the arousals. If the patient is absolutely not sleeping

with CPAP then BiPAP maybe tried, briefly until deeper sleep is achieved. Document reasons for initiating BiPAP.

2. When initiating BiPAP set the EPAP or around the pressure where apneas were eliminated, IPAP should be set ~~approximately~~ ^{3-5 cmh₂o} 3 cmh₂o above the EPAP for obstructive sleep apnea. Increase the IPAP for hypopneas, snoring and arousals. Increase EPAP for obstructive apneas.
3. Use EPAP until the apneas have been resolved. Increase the IPAP pressure until the hypopneas are resolved and adequate oxygen saturations have been reached.
4. For oxygen entrainment see above.
5. Titration of alveolar hypoventilation requires using patient tolerance and adequate oxygen saturation for levels of pressures.

Auburn Regional Medical Center Sleep Apnea Lab

Preliminary Tech Note

Time 24 hr	Epoch #	Video #	Position LRUSP	SaO2 Avg/Lo	Sleep Stage	PLM	Snore	Event	EKG? Avg HR	CPAP Cmh20	COMMENTS
											Snoring, Leak = 50
0307	924	-	R	95	REM	-	R1	-	70	11	Leak = 51
0341	936	-	R	95	Z	-	-	-	69	11	Leak = 51
035	958	TIR	I asked the pt to sleep on his back								
			same more TIR - 0336 (1440)								
0337	992	TIR	Replaced mask for high leak, Leak = 50								
			Adjusted several times but no improvements TIR - 0349								
0401	1072	-	S	95	W	-	-	-	70	11	Leak = 50
0411	1153	TIR	Pt is not too much aware for continue sleeping on his back. I helped him roll onto his right side TIR - 0409 (1156)								
0419	1201	TIR	Reattached M1 TIR - 0410 (1206)								
0431	1101	-	R	95	Z	-	-	-	70	11	Leak = 47
0509	1167	-	R	95	W	-	-	-	69	11	Leak = 49
0511	1180										END TEST

Tech Summary:	Best CPAP	Circuits	Size	Options	Pressure

O1 O2 C3 C4 F3 F4 E1 E2 M1 M2 CHIN1 CHIN2 REF

Date: 6/6/12
 Technician: PW
 Test: Diagnostic/Therapeutic/Split
 Montage: CPAP

PSG # 12348
 Room # 6



DOB: 08/26/1970 41 Y SX: M RES
 MRN: 688436 ADM/REG DT: 06/06/2012