

How can we make CBT-I and other BSM services widely available?

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Following several presentations and discussion panels regarding cognitive-behavior therapy for insomnia (CBT-I) during the 2007 annual meeting of the Associated Professional Sleep Societies in Minneapolis, it seems to many of us that the budding field of behavioral sleep medicine (BSM) is at a critical juncture.

Six events have occurred that bring us to the present crossroads. First, as result of the vision and generosity of the American Academy of Sleep Medicine (AASM), there is (as of 2004), a credentialing board for BSM that is underwritten and administered by the academy.¹ Second, the research literature regarding CBT-I has matured to a point where the 2005 NIH State of the Science panel acknowledged that this form of BSM is to be considered a first-line therapy for chronic insomnia.² Third, sleep medicine (with the change in the board-certification process from the American Board of Sleep Medicine to the American Board of Medical Specialties) has recently been redefined as a medical subspecialty and, as a result, BSM is not formally a part of sleep medicine. Fourth, with the revamping of AASM sections to be aligned with disease states (vs areas of specialty), BSM is no longer identified as a section within the Academy. Fifth, the recent AASM Comprehensive Academic Sleep Programs of Distinction initiative does not reference BSM nor require that centers within this program have BSM services.³ Sixth, and finally, it now appears that there is a substantial push to alter who should provide CBT-I (non-BSM “physician extenders” vs BSM specialists) and how treatment should be conducted (fewer and shorter sessions). Although each of the last 4 events is relevant for the continued growth of BSM as an allied

field and an interdisciplinary component of sleep medicine, the last and most recent event urgently needs to be addressed.

The push to make CBT-I more available by diversifying who can provide it and how it is provided is largely based on the following beliefs: (1) There are not enough credentialed BSM specialists to provide treatment for the millions of patients with insomnia, (2) reimbursement for BSM services is complicated and garners too low a level of reimbursement, (3) CBT-I can be conducted by anyone with a minimal amount of training, and (4) BSM specialists have little to offer sleep disorders centers beyond the treatment of insomnia (which can hardly keep one busy enough to justify a part-time equivalent or full-time equivalent salary).

Before addressing these issues specifically (and providing a series of recommendations), it is worth addressing the global perspective. Twenty to 30 years ago, sleep medicine itself was faced with many of the same daunting issues (e.g., too few specialists, problems with reimbursement, and a lack of evidence that sleep medicine alone could sustain a dedicated clinical enterprise). Yet, at that time, there was no call to populate the field with non-MDs to conduct polysomnography studies and evaluations (although this was allowed via the American Board of Sleep Medicine) nor was there a call to make polysomnography assessment studies half or one-third night studies to reduce the burden of the assessment process. Instead it was recognized that these issues required time and work to resolve and that only in this way could a clinical specialty be established. What has changed? Why is there such a sense of urgency and a rush toward solutions that can only diminish the effort to establish BSM as a subspecialty of sleep medicine (and behavioral medicine). Whatever the answer, it cannot be one that accepts that sleep medicine is, and should continue to be, a multidisciplinary field.

THERE ARE NOT ENOUGH CREDENTIALLED BSM SPECIALISTS TO PROVIDE TREATMENT FOR THE MILLIONS OF PATIENTS WITH INSOMNIA.

First, while it is estimated that 10% to 15% of the population suffers from chronic insomnia, it is unclear what proportion of this population is actively seeking help. Thus, the assumption that the demand far exceeds the supply remains to be formally documented. What is clear is that most accredited sleep disorders centers do not have full-time or part-time clinicians who special-

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ize in the treatment of insomnia (medical and/or behavioral treatment modalities) for the people who are actively seeking help.

Second, although it is unequivocally true that there are not enough CBSM specialists,⁴ it is not true that there are not enough qualified doctoral-level professionals to populate the ranks of this subspecialty. Any licensed clinicians with a PhD, PsyD, or MD is eligible for certification, provided they have the requisite basic education and/or they are willing to make a modest investment in postgraduate training. The real question here is how does one attract such individuals from allied fields? The first, and most potent incentive (one that no doubt attracted many to sleep medicine), is the existence of a procedure-based assessment method that garners a reasonable reimbursement. While applicable to sleep medicine, this is not applicable to BSM. The second incentive is the existence of a treatment modality that, although not well known, is effective⁵ and of relevance for a wide array of clinical practitioners. This incentive clearly applies to most mental health specialists because most Axis I disorders have insomnia as a defining feature, most patients with psychiatric illnesses experience insomnia, and most patients with chronic insomnia experience psychiatric symptomatology. This incentive also applies to clinicians who specialize in the treatment of chronic pain and/or cancer because these patients exhibit chronic insomnia at far greater rates than does the general population (50%-80%). Thus, given the absolute and relative efficacy of CBT-I (relative to medical treatment)⁵ and the ability of CBT-I to produce sustainable gains,⁵ it should be the case that this treatment modality is relevant for clinicians within at least these 3 allied specialties. This said, clinicians from these fields have not flocked into BSM. Part of this failure to thrive is related to reimbursement, and this issue will be addressed below. Part of this failure to thrive is related to the lack of awareness about CBT-I and the existence of training paths that can allow interested individuals to move from the desire to acquire skills, to skill acquisition, to certification.

Recommendations and Solutions

CREATE THE DEMAND

The AASM should mandate that all fully accredited sleep disorders centers, after some period of time (e.g., 2-4 years), be required to have a provider on staff (full time or part time) who is BSM “boarded” or board eligible.

The AASM should mandate that all “Comprehensive Academic Sleep Programs of Distinction” be required to have a full-time faculty member who is BSM “board” certified.

CREATE THE SUPPLY

The AASM and the BSM Committee should continue to make the eligibility criteria for the BSM exam as inclusive as possible and also consider a lesser certification for Masters-prepared clinicians (See below re: a second BSM certification).

The AASM and the BSM Committee should promote cross-training by formally partnering with organizations like the American Psychological Association, the American Psychiatric Nurses Association, and the National Association of Social Workers.

The AASM and the BSM Committee should attempt to attract clinicians from the aforementioned fields by soliciting their par-

ticipation in the annual meeting of the Associated Professional Sleep Societies, where solicitation uses incentives like formal invitations, waivers of the registration fee, and/or free continuing medical education credits. (This also has the added advantage of attracting new dues-paying members to our society.)

PROVIDE SUPPORT FOR TRAINING

Curricula should be developed and/or existing training opportunities should be endorsed by the AASM and the BSM Committee that provide intensive training opportunities in CBT-I.

BSM-credentialed clinicians should be encouraged by the AASM to provide peer supervision where encouragement could be as simple as a formal request from the leadership to provide these services. These peer-supervision arrangements, which should be privately arranged to isolate the AASM from the liabilities that stem from frank endorsements, are critical in that they will provide novitiates the supervised hours they require to be eligible for the BSM exam.

A mechanism to fund BSM fellowships should be developed. That is, although fellowship training programs exist and may be credentialed through the AASM (e.g., Rush Presbyterian Medical Center, Stanford University, University of Rochester, and University of North Texas⁶), there is no stable funding source or sources for these training opportunities. Solutions to this problem could include (1) support from our professional societies for the fellowships (e.g., the AASM and Sleep Research Society, the American Psychological Association), (2) AASM- or National Sleep Foundation-initiated partnerships with industry to support BSM fellowship programs,⁷ (3) a collaborative effort to form a multisite T32 for BSM training and research, and (4) financial support from the host sleep disorders centers.

REIMBURSEMENT FOR BSM SERVICES IS COMPLICATED AND NOT PARTICULARLY LUCRATIVE

Although it is unequivocally true that reimbursement for CBT-I is complicated and less lucrative than clinical interviews and/or follow-up visits for other sleep disorders (e.g., obstructive sleep apnea), this disincentive applies largely to physicians whose scope of practice is outside of psychiatry, psychology, or nursing. All practitioners who specialize in mental health and provide cognitive and/or behavioral interventions are well acquainted with, accustomed to, and have salary lines commensurate with mental health rates and copays. Thus, this problem represents a difficulty for the sleep medicine specialist who could and would practice BSM but simply cannot afford the hourly wage. The underlying, if not the real, problem here pertains to billing. Most sleep disorders centers do not have the requisite credentials and/or administrative skills required for mental health billing.

Recommendation/Solutions

The AASM and/or other sleep medicine education entities should offer courses on incorporating mental health billing into sleep disorder center’s billing systems.

The AASM and the BSM committee should explore how behavioral medicine or proper medical codes (vs mental health codes) can be applied to all patients seen in sleep disorders centers who receive BSM services.

The AASM and American Psychological Association should lobby Medicare and the 3 largest healthcare insurance companies to (1) uniformly reimburse BSM services provided by BSM-credentialed practitioners and (2) permit billing with an E&M code.

CBT-I CAN BE CONDUCTED BY ANYONE WITH A MINIMAL AMOUNT OF TRAINING

While it is probably true that most masters' level healthcare practitioners (and some bachelor's level workers) with training and reasonable clinical skills can quickly learn the mechanics of CBT-I, such individuals are woefully unprepared to conduct (without supervision):

- differential diagnoses within the sleep arena;
- differential diagnoses as they pertain to psychiatric comorbidities;
- the determination of when CBT-I (or components within the therapy) are contraindicated;
- therapy with treatment non-adherent and/or treatment resistant patients;
- behavioral therapies for sleep disorders other than insomnia;

Recommendations and Solutions

The AASM and the BSM Committee should provide, or endorse existing, training for individuals with masters-level credentials in mental health (e.g., psychiatric nurse practitioners, physicians assistants, and/or social workers).

The AASM and the BSM committee should provide an exam that allows for a lesser certification (e.g., CBSM vs a CBSM practitioner). We believe that, in order to maintain an adequate standard of care, eligibility for this exam should include

- A clinical masters degree
- A clinical license
- A clinical specialization that has mental health as a primary or secondary focus
- Two Courses on behavioral principles (graduate level)
- Formal CBT-I training via an AASM-credentialed or approved/endorsed program
- Documentation of 10 supervised cases
- A collaborative agreement with a PhD/MD credentialed BSM provider
- A collaborative agreement with a credentialed Sleep Medicine provider (ABSM or Sleep Medicine Exam)

BSM SPECIALISTS HAVE LITTLE TO OFFER BEYOND THE TREATMENT OF INSOMNIA (WHICH CAN HARDLY JUSTIFY A PART-TIME EQUIVALENT OR FULL-TIME EQUIVALENT SALARY)

Sadly, the effort to promote CBT-I has resulted in (1) the widespread belief that CBT-I and BSM are one and the same; (2) a lack of clinical research to empirically validate the efficacy and effectiveness of other forms of BSM, including the pro-

vision of care for pediatric insomnia, parasomnias, continuous positive airway pressure compliance, and treatment alternatives for other intrinsic sleep disorders; and (3) a marked underemphasis of the PhD/PsyD CBSM individuals' skills to conduct empiric validation of treatment, the novel assessment of treatment outcomes, and program evaluation,

Recommendations and Solutions

The AASM and the BSM Committee should jointly offer a position paper on the interdisciplinary nature of sleep medicine and the role of non-MDs in making sure that most, if not all, sleep disorders centers provide comprehensive and evidence-based sleep disorders care.

The AASM and the BSM Committee should collaborate with the program officers at the National Institutes of Health to craft a request for applications or request for proposals for (1) clinical research that provides efficacy and safety data on BSM interventions apart from CBT-I (e.g., continuous positive airway pressure compliance training, positional therapy for obstructive sleep apnea, sleep restriction for restless legs syndrome or Periodic limb movements of sleep, etc.) and (2) a multisite T32 that provides BSM clinical and research training.

In closing, we would to acknowledge that there are many possible pathways forward, and this article serves only to highlight a few of the possibilities. This said, it is our hope that this editorial will begin (or further augment) the process of thinking that will end with a program of action that ensures the health and well-being of BSM and that this, in turn, furthers our true mandate: that all sleep disorders centers provide comprehensive care for all patients with sleep disorders.

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ENDNOTES

1. <http://www.aasmnet.org/BSMSpecialists.aspx>
2. <http://consensus.nih.gov/2005/2005InsomniaSOS026main.htm>
3. <http://www.aasmnet.org/Articles.aspx?id=420>
4. Currently, 89 PhD, PsyD, and MDs are credentialed, See <http://www.aasmnet.org/BSMSpecialists.aspx>
5. For an overview re: the efficacy and effectiveness of CBT-I, we recommend the reader review the several meta-analysis published on this topic. A reference list and FAQs sheet can be provided by the first author at Michael_Perlis@URMC.Rochester.edu
6. <http://www.aasmnet.org/BSMPrograms.aspx>
7. Note: Of all of these possibilities, support from industry may seem to some the least likely source of funding. This said, the manufacturers of CPAP devices and actigraphs, and light boxes, etc. would clearly benefit from joining such an initiative and it is our experience (contrary to what might be expected) that several pharmaceutical companies have indeed been willing to provide support for CBT-I training.