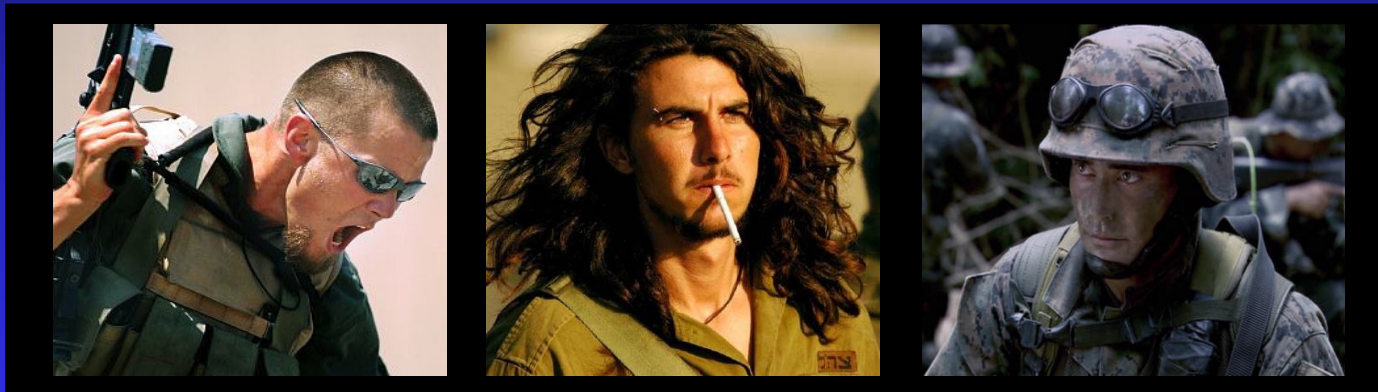


PROFESSIONAL SOLDIERS A VOLUNTEER ARMY OR A DRAFT:

WHO CAN AND SHOULD PROVIDE BSM SERVICES AND CBT-I?



Michael L. Perlis, Ph.D.

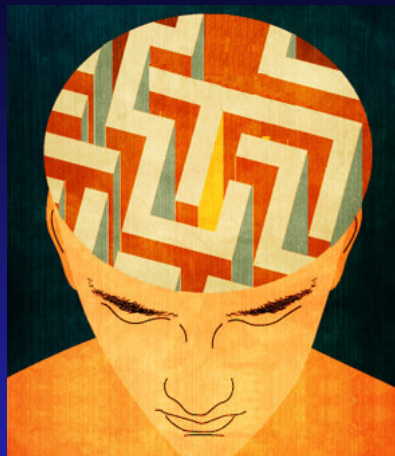
Associate Professor of Psychiatry
Department of Psychiatry
University of Pennsylvania

Director, The Upenn Behavioral Sleep Medicine Program



**THE CONTENTS OF THIS TALK
SIMPLY REPRESENT
ONE POINT OF VIEW**

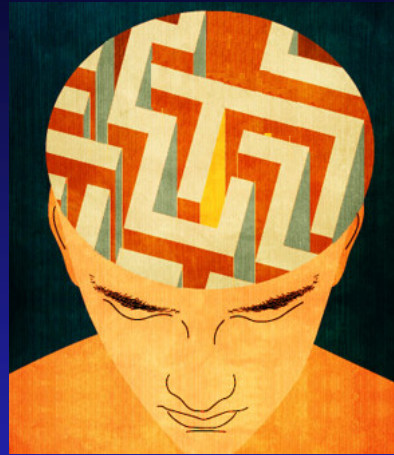
THE OLD PROBLEM



**IS CBT-I REALLY EFFICACIOUS
AND EFFECTIVE ?**

**IS CBT-I
REALLY COMPARABLE TO MEDICAL THERAPY ?**

THE OLD PROBLEM



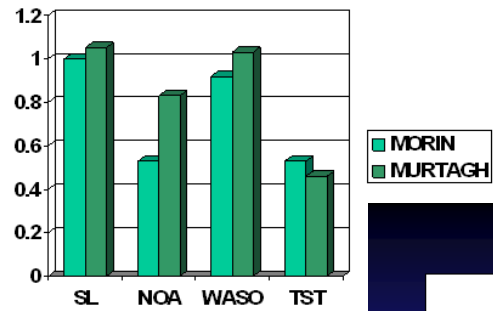
ANSWER:

YES.

YES.

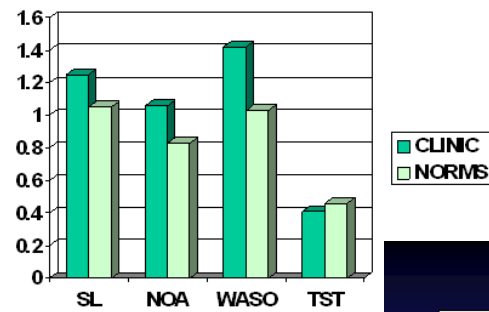
EFFICACY

EFFECT SIZES PRE-TO-POST WITH CBT-I



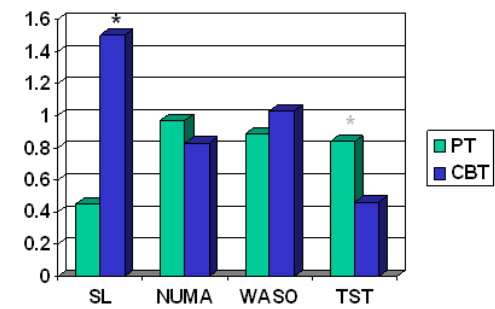
EFFECTIVENESS

EFFECT SIZES PRE-TO-POST WITH CBT-I

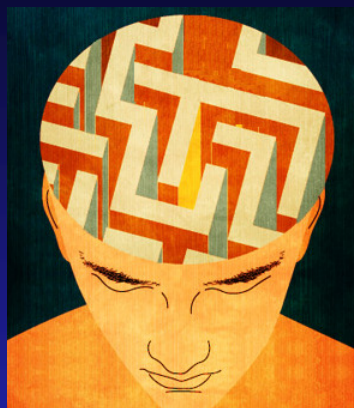


COMPARATIVE EFFICACY

EFFECT SIZE DIFFERENCES WITH ACUTE TX



THE NEW PROBLEM



HOW DO WE GET CBT-I TO BE READILY AVAILABLE ?

ANSWER: MORE QUESTIONS.

- WHAT IS THE TIME FRAME FOR “UNIVERSAL” ACCESS ?
- WHERE SHOULD SERVICES BE PROVIDED ?
- WHO SHOULD PROVIDE BSM AND CBT-I SERVICES ?
- HOW SHOULD PROVIDERS BE CREDENTIALLED ?
- HOW CAN WE PROVIDE FOR QA FOR NON CBSM THERAPISTS ?
- HOW DO WE RECRUIT/TRAIN NEW THERAPISTS ?

GOOD NEWS



ALL THESE QUESTIONS HAVE ANSWERS !

WHAT IS THE TIME FRAME FOR “UNIVERSAL” ACCESS ?



A: BEST GUESS NEXT 5 YEARS

WHERE SHOULD SERVICES BE PROVIDED ?

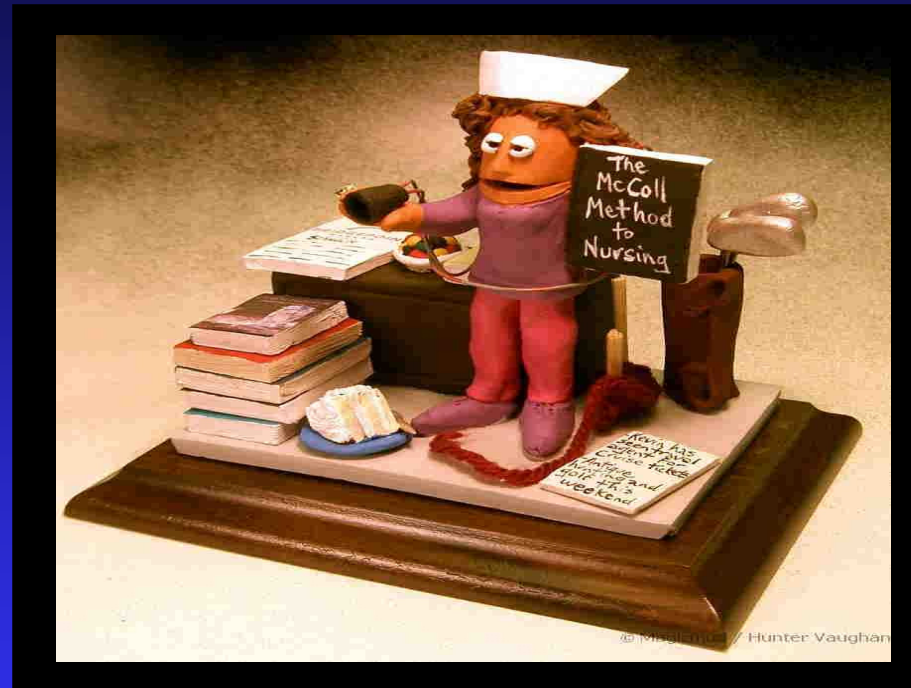


A: IDEALLY AT SDCS OR IN AFFILIATED CLINICS

WHO SHOULD PROVIDE BSM & CBT-I SERVICES ?



WHO SHOULD PROVIDE BSM & CBT-I SERVICES ?

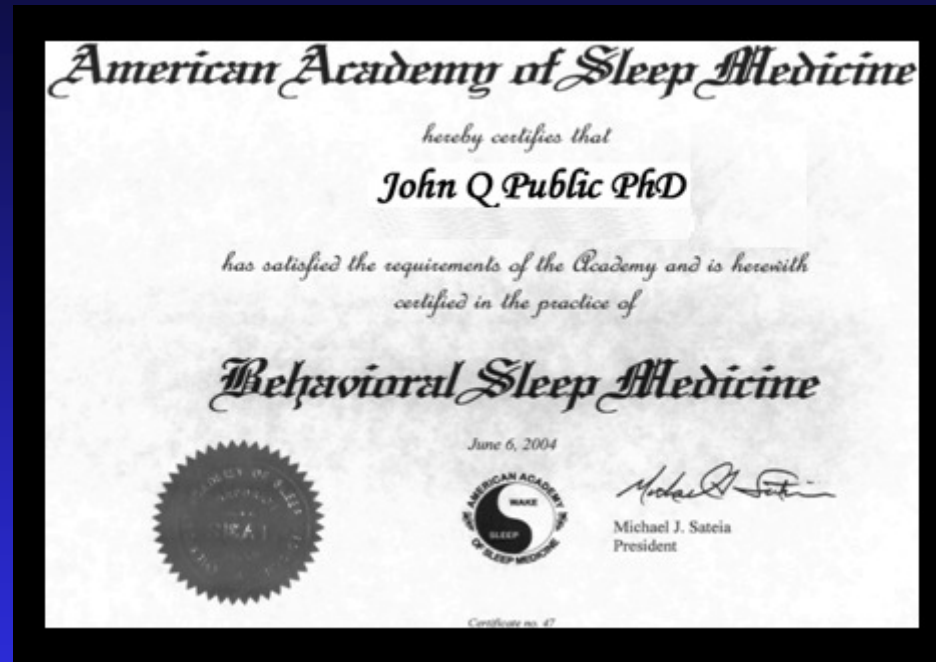


WHO SHOULD PROVIDE BSM & CBT-I SERVICES ?



**A: HOW ABOUT LICENSED MENTAL HEALTH
PROVIDERS**

HOW SHOULD PROVIDERS BE CREDENTIALLED ?



A1: IDEALLY, PHDS (MDS?) SHOULD BE “BOARD” CERTIFIED VIA THE CBSM

A2: NOTE: THERE IS ALSO DISCUSSION ABOUT SEEKING CERTIFICATION VIA ABPP

HOW CAN WE PROVIDE FOR QA FOR NON-CBSM AND/OR MA LEVEL THERAPISTS



A1: REQUIRE / RECOMMEND THE ESTABLISHMENT OF COLLABORATIVE ARRANGEMENTS WITH CBSM “DIPLOMATES”

A2: FORMALLY / INFORMALLY ESTABLISH A NETWORK OF PEER SUPERVISORS

HOW DO WE RECRUIT/TRAIN NEW THERAPISTS ?



HOW DO WE FIELD AN ARMY OF CLINICIANS IN 5 YEARS ?



THIS IS THE HARD QUESTION !

HOW DO WE RECRUIT/TRAIN NEW THERAPISTS ?

HOW DO WE FIELD AN ARMY OF CLINICIANS IN 5 YEARS ?



HERE'S WHAT APPEARS TO BE THE OPTIONS

GRADUATE PROGRAMS

PSYCHOLOGY INTERNSHIPS

ACCREDITED/INFORMAL BSM FELLOWSHIPS

ACCREDITED/INFORMAL MINI FELLOWSHIPS

CONTINUING EDUCATION PROGRAMS

TREATMENT MANUALS

BSM SERIES WEBINARS FOR CBT-I

GRADUATE PROGRAMS



THERE ARE 6-10 PROGRAMS

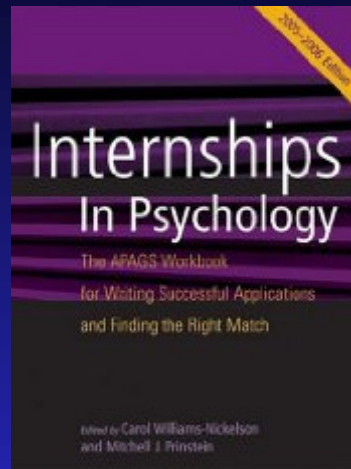
STRENGTHS: THESE INDIVIDUALS, UPON COMPLETION OF TRAINING, TEND TO BE “DYED IN THE WOOL” EXPERTS

WEAKNESSES: TOO FEW PROGRAMS

**THE PROGRAMS ARE SMALL
(1-5 TRAINEES PER PROGRAM)**

**PROGRAMS TEND TO PRODUCE RESEARCHERS
(VS. CLINICIANS)**

PSYCHOLOGY INTERNSHIPS



THERE ARE 6-10 PROGRAMS

STRENGTH: MOST PROGRAMS ALLOW FOR AN INTENSIVE TRAINING EXPERIENCE FOR 3-6 MONTHS

**WEAKNESS: TOO FEW PROGRAMS
PROGRAMS ARE SMALL (1-3 TRAINEES / YEAR)**

BSM FELLOWSHIPS



THERE ARE 9 PROGRAMS

**STRENGTHS: ALLOWS FOR AN INTENSIVE TRAINING EXPERIENCE
FOR 1-2 YEARS**

**WEAKNESS: TOO FEW PROGRAMS
PROGRAMS ARE SMALL (USUALLY 1 TRAINEE / YEAR)
PROGRAMS REQUIRE DEDICATED FINANCIAL RESOURCES**

BSM MINI-FELLOWSHIPS



**THE NUMBER OF INFORMAL AND FORMAL PROGRAMS IS UNKNOWN
BEST GUESS: 6-10**

**STRENGTHS: ALLOWS FOR AN INTENSIVE TRAINING EXPERIENCE
OVER A SHORT TIME INTERVAL (1-2 WEEKS)
PROGRAMS HAVE MANAGEABLE COSTS**

**WEAKNESSES: TOO FEW PROGRAMS
PROGRAMS ARE SMALL (1-5 TRAINEES / YEAR)**

CONTINUING EDUCATION COURSES

CE WORKSHOPS 2009

Back by Popular Demand!

117th APA Annual Convention
Toronto, Ontario, Canada August 6-9, 2009

Behavioral Sleep Medicine: Evidence-Based Treatments for Sleep Disorders (Workshop Code: #108)

Thursday, August 6, 2009

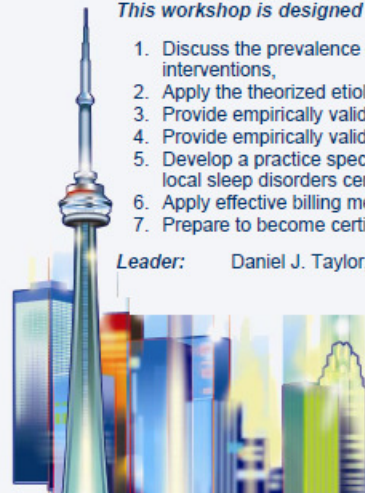
Workshop Description

An overwhelming number of patients have sleep problems, which can be disconcerting to clinicians without the training to treat these disorders. An abundance of evidence supports several psychological treatments of sleep disorders such as insomnia, parasomnias, and circadian rhythm disorders. There is a growing need for practitioners with expertise in these techniques. The main goal of this **INTRODUCTORY** workshop is to educate clinicians about how to provide and be reimbursed for, empirically validated treatments for common sleep disorders (e.g., insomnia).

This workshop is designed to help you:

1. Discuss the prevalence of sleep disorders treatable with behavioral and cognitive interventions,
2. Apply the theorized etiology of these disorders in developing a treatment plan,
3. Provide empirically validated treatments for these disorders in adults,
4. Provide empirically validated treatments for these disorders in children,
5. Develop a practice specialty in behavioral sleep medicine through collaboration with local sleep disorders centers,
6. Apply effective billing methods for behavioral sleep medicine services, and
7. Prepare to become certified in behavioral sleep medicine.

Leader: Daniel J. Taylor, PhD, University of North Texas, Denton, TX



AMERICAN PSYCHOLOGICAL ASSOCIATION
EDUCATION DIRECTORATE

This activity is intended for level Nurses and Physicians for treatment of insomnia

The seminar will provide and non-pharmacological

This activity has been credited™. Psychologist

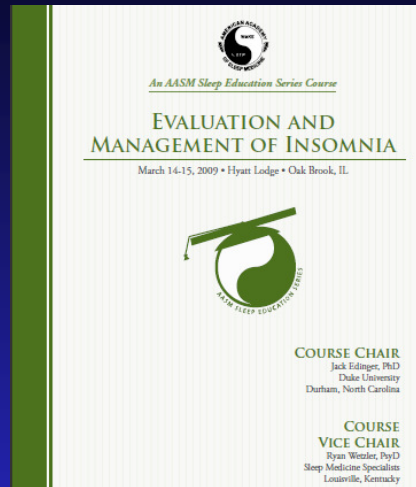
ts should be able to:

nd RDC criteria
ences of insomnia
trinsic sleep disorders
the available medical

or CBT-I

Academy of Sleep

AASM BSM/INSOMNIA COURSE (2 DAYS)



STRENGTH: ALLOWS FOR AN INTENSIVE TRAINING EXPERIENCE OVER A WEEKEND SEMINAR LED BY LEADING BSM EXPERTS

IS SPONSORED BY, AND UNDERWRITTEN BY, THE AASM

**ALLOWS FOR A LARGE NUMBER OF TRAINEES
(100-200 PEOPLE / COURSE)**

WEAKNESS: TRAINING IS AN OVERVIEW OF BSM AND NOT DEDICATED TO CBT-I TRAINING

**TARGET AUDIENCE IS FROM WITHIN THE SLEEP COMMUNITY
A MODERATE TO LARGE PERCENTAGE DO NOT GO ON TO
PRACTICE CBT-I**

UR/UPENN CBT-I WEEKEND SEMINAR (3 DAYS)

**Principles & Practice of
Cognitive Behavioral Therapy for Insomnia (CBT-I)**


October 3 – 5, 2008 Hyatt Regency Crystal City, Arlington, VA

For complete schedule, accommodations, and registration information please visit:
www.urmc.rochester.edu/cpe/CBT-I

This activity is intended for Clinical Psychologists, PhD/NP level Nurses and Physicians interested in the assessment and treatment of insomnia. Clinical Trainees are also welcome.

The seminar will provide information on both pharmacologic and non-pharmacologic treatment of insomnia.

This activity has been approved for AMA PRA Category 1 credits™. Psychologist CE credits available.



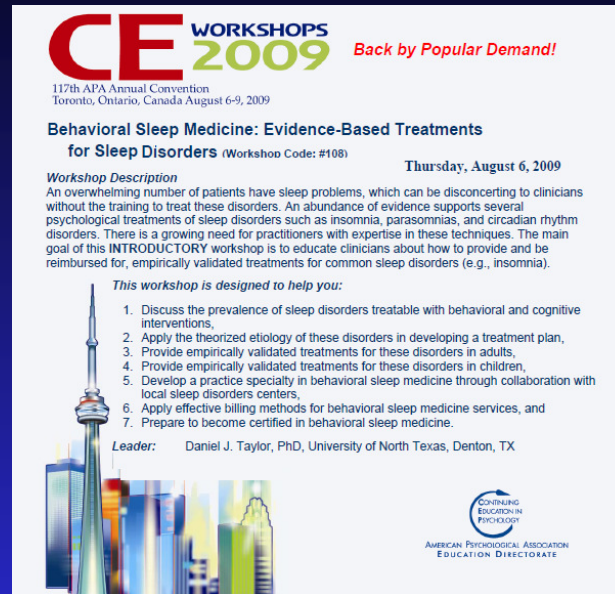
Course Objectives:
At the conclusion of this activity participants should be able to:

- Define insomnia according to ICSD and RDC criteria
- Identify the prevalence and consequences of insomnia
- Conduct a differential diagnosis re: intrinsic sleep disorders
- Assess the merits and applicability of the available medical treatments
- Determine who is a good candidate for CBT-I
- Conduct CBT-I with peer supervision
- Prepare oneself for eligibility for the Academy of Sleep Medicine's BSM exam

STRENGTHS: **ALLOWS FOR AN INTENSIVE TRAINING DEDICATED TO CBT-I**
COURSE IS BASED ON A PUBLISHED TRAINING MANUAL
THE TARGET AUDIENCE IS NON-SLEEP MENTAL HEALTH CLINICIANS
ALLOWS FOR 50-100 PEOPLE / COURSE
COURSE IS SET OUT AS “STEP 1 EXPERIENCE” WITH A CLEAR
PATH TOWARDS PRACTICE AND CERTIFICATION

WEAKNESSES: **THE PERCENTAGE OF CLINICIANS THAT GO ON TO FOLLOW THE**
“PRESCRIBED PATH” TO FULL TRAINING IS UNKNOWN
THE PERCENTAGE OF CLINICIANS THAT GO ON TO PRACTICE
CBT-I PART OR FULL TIME IS UNKNOWN
SOME MAY CONSIDER THE CBT-I TRAINING TOO NARROW
AND TOO FOCUSED ON A SINGLE APPROACH

APA BSM/INSOMNIA COURSE (1 DAY)



STRENGTH: ALLOWS FOR AN EXCELLENT OVERVIEW OF BSM AND IS LEAD BY BSM EXPERTS

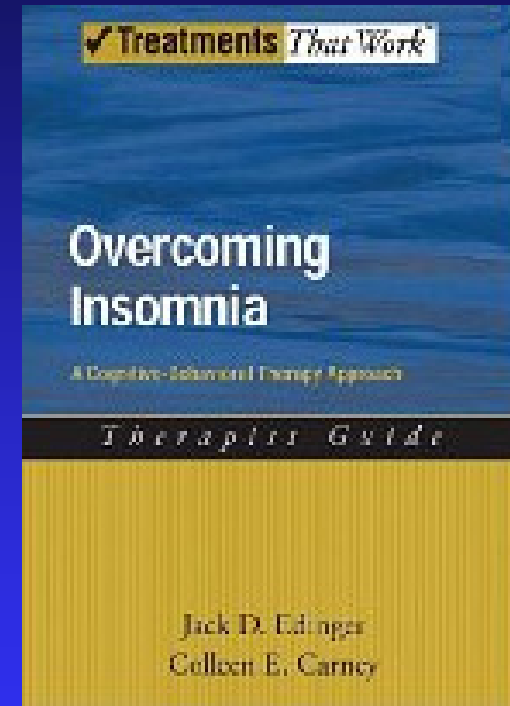
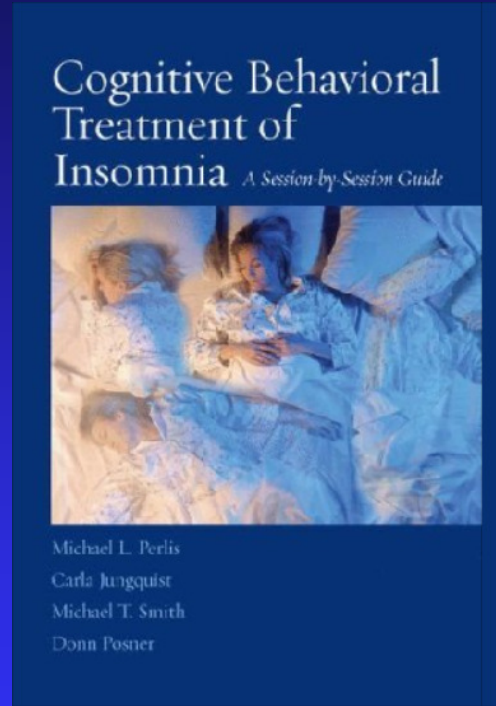
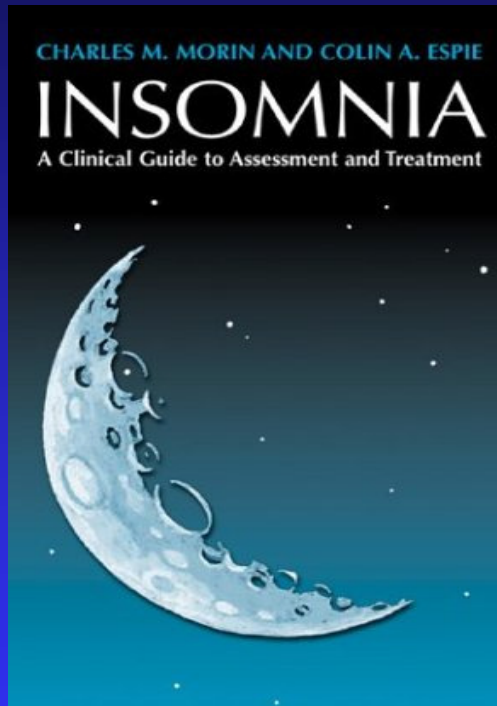
TARGETS A NON-SLEEP AUDIENCE

**ALLOWS FOR A LARGE NUMBER OF TRAINEES
(50 PEOPLE / COURSE)**

WEAKNESS: TRAINING IS AN OVERVIEW OF BSM AND NOT DEDICATED TO CBT-I TRAINING

A MODERATE TO LARGE PERCENTAGE DO NOT GO ON TO PRACTICE CBT-I

PUBLISHED TREATMENT MANUALS



PUBLISHED TREATMENT MANUALS



STRENGTHS: **ALLOW FOR AN UNLIMITED ACCESS TO THE TECHNIQUES**
ALLOW FOR HIGHLY DETAILED AND REFINED
PRESENTATION OF METHODS.

WEAKNESS: **OFTEN DO NOT EMPHASIZE THE NEED FOR TRAINING**
BEYOND“BOOK LEARNING”
THE PERCENTAGE OF CLINICIANS THAT GO ON TO PRACTICE
CBT-I PART OR FULL TIME IS UNKNOWN
DO NOT ALLOW FOR QUALITY CONTROL.

AASM WEBINAR



The advertisement features a dark blue header with the text "AASM Board Review Course CD-ROM" in a serif font. To the left of the header is a red banner that says "Pre-order now and save!" with a CD-ROM icon. Below the header, there is a list of products under the heading "NEW BEHAVIORAL SLEEP MEDICINE SERIES". The products are: "Behavioral Sleep Medicine Series: Cognitive Approaches to Insomnia Treatment Webinar Archive CD-ROM", "Behavioral Sleep Medicine Series: Relaxation Approaches for Insomnia Webinar CD-ROM Archive", "Behavioral Sleep Medicine Series: Sleep Hygiene Webinar Archive CD-ROM", "Behavioral Sleep Medicine Series: Sleep Restriction Webinar Archive CD-ROM", and "Behavioral Sleep Medicine Series: Stimulus Control Webinar Archive CD-ROM". A "more information" link with a red arrow icon is located at the bottom right of the header.

Pre-order now and save!

AASM Board Review Course CD-ROM

• Audio recordings/slide presentations from the August 14-16, 2009 Board Review Course [more information](#)

NEW BEHAVIORAL SLEEP MEDICINE SERIES

- Behavioral Sleep Medicine Series: Cognitive Approaches to Insomnia Treatment Webinar Archive CD-ROM
- Behavioral Sleep Medicine Series: Relaxation Approaches for Insomnia Webinar CD-ROM Archive
- Behavioral Sleep Medicine Series: Sleep Hygiene Webinar Archive CD-ROM
- Behavioral Sleep Medicine Series: Sleep Restriction Webinar Archive CD-ROM
- Behavioral Sleep Medicine Series: Stimulus Control Webinar Archive CD-ROM

STRENGTHS:

- CREATED BY BSM EXPERTS**
- ALLOWS FOR AN UNLIMITED ACCESS**
- ALLOWS FOR HIGHLY DETAILED & REFINED PRESENTATIONS**
- ALLOWS FOR SELF-PACED LEARNING**

WEAKNESSES:

- DOES NOT TARGET A NON-SLEEP AUDIENCE**
- DOES NOT EMPHASIZE THE NEED FOR TRAINING BEYOND “BOOK LEARNING”**
- THE PERCENTAGE OF CLINICIANS THAT GO ON TO PRACTICE CBT-I FTE/PTE IS UNKNOWN**
- DOES NOT ALLOW FOR QUALITY CONTROL.**

RECOMMENDATIONS



RECOMMENDATIONS



WORK TOWARDS A POLICY WHERE ALL FULLY ACCREDITED SDCs HAVE A FTE/PTE CBSM ON STAFF WITHIN 5 YEARS

ESTABLISH GUIDELINES FOR PRACTICE AND PRACTICE AGREEMENTS FOR ALL MA LEVEL CLINICIANS

ESTABLISH FORMAL OR AN INFORMAL NETWORK OF PEER SUPERVISORS FOR BSM NOVITIATES AND/OR MA LEVEL CLINICIANS

EXPAND NUMBER OF INTERNSHIPS, FELLOWSHIPS, MINI-FELLOWSHIPS. PERHAPS VIA INCENTIVES

EXPAND TARGET AUDIENCE FOR THE AASM BSM COURSE TO APA & ABCT

EXPLORE THE PROVISION OF AASM ACREDITATION FOR NON-AASM TRAININGS

PARTNER WITH INDUSTRY TO DISTRIBUTE THE 3 TX MANUALS TO ALL SDCs

FINALLY,
MANY OF THE IDEAS COVERED HERE
ARE DISCUSSED IN

EDITORIAL

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

Michael L. Perlis, Ph.D.¹; Michael T. Smith, Ph.D.²

¹University of Rochester, Sleep & Neurophysiology Research Laboratory, Rochester, NY; ²Johns Hopkins University, Behavioral Medicine Research Laboratory and Clinic, Baltimore, MD

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-

Disclosure Statement

Dr. Perlis has received research support from Cephalon and Sanofi-Aventis; has consulted for Elan-King Pharmaceuticals, Gerson Lehman, Clinical Advisors, and MedaCorp; has participated in speaking engagements for Sanofi-Aventis; has received use of equipment from Respro-nics; and has financial interests in Internet Didactic Services. Dr. Smith has received research support from Sepracor.

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THANKS FOR LISTENING





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