

## LETTERS TO THE EDITOR

## Treatment for Insomnia in 2017: “Don’t Ask, Don’t Treat”

Gautam Ganguly, MD, FAASM

Neurology Consultants Medical Group, Whittier, California

I read with great interest the article by Ulmer et al. along with the commentary by Grander and Chakravorty.<sup>1,2</sup> Surprisingly we observe a similar trend in treating insomnia among the community primary care physicians (PCPs). So, it raises a question of whether we as sleep physicians are doing enough to change the misperceptions of insomnia treatments among the PCPs.

The study highlights the tendency of Veterans Affairs PCPs to inadequately document insomnia. Can this be a reflection of their own perception about sleep? Many physicians often are used to chronic sleep deprivation by virtue of their profession. So, are the PCP responses partly from their own belief of sleep being a “not so important issue”?

It was also obvious from PCP responses that they lack confidence in cognitive behavioral therapy for insomnia (CBT-I). Eligible patients were not referred for CBT-I despite 86% of the respondents being aware of CBT-I. Was this only because of unavailability of CBT-I or an “out of sight, out of mind” phenomenon? Currently, PCPs are under severe time constraints for patient visits. They are being evaluated according to the value-based care they provide in controlling diabetes, hypertension, vaccinations, or cancer screening in their patient population. Sleep disorders, including insomnia and sleep apnea, are underdiagnosed because it is not part of their value-based care. There is no incentive for a PCP to discuss sleep issues with their patients, especially when they believe they have limited treatment options. It only adds more time for each patient visit.

So, the sleep community needs to provide these PCPs with tools they can use in the electronic medical record to help with their workflow. One possibility is a pop-up reminder to use CBT-I when encounter forms show insomnia or pharmacotherapy for insomnia is being prescribed. This may increase the use of CBT-I by default. Also, major payors such as Medicare need to endorse CBT-I as the primary treatment for insomnia among its members and their PCPs.

Availability and affordability are the basic requirements for any treatment to be acceptable. Unfortunately, in addition to

significant shortage for CBT-I therapists, there is confusion about CBT-I among payors, too. A patient often has to pay up-front for the treatment before getting reimbursed by Medicare. These hassles make CBT-I less acceptable as a primary therapy for insomnia by the PCPs and their patients, forcing them to choose the next-best standard of care with medications or sleep hygiene. Until we provide our primary care colleagues with the tools to tackle some of these problems, we should not hope to see any difference in insomnia evaluation and treatment, and it will remain in the “don’t ask, don’t treat” category.

## CITATION

Ganguly G. Treatment for insomnia in 2017: “don’t ask, don’t treat.” *J Clin Sleep Med*. 2018;14(1):155.

## REFERENCES

1. Ulmer CS, Bosworth HB, Beckham JC, et al. Veterans affairs primary care provider perceptions of insomnia treatment. *J Clin Sleep Med*. 2017;13(8):991–999.
2. Grander MA, Chakravorty S. Insomnia in primary care: misreported, mishandled and just plain missed. *J Clin Sleep Med*. 2017;13(8):937–939.

## SUBMISSION &amp; CORRESPONDENCE INFORMATION

Submitted for publication October 4, 2017

Submitted in final revised form October 4, 2017

Accepted for publication October 12, 2017

Address correspondence to: Gautam Ganguly, M.D., Neurological Consultants Medical Group, 12291 E Washington Blvd, Ste#303, Whittier, CA 90606; Tel: (562)698-6296; Fax: (562)693-6752; Email: gangulyg123@gmail.com

## DISCLOSURE STATEMENT

Dr Ganguly reports no conflicts of interest.