New Sleep Education Website

Sleep Health*Centers* believes that sleep disorders and related issues have a significant impact on the community, business, productivity and personal well-being. That is why we are introducing our new sleep education website...

Sleep and You raises awareness about sleep, sleep disorders, and issues impacting sleep, providing consumers and patients with information to improve and enhance their health and quality of life. The program explains the importance of sleep, the effect sleep disorders can have throughout an individual's life, and the options available for treatment and care for sleep concerns. It highlights the connection between sleep and other co-morbid conditions, such as diabetes, stroke, weight management and cardiovascular disease

We hope you and your patients find this to be a valuable resource for sleep education.

Sleep Health*Centers* is a network of sleep medicine centers staffed by experts in the field of sleep medicine. Our integrated care system provides all the services needed to diagnose and treat patients with the entire array of sleep disorders including obstructive sleep apnea, insomnia, narcolepsy and restless legs syndrome.

In this issue of the Sleep Health*Centers* Newsletter…

- The Case of Insomnia and Sleep Apnea by Claudia M. Toth, PsyD
- Medicare's New Regulations for DME Coverage for Medicare Patients
- CEO Corner:
  - Sleep Health*Centers* launches new websites
  - North East Sleep Society's 23rd Annual Conference Recap
- Research Activities

Massachusetts Affiliations: Beth Israel Deaconess Medical Center, Brigham and Women's Hospital, Faulkner Hospital, Hallmark Health, Marlborough Hospital, Massachusetts Eye and Ear Infirmary, McLean Hospital, New England Sinai Hospital, Southcoast Hospitals Group; *New York Affiliations:* Beth Israel Medical Center

Massachusetts Locations: Bedford, Beverly, Boston, Brighton, Framingham, Jamaica Plain, Marlborough, Medford, North Dartmouth, Stoughton, Weymouth, Worcester; *New York Locations:* Manhattan; *Rhode Island Locations:* Cumberland

For more information, please contact us at: 1-877-SLEEPHC (1-877-753-3742) or visit our website at www.sleephealth.com.

Requisition forms are available on our website.

Sleep HealthCenters® Newsletter

Lawrence J. Epstein, MD, Editor .... Spring 2009

Dear Colleague:

In this issue of the Sleep Health*Centers* Newsletter, Claudia Toth, PsyD, writes our feature article about Insomnia and Sleep Apnea. Both are common disorders and can arise independently of each other. However, insomnia can interfere with the treatment of sleep apnea or occur as a consequence of the therapy for sleep apnea. As a result, it is important to identify and address both issues. Dr. Toth describes the features and causes of insomnia then explains the interaction between insomnia and sleep apnea. The next section details the treatments for insomnia with particular emphasis on behavioral methods, which are often more effective and longer lasting than pharmacological therapies. She also describes how to apply these therapies in the setting of sleep apnea. Last, Dr. Toth presents the case of a sleep apnea patient who develops insomnia to illustrate the management principles.

Sleep Health*Centers* recently implemented a new electronic medical record system, eClinicalWorks. All of our 15 centers have converted to the new system and we anticipate the system will improve our ability to communicate with each other and referring providers, as well as assist our efforts to give our patients the highest quality of care.

In March 2008, the Center for Medicare and Medicaid Services (CMS) released a new National Coverage Determination (NCD) policy for the coverage of continuous positive airway pressure (CPAP) for patients with obstructive sleep apnea (OSA). In August of last year, the four regional Medicare durable medical equipment administrative contractors issued local coverage determination policies that provided the details on how to implement the CPAP NCD. These policies shifted the emphasis from diagnosis to providing effective treatment by ensuring patients use their devices and benefit from use of the device. This requires that managing clinicians provide follow-up care and document adherence and response to treatment. Starting November 1, 2008, clinicians managing OSA patients were required to follow these new guidelines in order for their patients to be treated with CPAP. In a special section, these new guidelines are explained in full detail.

In the CEO Corner, Paul Valentine introduces our newly designed websites sleephealth.com and sleepandyou.com, recaps the 2009 North East Sleep Society meeting and shares an important honor bestowed upon our Brighton location.

If you have any questions about sleep disorders, our services, our affiliations or our locations, please feel free to contact us.

Sincerely,

Lawrence J. Epstein, MD

Medical Director

Sleep Health*Centers* LLC

1-877-SLEEPHC

1-877-753-3742

The Case of Insomnia and Sleep Apnea

Claudia M. Toth, PsyD

Dr. Claudia Toth is a licensed clinical psychologist working in Behavioral Sleep Medicine at Sleep HealthCenters. She earned her doctoral degree from the University of Hartford in Connecticut, followed by a Clinical and Research Postdoctoral Fellowship at Harvard Medical School in the Massachusetts General Hospital Weight Center. She provides direct clinical services to outpatients with a range of sleep disorders using cognitive behavioral therapy (CBT).

What is insomnia?

The most common sleep complaint is insomnia (Sateia et al., 2000). It is usually defined as difficulty falling asleep, difficulty staying asleep, waking up earlier than desired, or having a general sense of dissatisfaction with the quality of one's sleep. Experienced by almost everyone at some point in life, disruptions in sleep are generally transient and improve on their own once the stressor (change in work status, relationship conflict, illness) has passed. In some cases, difficulties persist and have a negative impact on daytime functioning. In these situations, insomnia symptoms warrant further attention. For healthcare providers and individuals, having a better understanding of the often predictable circumstances under which insomnia is likely to develop may help better manage disruptions to sleep.

How common is it?

Estimates of the prevalence of insomnia depend on how it is defined. However, it is generally accepted that about one-third of the population is experiencing insomnia symptoms (National Sleep Foundation, 2002). Studies using the DSM-IV criteria (which require not only disruption during sleep but also resulting daytime impairment such as fatigue, mood disturbance, cognitive impairment, social or occupational impairment) suggest a range of 9-15% of the population has a chronic form of insomnia (Ohayon, 2002). When one looks specifically at individuals presenting to primary care, research suggests about 50% of patients report occasional insomnia and 19% report chronic problems (Shochat et al., 1999).

What causes it?

Insomnia has a number of known risk factors, comorbidities, and causes. Age, gender, psychiatric condition, medical condition, and socioeconomic status all affect the likelihood that an individual has insomnia (Buscemi et al., 2005). For instance, it is known that women are more likely to present with insomnia complaints than men, and older adults more likely than younger adults. And the health risks go both ways. For example, insomnia is more common in those with depression and anxiety but having insomnia increases the risk of subsequently developing psychiatric disorders, such as anxiety and depression (Breslau et al., 1996). More individuals with chronic insomnia have co-morbid medical problems, such as heart disease, high blood pressure, urinary problems, chronic pain, and gastrointestinal problems, than individuals without insomnia (Taylor et al., 2007). Studies have suggested it is not only comorbid conditions that effect the presence of insomnia but even the perception of poor health is associated with increased risk (Sutton et al., 2001).

Insomnia may be a primary disorder but it often occurs secondary to other causes. Behavioral and environmental factors are often contributors to insomnia. For example, decreasing caffeine intake, reducing alcohol use, increasing physical activity level, and addressing distracting noises in the sleeping environment are common areas for intervention. Medical conditions, psychiatric illness, medication, and substance use often cause insomnia. Even other sleep disorders, such as sleep apnea, are often the trigger to the development of insomnia.

How common is sleep apnea with insomnia?

It is known that obstructive sleep apnea (OSA) is common, occurring in about 4% of men and 2% of women in the population (Young et al., 1993). Healthcare providers, however, will encounter sleep apnea with much greater frequency, as research suggests about one-third of patients presenting to a primary care setting have OSA (Netzer et al., 2003). It is known that snoring and excessive sleepiness are some of the most common complaints in sleep disordered breathing. Yet what is often overlooked is that OSA can occur with insomnia. One study of patients with OSA, for example, found that 42% of individuals showed at least one problematic insomnia symptom (Chung, 2005.) Women with OSA are particularly likely (and much more likely than men) to present with insomnia (Shepertycky et al., 2005). Given the high overlap of these conditions, it is essential for healthcare providers to be aware of this fact and be attuned to the need to address both these problem areas.

How does sleep apnea with insomnia present?

When OSA and insomnia co-occur, they can present themselves in a variety of ways. Sometimes individuals have struggled with insomnia for years and later develop OSA, such as (continued on page 2)

(continued from page 1) following increased weight gain or following or during menopause. In some cases, the insomnia may be due solely to the OSA – with frequent awakenings caused by the breathing disruptions – and will usually resolve with proper treatment of the primary underlying sleep disorder. At other times, individuals may develop insomnia symptoms after developing OSA. The experience of chronic disruption to sleep and the ensuing daytime sleepiness with its pervasive impact on daytime functioning often leads individuals to feel frustrated and distressed about their sleep. Individuals with OSA may seem to develop insomnia suddenly, such as in response to initiating treatment with continuous positive airway pressure (CPAP). It is common for individuals to report increased anxiety and discomfort when trying to adapt to the CPAP interface – a very unfamiliar circumstance for anyone trying to fall asleep. Given these varied but common presentations, diagnosing OSA and simply prescribing CPAP may often be insufficient in treating an individual's experience of poor sleep.

How does one go about treating this co-occurrence?

The key to treating the co-occurrence of OSA and insomnia is to recognize that both conditions are at play and to set reasonable goals to address both problem areas. Most of the time the OSA is treated first because it is a known cause for insomnia, and the reverse is never true: insomnia does not cause sleep apnea. The most common scenario is for CPAP therapy, by far the most common treatment for OSA, to be initiated. If insomnia symptoms remain even after individuals are engaged in treatment for OSA, addressing insomnia can more productively be pursued. It is often the case, however, that in order to fully treat the sleep apnea, treatment for insomnia must begin concurrently. In talking to individuals starting out in treatment for their OSA and insomnia, unhelpful thoughts and behaviors surrounding CPAP use are often uncovered. These thoughts and behaviors, although common, are often maladaptive and may make it more difficult to engage in CPAP therapy, and may lead to a worsening of insomnia symptoms. Early detection and appropriate intervention is crucial. Behavioral sleep medicine approaches are available to help individuals with both sleep apnea and insomnia to improve their sleep.

One of the most effective treatments for insomnia is cognitive behavioral therapy (CBT) (Edinger et al., 2001), which has also been shown to be specifically useful for helping individuals improve their use of CPAP therapy (Richards et al., 2007). CBT is used to treat a variety of health problems, including anxiety, depression, eating disorders, and substance use. CBT specific to insomnia is a collection of techniques, which include sleep hygiene education, sleep restriction, stimulus control, cognitive therapy, and relaxation training. Through the treatment process, individuals are assisted in identifying and changing thoughts and behaviors that are not sleep promoting. They are encouraged to address factors that may be having a negative impact on sleep, such as caffeine, alcohol, noise, or more complex issues such as relationship dynamics. They are provided specific instruction on how to use their bodies' natural drive for sleepiness to consolidate sleep, how to minimize time spent in bed awake, and how to regulate their sleep schedule.

In addition to changing thinking patterns and behavior, individuals' ability to relax, which in turn relates to the ability to sleep, is also explored. Often times individuals report busy or high stress lives in which little time is set aside for winding down at the end of the day. Individuals are encouraged to create more time separation between the busy to-do's of everyday life and the slowing down of activity that leads to sleep. They are assisted in broadening their repertoire of relaxing activities. Too much muscle tension, for instance, may make it difficult to fall asleep or stay asleep. Progressive muscle relaxation addresses this problem and has been shown to have a positive impact on sleep (Means et al., 2000). This relaxation technique involves alternating tensing and relaxing muscles in a sequence intended to cause deepened relaxation states. Routine practice of specific relaxation techniques can help reduce muscle tension prior to bedtime and for many can help with easing the transition into CPAP use.

Another treatment option for insomnia is pharmacological treatment. In controlled studies of individuals with insomnia but without OSA, treatment with sedative hypnotics is almost as effective as CBT but not as long lasting (Morin et al., 1999). Studies using sedative-hypnotics in conjunction with CPAP have had mixed results. Some studies have shown hypnotic medication combined with CPAP during early treatment is not of benefit (Bradshaw et al., 2007). Other studies have shown that using a hypnotic during individuals' initial exposure to CPAP (during titration) improves adherence to ongoing treatment (Collen et al., 2009). Nevertheless, clinical experience suggests that these medicines may be beneficial for certain individuals with high anxiety levels concerning CPAP use, underlying affective disorders, or those having difficulty implementing behavioral measures to improve adherence.

The role of healthcare providers.

Despite the widespread prevalence of insomnia and other sleep disorders, most individuals do not initiate discussion about sleep with their healthcare providers. A large National Sleep Foundation survey suggested that only about 25% of individuals experiencing insomnia discussed their sleep problems with their physician, but even then the sleep problem was not the primary focus of their visit. Only 5% of individuals interviewed reported that they specifically visited their physician to discuss a sleep problem (Ancoli-Israel & Roth, 1999). It is therefore imperative for healthcare providers to actively engage patients in discussion about sleep.

Unlike sleep apnea, which should be screened for, but requires a sleep study to properly diagnose, insomnia can be diagnosed at first contact. Since insomnia is a subjective experience, healthcare providers can identify symptoms through direct interview. Is there difficulty falling asleep or staying asleep? Is this pattern perceived as a problem? Is it causing clinically significant problems during the day? It is important to ask about medical problems that might be contributing to difficulty with sleep, conditions such as arthritis, acid reflux, asthma, heart disease, seizures, and chronic pain – to name a few. It is helpful to get a sense of individuals' mood functioning – are they anxious or depressed? Are they taking any medicines or substances that might be contributing to disruptions in sleep, such as stimulants, steroids, or alcohol? Are there any signs and symptoms of other sleep disorders such as OSA that might be co-occurring or causing the insomnia?

Well-established and effective treatments are readily available to treat insomnia and sleep apnea, whether they occur together or separately. It is hoped that through increased awareness from healthcare providers individuals will be led more quickly to appropriate treatments to help them achieve better health through better sleep.

For a complete list of references, please visit our website at www.sleephealth.com.

Research Activities

Sleep Health*Centers* is proud to work with some of the premier sleep researchers in the country. The following research studies are currently underway in conjunction with our partners. To take part in a study or for more information, please contact us toll free at 877-SLEEPHC (877-753-3742). For a full listing of our research activities, please visit www.sleephealth.com.

Do You Snore?

Sleep Health*Centers* is looking for people who have never had an overnight sleep study. The purpose of this research study is to see how well devices called portable monitors work for diagnosing Obstructive Sleep Apnea at home. Participants will wear a portable monitor for two consecutive nights at home and will wear a portable monitor during their scheduled overnight sleep study.

If interested, please contact Nicky Granville at Sleep Health*Centers* by calling 617-783-1496 x1117 or emailing SleepResearch@sleephealth.com.

Newly Diagnosed with Obstructive Sleep Apnea?

Sleep HealthCenters is conducting a research study to evaluate a device for the non-invasive treatment of Obstructive Sleep Apnea. This study will provide further research on the treatment device, which has been cleared by the United States Food & Drug Administration (FDA) for investigational use in patients with sleep apnea.

Participants will be enrolled for 3 months and come to the clinic for a total of two daytime visits and four overnight visits. Eligible participants must have been diagnosed with OSA within the last 12 weeks. Participants must be untreated and have no current or past use of CPAP in the home. You may receive up to $1050.

If interested, please contact Nicky Granville at Sleep Health*Centers* by calling 617-783-1496 x117 or emailing SleepResearch@sleephealth.com.

CEO Corner

Paul S. Valentine
President and
Chief Executive Officer

Sleep Health*Centers* has had an exciting quarter. We are thrilled to unveil our newly redesigned websites, **sleephealth.com** and **sleepandyou.com**.

Sleephealth.com provides comprehensive and detailed information for patients and providers, as well as those who may think they are suffering from a sleep disorder. For the CPAP patient, sleephealth.com offers sleep apnea education, support and the opportunity to order CPAP equipment and supplies. Behavioral sleep medicine, dental sleep medicine and other treatment programs are outlined extensively. For the providers, our Referral Info page walks providers through our referral process. The new site also provides details on the Brigham and Women's sleep medicine fellowship program conducted at Sleep Health*Centers*, as well as our A-STEP technologist training classes. Our News and Events section includes recent press releases and articles where Sleep Health*Centers* and our renowned physicians have been featured.

Sleepandyou.com was created to help raise awareness about sleep, sleep disorders, and issues impacting sleep, providing consumers and patients with information to improve and enhance their health and quality of life. Sleepandyou.com explains the importance of sleep, the effect sleep disorders can have throughout an individual's life and the options available for treatment and care for sleep concerns. It highlights the connection between sleep and other comorbid conditions, such as diabetes, stroke, weight management and cardiovascular disease.

We are also proud to have sponsored North East Sleep Society's 23rd annual conference, themed *Combatting Sleeplessness: Law Life and Lab*. Held at the Newton Marriott on March 20th and 21st, Sleep Health*Centers* developed the NESS 2009 content as well as managed the details of the event itself. Over 600 people in the sleep medicine profession travelled from all over the Northeast. Speakers included Dr. Charles A. Czeisler, Director of the Division of Sleep Medicine at Harvard Medical School and Chief of the Division of Sleep Medicine in the Department of Medicine at Brigham and Women's Hospital in Boston, and Dr. M. Susan Esther, President of the American Academy of Sleep Medicine. Dr. Mark Mahowald, Professor of Neurology at the University of Minnesota Medical School gave the opening address and Dr. Stuart F. Quan, Interim Editor of the Sleep and Health Education Program at Harvard Medical School, Division of Sleep Medicine, gave the keynote speech during the Friday night dinner. Other topics included Pharmacologic Advancements in the Treatment of Insomnia and Understanding the New CMS Regulations. We were honored to host the event.

Lastly, Sleep Review magazine will feature Brigham and Women's Comprehensive Academic Sleep Program of Distinction in an article this coming spring. After a decade-long partnership with Harvard-affiliated Brigham and Women's Hospital, Sleep Health*Centers'* Brighton location helped the BWH Division of Sleep Medicine attain the American Academy of Sleep Medicine's Comprehensive Academic Sleep Program of Distinction award. We are excited to be part of this achievement and take pride in our collaborative relationship with BWH.

We are happy to continue to provide sleep medicine services to your patients. Please do not hesitate to contact us if you have any questions.

Medicare's Newly Released Regulations for DME Coverage* for Medicare Patients

Medicare now requires a face-to-face sleep evaluation prior to a patient's sleep study in order to provide CPAP or Bi-Level PAP treatment for obstructive sleep apnea.

Continued coverage of a PAP device beyond the first three months of therapy requires a face-to-face clinical re-evaluation during the second two months after initiating therapy.

Sleep Health*Centers* will send Medicare Compliance Forms for all Medicare patients requiring a sleep study and/or PAP therapy for your approval.

On the compliance form, you can choose to have Sleep Health*Centers* manage compliance and Medicare paperwork by having your patient evaluated by Sleep Health*Centers* prior to the sleep study; OR, you can choose to manage the patient yourself by providing required information to Sleep Health*Centers* along with your sleep study referral.

Detailed requirements are available on our website along with the Sleep Health*Centers* compliance forms. Go to www.sleephealth.com/medicare-regulations.htm.

If you have questions about these new regulations, please contact us at 877-753-3742.

Compliance forms must be completed or the PAP device and related accessories will be considered not medically necessary and coverage will be denied by Medicare.

*Reference LCD for Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea (L11528). If you would like to read the complete LCD, please visit our website.

Case Study

Joe is a 47-year old man diagnosed with obstructive sleep apnea. His primary complaint was feeling tired during the day and having frequent awakenings during the night. He recently started CPAP therapy and since that time reports increased difficulty falling asleep. Despite notable improvements to the continuity of his sleep when using CPAP, he now reports feeling more distressed about his sleep in general. He notices his mind "racing" once he gets into bed and finds it takes longer for him to fall asleep when he uses the device. He finds himself thinking… "Will I ever be able to fall asleep with this machine? Maybe I'll sleep fine without it…I wonder if my wife will ever want to be close to me now that I have to wear this thing on my face… I must be ruining her sleep too…" In addition to developing unhelpful and rather unrealistic thoughts about sleep and CPAP use, Joe has begun to change his behavior in response to his new thoughts and experiences. He is getting into bed earlier and trying harder to get to sleep because he is expecting difficulty with falling asleep. Even just the approach of bedtime or entering the bedroom increases his anxiety level as he mentally prepares himself for the nightly routine of struggling to fall asleep. Over time it is shown that he remains in bed for more extended periods of time worrying.

These thoughts and behaviors, although common, make it more difficult for him to engage in CPAP therapy, and are making his insomnia worse. The medical provider caring for Joe quickly recognizes a worsening in symptoms of insomnia and recommends additional support through a referral to the behavioral sleep medicine service.

As part of cognitive behavioral therapy, Joe's worries about CPAP treatment were explored. He was helped to avoid getting into bed when he was not sleepy. He was helped to challenge unhelpful and unrealistic thoughts such as his ruining his relationship if he uses the therapy. He was helped to understand that the CPAP therapy is not as disruptive as he thinks – but instead, it is his own thinking and behavior that is disruptive. He was helped to return to a more relaxing bedtime routine, one that landed him in bed with less worries on his mind and hungry for sleep. The sleepier he was come bedtime, the easier it was for him to fall asleep with the CPAP device. Slowly in time the pattern began to shift, with an increased number of nights in which he was falling asleep with the device on and he began wearing it for increased number of hours across the night. He became progressively more accustomed to the feel of the CPAP interface during the night and more confident in his ability to fall asleep and remain asleep while using the treatment.

As a result of this process, he was spending more time treating his sleep apnea, which in turn was having a positive impact on his daytime functioning. He began to report a decreased urge for napping, was more attentive during meetings at work, and was taking more pleasure from interactions with his wife. These positive effects during the day over time strengthened his resolve to continue in CPAP treatment. He is now seen in clinic only twice per year to check in on his progress and to address any routine equipment needs.