# VA/DoD CLINICAL PRACTICE GUIDELINES

## The Management of Chronic Insomnia Disorder and Obstructive Sleep Apnea

### Sidebar 1: Clinical Features of OSA and Chronic Insomnia Disorder

**OSA (see Appendix D in the full CPG for detailed ICSD-3 diagnostic criteria):**

- Sleepiness
- Loud, bothersome snoring
- Witnessed apneas
- Nightly gasping/choking
- Obesity (BMI >30 kg/m$^2$)
- Treatment resistant hypertension

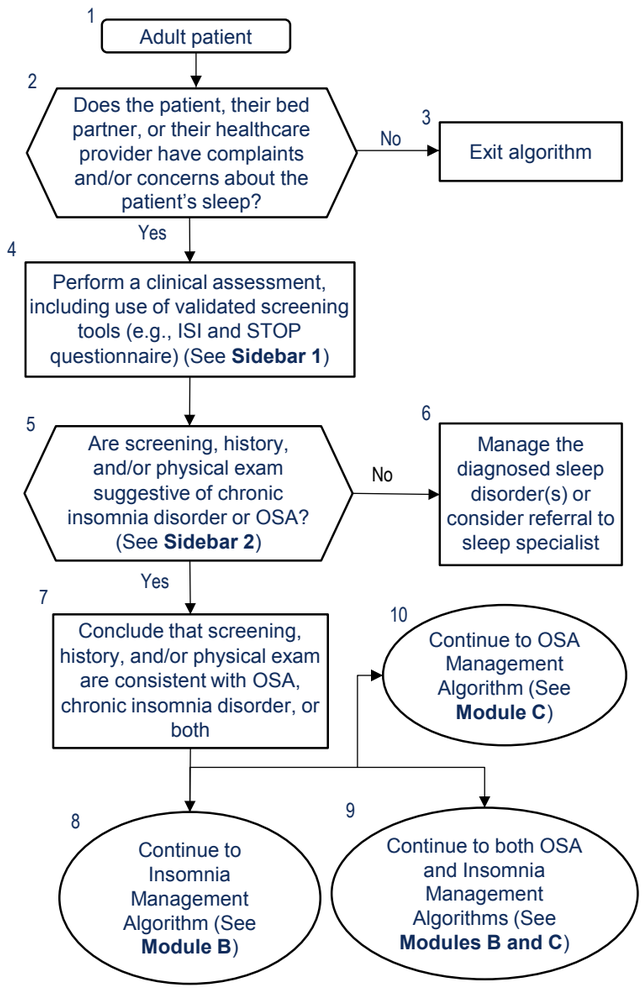
**Chronic Insomnia Disorder (see Appendix D in the full CPG for detailed ICSD-3 diagnostic criteria):**

- Difficulty initiating sleep, difficulty maintaining sleep, or early-morning awakenings
- The sleep disturbance causes clinically significant distress or impairment in important areas of functioning
- The sleep difficulty occurs at least 3 nights per week
- The sleep difficulty has been present for at least 3 months
- The sleep difficulty occurs despite adequate opportunity for sleep
- The insomnia is not better explained by and does not occur exclusively during the course of another sleep-wake disorder
- The insomnia is not attributable to the physiological effects of a substance
- Coexisting mental disorders and/or medical conditions do not adequately explain the predominant complaint of insomnia

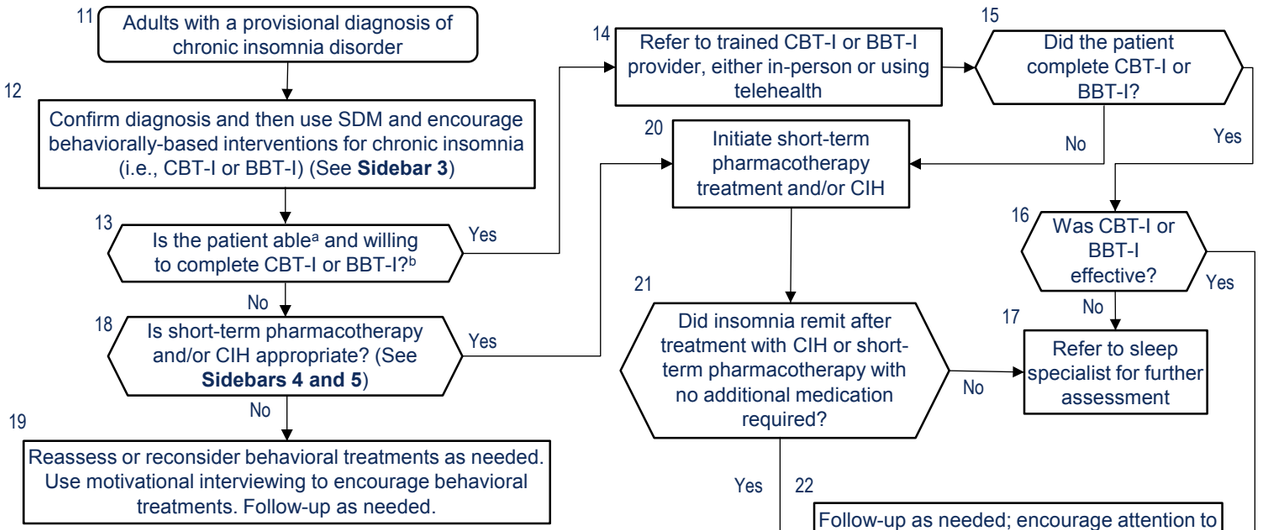
### Sidebar 2: Other Sleep Disorders

- Insufficient sleep syndrome
- Restless legs syndrome
- Narcolepsy/idiopathic CNS hypersomnia
- Nightmare disorder
- REM sleep behavior disorder
- Circadian rhythm sleep disorders
- NREM parasomnias – sleepwalking/sleep eating
- Central sleep apnea

## Module A: Screening for Sleep Disorders




## Module B: Management of Chronic Insomnia Disorder




[a] In cases where the patient requires immediate intervention, providers may exercise clinical judgment to determine if pharmacotherapy may be safely initiated.

[b] CBT-I and BBT-I are not equivalent, and there is more robust evidence for CBT-I. While this algorithm uses CBT-I and BBT-I similarly, providers referring patients for these treatments should consider availability of the treatment, the complexity and comorbidities of the patient, and the training of the provider.

### Sidebar 3: Components of Sleep Education, Overview of Behavioral Interventions, and Contraindications

**Patient education and SDM:**

- General information on insomnia disorder
- Education about behavioral treatment options
- Discussion of treatment options (risks, benefits, preferences, and alternatives)

**Behavioral treatment components (CBT-I and BBT-I):**

- Sleep Restriction Therapy: Limits time in bed to actual sleep duration to increase sleep drive; time in bed extended across treatment
- Stimulus Control: Strengthens bed as a cue for sleep rather than wakefulness
- Relaxation: Reduces physiological arousal and promotes optimal conditions for sleep
- Sleep Hygiene Education: Counseling regarding behaviors that interfere with sleep
- Cognitive Restructuring (CBT-I only): Addresses cognitive arousal (busy or racing mind) by challenging unhelpful thoughts and beliefs about sleep, a natural result of the struggle with insomnia

**Conditions requiring tailored or delayed CBT-I:**

- Medically unstable
- Active alcohol or drug use disorder
- Excessive daytime sleepiness
- Engaged in exposure-based PTSD treatment
- Uncontrolled seizure disorder
- Bipolar disorder
- Current acute mental health symptoms

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## Sidebar 4: Pharmacotherapy Considerations for Chronic Insomnia Disorder

**Before starting short-term pharmacotherapy, review sleep history, and evaluate contraindications for pharmacotherapy:**

- Evaluate for other sleep disorders (e.g., apnea, NREM parasomnias), daytime sleepiness, respiratory impairment, cognitive impairment, substance abuse history, and medication interactions
- Encourage non-pharmacologic approaches (e.g., CBT-I or BBT-I)

**When short-term pharmacotherapy is appropriate, consider the following:**

- Low-dose doxepin; or
- Non-benzodiazepine benzodiazepine receptor agonists (all patients offered treatment with a non-benzodiazepine benzodiazepine receptor agonist should be specifically counseled regarding the risk of complex sleep-related behaviors)

**The use of antipsychotic agents is NOT suggested for treatment of chronic insomnia disorder.**

**Consider sleep specialist referral in patients who do not respond to pharmacotherapy.**

## Sidebar 5: Other Approaches

**CIH treatments suggested for chronic insomnia disorder:**

- Auricular acupuncture with seed and pellet

**Other treatments NOT suggested for chronic insomnia disorder:**

- Alpha-stim
- Cranial electrical stimulation
- Diphenhydramine
- Melatonin
- Chamomile
- Valerian

**CIH treatments NOT recommended for chronic insomnia disorder:**

- Kava

## Sidebar 6: Risk of OSA*

**Consider using STOP questionnaire for risk stratification:**

1. for hypSnoring loudly
2. Tired, fatigue, sleepy in daytime
3. Observed to stop breathing
4. Treated ertension

**High risk if ≥2 items are answered "yes"**

**Low risk if <2 items are answered "yes"**

**STOP questionnaire should not replace clinical judgment; clinical assessment should include: BMI >30 kg/m$^2$, age >50, menopausal status, neck circumference, family history, and crowded oropharynx**

*i.e., high risk or high pretest probability of OSA

## Sidebar 7: Comorbidities

- Significant cardiorespiratory disease
  - Cardiovascular comorbidities including congestive heart failure
  - Pulmonary comorbidities that impact baseline oxygen saturation (or requiring oxygen therapy) including chronic obstructive pulmonary disease: GOLD Stage III or IV
- Stroke
- Respiratory muscle weakness
- Hypoventilation/suspected hypoventilation due to neuromuscular or pulmonary disorder
- Opioid use
- Chronic insomnia
- PTSD

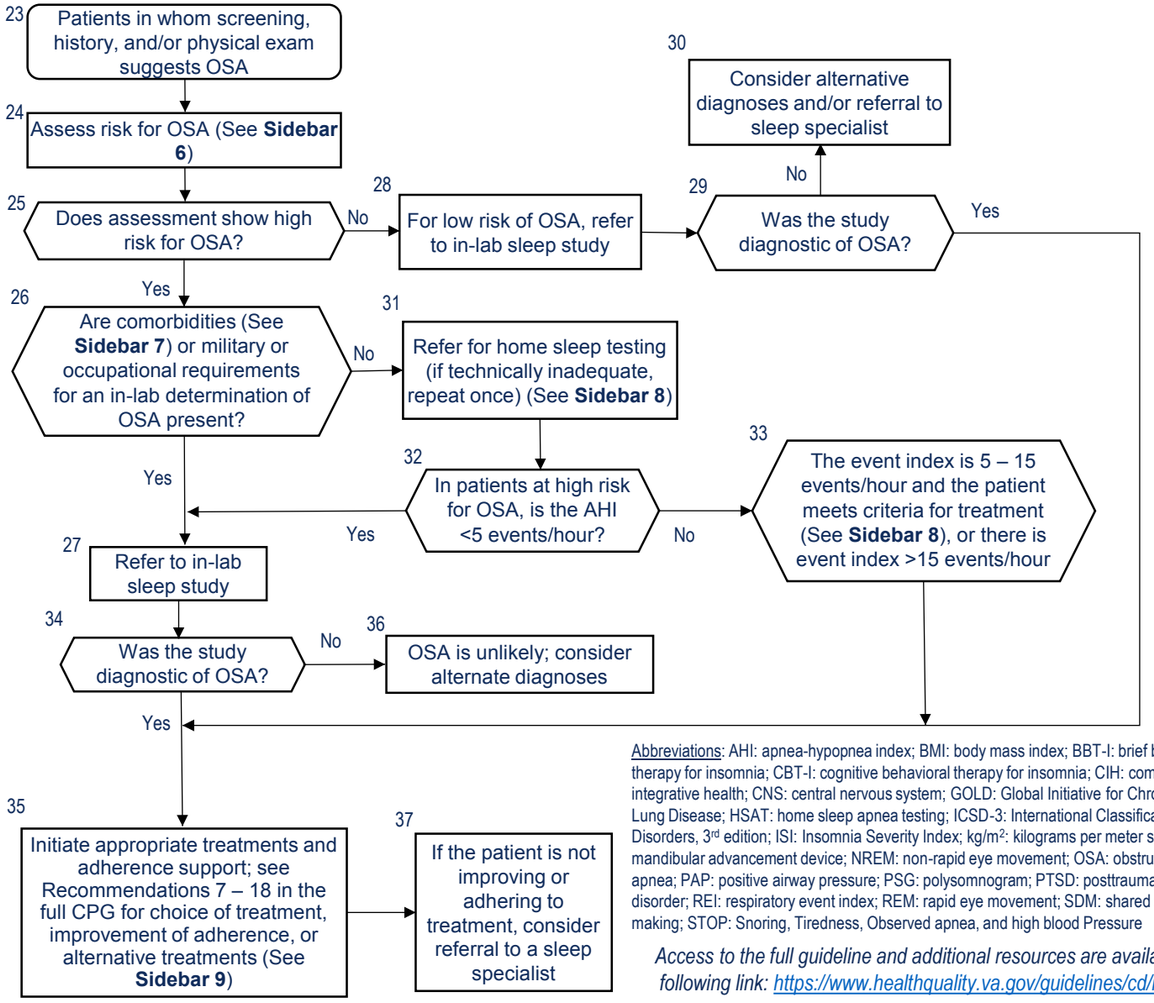
## Sidebar 8: AHI 5 – 15 on HSAT

1. Treatment for OSA is recommended for symptomatic patients with an AHI or REI of 5 – 15 events per hour
2. For patients who will have limitations to their work and/or lifestyle, definitive testing with an in-lab PSG is recommended
3. For the general population without such restrictions, an AHI of 5 – 15 events per hour on HSAT should be treated as OSA

## Sidebar 9: Treatment of OSA

1. For patients with severe OSA (i.e., AHI ≥30 events per hour), the recommended initial therapy is PAP
2. For patients with mild to moderate OSA (i.e., AHI 5 – <30 events per hour), either PAP or MAD therapy can be considered for initial therapy; choice of treatment should be based on clinical evaluation, comorbidities, and patient preference
3. Educational, behavioral therapy, and supportive interventions should be offered to improve PAP adherence
4. Weight loss and a comprehensive lifestyle intervention program should be encouraged in all patients with OSA who are overweight or obese; while weight loss alone is typically insufficient as therapy for OSA, weight loss may result in improvement of AHI
5. In those OSA patients who are not adherent to PAP and/or MAD therapy or have persistent symptoms despite adequate therapy, referral to a physician with expertise in sleep medicine is recommended

## Module C: Management of Obstructive Sleep Apnea




Abbreviations: AHI: apnea-hypopnea index; BMI: body mass index; BBT-I: brief behavioral therapy for insomnia; CBT-I: cognitive behavioral therapy for insomnia; CIH: complementary and integrative health; CNS: central nervous system; GOLD: Global Initiative for Chronic Obstructive Lung Disease; HSAT: home sleep apnea testing; ICSD-3: International Classification of Sleep Disorders, 3rd edition; ISI: Insomnia Severity Index; kg/m$^2$: kilograms per meter squared; MAD: mandibular advancement device; NREM: non-rapid eye movement; OSA: obstructive sleep apnea; PAP: positive airway pressure; PSG: polysomnogram; PTSD: posttraumatic stress disorder; REI: respiratory event index; REM: rapid eye movement; SDM: shared decision making; STOP: Snoring, Tiredness, Observed apnea, and high blood Pressure

*Access to the full guideline and additional resources are available at the following link: https://www.healthquality.va.gov/guidelines/cd/insomnia/*