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, bothearm snoring
- Witnessed apneas
- Nightly gasping/choking
- Obesity (BMI ≥ 30 kg/m²)
- 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

Module A: Screening for Sleep Disorders

1. Adult patient
2. Does the patient, their bed partner, or their healthcare provider have complaints and/or concerns about the patient’s sleep?
3. Yes: Exit algorithm
4. No: Perform a clinical assessment, including use of validated screening tools (e.g., ISI and STOP questionnaire) (See Sidebar 1)
5. Are screening, history, and/or physical exam suggestive of chronic insomnia disorder or OSA? (See Sidebar 2)
6. Yes: Manage the diagnosed sleep disorder(s) or consider referral to sleep specialist
7. No: Conclude that screening, history, and/or physical exam are consistent with OSA, chronic insomnia disorder, or both
8. Continue to OSA and Insomnia Management Algorithm (See Module C)
9. Continue to Inomnia Management Algorithm (See Module B)

Module B: Management of Chronic Insomnia Disorder

10. Adults with a provisional diagnosis of chronic insomnia disorder
11. Confirm diagnosis and then use SEM and encourage behaviorally-based interventions for chronic insomnia (i.e., CBT-I or BBT-I) (See Sidebars 3)
12. Is the patient able and willing to complete CBT-I or BBT-I? (See Sidebars 3 and 4)
13. Yes: Short-term pharmacotherapy and/or CBT-I appropriate? (See Sidebars 4 and 5)
14. No: Reassess or reconsider behavioral treatments as needed. Use motivational interviewing to encourage behavioral treatments. Follow-up as needed.
15. Did the patient complete CBT-I or BBT-I?
16. Yes: Refer to trained CBT-I or BBT-I provider, either in-person or using telehealth
17. No: Refer to sleep specialist for further assessment
18. Was CBT-I or BBT-I effective?
19. Yes: Did insomnia remit after treatment with CBT-I or short-term pharmacotherapy with no additional medication required?
20. No: Initiate short-term pharmacotherapy treatment and/or CIH
21. Follow-up as needed; encourage attention to relapse prevention strategies among those benefiting from behavioral treatments for insomnia disorder

Sidebar 2: Other Sleep Disorders

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

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)
- 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.
Module C: Management of Obstructive Sleep Apnea

**Sidebar 8: AHI 5 – 15 on HSAT**

1. For patients with severe OSA (i.e., AHI >50 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 OSA.
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.

**Sidebar 9: Treatment of OSA**

1. For patients with severe OSA (i.e., AHI >50 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 OSA.
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.

**Sidebar 7: Comorbidities**

- Significant cardiopulmonary 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 hyperventilation due to neuromuscular or pulmonary disorder
- Opoid use
- Chronic insomnia
- PTSD

**Sidebar 6: Risk of OSA**

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Score</th>
</tr>
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<tbody>
<tr>
<td>BMI &gt;30 kg/m²</td>
<td>Yes</td>
</tr>
<tr>
<td>Age &gt;50</td>
<td>Yes</td>
</tr>
<tr>
<td>Menopausal status</td>
<td>Yes</td>
</tr>
<tr>
<td>Neck circumference</td>
<td>Yes</td>
</tr>
<tr>
<td>Family history</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk of OSA?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Module C: Management of Obstructive Sleep Apnea**

- Consider alternative treatments and/or referral to sleep specialist

**Sidebar 4: Pharmacotherapy Considerations for Chronic Insomnia Disorder**

Before starting short-term pharmacotherapy, review sleep history, and evaluate for other treatments NOT considered contraindications for pharmacotherapy:

- Evaluate for other sleep disorders (e.g., sleep 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 recommended for treatment of chronic insomnia disorder.

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

**Sidebar 5: Other Approaches**

CIT treatments suggested for chronic insomnia disorder:

- Auricular acupuncture with seed and pellet
- Cranial electrical stimulation
- Diphenhydramine
- Chamomile
- Valerian

CIT treatments NOT recommended for chronic insomnia disorder:

- Kava

Abbreiviations: 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 Encouraging nicotine; Lung Disease; HSAT: home sleep apnea testing; ICSD-3: International Classification of Sleep Disorders 3rd edition; IS: insomnia severity index; kg/m²: kilograms per meter squared; MAD: mandibular advancement device; NREM: non-rapid eye movement; OSA: obstructive sleep apnea; PAP: positive airway pressure; PSG: polysomnogram; PTSD: post-traumatic 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/