Chronic Insomnia

This CPM presents a model of care based on scientific evidence available at the time of publication. It is not a prescription for every physician or every patient, nor does it replace clinical judgment. All statements, protocols, and recommendations herein are viewed as transitory and iterative.

Although physicians are encouraged to follow the CPM to help focus on and measure quality, deviations are a means for discovering improvements in patient care and expanding the knowledge base.

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This CPM is part of Presbyterian’s Clinical Care Model, a broad, enterprise-wide body of documentation covering PHS’ functions, programs, and care pathways, intended to build organizational acumen, facilitate cross-system collaboration, and accelerate our implementation of clinical initiatives.

Find all of PHS’ Care Model at www.PHSCareModel.org.

This Clinical Practice Model (CPM) is designed for:
• Adults over the age of 18
• With suspected chronic insomnia
• Being seen in an outpatient setting (PMG Clinic or PHS Hospital)

This CPM recommends an evidence-based protocol for the diagnosis and treatment of chronic insomnia.

Why Focus on Chronic Insomnia?
Insomnia is one of the most common reasons patients visit their doctors, causing more than five million visits annually in the United States. As many as 69% of primary care patients cite some instance of insomnia-related symptoms, with approximately 19% of those being categorized as “chronic insomnia.” Chronic insomnia is characterized as insomnia for three nights or more per week for more than three months. This sustained lack of sleep can negatively impact an individual’s quality of life professionally, socially, and emotionally.

Care Pathway Roles and Responsibilities

<table>
<thead>
<tr>
<th>Responsibility</th>
<th>Clinician</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial diagnosis and treatment for chronic insomnia</td>
<td>Primary Care Physician or Advanced Practice Clinician</td>
</tr>
<tr>
<td>Cognitive Behavioral Therapy for Insomnia as needed through Insomnia groups or individual treatment, or if presenting with psychiatric comorbidities</td>
<td>Behavioral Health Clinician</td>
</tr>
<tr>
<td>Diagnosis and treatment for insomnia with comorbid primary disorders, such as Obstructive Sleep Apnea, Narcolepsy, RLS, Circadian Rhythm Disorders, or Parasomnia</td>
<td>Sleep Medicine Physician</td>
</tr>
</tbody>
</table>

Evidence/Resources

American Academy of Sleep Medicine
American Psychiatric Association
American Geriatric Society
Diagnosis and Treatment

Patient presents with chronic sleep disturbance

PCP takes detailed history

Symptoms of OSA, Narcolepsy, Circadian Rhythm Disorders, or RLS?

- YES
  - PCP chooses to treat OR refers to Sleep Clinic

- NO
  - Treat as appropriate

Confirmation of insomnia?

- NO
  - Initiate de-prescribing
    - YES
      - Discuss de-prescribing with patient
        - Taper dose and monitor closely
    - NO
      - PCP conducts CBT-I OR Refers to Integrated BHC for CBT-I (group or individual)

- YES
  - Patient on medication for insomnia?
    - NO
      - and simultaneously
    - YES
      - 1 group insomnia session with BHC Review sleep hygiene rules & sleep diary handout (or individual session if unable or unwilling to attend group)

Continue to Response page 3
Diagnosis and Testing

The recommended first step in diagnosis is a detailed history and physical examination, as well as the ruling out of any red flags potentially associated with Obstructive Sleep Apnea (OSA), Narcolepsy, Restless Leg Syndrome (RLS), or Circadian Rhythm Disorders.

Diagnosis

- Medical history & physical exam
- If OSA, Narcolepsy, RLS, or Circadian Rhythm Disorders are indicated, the PCP may choose to treat or refer to Sleep Clinic.
  - OSA is indicated by a high score (between 5 and 8) on the STOP/BANG evaluation, which includes 8 yes/no questions to determine the presence of symptoms such as snoring, high blood pressure, and observed cessation of breathing during sleep
  - Narcolepsy may be indicated by reports of excessive daytime sleepiness, hallucinations, or sleep paralysis, among other symptoms.
  - RLS symptoms include an urge to move the legs, potentially accompanied by painful, creeping, crawling, itching, or jittery sensations that are relieved briefly through movement

Treatment goal is full remission:

A Sleep Efficiency score of 90% or greater can be used as the full remission goal.

Sleep Efficiency can be calculated as 
\[
\text{Sleep Efficiency} = \frac{\text{total sleep}}{\text{time in bed}} \times 100
\]

*GOOD RESPONSE: >90% Sleep Efficiency
PARTIAL RESPONSE: 80%-90% Sleep Efficiency
NO RESPONSE: <80% Sleep Efficiency
Patients with Circadian Rhythm Disorders may have trouble initiating or maintaining sleep and exhibit poor concentration, excessive daytime sleepiness, and impaired cognitive performance.

- Evaluate any comorbidities, which may include:
  - Psychiatric disorders: depression, anxiety, substance abuse, or posttraumatic stress disorder
  - Medical conditions: pulmonary disease, hypertension, diabetes, cancer, chronic pain, or heart failure
  - Medication or substance, including, but not limited to: caffeine, alcohol, beta antagonists, anti-depressants, and glucocorticoids
  - Other sleep disorders (referenced above)

- If the patient is currently on medication for insomnia, discuss de-prescribing (see page 9).
- Depending on time and the PCP’s comfort level with sleep disorders, they may then choose:
  - To conduct modified CBT-I, beginning with
    - Reviewing Rules for Sleep Hygiene (see Patient Guide) and
    - The patient completing a Sleep Diary to confirm existence, frequency, and pattern of insomnia
  - Or, to refer the patient for CBT-I Insomnia group or individual treatment by BHC as appropriate
- Follow up to confirm diagnosis as necessary.

**STOP-BANG Sleep Apnea Questionnaire**

<table>
<thead>
<tr>
<th>STOP</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>Do you SNORE loudly (louder than talking or loud enough to be heard through closed doors)?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Do you often feel TIRED, fatigued, or sleepy during daytime?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Has anyone OBSERVED you stop breathing during your sleep?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Do you have or are you being treated for high blood PRESSURE?</td>
<td>Yes</td>
<td>No</td>
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<table>
<thead>
<tr>
<th>BANG</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>BMI more than 35kg/m²?</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>AGE over 50 years old?</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>NECK circumference &gt; 16 inches (40cm)?</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>GENDER: Male?</td>
<td>Yes</td>
<td>No</td>
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</tbody>
</table>

**High risk of OSA: Yes 5 - 8**
**Intermediate risk of OSA: Yes 3 – 4**
**Low risk of OSA: Yes 0 - 2**

Total Score:


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1 PHS login is required to access this document.
Treatment

The primary recommended treatment for insomnia centers around Behavioral Sleep Management, which includes practicing good sleep hygiene, reframing the patient's expectations about sleep, and Modified Behavioral Therapy as needed. Choosing Wisely recommendations include avoiding polysomnography unless symptoms suggest a comorbid sleep disorder, as well as avoiding hypnotics as the primary therapy. If the patient is in distress, short-term pharmacological therapy may be considered in conjunction with behavioral intervention.

Behavioral Sleep Management

Behavioral Sleep Management is best done under the care of a Behavioral Health Clinician, many of whom are embedded in Patient-Centered Medical Homes across the PMG network of clinics. When a patient presents with insomnia, the PCP can refer them to BHC for treatment. Typically, there are three components to the initial treatment.

Insomnia Group Sessions

- Insomnia Group Sessions offer patients a way to obtain CBT-I support for a short time (starting with 1 session, with up to 4 as needed).
- Groups are available at Kaseman and currently open to patients of Kaseman Internal Medicine, Family Practice, and the Sleep Clinic, with plans to expand to other locations and open to other clinics.
- During these sessions, patients will learn more about sleep and how best to manage it, including strategies for dealing with insomnia triggers (see Facts about Sleep and Behavioral Sleep Management and Controlling Bedtime Worry in Patient Guide).
- These sessions may also be the best venue for patients to learn more about sleep hygiene optimization and how to complete a sleep diary to understand their sleep patterns.

Sleep Hygiene Optimization

- See Rules for Better Sleep Hygiene in Patient Guide. Encourage patients to follow these rules to help improve the quantity and quality of their sleep.
- Assisting the patient in setting and adhering to a sleep schedule may also be beneficial.

Modified Behavioral Therapy

- Sleep Restriction
  - Change bedtime and wake-up time in order to decrease Total In-Bed Time (TIB) and increase Sleep Efficiency >90%. Do not decrease TIB to less than 5.5 to 6 hours total.
    - Sleep Efficiency may be calculated as (total sleep/TIB) x 100
      - E.g., (4 hours sleep/6 hours TIB) x 100 = 67% Sleep Efficiency
  - Stimulus Control
    - Re-establish and strengthen the association between bed (as a stimulus) and sleep (as desired behavior)
  - Follow up in 2 to 4 weeks
    - If Good Response (Sleep Efficiency >90%), extend TIB and maintain:
      - Allow patient to go to bed 15-20 minutes earlier every 4-5 days while maintaining Sleep Efficiency >90%.
      - Once optimal sleep duration is attained, discuss Sleep Maintenance and Relapse Prevention procedures (in Patient Guide).
    - If Partial Response (Sleep Efficiency improved but still at 80-90%), repeat treatment and follow up
    - If No Response (Sleep Efficiency <80%), refer for formal Cognitive Behavioral Therapy for Insomnia (CBT-I) with Behavioral Health Clinician or Sleep Clinic and/or consider pharmacological treatment

Medications

Pharmacological treatment of insomnia is recommended as a last resort, in case of the failure of behavioral methods, and is meant only for short-term use of a few weeks to a few months. While undergoing medication therapy, patients are advised to continue to practice...
proper sleep hygiene and stimulus control. Unless clinically indicated, it is recommended that providers attempt to wean patients off of medication periodically every 2 to 3 months (see de-prescribing, below). It should also be noted that patients who use hypnotics chronically are still considered insomniacs, even if the medication has resolved their insomnia. In these situations, an evaluation by a Sleep physician or psychiatrist might be advisable, depending on the underlying cause of the insomnia.

Various types of medication are more suited to some types of insomnia than others. The first step in pharmacological treatment is to determine the type of insomnia:

- **Initial:** Increase in Sleep Onset Latency (SOL)
  - By definition, this is >30 minutes SOL, but in practice may be >30-60 minutes SOL
- **Middle/Maintenance:** Increase in Wake After Sleep Onset (WASO) time
  - By definition, this is also >30 minutes, but in practice may be >30-60 minutes
- **Terminal:** Waking up too early and unable to fall back to sleep (usually 2-3 hours before desired wakeup time)
- **Mixed type:** some combination of the above

The patient's age is also a consideration when prescribing, with certain medications being more appropriate for patients under or over 60 years of age.

Choosing Wisely recommendations include the following:

- Avoid using hypnotics as primary therapy
- Do not routinely prescribe antipsychotics for insomnia
- Avoid benzodiazepines and other sedative-hypnotics for older adults

For lists of medications used to treat Insomnia, see below (pages 6-8).

<table>
<thead>
<tr>
<th>Class</th>
<th>Drug</th>
<th>Notes</th>
<th>Strength</th>
<th>Cost</th>
<th>PHP Formulary</th>
</tr>
</thead>
</table>
| Antidepressants | trazodone (immediate release, generics) | • Half-life: 7-12 hours  
• Off-label use  
• May be used as first line treatment for initial and middle/mixed-type insomnia or insomnia with depressive and/or anxiety features.  
• 25mg-200mg is recommended for patients 18-60 years old.  
• 12.5mg-50mg is recommended for patients >60 years old. | tablets: 50mg, 100mg, 150mg | $2.00 to $7.00 | Centennial Care: F  
Commercial/Metal Level Plans: T1  
Senior Care/Medicare: T1 |
| | mirtazapine (Remeron, generics) | • Half-life: 20-40 hours  
• Off-label use  
• May be used for insomnia with depressive and/or anxiety features.  
• 15mg-30mg is recommended for patients 18-60 years old.  
• 7.5mg-15mg is recommended for patients >60 years old.  
• Proceed with caution, as in some patients, a higher dose may be more stimulating (e.g., above 15mg). Avoid use in patients with manic features. | tablets: 7.5mg, 15mg, 30mg | $5.00 to $53.00 | Centennial Care: F, QL (30 per 30 days)  
Commercial/Metal Level Plans: T1, QL (30 per 30 days)  
Senior Care/Medicare: T2  
Note: 7.5mg tablets are NF on Centennial Care and Commercial/Metal Level Plans |
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<tr>
<th>Class</th>
<th>Drug</th>
<th>Notes</th>
<th>Strength</th>
<th>Cost</th>
<th>PHP Formulary</th>
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</thead>
<tbody>
<tr>
<td>Benzodiazepine Hypnotic</td>
<td>temazepam</td>
<td>• Half-life: 3.5-18.4 hours (mean 8.8 hours)</td>
<td>capsules: 15mg, 30mg</td>
<td>$24.00</td>
<td>Centennial Care: F, QL (15mg = 60 per 30 days, 30mg = 30 per 30 days) Commercial/Metal Level Plans: T1, QL (15mg = 60 per 30 days, 30mg = 30 per 30 days Senior Care/Medicare: T2, QL (15mg = 60 per 30 days, 30mg = 30 per 30 days)</td>
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<tr>
<td></td>
<td>(Restoril, generics)</td>
<td>• Most suitable for initial or middle/mixed-type insomnia</td>
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<td></td>
<td></td>
<td>• NOT RECOMMENDED FOR USE IF THERE IS SUSPICION OF SLEEP-DISORDERED BREATHING.</td>
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<td>• 7.5mg-15mg is recommended for female patients 18-60 years old and any patient &gt;60 years old.</td>
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<td>• 7.5mg-30mg is recommended for male patients 18-60 years old.</td>
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<td>• Consider with caution for potential side effects in patients &gt;60 years old. (benefit risk analysis should be documented).</td>
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<td>• Temazepam capsules are also available in 7.5mg and 22.5mg strengths. These strengths are non-formulary ($240.00/30 day supply).</td>
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<td>zolpidem tartrate</td>
<td>• Half-life: 2.5 hours</td>
<td>tablets: 5mg, 10mg</td>
<td>$9.00</td>
<td>Centennial Care: F, QL (30 per 30 days) Commercial Plans: T1, QL (30 per 30 days) Metal Level Plans: PA, QL (30 per 30 days) Senior Care/Medicare: T2, QL (90 per 365 days)</td>
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<tr>
<td></td>
<td>(Ambien, generics)</td>
<td>• Most suitable for initial and possibly middle insomnia</td>
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<td></td>
<td>• Recommended only for short-term use of a few weeks to a few months</td>
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<td></td>
<td>• High-risk medication if used for &gt;90 days. Increased risk of diminished mental status, falls, delirium, and complex sleep-related behavior.</td>
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<td></td>
<td>zaleplon</td>
<td>• Half-life: 1 hour</td>
<td>capsules: 5mg, 10mg</td>
<td>$10.00 to $60.00</td>
<td>Centennial Care: F, QL (60 per 30 days) Commercial/Metal Level Plans: T1, QL (60 per 30 days) Senior Care/Medicare: T2, QL (90 per 365 days)</td>
</tr>
<tr>
<td></td>
<td>(Sonata, generics)</td>
<td>• Most suitable for initial insomnia</td>
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<td></td>
<td></td>
<td>• Recommended only for short-term use of a few weeks to a few months</td>
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<tr>
<td></td>
<td></td>
<td>• High-risk medication if used for &gt;90 days. Increased risk of diminished mental status, falls, delirium, and complex sleep-related behavior.</td>
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<td></td>
<td>eszopiclone</td>
<td>• Half-life: 6 hours</td>
<td>tablets: 1mg, 2mg, 3mg</td>
<td>$70.00</td>
<td>Centennial Care: F, ST, QL (30 per 30 days) Commercial/Metal Level Plans: T1, ST, QL (30 per 30 days) Senior Care/Medicare: NF</td>
</tr>
<tr>
<td></td>
<td>(Lunesta, generics)</td>
<td>• Most suitable for middle and terminal insomnia</td>
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<td>• 1mg-2mg is recommended for female patients 18-60 years old and any patient &gt;60 years old.</td>
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<tr>
<td></td>
<td></td>
<td>• 1mg-3mg is recommended for male patients 18-60 years old.</td>
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<td></td>
<td></td>
<td>• Consider with caution for potential side effects in patients &gt;60 years old. (benefit risk analysis should be documented).</td>
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<tr>
<td></td>
<td></td>
<td>• High-risk medicine if used for &gt;90 days. Increased risk of diminished mental status, falls, delirium, and complex sleep-related behavior.</td>
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<td></td>
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<td>• Patient must have a prescription fill history for two (2) of the following medications within the past 545 days: trazodone or zolpidem tablets, a formulary benzodiazepine used for the treatment of insomnia.</td>
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<td></td>
<td>ramelteon</td>
<td>• Half-life: 1-2.6 hours</td>
<td>tablets: 8mg</td>
<td>$403.00</td>
<td>Centennial Care: F, PA, QL (30 per 30 days) Commercial/Metal Level Plans: T3, PA, QL (30 per 30 days) Senior Care/Medicare: T3, QL (30 per 30 days)</td>
</tr>
<tr>
<td></td>
<td>(Rozerem)</td>
<td>• Most suitable for initial insomnia</td>
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<td></td>
<td></td>
<td>• Consider with caution for potential side effects in patients &gt;60 years old. (benefit risk analysis should be documented).</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Patient must have a documented trial and failure of zolpidem tablets, a formulary benzodiazepine used for the treatment of insomnia and trazodone.</td>
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</tbody>
</table>
### Over-the-counter Sleep Aids

<table>
<thead>
<tr>
<th>Class</th>
<th>Drug</th>
<th>Notes</th>
<th>Strength</th>
<th>Cost</th>
<th>PHP Formulary</th>
</tr>
</thead>
</table>
| melatonin | • Half-life: 20-50 minutes  
• Not recommended as treatment for initial or middle/mixed time insomnia in adults  
• Most suitable for patients whose sleep disturbances are due to circadian rhythm disorders  
• Short-term use of ≤10mg/day appears to be safe in healthy adults. Usual dose for insomnia ranges between 0.3 to 5mg/day. | capsules: 1mg, 2.5mg, 3mg, 5mg, 10mg  
tablets: 0.2mg, 0.3mg, 0.5mg, 1mg, 1.5mg, 2.5mg, 3mg, 5mg, 10mg  
controlled-release tablets: 1mg, 3mg, 5mg, 10mg | $5.00 | Centennial Care: NF, available for purchase over the counter  
Commercial/Metal Level Plans: NF, available for purchase over the counter  
Senior Care/Medicare: NF, available for purchase over the counter |
| doxylamine (Unisom Sleep Tabs, generics) | • Half-life: 10-12 hours  
• Off-label use  
• High-risk medicine due to increased risk of confusion, dry mouth, blurred vision, difficulty urinating. Tolerance develops when used as a hypnotic. | 2mg | $4.00 | Centennial Care: NF, available for purchase over the counter  
Commercial/Metal Level Plans: NF, available for purchase over the counter  
Senior Care/Medicare: F |
| diphenhydramine (Benadryl, ZzzQuil, generics) | • Half-life: 7-9 hours (adult); 9-18 hours (elderly)  
• Off-label use  
• High-risk medicine due to increased risk of confusion, dry mouth, blurred vision, difficulty urinating. Tolerance develops when used as a hypnotic | 25mg to 50mg | $5.00 to $16.00 | Centennial Care: NF, available for purchase over the counter  
Commercial/Metal Level Plans: NF, available for purchase over the counter  
Senior Care/Medicare: NF, available for purchase over the counter |

F = Formulary  
NF = Non-Formulary  
T = Tier  
PA = Prior Authorization  
QL = Quantity Limit  
ST = Step Edit  
Cost is based on a 30-day supply and is subject to change.  
Half-life varies widely from source to source; those presented here come from drugs.com.

### Possible non-FDA Use:

In some situations, it may be appropriate to consider non-FDA medications.

- Insomnia with depressive and/or anxiety features:
  - Consider trazodone or mirtazapine as detailed in the table above
  - Alternatively consider starting an SSRI and hypnotic
  - Gradual titration of medication is advised to avoid potentially increasing anxiety or insomnia
  - Consider referral to psychiatry
- Insomnia due to PTSD (with nightmares)
  - Prazosin 1-2mg at bedtime
    - Starting medication without a hypnotic is recommended, though one may be added if deemed necessary
  - Clonodine .1mg at bedtime
  - Consider starting SSRI treatment
  - In some cases, trazodone and venlafaxine may exacerbate nightmares
  - Consider referral to psychiatry
- Insomnia with manic/hypomanic/psychotic features
  - Seroquel 25-50mg at bedtime
  - Olanzapine 2.5-5mg at bedtime
  - Referral to psychiatry strongly recommended
Insomnia with a history of alcohol/substance use disorder
  - Gabapentin 100-600mg at bedtime
  - Clonodine .1mg at bedtime
  - See insomnia with depression/anxiety/hypomanic features
  - Consider referral to psychiatry

Other Clinical Concerns & Comorbid Disorders

- Restless Leg Syndrome
  - Gabapentin 100-300mg 30-60 minutes prior to bedtime
  - Check ferritin level
    - If ferritin <50ng/ml, prescribe supplemental Iron
  - Consider referral to Sleep Clinic for management

- Circadian Rhythm Disorders
  - Melatonin 3mg 2-3 hours prior to bedtime
  - Light Therapy for one hour at the intended wake up time
  - Modified CBT-I
  - Consider referral to Sleep Clinic for Chronotherapy

Further Alternatives
If insomnia persists after behavioral and medication interventions as described above, it may be appropriate to consider the following pharmaceutical alternatives:

- Doxepin
  - 3-6mg

- Suvorexant
  - 10-15mg for female patients 18-60 years old
  - 10-20mg for male patients 18-60 years old
  - 10mg for patients >60 years old

These medications should be considered with caution for potential side effects, and it may be advisable to document a benefit-risk analysis.

De-prescribing
Typically, medication therapy is not recommended as a long-term solution. It is suggested that providers and patients work to “de-prescribe” and discontinue regular use every two to three months. The following are strategies for de-prescribing specific to benzodiazepines and z-drugs (BZRAs).

- Engage patient in decision making/planning the discontinuation
  - Discuss the potential risks, benefits, withdrawal plan, possible symptoms, and likely duration

- Taper and then stop BZRAs
  - Slowly, and in collaboration with the patient, gradually reduce the dose (for example, by 25% every two weeks, with 12.5% reductions and/or planned drug-free days near the end) and monitor closely
  - Continue to offer behavioral sleeping advice and consider CBT-I if available

- Monitor every 1-2 weeks for the duration of the tapering
  - Track expected benefits
    - Alertness, cognition, daytime sleepiness, reduced likelihood of falls
    - Insomnia, anxiety, irritability, sweating, gastrointestinal symptoms

- Continue to use CBT-I to continue to manage insomnia and decrease chance of relapse
- If symptoms relapse:
Patient Education and Support

Encourage patients to follow the Rules for Better Sleep Hygiene (in Patient Guide). If a patient’s sleep efficiency is improving, it is also important to educate them on how best to maintain the gains they have made through treatment. Education also includes a component of reassurance, helping the patient understand that they do have strategies and tools at their disposal to increase the quality and quantity of their sleep.

If medication therapy is used, education should also cover the fact that pharmacological treatment is meant for short-term use of a few weeks to a few months, and it is not a long-term solution. Engage patients early and often in discussions around de-prescribing plans and encourage proactive management of insomnia with behavioral strategies.

Informational materials are available within Epic, such as the PHS PI Improving Sleep through Behavior Change handout. This can be found in Patient Instructions by typing “sleep” in the “Insert SmartText” box.

Printable patient education materials include:

1. **Patient Guide to Chronic Insomnia**
   - Facts about Sleep and Behavioral Sleep Management
   - Controlling Bedtime Worry
   - Rules for Better Sleep Hygiene
   - Sleep Scheduling Instructions
   - Sleep Maintenance and Relapse Prevention

2. **Sleep Diary**

Clinical Definitions

**Patient Centered Medical Home (PCMH)**

A way of organizing primary care that emphasizes care coordination and communication to transform primary care into “what patients want it to be.” Medical homes can lead to higher quality and lower costs, and can improve patients’ and providers’ experience of care.

**Insomnia**

Insomnia is present when all three of the following criteria are met: 1) A complaint of difficulty initiating sleep, difficulty maintaining sleep, or waking up too early. In children or individuals with dementia, the sleep disturbance may manifest as resistance to going to bed at the appropriate time or difficulty in sleeping without caregiver assistance; 2) The above sleep difficulty occurs despite adequate opportunity and circumstances for sleep; and 3) The impaired sleep produces deficits in daytime function.

Additional References

**Related Care Model Topics**

- [Patient-Centered Medical Home](#)

**Training** [PHS login required]

- [Epic EHR Training Supplement: Sleep Pulmonary](#)

**Policies and Procedures** [PHS login required]

- [SLP.PDS.202 Multiple Sleep Latency Test](#)

**Other Resources**