DISCLAIMER: The information contained in this document originates from a third party and is intended to provide guidance and, generally, allows for professional discretion and/or deviation when the individual health care provider, or if applicable, the "Approver" deems appropriate under the circumstances. Baylor Scott & White Quality Alliance recommends following the third-party guideline and to support alignment has summarized key findings from the third party as described in this Guideline Alignment.

Title:	Chronic Insomnia Assessment and Management	
Applicable to:	Primary Care Providers	
Source(s):	See References	
Read Full Guideline:	See References	
Developer(s):	BSWQA Clinical Pharmacy Team	
Reviewer(s):	Scott & White Health Plan (06/2025)	
Approver(s):	BSWQA Pharmacy & Therapeutics Subcommittee (changes approved 08/2025) BSWQA Quality Improvement Committee (changes approved 08/2025) BSWQA Board of Managers (changes approved month/year)	
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SUMMARY

This document applies to Baylor Scott & White Quality Alliance ("BSWQA").

DEFINITIONS

When used in this document with initial capital letter(s), the following word(s)/phrase(s) have the meaning(s) set forth below unless a different meaning is required by context.

Insomnia: a persistent difficulty initiating, maintaining, or consolidating sleep, despite adequate opportunity, with resulting dissatisfaction or daytime impairment such as fatigue, irritability, or reduced concentration. [1]

Sleep Onset**:** time to fall asleep following bedtime.

Types of Insomnia:

Acute: periods of sleep difficulty lasting between one night and a few weeks[2]

Transient: no more than a few nights[3]

Chronic: sleep difficulty occurring at least three nights per week for one month or more[2]

Primary insomnia: includes sleep-disordered breathing/sleep apnea, restless leg syndrome/periodic limb movement disorder, and circadian dysfunction[4]

Secondary insomnia: arises out of underlying medical or psychiatric disorders or medication effects[4]

Measures:

Wake after Sleep Onset (WASO)**:** the sum of wake times from sleep onset to the final awakening

Sleep Latency (SL)**:** time to fall asleep following bedtime

Total Sleep Time**:** time in bed minus SL and minus WASO

Insomnia Diagnosis: *See BSWQA.CLE.009.A1*

GUIDELINE

These guidelines are for the evaluation and management of chronic insomnia for patients ≥18 years of age.

Goals of Treatment

The goals of chronic insomnia treatment are to improve the quality and quantity of sleep and related daytime functioning. *Two options*: 1) Non-Pharmacologic Treatment and 2) Pharmacologic Treatment

Non-Pharmacologic Treatment of Insomnia

First line treatment: Clinicians should use multicomponent Cognitive Behavioral Therapy for Insomnia (CBT-I) for the treatment of chronic insomnia in adults[22] pharmacological treatment. It can be used alongside medication to improve sleep and may help reduce or stop the need for meds over time. CBT-I is especially helpful if symptoms continue despite medication or during the process of tapering off sleep aids.

Pharmacologic Treatment of Insomnia

Primary Indication: short-term management of insomnia[2,8]

- Consider for stressful event, to prevent short term insomnia from evolving into chronic insomnia[7]
- Consider for chronic insomnia when CBT-I is not available or feasible, as a temporary adjust to CBT-I, or when symptoms persist despite CBT-I.[16]
- Base decision to initiate pharmacotherapy on the presence and severity of daytime symptoms, and impact on quality of life[4]

Five Basic Principles for Hypnotic Prescribing:

1. Use of the lowest effective dose
2. Use of intermittent dosing (2 to 4 times weekly): use after 2 consecutive bad nights of sleep and not on consecutive nights)
3. Short-term medication prescribing (regular use for not more than 3 to 4 weeks)
4. Consider gradual medication discontinuation to reduce rebound insomnia
5. Medications with shorter elimination half-lives are preferred to minimize daytime sedation
6. Re-evaluate patients if insomnia persists or worsens, and reconsider nonpharmacologic treatments—especially if medications are used long-term[16]

Contraindications: A comprehensive list of adverse effects or contraindications is outside the scope of this document-please see individual agent drug labeling and other resources.

Note: Specific monitoring recommendations are left to clinical judgement and individualized care, though most clinicians would agree to closely monitor patients with hepatic, renal or pulmonary disease if using hypnotic medications.

Considerations for Patients aged 65+:[9] Medications often prescribed for treatment of insomnia are considered Potentially Inappropriate Medications (PIMs) for older adults per the American Geriatrics Society Beers Criteria. *Providers should consider the following when prescribing medications to treat insomnia for patients aged 65 years+*:

- Benzodiazepines: AVOID—Strong Recommendation
  - Rationale: Older adults have increased sensitivity to benzodiazepines and decreased metabolism of long-acting agents; in general, all benzodiazepines increase risk of cognitive impairment, delirium, falls, fractures, and motor vehicle crashes in older adults

- Nonbenzodiazepine, benzodiazepine receptor agonist hypnotics: AVOID — Strong Recommendation

- Rationale: Benzodiazepine-receptor agonists have adverse events like those of benzodiazepines in older adults (e.g., delirium, falls, fractures); increased emergency department visits and hospitalizations; motor vehicle crashes; minimal improvement in sleep latency and duration

Patient Education

1. Expectations and Risks associated with medications for sleep— "The benefits might be smaller than you hoped for, and the risks may be greater"[10]

   a. Develop Tolerance – Stop working overtime
   b. Habit Forming – Risk of dependency
   c. Withdrawal – Symptoms include worsening insomnia, anxiety, muscle twitches, photophobia, tinnitus, auditory and visual hypersensitivity, and seizures.
   d. Daytime Drowsiness – Use lowest effective dose
   e. Rebound Insomnia – May occur when medication discontinued suddenly
   f. Memory Impairment – May affect ability to create new memories
   g. Fall Risk – Each year, 2.8 million older people are treated in emergency departments for fall injuries[11]

2. Fall Prevention[11,12]

a. Keep Moving — Activities that strengthen legs and help balance can help prevent falls
b. Have Eyes and Feet Checked
c. Make the Home Safe — Good lighting, handrails, clutter, and small throw rug removal

ATTACHMENTS

1. Diagnosing Insomnia (BSWQA.CLE. 009.A1)
2. Conditions Associated with Chronic Insomnia (BSWQA.CLE. 009.A2)
3. Epworth Sleepiness Scale (BSWQA.CLE. 009.A3)
4. Sleep Diary Template (BSWQA.CLE. 009.A4)
5. Hypnotic Medication Discontinuation Strategies General Considerations (BSWQA.CLE. 009.A6)

REFERENCES

1. American Academy of Sleep Medicine. *International Classification of Sleep Disorders—Third Edition, Text Revision (ICSD-3-TR).* Darien, IL: AASM; 2023.Rajput V, Bromley SM. Chronic insomnia: a practical review. *American family physician.* 1999;60(5):1431-1438; discussion 1441-1432.
2. Kamel NS, Gammack JK. Insomnia in the elderly: cause, approach, and treatment. *The American journal of medicine.* 2006;119(6):463-469.
3. Krishnan P, Hawranik P. Diagnosis and management of geriatric insomnia: a guide for nurse practitioners. *Journal of the American Association of Nurse Practitioners.* 2008;20(12):590-599.
4. Sateia MJ, Doghramji K, Hauri PJ, Morin CM. Evaluation of chronic insomnia. An American Academy of Sleep Medicine review. *Sleep.* 2000;23(2):243-308.
5. Jacobs GD. *Say good night to insomnia: the six-week, drug-free program developed at Harvard Medical School.* Macmillan; 2009.
6. Wroble R, Nagle BA, Cataldi LA, Monane M. Insomnia in the elderly: assessment and management in a primary care setting. 2000.
7. American Geriatrics Society 2019 Updated AGS Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults. By the 2019 American Geriatrics Society Beers Criteria® Update Expert Panel.J Am Geriatr Soc. 2019 Apr;67(4):674-694. doi: 10.1111/jgs.15767. Epub 2019 Jan 29.PMID: 30693946
8. Consumer Reports. Why the Best Insomnia Treatment is Not a Drug. *Consumer Reports.* 2017. https://www.consumerreports.org/cro/2014/05/sleeping-pills-for-insomnia/index.htm#.
9. Centers for Disease Control and Prevention. Family Caregivers: Protect Your Loved Ones From Falling. In: U.S. Department of Health and Human Services, ed. *STEADI: Stopping Elderly Accidents, Deaths & Injuries*.

10. Centers for Disease Control and Prevention. Important Facts about Falls. 2017. https://www.cdc.gov/homeandrecreationalsafety/falls/adultfalls.html.
11. Ong JC, Suh S. Diagnostic Tools for Insomnia A2 - Kushida, Clete A. *Encyclopedia of Sleep*. Waltham: Academic Press; 2013:268-273.
12. Schutte-Rodin S, Broch L, Buysse D, Dorsey C, Sateia M. Clinical guideline for the evaluation and management of chronic insomnia in adults. *Journal of clinical sleep medicine: JCSM: official publication of the American Academy of Sleep Medicine.* 2008;4(5):487.
13. Toward Optimized Practice Program. *Adult Insomnia: Assessment to Diagnosis.* Edmonton, AB2007.
14. Sateia MJ, Buysse DJ, Krystal AD, Neubauer DN, Heald JL. Clinical practice guideline for the pharmacologic treatment of chronic insomnia in adults: an American Academy of Sleep Medicine Clinical Practice Guideline. *Journal of clinical sleep medicine: JCSM: official publication of the American Academy of Sleep Medicine.* 2017;13(2):307-349.
17. Baylor Scott & White Health. *Pain Management & Opioid Prescribing: A Provider and Community Resource.* 2017.
18. Edinger JD, Arnedt JT, Bertisch SM, Carney CE, Harrington JJ, Lichstein KL, Sateia MJ, Troxel WM, Zhou ES, Kazmi U, Heald JL, Martin JL. Behavioral and psychological treatments for chronic insomnia disorder in adults: an American Academy of Sleep Medicine clinical practice guideline. *Journal of Clinical Sleep Medicine*. 2021;17(2):255-262.

Attachment 1: Diagnosing Insomnia (BSWQA.CLE.009.A1)

1. Clinical Interview[13]

A. Information about the nature and impact of the sleep disturbance, the developmental course, and the specific features of the sleep problems
   a. Four Domains:*
      i. Current sleep patterns and daytime functioning
      ii. History and developmental course of the sleep problem
      iii. Comorbid conditions or factors
      iv. Specific etiological features
   b. *Not mutually exclusive domains and do not have to be assessed in this order

B. DSM-5 diagnostic criteria: difficulty initiating or maintaining sleep ≥ 3 nights per week for ≥ 3 months, despite adequate opportunity for sleep, with associated daytime distress or impairment.

2. Physical and Mental Status Examination

   a. Identify or rule out comorbid conditions (*see BSWQA.CLE.009.A2*)
   b. Multiple primary and comorbid insomnia disorders may exist
      i. The presence of one does not exclude the presence of others

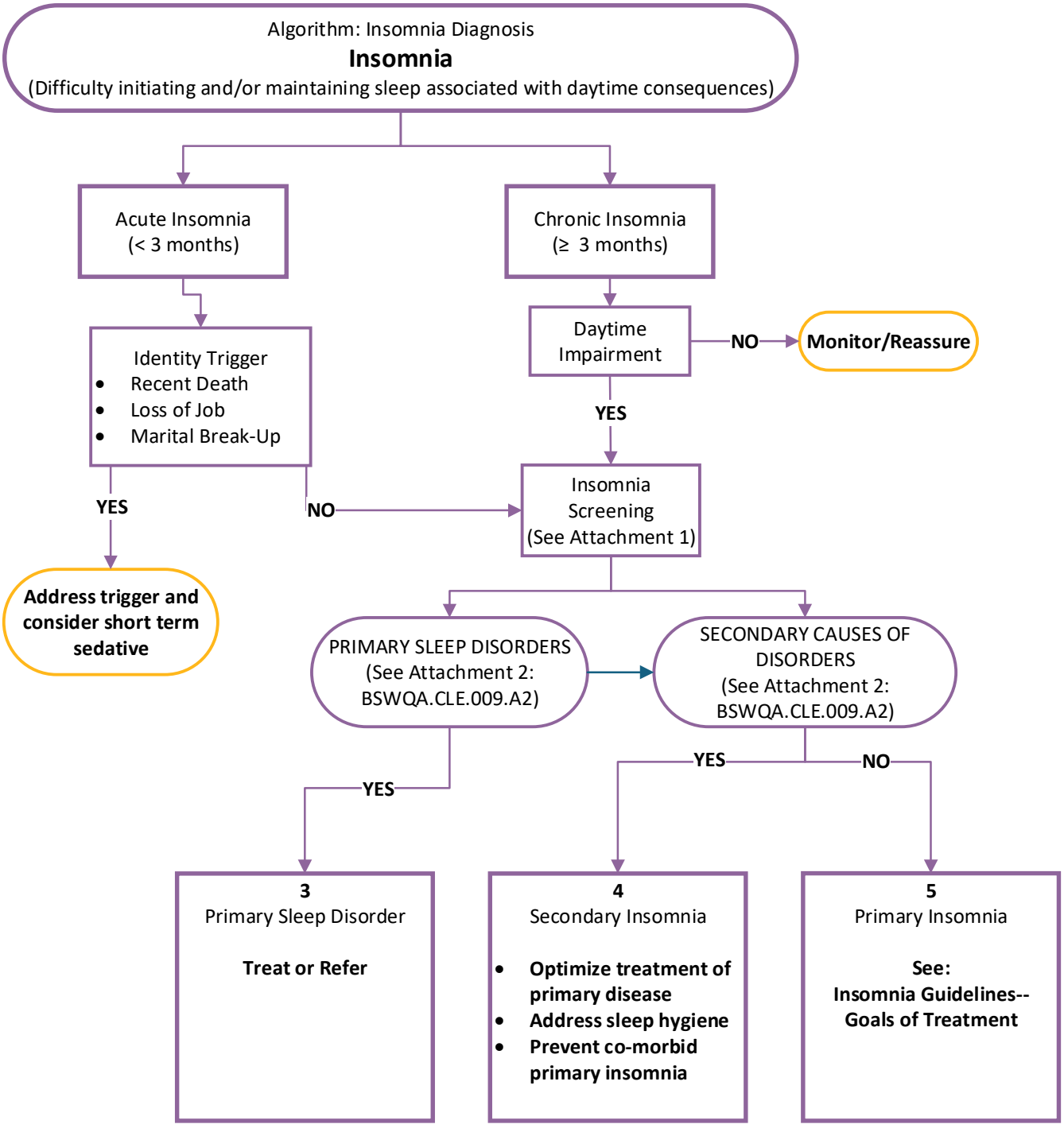
3. Insomnia Screening and Management Tools:

   a. **Insomnia Severity Index (ISI):** A 7-item self-report questionnaire measuring the severity and impact of insomnia symptoms; typically takes about 2–5 minutes to complete
      i. https://eprovide.mapi-trust.org/instruments/insomnia-severity-index
      ii. Copyrighted, however available to students and physicians in clinical practice
   b. Epworth Sleepiness Scale (*see BSWQA.CLE.009.A3*)
   c. Sleep Diary[7] *(see BSWQA.CLE.009.A4)*
      i. Patients should be asked to complete a sleep diary log before and during treatment to evaluate sleep wake patterns

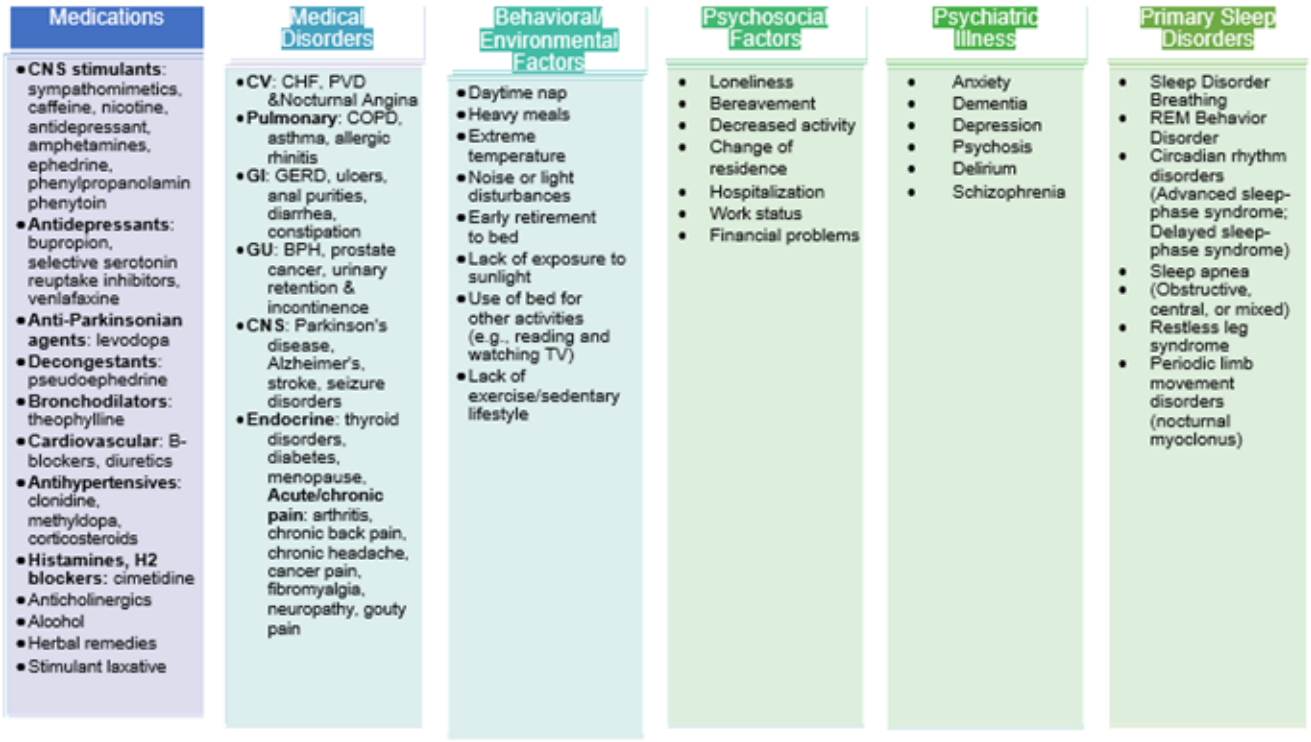
4. Polysomnography is not indicated in the routine diagnosis of chronic insomnia

   a. Polysomnography may be indicated for the diagnosis of sleep apnea or movement disorders or when treatment fails[5,14]
   b. Other laboratory testing may be considered to diagnosis comorbid disorders but is not indicated for the routine evaluation of chronic insomnia

5*NOTE:* See “Algorithm: Insomnia Diagnosis” for diagnosis flowchart[15] Update: Acute Insomnia less than three months; Chronic Insomnia three months or more


Algorithm: Insomnia Diagnosis
Insomnia
(Difficulty initiating and/or maintaining sleep associated with daytime consequences)
Acute Insomnia
(< 3 months)
Chronic Insomnia
(≥ 3 months)
Identity Trigger
Recent Death
Loss of Job
Marital Break-Up
YES
NO
Address trigger and consider short term sedative
Daytime Impairment
NO
Monitor/Reassure
YES
Insomnia Screening
(See Attachment 1)
PRIMARY SLEEP DISORDERS
(See Attachment 2: BSWQA.CLE.009.A2)
SECONDARY CAUSES OF DISORDERS
(See Attachment 2: BSWQA.CLE.009.A2)
YES
YES
NO
3
Primary Sleep Disorder
Treat or Refer
4
Secondary Insomnia
Optimize treatment of primary disease
Address sleep hygiene
Prevent co-morbid primary insomnia
5
Primary Insomnia
See:
Insomnia Guidelines--Goals of Treatment

Attachment 2: Conditions Associated with Insomnia (BSWQA.CLE.009.A2)



Attachment 3: The Epworth Sleepiness Scale (BSWQA.CLE. 009.A3)

The Epworth Sleepiness Scale is widely used in the field of sleep medicine as a subjective measure of a patient's sleepiness. The test is a list of eight situations in which you rate your tendency to become sleepy on a scale of 0, no chance of dozing, to 3, high chance of dozing. When you finish the test, add up the values of your responses. Your total score is based on a scale of 0 to 24. The scale estimates whether you are experiencing excessive sleepiness that possibly requires medical attention.

How Sleepy Are You?

How likely are you to doze off or fall asleep in the following situations? You should rate your chances of dozing off, not just feeling tired. Even if you have not done some of these things recently try to determine how they would have affected you. For each situation, decide whether or not you would have:

- No chance of dozing =0
- Slight chance of dozing =1
- Moderate chance of dozing =2
- High chance of dozing =3

Write down the number corresponding to your choice in the right-hand column. Total your score below.

Situation	Chance of Dozing
Sitting and reading	•
Watching TV	•
Sitting inactive in a public place (e.g., a theater or a meeting)	•
As a passenger in a car for an hour without a break	•
Lying down to rest in the afternoon when circumstances permit	•
Sitting and talking to someone	•
Sitting quietly after a lunch without alcohol	•
In a car, while stopped for a few minutes in traffic	•

Total Score = _____

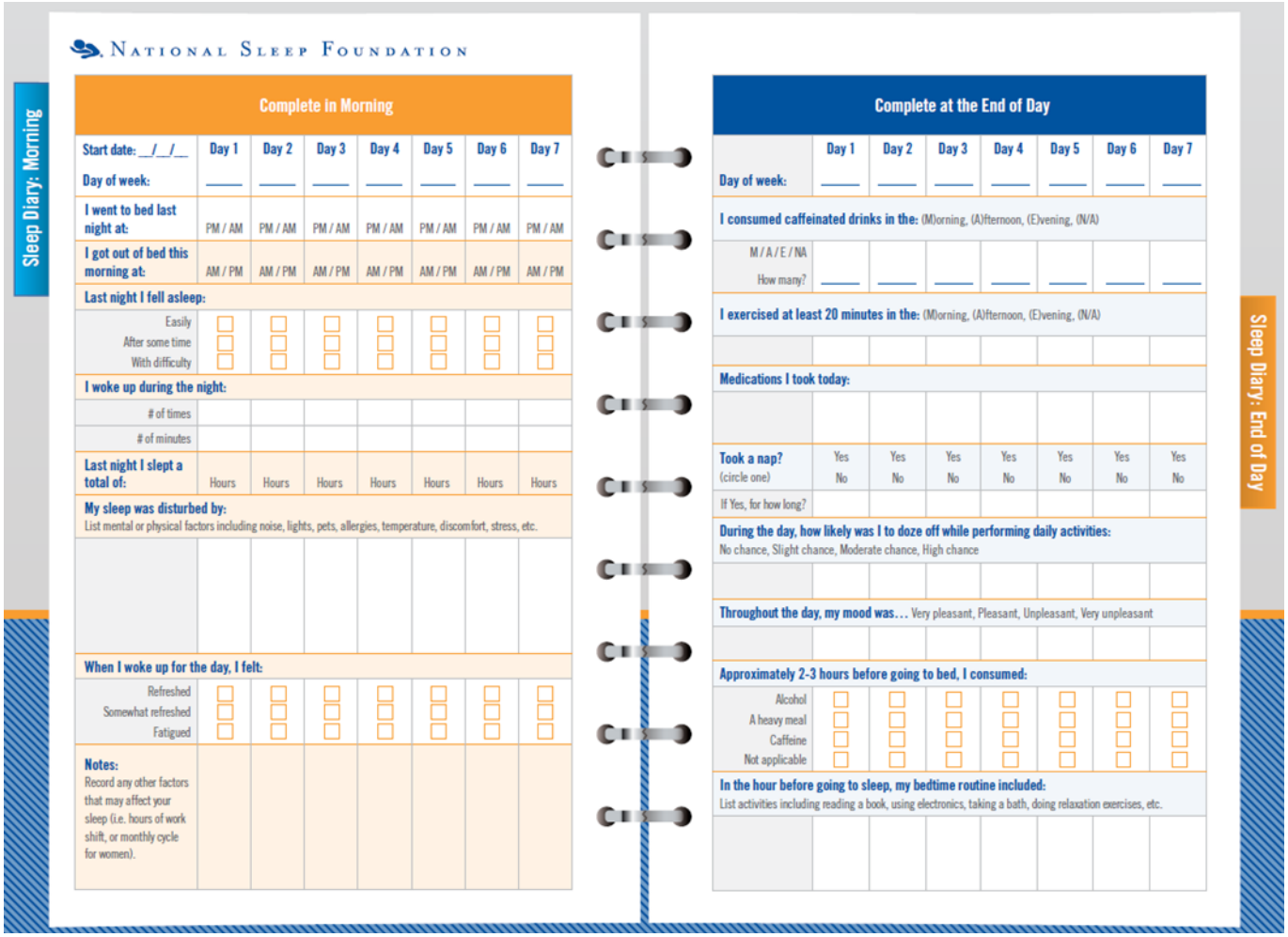
Analyze Your Score

Interpretation:

0-7: It is unlikely that you are abnormally sleepy.
8-9: You have an average amount of daytime sleepiness.
10-15: You may be excessively sleepy depending on the situation. You may want to consider seeking medical attention.
16-24: You are excessively sleepy and should consider seeking medical attention.

Reference: Johns MW. A new method for measuring daytime sleepiness: The Epworth Sleepiness Scale. *Sleep* 1991: 14(6):540-5.

Attachment 4: Sleep Diary Template (BSWQA.CLE. 009.A4)



NATIONAL SLEEP FOUNDATION

Sleep Diary: Morning

Complete in Morning

Start date: __/__/__	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Day of week:							
I went to bed last night at:	PM / AM	PM / AM	PM / AM	PM / AM	PM / AM	PM / AM	PM / AM
I got out of bed this morning at:	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM
Last night I fell asleep:							
Easily	☐	☐	☐	☐	☐	☐	☐
After some time	☐	☐	☐	☐	☐	☐	☐
With difficulty	☐	☐	☐	☐	☐	☐	☐
I woke up during the night:							
# of times							
# of minutes							
Last night I slept a total of:	Hours	Hours	Hours	Hours	Hours	Hours	Hours
My sleep was disturbed by: List mental or physical factors including noise, lights, pets, allergies, temperature, discomfort, stress, etc.							
When I woke up for the day, I felt:							
Refreshed	☐	☐	☐	☐	☐	☐	☐
Somewhat refreshed	☐	☐	☐	☐	☐	☐	☐
Fatigued	☐	☐	☐	☐	☐	☐	☐
Notes: Record any other factors that may affect your sleep (i.e. hours of work shift, or monthly cycle for women).							

Complete at the End of Day

Day of week:	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
I consumed caffeinated drinks in the: (M)orning, (A)fternoon, (E)vening, (N/A)							
M / A / E / NA							
How many?							
I exercised at least 20 minutes in the: (M)orning, (A)fternoon, (E)vening, (N/A)							
Medications I took today:							
Took a nap? (circle one)	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
If Yes, for how long?							
During the day, how likely was I to doze off while performing daily activities: No chance, Slight chance, Moderate chance, High chance							
Throughout the day, my mood was… Very pleasant, Pleasant, Unpleasant, Very unpleasant							
Approximately 2-3 hours before going to bed, I consumed:							
Alcohol	☐	☐	☐	☐	☐	☐	☐
A heavy meal	☐	☐	☐	☐	☐	☐	☐
Caffeine	☐	☐	☐	☐	☐	☐	☐
Not applicable	☐	☐	☐	☐	☐	☐	☐
In the hour before going to sleep, my bedtime routine included: List activities including reading a book, using electronics, taking a bath, doing relaxation exercises, etc.							

Sleep Diary: End of Day

Attachment 5: Hypnotic Medication Discontinuation Strategies (BSWQA.CLE. 009.A6)

General Considerations[17]

- Some short-term increase in anxiety is to be expected during the tapering process. This is usually transient, and after achieving a reduced baseline dose, the patient is likely to experience decreased medication-related side effects without an increase in anxiety. Many times [hypnotics] may be completely discontinued with no increase in symptoms, but with improved function and quality of life.

- The slower the taper, the less the short-term discomfort. Educating the patient about the risks of their current regimen and what to expect as they taper off the medications can be helpful.

- Some highly motivated patients prefer a rapid taper (weeks versus months). Patient preference needs to be considered in designing a tapering schedule.

- Psychosocial support is an essential component of successful medication withdrawal for patients who have been on long-term [hypnotic] therapy. Discussions about weaning are often associated with fear and anxiety about the recurrence or worsening of anxiety and/or the development of other withdrawal symptoms. Reassure each patient that supportive adjunctive treatment of withdrawal will be provided as needed, and may be quite helpful, but set expectations that this will not include dangerous replacement medications.

- *Patient empowerment is key to success*. Involve patients in planning from the beginning. Elicit suggestions for healthy activities that can replace reliance on medications.

- Certain therapies, CBT, and trauma-focused care, for example, can be quite helpful in supporting patients through the tapering process and beyond.

- The last part of the dosage reduction is the most difficult for patients. This is a phenomenon that is true for many psychoactive drugs. You and your patients should anticipate this and use support that are meaningful to your patients. Even in motivated patients, a slow-down of the tapering process may be necessary toward the end. Liquid form of medication, often available from compounding pharmacies, may be helpful when gradually reducing doses.

- FDA labeling for hypnotics advises a gradual, patient-specific taper to reduce withdrawal risk

- *NOTE:* **Specific tapering instructions for benzodiazepines are beyond the scope of this guide; however, detailed clinical recommendations are available through the American Society of Addiction Medicine (ASAM) 2025 Benzodiazepine Tapering Guideline** (*available at*: https://www.asam.org/quality-care/clinical-guidelines/benzodiazepine-tapering