QUALITY STANDARDS

Insomnia Disorder

Care for Adults

FEBRUARY 2025

Ontario Health

Scope of This Quality Standard

This quality standard addresses care for adults aged 18 years or older who have insomnia disorder (also known as chronic insomnia). Insomnia disorder is defined as distress or daytime impairment that lasts 3 or more months, and that is associated with 1 or more of the following: difficulty initiating sleep, difficulty maintaining sleep, or early morning waking with difficulty returning to sleep, despite adequate opportunity for sleep.[1] This quality standard applies to all health care settings. It does not include care for people whose sleeping difficulty is better explained by a different sleep disorder.

What Is a Quality Standard?

Quality standards outline what high-quality care looks like for conditions or processes where there are large variations in how care is delivered, or where there are gaps between the care provided in Ontario and the care patients should receive. They:

- Help patients, families, and care partners know what to ask for in their care
- Help clinicians know what care they should be offering, based on evidence and expert consensus
- Help health care organizations measure, assess, and improve their performance in caring for patients

Quality standards and their accompanying patient guides are developed by Ontario Health, in collaboration with clinicians, patients, and care partners across Ontario.

For more information, contact QualityStandards@OntarioHealth.ca.

Quality Statements to Improve Care: Summary

These quality statements describe what high-quality care looks like for people with insomnia disorder.

Quality Statement 1: Comprehensive Assessment

People suspected of having insomnia disorder receive a comprehensive assessment to inform diagnosis.

Quality Statement 2: Individualized, Person-Centred, Comprehensive Care Plan

People with insomnia disorder, care partners (as appropriate), and clinicians collaborate to develop an individualized, person-centred, comprehensive care plan. They review this plan together regularly.

Quality Statement 3: Management of Insomnia Disorder in People With Comorbidities

People who have insomnia disorder and comorbidities receive timely treatment for their insomnia disorder and any other health conditions as part of a comprehensive care plan.

Quality Statement 4: Cognitive Behavioural Therapy for Insomnia

People with insomnia disorder have timely access to cognitive behavioural therapy for insomnia as first-line treatment. Therapy is delivered in a way that best fits the person's needs and preferences.

Quality Statement 5: Pharmacotherapy

People with insomnia disorder are offered effective medications at the lowest possible dose, for the shortest possible duration, and after an adequate trial of cognitive behavioural therapy for insomnia. A medication is offered only after a discussion about its benefits and risks.

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A Note on Terminology

Insomnia disorder is defined as distress or daytime impairment that lasts 3 or more months, and that is associated with 1 or more of the following: difficulty initiating sleep, difficulty maintaining sleep, or early morning waking with difficulty returning to sleep, despite adequate opportunity for sleep.[1] This definition aligns with the definitions of "chronic insomnia disorder" in the American Academy of Sleep Medicine *International Classification of Sleep Disorders – Third Edition*[2] and "insomnia disorder" in the American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*.[3]

Why This Quality Standard Is Needed

People with insomnia disorder experience numerous adverse effects related to their functional ability, personal life, social life, health, and quality of life.[1,4,5] Insomnia is a common sleep disorder: according to the Canadian Community Health Survey (CCHS), just over 20% of adults in Ontario (aged 18 years and older) reported having trouble going to sleep or staying asleep (CCHS, 2021). Insomnia symptoms were more prevalent among women: 24% of women in Ontario had trouble going to or staying asleep, compared to 16% of men.

Insomnia may negatively affect quality of life. Among adults aged 45 to 85 years in the Canadian Longitudinal Study on Aging (after adjusting for sociodemographic, lifestyle, and clinical factors), those with insomnia self-reported more dissatisfaction with life (54% higher), more psychological distress (28% higher), and more poor or fair mental health (65% higher) compared to those without insomnia.[6] Similarly, adults with sleep dissatisfaction and daytime impairment due to insomnia also reported higher dissatisfaction with life, psychological distress, and poor mental health compared to those without. Older age further exacerbates the relationship between daytime impairment and dissatisfaction with life: in the study, the prevalence of dissatisfaction rose by 11% for every 10-year increase in age.

People with hypertension, heart failure, anxiety, depression, or obesity are more likely to report trouble sleeping than people without these conditions.[7,8] Conversely, having insomnia increases the risk of outcomes such as cardiovascular disease, hypertension, type 2 diabetes, depression, cognitive decline, and road accidents.[9] In Canada, the estimated total cost of insomnia attributable to these 6 outcomes was $1.9 billion in 2021.

The best available evidence recommends cognitive behavioural therapy for insomnia (CBT-I) as the first-line treatment for insomnia disorder.[10-12] Despite the proven efficacy of CBT-I, prescribed medications are still the most widely used insomnia treatment in Canada,[13] even though the medications prescribed might not always be appropriate. For example, about 18% of adults in Ontario aged 66 or older were prescribed sedative medications for insomnia, even though serious adverse events have been associated with these medications, including falls, cognitive effects, and mortality.[14,15] Evidence has also demonstrated that on its own, sleep hygiene (i.e., recommendations such as avoiding caffeine and minimizing loud noises or screen time) is ineffective[16]; despite this, a 2019 online survey of 20 clinical psychologists in the United States and Canada found that 64% recommended sleep hygiene to treat insomnia and only 17% offered CBT-I.[17] In another study,

about 90% of medical professionals recommended sleep hygiene, and over 60% recommended pharmacotherapy.[18] Together, these findings point to a need to improve knowledge about and access to CBT-I.

This quality standard includes 5 quality statements that address areas identified by the Insomnia Disorder Quality Standard Advisory Committee as having high potential to improve care for people with insomnia disorder in Ontario.

Measurement to Support Improvement

The Insomnia Disorder Quality Standard Advisory Committee identified 3 overarching indicators to monitor the progress being made toward improving care for people with insomnia disorder in Ontario. The committee did not identify any provincially measurable indicators because provincial data sources on care for insomnia disorder are limited, as is the ability to identify people with insomnia disorder. When data sources or methods are developed that can accurately identify people with insomnia disorder, the committee will reconsider provincial measures of success for this quality standard.

Indicators That Can Be Measured Using Only Local Data

- Percentage of people who report that their sleep has improved after treatment of their insomnia disorder
- Percentage of people with insomnia disorder and taking insomnia medication who report that their medication was prescribed based on a documented discussion with their clinician
- Percentage of people who report improved quality of life after treatment of their insomnia disorder

Quality Statement 1: Comprehensive Assessment

> People suspected of having insomnia disorder receive a comprehensive assessment to inform diagnosis.
>
> Source: Department of Veterans Affairs/Department of Defense, 2019[12]

Definition

Comprehensive assessment: A comprehensive assessment for insomnia disorder includes the use of subjective measures (sleep history, insomnia assessment tools) and physical and mental health histories. Diagnosis is based on the person's perception of their sleep or on a care partner's report, where appropriate.[19] Clinicians should assess people for possible insomnia disorder using the criteria in the most recent versions of the *Diagnostic and Statistical Manual of Mental Disorders*[3] or the *International Classification of Sleep Disorders*.[2] Objective measures such as polysomnography or actigraphy (2 types of sleep/wake studies) are not indicated as part of an assessment for insomnia disorder, unless they are used to rule out other sleep disorders.[12]

A comprehensive assessment should include the following components, at a minimum:

- Sleep history
  - Specific insomnia complaints, such as inability to fall asleep, inability to maintain sleep, early waking
  - Daytime consequences, such as effects on quality of life, impaired daytime functioning, sleepiness (a desire to fall asleep), or fatigue (a sense of diminished energy or lethargy that interferes with daily activities)
  - Environmental factors, such as noise, temperature, the disruptive presence of a partner or animal, an uncomfortable bed
- Insomnia assessment tools, such as
  - Insomnia Severity Index[12,20]: a validated tool used to determine the severity of insomnia disorder and monitor treatment efficacy
  - Consensus Sleep Diary (paper- or web-based)[21]: a sleep diary to track sleep history and learn sleep patterns (advisory committee consensus)
- Physical and mental health histories
  - Physical health comorbidities that may contribute to insomnia (e.g., pain disorder, thyroid disorder, anemia)

- Mental health comorbidities that may contribute to insomnia (e.g., anxiety disorder, depression, bipolar disorder, post-traumatic stress disorder)
- Medication and substance history (e.g., antidepressants, steroids, diuretics before bedtime, alcohol, caffeine, nicotine, marijuana, cocaine, amphetamines)

Rationale

Assessment can be conducted effectively by any clinician (including primary care clinicians such as family physicians and nurse practitioners) and in an office or virtual setting.[12] It is not necessary to consult a clinician with expertise in sleep medicine to obtain an assessment for insomnia disorder.

Objective sleep measures such as polysomnography are not needed to assess people for insomnia disorder.[12,19] Referral to a sleep laboratory for assessment is costly, and it may act as a barrier for people who cannot or do not want to undergo an overnight sleep study. Sleep studies may be indicated if the clinician suspects that the cause of the sleep impairment is a different sleep disorder, such as obstructive or central sleep apnea, narcolepsy, nocturnal seizures, parasomnia, idiopathic hypersomnia, circadian rhythm disorder, periodic limb movement disorder, or nocturnal oxygen desaturation.[19,22]

What This Quality Statement Means

For People With Insomnia Disorder

If you are having trouble sleeping, your clinician should talk with you about your sleep and how it is affecting your daily life. They should ask you or your care partner about your sleep history and your medical history, including your physical and mental health.

For Clinicians

If you suspect that a patient has insomnia disorder, complete a thorough sleep history, use standardized insomnia assessment tools, and take physical and mental health histories as part of a comprehensive assessment to inform diagnosis. In most cases, objective measures such as sleep studies are not necessary for the assessment of insomnia disorder unless they are used to rule out other sleep disorders.

For Organizations and Health Services Planners

Ensure that people have access to a primary care clinician, and that primary care clinicians have adequate time, tools, and resources to conduct comprehensive assessments for insomnia disorder.

Quality Indicator: How to Measure Improvement for This Statement

- Percentage of people suspected of having insomnia disorder who receive a comprehensive assessment to inform diagnosis

Measurement details for this indicator, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Quality Statement 2: Individualized, Person-Centred, Comprehensive Care Plan

> People with insomnia disorder, care partners (as appropriate), and clinicians collaborate to develop an individualized, person-centred, comprehensive care plan. They review this plan together regularly.
>
> Source: Department of Veterans Affairs/Department of Defense, 2019[12]

Definitions

Individualized, person-centred, comprehensive care plan: Care plans are customized for each person based on their values, wishes, goals, and unique needs. A person-centred approach involves a partnership between the person with insomnia disorder and their clinician; the person with insomnia disorder drives decisions about their care. The goal of the care plan is to improve sleep quality and reduce insomnia-related daytime impairments; it should address the following, at a minimum[4,10,12]:

- Assessment of needs (e.g., the Consensus Sleep Diary can be used to monitor sleep history and sleep patterns)[21]
- Discussion of expectations (e.g., what treatment will involve)
- Management of physical and mental health comorbidities (see quality statement 3)
- Cognitive behavioural therapy for insomnia (see quality statement 4)
- Consideration of pharmacotherapy, when appropriate (see quality statement 5)
- Consultation with or referral to a clinician with relevant expertise (when appropriate) for those who:
  - Have comorbidities that are unresolved
  - Do not see improvement in their symptoms after trying treatments for insomnia disorder

Regularly: At least every 2 months until the insomnia disorder has improved, and then at least annually until it has resolved (advisory committee consensus).

Rationale

Clinicians should offer information about insomnia disorder and talk to the person with insomnia about their goals for care.[12] The person with insomnia disorder, their care partners (as appropriate), and their clinician collaborate to develop the care plan so that it is relevant to the person's values and

circumstances and to help ensure the best possible outcomes.[4] Clinicians should use a person-centred, motivational interviewing approach and empower people to make decisions by describing their care options (e.g., what may be offered by primary care, when additional expertise in sleep medicine may be required, and whether some management options can be offered by telephone or virtually through telemedicine or other technologies). The care plan should be reviewed regularly to ensure that the person's symptoms are improving.

What This Quality Statement Means

For People With Insomnia Disorder

Your clinician should work with you to create a care plan that fits with your values, wishes, goals, and needs. They should ask what better sleep would look like for you. They should work with you to update your care plan at least every 2 months until you are sleeping better, and then once a year until your insomnia disorder has resolved.

For Clinicians

Work with patients to determine their goals and wishes, and collaborate with them to develop and implement a comprehensive care plan. Review the care plan at least every 2 months until their insomnia disorder has improved, and then at least annually until it has resolved.

For Organizations and Health Services Planners

Ensure that training, tools, and resources are available for clinicians to develop individualized, person-centred, comprehensive care plans for people with insomnia disorder. Ensure that clinicians have the time and resources to review care plans regularly and confirm that their patient's symptoms are improving or have resolved.

Quality Indicators: How to Measure Improvement for This Statement

- Percentage of people with insomnia disorder who have a documented care plan
- Percentage of people with insomnia disorder and a care plan who report that the care plan is reviewed regularly (i.e., at least every 2 months until the insomnia disorder has improved, then at least annually until it has resolved)
- Percentage of people with insomnia disorder who report that their clinician always or often involves them in decisions about care for their insomnia disorder

Measurement details for these indicators, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Quality Statement 3: Management of Insomnia Disorder in People With Comorbidities

> People who have insomnia disorder and comorbidities receive timely treatment for their insomnia disorder and any other health conditions as part of a comprehensive care plan.
>
> Source: Department of Veterans Affairs/Department of Defense, 2019[12]

Definitions

Comorbidities: It is common for people with insomnia disorder to have other health conditions at the same time, such as pain, heart failure, anxiety, depression, or obesity. Insomnia disorder also increases people's risk of developing other physical and mental health conditions.[7,8,12] Comorbidities should be identified as part of the comprehensive assessment (see quality statement 1) and during regular reviews of the care plan (see quality statement 2).

Timely treatment: Treatment should begin as soon as possible. Insomnia disorder can be diagnosed as an independent condition, whether or not the person has a comorbidity or another sleep disorder. The presence of a comorbidity should not delay treatment of insomnia disorder with CBT-I (see quality statement 4).[12]

Rationale

The relationship between insomnia and comorbid health conditions is not always clear and may change over time.[12,19] In the past, clinicians tried to differentiate between primary insomnia (i.e., insomnia that was not associated with another health condition) and comorbid insomnia (i.e., insomnia that developed as a result or a symptom of another health condition), because the recommended treatments were different.[23] Now, insomnia disorder can be diagnosed as an independent condition, whether or not the person also has a comorbidity or another sleep disorder.[19] It is understood that habits or ways of thinking that may develop in response to another condition (for example, trying to catch up on sleep by going to bed early, or staying in bed late) can lead to an insomnia disorder that should be treated on its own, not as a symptom of another health condition.[12]

If clinicians lack the knowledge and skills to treat people with insomnia disorder and a comorbidity, they should consider referral to a clinician with relevant expertise in sleep medicine (e.g., a psychiatrist). Some physical and mental health conditions may require early consultation to determine how best to deliver and coordinate the person's care.[12] People who are receiving ongoing treatment from a clinician with expertise in sleep medicine should be supported by an

interprofessional team that includes their primary care clinician to ensure that they receive comprehensive care as needed, based on their care plan.

What This Quality Statement Means

For People With Insomnia Disorder

If you have other health conditions as well as insomnia disorder, your clinician should offer you treatment for your insomnia as well as those other conditions. For example, if you develop insomnia during an episode of depression, you should be treated for both insomnia and depression.

For Clinicians

Treat insomnia disorder as an independent condition, not as a symptom of another health condition. Do not wait for comorbidities to be resolved before starting treatment for insomnia disorder. For example, if someone with insomnia disorder has pain, treat their insomnia disorder in addition to their pain, even if the pain is unresolved.

For Organizations and Health Services Planners

Ensure the availability of information on insomnia disorder and comorbidities so that clinicians know that insomnia disorder should be treated as soon as possible, regardless of comorbidities. Ensure that clinicians have the necessary protocols, tools, and resources to communicate effectively with clinicians who have additional expertise in the treatment of insomnia disorder with comorbidities.

Quality Indicator: How to Measure Improvement for This Statement

- Percentage of people with insomnia disorder and comorbidities who receive timely treatment for their insomnia disorder

Measurement details for this indicator, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Quality Statement 4: Cognitive Behavioural Therapy for Insomnia

People with insomnia disorder have timely access to cognitive behavioural therapy for insomnia as first-line treatment. Therapy is delivered in a way that best fits the person's needs and preferences.

Sources: American Academy of Sleep Medicine, 2021[11] | American College of Physicians, 2016[10] | Department of Veterans Affairs/Department of Defense, 2019[12]

Definitions

Timely access: People with insomnia disorder are offered CBT-I as soon as possible after they receive a diagnosis of insomnia disorder. If it is not possible to start CBT-I with a trained clinician immediately, people should be directed to self-guided CBT-I resources (online resources or books) that they can use to begin practising some components of CBT-I.

Cognitive behavioural therapy for insomnia: CBT-I is a structured, multisession psychological program that focuses on sleep-specific thoughts and behaviours using a combination of treatments.[12] It can be administered in primary care settings and delivered by primary care clinicians or other clinicians with the necessary training (e.g., psychotherapists).[12,24,25] The components of CBT-I include the following and should be included as part of the care plan (see quality statement 2):

- Cognitive therapy – therapy aimed at identifying, challenging, and replacing unhelpful (sleep-interfering) beliefs and attitudes about sleep
- Sleep restriction – behavioural instructions to limit time in bed, which are aimed at reducing time awake in bed, making sleep more efficient, and gradually increasing time in bed as sleep improves
- Stimulus control – behavioural instructions aimed at changing habits to strengthen the association between bed and sleep, remove associations between bed and stimulating activities, and establish consistent sleep patterns
- Relaxation therapy – any relaxation technique that the person finds effective to calm their mind and body to facilitate sleep (e.g., mindfulness, muscle relaxation, daytime thought diary)
- Sleep hygiene – recommendations relating to environmental factors and habits that promote sound sleep, such as avoiding caffeine late in the day (note: sleep hygiene has been shown to be ineffective as a standalone treatment)[12,16]

Delivered in a way that best fits the person's needs and preferences: CBT-I is delivered in a way that is effective and accessible for the person receiving it. It may be conducted in individual or group sessions using various formats (i.e., in person, or virtually through telemedicine or other technologies), with 4 to 8 sessions that vary in length but typically last 1 to 2 hours.[11,26] Resources for self-guided CBT-I (i.e., from the internet or books) are also available, but those who do not experience resolution of symptoms with self-guided CBT-I are offered standard CBT-I with a trained clinician.

Rationale

CBT-I has been shown to be more effective than pharmacotherapy in reducing symptoms of insomnia and maintaining sleep improvements over time.[12,27] People with insomnia disorder and their clinicians often prefer nonpharmacological approaches because they have long-lasting benefits and avoid the adverse effects that many people experience with sleep medication.[12,28]

Primary care clinicians are often aware of the need to reduce their prescribing of medication for insomnia disorder but may have limited knowledge about and access to CBT-I.[29,30] Access to CBT-I requires the availability of clinicians with relevant training, and this may be particularly challenging in rural or remote locations. As well, some people may perceive the relatively frequent clinic visits for CBT-I to be a challenge. Given the evidence supporting CBT-I for the treatment of insomnia disorder, clinicians can empower people in their decision-making by accurately describing the treatment options (e.g., letting people know that treatments are offered by clinicians with relevant training in CBT-I and that some sessions can take place over the telephone or virtually through telemedicine or other technologies).[11]

What This Quality Statement Means

For People With Insomnia Disorder

Your clinician should offer you CBT-I as soon as possible after your diagnosis, in a format that best fits your needs and preferences. A clinician trained in CBT-I will work with you to make changes in your sleep-related thoughts and behaviours. They should talk with you about what you most hope to achieve with insomnia treatment, and what you would like to change about your sleep.

For Clinicians

Offer CBT-I as first-line treatment for people with insomnia disorder, as soon as possible after diagnosis. People should receive CBT-I from a clinician who has training in this type of therapy, and treatment should be delivered in a way that that best fits their needs and preferences.

For Organizations and Health Services Planners

Provide adequately resourced systems and services to ensure that people with insomnia disorder have timely access to CBT-I. Ensure that clinicians have the training, tools, time, and resources to offer CBT-I locally or virtually as a first-line treatment for people with insomnia disorder.

Quality Indicator: How to Measure Improvement for This Statement

- Percentage of people with insomnia disorder who have timely access to CBT-I as first-line treatment

Measurement details for this indicator, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Quality Statement 5: Pharmacotherapy

People with insomnia disorder are offered effective medications at the lowest possible dose, for the shortest possible duration, and after an adequate trial of CBT-I. A medication is offered only after a discussion about its benefits and risks.

Sources: American Academy of Sleep Medicine, 2017[4] | American College of Physicians, 2016[10] | Department of Veterans Affairs/Department of Defense, 2019[12]

Definitions

Effective medications: Medications that are effective in treating insomnia disorder with the fewest possible adverse effects and the lowest harm profile. The efficacy of pharmacotherapy for insomnia varies. Clinicians should review current clinical practice guidelines for information about evidence-based pharmacological treatments that are specific to the person's sleep complaint (e.g., choice of medications, dosing, adjunctive medications, duration of treatment, benefits, and risks).

Adequate trial of CBT-I: An adequate trial includes offering CBT-I as first-line treatment as soon as possible after a person receives a diagnosis of insomnia disorder. CBT-I may be conducted in individual or group sessions, using various formats (i.e., in person, or by videoconference), with 4 to 8 sessions that vary in length but typically last 1 to 2 hours.[11,26] Those who try self-guided CBT-I (i.e., from the internet or books) first, but who do not experience resolution of symptoms are offered standard CBT-I with a trained clinician, in person or by videoconference (see quality statement 4).

Discussion about benefits and risks: A conversation should include information about the effectiveness of the medication being considered, possible adverse effects (tolerance, dependence, sedation, cognitive impairment), plans for regular follow-up, and the person's individual needs and preferences. It may also need to include consideration of deprescribing medications the person is already taking that may have sedating side effects (e.g., falls, confusion) or are not indicated for treating insomnia and other comorbidities (e.g., antipsychotic drugs and antidepressants).[4,10,12,31,32] The clinician and the person with insomnia disorder can use the results of this discussion to decide on the best course of treatment and include it as part of the care plan (see quality statement 2).

Rationale

For people with insomnia disorder, CBT-I should always be offered first (see quality statement 4). If psychological treatment is not feasible or is not working, pharmacological treatment can be initiated at the lowest possible dose and for the shortest possible duration; treatment should be revaluated after 4 weeks.[12,33] Before pharmacotherapy is initiated, clinicians and patients should discuss the

potential benefits and risks of the medication being considered. The choice of medication, as well as its dosage and duration, should be guided by current clinical practice guidelines, and it should be appropriate to the person's age, the severity of their condition, the presence of any comorbidities, their preferences, and their response to treatment.

Long-term use of pharmacotherapy may be appropriate for some people, including those with severe or refractory insomnia (i.e., insomnia disorder that does not improve with CBT-I) or those with physical or mental health comorbidities.[4] To reduce the risk of medication tolerance (i.e., diminished response to a drug with prolonged use) or dependence, clinicians should talk with their patients about plans for reducing medication dosage or frequency, regular follow-up, and reassessment as symptoms resolve.[34]

What This Quality Statement Means

For People With Insomnia Disorder

If you have insomnia disorder and your symptoms are not getting better with CBT-I, your clinician may talk to you about medication options. The type of medication you take (as well as how much and for how long) will depend on your age, your health conditions, and your preferences. Your clinician should talk to you about the potential benefits and risks of the medication they are offering. They should follow up with you after 4 weeks to see how you are doing.

For Clinicians

Discuss the benefits and risks of pharmacotherapy with patients who cannot engage in CBT-I or who do not see improvement of their symptoms after trying it. Ensure that choices of pharmacological treatment for people with insomnia disorder are evidence-based, and that medications are prescribed at the lowest possible dose for the shortest possible duration. Regularly assess patients for medication efficacy, adverse effects, and opportunities for dose reduction and deprescribing.

For Organizations and Health Services Planners

Ensure that clinicians have the training, tools, and resources to offer effective pharmacotherapy for insomnia disorder when indicated. Ensure that clinicians have the time and resources to follow up with their patients regularly and make sure that their symptoms of insomnia disorder are improving.

Quality Indicator: How to Measure Improvement for This Statement

- Percentage of people with insomnia disorder and taking insomnia medication who report that their medication was prescribed based on a documented discussion with their clinician

Measurement details for this indicator, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Appendix 1: About This Quality Standard

How to Use This Quality Standard

Quality standards inform patients, clinicians, and organizations about what high-quality care looks like for health conditions or processes deemed a priority for quality improvement in Ontario. They are based on the best evidence.

Guidance on how to use quality standards and their associated resources is included below.

For People With Insomnia Disorder

This quality standard consists of quality statements. These describe what high-quality care looks like for people with insomnia disorder.

Within each quality statement, we have included information on what these statements mean for you, as a person seeking care for insomnia disorder.

In addition, you may want to download this accompanying patient guide on insomnia disorder to help you and your family have informed conversations with your clinicians. Inside, you will find information and questions you may want to ask as you work together to make a plan for your care.

For Clinicians and Organizations

The quality statements within this quality standard describe what high-quality care looks like for people with insomnia disorder. They are based on the best evidence and designed to help you know what to do to reduce gaps and variations in care.

Many clinicians and organizations are already providing high-quality, evidence-based care. However, there may be elements of your care that can be improved. This quality standard can serve as a resource to help you prioritize and measure improvement efforts.

Tools and resources to support you in your quality improvement efforts accompany each quality standard. These resources include indicators and their definitions, available in the technical specifications. Measurement is key to quality improvement. Collecting and using data when implementing a quality standard can help you assess the quality of care you are delivering and identify gaps in care and areas for improvement.

There are also a number of resources online to help you, including:

- Our patient guide on insomnia disorder, which you can share with patients and families to help them have conversations with you and their other clinicians. Please make the patient guide available where you provide care
- Our measurement resources, including the technical specifications for the indicators in this quality standard, the “case for improvement” slide deck to help you to share why this standard

was created and the data behind it, and our measurement guide containing supplementary information to support the data collection and measurement processes

- Our placemat, which summarizes the quality standard and includes links to helpful resources and tools
- Our *Getting Started Guide*, which includes links to templates and tools to help you put quality standards into practice. This guide shows you how to plan for, implement, and sustain changes in your practice
- Quorum, an online community dedicated to improving the quality of care across Ontario. This is a place where clinicians can share information and support each other, and it includes tools and resources to help you implement the quality statements within each standard

How the Health Care System Can Support Implementation

As you work to implement this quality standard, there may be times when you find it challenging to provide the care outlined due to system-level barriers or gaps. These challenges have been identified and documented as part of the development of the quality standard, which included extensive consultation with clinicians and lived experience advisors and a careful review of available evidence and existing programs. Many of the levers for system change fall within the purview of Ontario Health, and as such we will continue to work to address these barriers to support the implementation of quality standards. We will also engage and support other provincial partners, including the Ministry of Health or other relevant ministries, on policy-level initiatives to help bridge system-level gaps.

In the meantime, there are many actions you can take on your own, so please read the standard and act where you can.

Appendix 2: Glossary

Term	Definition
Adults	People aged 18 years and older.
Care partner	An unpaid person who provides care and support in a nonprofessional capacity, such as a parent, other family member, friend, or anyone else identified by the person with insomnia disorder. Other terms commonly used to describe this role include “caregiver,” “informal caregiver,” “family caregiver,” “carer,” and “primary caregiver.”
Clinicians	Regulated professionals who provide care to patients or clients. Examples are nurses, nurse practitioners, pharmacists, physicians, psychologists, psychotherapists, and social workers.
Primary care	A setting where people receive general health care (e.g., screening, diagnosis, and management) from a clinician who the person can access directly without a referral. This is usually the primary care clinician, family physician, nurse practitioner, or other clinician with the ability to make referrals, request biological testing, and prescribe medications.
Primary care clinician	A family physician (also called a primary care physician) or nurse practitioner.

Appendix 3: Values and Guiding Principles

Values That Are the Foundation of This Quality Standard

This quality standard was created, and should be implemented, according to the *Patient, Family and Caregiver* *Declaration of Values for Ontario*. This declaration "is a vision that articulates a path toward patient partnership across the health care system in Ontario. It describes a set of foundational principles that are considered from the perspective of Ontario patients and serves as a guidance document for those involved in our health care system."

These values are:

- Respect and dignity
- Empathy and compassion
- Accountability
- Transparency
- Equity and engagement

A quality health system is one that provides good access, experience, and outcomes for all people in Ontario, no matter where they live, what they have, or who they are.

Guiding Principles

In addition to the above values, this quality standard is guided by the principles outlined below.

Acknowledging the Impact of Colonization and Racism

Clinicians should acknowledge and work toward addressing the historical and present-day impacts of colonization in the context of the lives of Indigenous Peoples and racialized people throughout Canada.[35] This work involves being sensitive to the impacts of intergenerational and present-day traumas and the physical, mental, emotional, and social harms experienced by Indigenous and racialized people, families, and communities, as well as recognizing their strength and resilience. This quality standard uses existing clinical practice guideline sources that may not include culturally relevant care or acknowledge traditional beliefs, practices, and models of care.

French Language Services

In Ontario, the *French Language Services Act* guarantees an individual's right to receive services in French from Government of Ontario ministries and agencies in 26 designated areas and at government head offices.[36]

Social Determinants of Health

Homelessness and poverty are 2 examples of economic and social conditions that influence people's health, known as the social determinants of health. Other social determinants of health include employment status and working conditions, race and ethnicity, food security and nutrition, gender, housing, immigration status, social exclusion, and residing in a rural or urban area. Social determinants of health can have strong effects on individual and population health; they play an important role in understanding the root causes of poorer health. For example, older age, being female, and being from a lower income group have all been associated with insomnia disorder.[37]

Strengths-Based Practice

A strengths-based practice actively involves the person and the clinician who supports them in working together to achieve the person's intended outcomes in a way that draws on the person's strengths.[38,39] The person is recognized and acknowledged as the expert of their own lived experience, and the clinician is recognized as an expert in their discipline and in facilitating a conversation that reinforces the person's strengths and resources.

Trauma-Informed Care

Trauma-informed care is health care that reflects an understanding of trauma, the impact that traumatic experiences can have on human beings, and the potential to traumatize or retraumatize patients when providing them with care.[40,41] A trauma-informed approach does not necessarily involve addressing the trauma directly. Rather, it involves acknowledging that a person may have experienced a previous traumatic event that may contribute to their current health concerns, and taking steps to reduce opportunities for traumatization (e.g., using active strategies around consent, attending to individual patient needs, recognizing the inherent power imbalance in clinician–patient relationships, and facilitating greater patient agency and choice in all interactions).[42,43] A trauma-informed approach emphasizes the creation of an environment in which a person can feel comfortable disclosing trauma, and it involves understanding, respecting, and responding to the effects of trauma.[41-43]

Acknowledgements

Advisory Committee

Ontario Health thanks the following individuals for their generous, voluntary contributions of time and expertise to help create this quality standard:

Sophiya Benjamin (co-chair)
Geriatric Psychiatrist, Associate Professor and Schlegel Chair for Mental Health in Aging, McMaster University

Colleen Carney (co-chair)
Psychologist, Professor and Director of the Sleep and Depression Laboratory, Toronto Metropolitan University

Beverley David
Clinical Psychologist and Director, Your Psychology Centre

Jean Grenier
Clinical Psychologist, Researcher, Montfort Hospital

Jennifer Guest
Lived Experience Advisor

Kristin Hanhimaki
Social Worker, City of Lakes Family Health Team

Rhonda Heft
Social Worker, Ingersoll Nurse Practitioner–Led Clinic

Jennifer Hirsch
Psychiatrist, Sleep Medicine Specialist, MedSleep and Mount Sinai Hospital

Mohamed Hussain
Family Medicine and Sleep Specialist, Medical Director and Quality Advisor, Tri-Hospital Sleep Laboratory West

Margaret Jin
Pharmacist and Academic Detailing Coordinator, Hamilton Family Health Team

Eric Lui
Pharmacist, North York Family Health Team

Richard Norman
Geriatric Medicine Specialist, Sinai Health System

Brigita Proskalo Mantz
Nurse Practitioner, Ingersoll Nurse Practitioner–Led Clinic

Jaan Reitav
Psychologist, University Health Network

Andrea Schaefer
Lived Experience Advisor

Shayna Watson
Family Medicine, Assistant Professor, Queen's University

Joanne West
Clinical Psychologist, Private Practice

References

(1) Brasure M, MacDonald R, Fuchs E, Olson CM, Carlyle M, Diem S, et al. Management of insomnia disorder. Comparative effectiveness review no. 159. (Prepared by the Minnesota Evidence-Based Practice Center under contract no. 290-2012-00016-I). AHRQ publication no.15(16)-EHC027-EF. Rockville (MD): Agency for Healthcare Research and Quality; 2015.

(2) American Academy of Sleep Medicine. The AASM international classification of sleep disorders – third edition, text revision (ICSD-3-TR). Darien (IL): The Academy; 2023.

(3) American Psychiatric Association. Diagnostic and statistical manual of mental disorders, fifth edition, text revision. Washington (DC): The Association; 2022.

(4) 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. J Clin Sleep Med. 2017;13(2):307-49.

(5) Daley M, Morin CM, LeBlanc M, Gregoire JP, Savard J, Baillargeon L. Insomnia and its relationship to health-care utilization, work absenteeism, productivity and accidents. Sleep Med. 2009;10(4):427-38.

(6) Rodrigues R, Nicholson K, Guaiana G, Wilk P, Stranges S, Anderson KK. Sleep problems and psychological well-being: baseline findings from the Canadian Longitudinal Study on Aging. Can J Aging. 2023;42(2):230-40.

(7) Katz DA, McHorney CA. Clinical correlates of insomnia in patients with chronic illness. Arch Intern Med. 1998;158(10):1099-107.

(8) Pearson NJ, Johnson LL, Nahin RL. Insomnia, trouble sleeping, and complementary and alternative medicine: analysis of the 2002 National Health Interview Survey data. Arch Intern Med. 2006;166(16):1775-82.

(9) Chaput JP, Janssen I, Sampasa-Kanyinga H, Carney CE, Dang-Vu TT, Davidson JR, et al. Economic burden of insomnia symptoms in Canada. Sleep Health. 2023;9(2):185-9.

(10) Qaseem A, Kansagara D, Forciea M, Cooke M, Denberg T, for the Clinical Guidelines Committee of the American College of Physicians. Management of chronic insomnia disorder in adults: a clinical practice guideline from the American College of Physicians. Ann Intern Med. 2016;165(2):125-33.

(11) Edinger JD, Arnedt JT, Bertisch SM, Carney CE, Harrington JJ, Lichstein KL, et al. Behavioral and psychological treatments for chronic insomnia disorder in adults: an American Academy of Sleep Medicine clinical practice guideline. J Clin Sleep Med. 2021;17(2):255-62.

(12) Department of Veterans Affairs, Department of Defense, The Management of Chronic Insomnia Disorder and Obstructive Sleep Apnea Work Group. VA/DoD clinical practice guideline for the management of chronic insomnia disorder and obstructive sleep apnea [Internet]. Washington (DC): The Departments; 2019 [cited 2024 Aug 14]. Available from: https://www.healthquality.va.gov/guidelines/CD/insomnia/VADoDSleepCPGFinal508.pdf

(13) Morin CM, LeBlanc M, Belanger L, Ivers H, Merette C, Savard J. Prevalence of insomnia and its treatment in Canada. Can J Psychiatry. 2011;56(9):540-8.

(14) Clarke K, Orlov N, Soong C. Treatment of chronic insomnia in adults. Can Fam Physician. 2024;70:176-8.

(15) Pop P, Bronskill SE, Piggott KL, Stall NM, Savage RD, Visentin JD, et al. Management of sleep disorders in community-dwelling older women and men at the time of diagnosis. J Am Geriatr Soc. 2019;67(10):2094-101.
(16) Trauer JM, Qian MY, Doyle JS, Rajaratnam SM, Cunnington D. Cognitive behavioral therapy for chronic insomnia: a systematic review and meta-analysis. Ann Intern Med. 2015;163(3):191-204.
(17) Zhou ES, Mazzenga M, Gordillo ML, Meltzer LJ, Long KA. Sleep education and training among practicing clinical psychologists in the United States and Canada. Behav Sleep Med. 2021;19(6):744-53.
(18) Moss TG, Lachowski AM, Carney CE. What all treatment providers should know about sleep hygiene recommendations. Behav Therapist. 2013;36(4):76-83.
(19) American Psychiatric Association, DSM-5 Task Force. Diagnostic and statistical manual of mental disorders. 5th ed. Arlington (VA): American Psychiatric Publishing; 2013.
(20) Bastien CH, Vallieres A, Morin CM. Validation of the Insomnia Severity Index as an outcome measure for insomnia research. Sleep Med. 2001;2(4):297-307.
(21) Consensus Sleep Diary [Internet]. Toronto (ON): Consensus Sleep Diary; c2024 [cited 2024 Jul 31]. Available from: https://consensussleepdiary.com/
(22) Clinical appropriateness guidelines. Sleep disorder management. Appropriate use criteria: diagnostic and treatment management [Internet]. Chicago (IL): AIM Specialty Health; 2020 [cited 2024 Aug 14]. Available from: https://aimspecialtyhealth.com/wp-content/uploads/2019/11/AIMSleepDisorderManagement_Guidelines.pdf
(23) Sateia MJ. International classification of sleep disorders, third edition: highlights and modifications. Chest. 2014;146(5):1387-94.
(24) Cheung JMY, Jarrin DC, Ballot O, Bharwani AA, Morin CM. A systematic review of cognitive behavioral therapy for insomnia implemented in primary care and community settings. Sleep Med Rev. 2019;44:23-36.
(25) Davidson JR, Dawson S, Krsmanovic A. Effectiveness of group cognitive behavioral therapy for insomnia (CBT-I) in a primary care setting. Behav Sleep Med. 2019;17(2):191-201.
(26) Walker J, Muench A, Perlis ML, Vargas I. Cognitive behavioral therapy for insomnia (CBT-I): a primer. Klin Spec Psihol. 2022;11(2):123-37.
(27) American Academy of Sleep Medicine. Clinical guideline for the evaluation and management of chronic insomnia in adults [Internet]. Darien (IL): The Academy; 2008 [cited 2024 Jul]. Available from: http://www.aasmnet.org/Resources/clinicalguidelines/040515.pdf
(28) Perez E, Donovan EK, Rybarczyk BD, Dzierzewski JM. Insomnia treatment preferences among primary care patients. Clin Ther. 2022;44(4):630-7.
(29) Koffel E, Bramoweth AD, Ulmer CS. Increasing access to and utilization of cognitive behavioral therapy for insomnia (CBT-I): a narrative review. J Gen Intern Med. 2018;33(6):955-62.
(30) Vargas I, Egeler M, Walker J, Diaz Benitez D. Examining the barriers and recommendations for integrating more equitable insomnia treatment options in primary care. Front Sleep. 2023;2:1279903.
(31) Bjerre LM, Farrell B, Hogel M, Graham L, Lemay G, McCarthy L, et al. Deprescribing antipsychotics for behavioural and psychological symptoms of dementia and insomnia: evidence-based clinical practice guideline. Can Fam Physician. 2018;64(1):17-27.
(32) Pottie K, Thompson W, Davies S, Grenier J, Sadowski CA, Welch V, et al. Deprescribing benzodiazepine receptor agonists: evidence-based clinical practice guideline. Can Fam Physician. 2018;64(5):339-51.

(33) Alberta Medical Association. Assessment to management of adult insomnia: clinical practice guideline. [Internet]. Edmonton (AB): The Association; 2015 [cited 2024 Aug 14]. Available from: http://www.topalbertadoctors.org/CPGs/Lists/CPGDocumentList/Adult-Insomnia-CPG.pdf
(34) Campbell R, Chabot I, Rousseau B, Bridge D, Nicol G, Meier G. Understanding the unmet needs in insomnia treatment: a systematic literature review of real-world evidence. Int J Neurosci. 2023;133(8):864-78.
(35) Hassen N, Lofters A, Michael S, Mall A, Pinto AD, Rackal J. Implementing anti-racism interventions in healthcare settings: a scoping review. Int J Environ Res Public Health. 2021;18(6).
(36) Ministry of Health, Ministry of Long-Term Care. French language health services: the French Language Services Act, 1986 (FLSA) [Internet]. Toronto (ON): Queen's Printer for Ontario; 2021 [cited 2024 Jul 31]. Available from: https://www.health.gov.on.ca/en/public/programs/flhs/flsa.aspx
(37) Rodrigues R, Jing A, Anderson KK, Alonzo R, Wilk P, Reid GJ, et al. Who sleeps well in Canada? The social determinants of sleep health among middle-aged and older adults in the Canadian Longitudinal Study on Aging. Sleep Health. 2024;10(1):104-13.
(38) National Institute for Health and Care Excellence. Transition from children's to adults' services for young people using health or social care services [Internet]. London: The Institute; 2016 [cited 2023 Jun 14]. Available from: https://www.nice.org.uk/guidance/ng43
(39) Social Care Institute for Excellence. Strengths-based approaches: Care Act guidance on strengths-based approaches [Internet]. Egham, United Kingdom: The Institute; 2015 [cited 2023 Aug]. Available from: https://www.scie.org.uk/strengths-based-approaches/guidance
(40) Kuehn BM. Trauma-informed care may ease patient fear, clinician burnout. JAMA. 2020;323(7):595-7.
(41) Ravi A, Little V. Providing trauma-informed care. Am Fam Physician. 2017;95(10):655-7.
(42) Dowdell EB, Speck PM. Trauma-informed care in nursing practice. Am J Nurs. 2022;122(4):30-8.
(43) Fleishman J, Kamsky H, Sundborg S. Trauma-informed nursing practice. Online J Issues Nurs. 2019;24(2).

About Us

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Equity, Inclusion, Diversity, and Anti-Racism

Ontario Health is committed to advancing equity, inclusion and diversity and addressing racism in the health care system. As part of this work, Ontario Health has developed an *Equity, Inclusion, Diversity and Anti-Racism Framework*, which builds on existing legislated commitments and relationships and recognizes the need for an intersectional approach.

Unlike the notion of equality, equity is not about sameness of treatment. It denotes fairness and justice in process and in results. Equitable outcomes often require differential treatment and resource redistribution to achieve a level playing field among all individuals and communities. This requires recognizing and addressing barriers to opportunities for all to thrive in our society.

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Ontario Health
500–525 University Avenue
Toronto, Ontario
M5G 2L3

Toll Free: 1-877-280-8538
TTY: 1-800-855-0511
Email: QualityStandards@OntarioHealth.ca
Website: hqontario.ca

Need this information in an accessible format? 1-877-280-8538, TTY 1-800-855-0511, info@OntarioHealth.ca
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ISBN 978-1-4868-8742-2 (PDF)