

The missing link: Re-engagement and continuity in OSA care

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OSA is chronic yet care systems treat drop-off as an endpoint. Re-engagement and continuity pathways are essential to improving outcomes and reducing inequities.

Obstructive sleep apnea (OSA) is a chronic, evolving disease. While surgical interventions or lifestyle changes like major weight loss may lessen disease severity, they rarely eliminate the need for ongoing monitoring or therapy. Current guidelines reflect this reality, calling for continuous management rather than episodic care.¹ Yet many care pathways still center almost entirely on diagnosis and PAP initiation, with few mechanisms to help patients stay in therapy or re-enter care after discontinuation.

Millions of patients worldwide discontinue therapies and are never systematically re-evaluated. Preventable symptoms and cardiometabolic risk accumulate outside the formal care system. Re-engagement is not encouraged by most reimbursement frameworks, and discontinuation is treated as an endpoint rather than a pause where care can be reset and optimized.²

| OSA is cyclical, not linear

OSA severity and symptom shift over time with weight change, aging, menopause and evolving comorbidities. Patients' motivations, health literacy, support systems and life priorities also change. Temporary drop-off is predictable, not exceptional.

Evidence shows that many patients who stop PAP later restart still benefit meaningfully. More, survival benefits for those who pause and resume CPAP therapy are

similar to patients who stay on therapy from their first initiation. This reinforces the need for a cyclical model with clear, supported re-entry pathways rather than a one-way track from diagnosis to discharge.²

| How current systems block re-entry

Many reimbursement models tie coverage to short-term adherence thresholds. The 90-day PAP rule in the U.S. Medicare program is a well-known example. The rule demands four or more hours of PAP use on 70 percent of nights in the first 90 days. Patients who miss this mark lose coverage. Structures like these effectively penalize temporary discontinuation and offer little to no funding for reassessment after a "failed" trial.

Fragmented data exchanges between sleep labs, primary care and homecare providers make it difficult to even see who has disengaged. With no shared visibility and no automatic trigger for outreach, patients simply disappear from view.

Those who struggle early may be labeled "non-compliant," lose access to support or feel blamed and discouraged from trying again. These barriers fall hardest on patient populations with limited digital access, more complex comorbidities or fewer resources, widening existing inequities in sleep health.^{3,4}

Continuity is a design outcome

Just as adherence can be shaped by reimbursement redesign, digital infrastructure and policy evolution, so can continuity. A “continuity infrastructure” for OSA would include explicit funding for re-evaluation after discontinuation or major health events, coverage rules that allow re-entry without penalty and reimbursement incentives for longitudinal monitoring and sustained outcomes.

Re-engagement works in the real world

Large-scale French data show that about one-quarter of patients who terminate PAP restart within a year, and nearly two-thirds of those who restart remain on therapy for at least another year. Patients who resumed and continued PAP had roughly a 38 percent lower all-cause mortality risk compared with those who discontinued again. Re-engagement measurably saves lives.²

Other studies show that structured re-titration or REPAP-style protocols can reverse apparent PAP “failure” by identifying and addressing correctable barriers such as mask fit issues, pressure settings or residual insomnia.⁵ Together, these findings position re-engagement as both a clinical imperative and an economic opportunity to avoid downstream cardiovascular events, hospitalizations and productivity loss associated with untreated OSA.

Systems that already support continuity

France’s national telemonitoring and reimbursement model, the *liste de activités de télésurveillance médicale* (LATM), demonstrates that continuity can be built into the system. By tying PAP reimbursement to continuous telemonitoring and outcomes, LATM directs more support to patients who struggle with adherence and rewards improvement. National data show higher overall adherence and more patients achieving four or more hours of nightly use with this model.⁶

The UK and Japan provide similar evidence. England’s National Institute for Health and Care Excellence (NICE) guidance made 12-month remote monitoring standard for PAP in 2021 and recommends extending follow-up beyond the first year. Japan’s national fee schedule has also reimbursed PAP telemonitoring since 2018, normalizing longitudinal digital engagement.^{7,8} Germany adds another dimension by expanding statutory coverage to include mandibular advancement devices. Covering multiple therapy types can support smoother clinical transitions and reduce total drop-off caused by gaps in eligibility.⁹

Together, these models show that systems can adapt for continuity without adding unnecessary cost.

Building the foundation for continuity

To make continuity a standard feature of chronic OSA care, systems need to move on three fronts:

1. Policy and reimbursement alignment

- Redefine coverage to support OSA treated as chronic and cyclical.
- Fund re-evaluation, therapy re-entry and ongoing monitoring as core benefits versus exceptions to the rule.
- Remove penalties tied to temporary discontinuation.

2. Data connectivity

- Link digital tools and electronic health records (EHRs) to flag drop-off in real time.
- Build in automated prompts to clinicians and care teams to proactively re-engage.
- Enable shared visibility across specialists, primary care and homecare providers.

3. Equity and re-engagement targeting

- Identify high-risk or under-engaged groups using clinical and social data.
- Create structured recall programs that offer tailored support, such as multilingual outreach, community-based navigation or alternative visit formats, not one-size-fits-all reminders.

- Ensure re-entry pathways are accessible to patients with limited digital access or complex comorbidities.

As these levers align, longitudinal engagement should become a performance indicator for both payers and health systems. Measuring how well systems support sustained and repeat engagement moves the focus from compliance enforcement to continuity enablement, which is the true hallmark of mature chronic care.

| From compliance to continuity

Binary labels like “adherent” and “non-adherent” do not fit a chronic condition that shifts over decades. A more appropriate mindset sees patients as engaged,

re-engaged and supported, with care systems ready at every point. Clinically and ethically, a patient who returns to therapy should be celebrated, not penalized. In chronic care, return is resilience, not relapse.

The pieces needed for continuity already exist. Evidence, technology and policy precedents are in place. What is missing is alignment across reimbursement, data systems and workflow design. Payers, policymakers and health system leaders can close the loop by funding the “middle” of the patient journey, not just initiation or discharge. Re-evaluation, re-initiation and long-term support should be built in as standard practice. We have shown that adherence can be supported by design. Now it is time to make continuity the next frontier of chronic OSA care.

References

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