Obstructive Sleep Apnea Clinical Decision-making Tool

Screening Tools

Screening Tool	Best For	When to Use	Direct Link
STOP-Bang Questionnaire	Primary care, general screening, and preoperative assessment	Patients with snoring, fatigue, or witnessed apneas; preoperative screening	The Official STOP-Bang Questionnaire
Epworth Sleepiness Scale (ESS)	Assessing excessive daytime sleepiness (EDS) and differentiating sleep disorders	Patients with daytime sleepiness, drowsiness while driving, or needing therapy monitoring	Epworth Sleepiness Scale
Berlin Questionnaire	Primary care risk stratification especially in patients with obesity and hypertension	Patients with multiple risk factors like obesity, hypertension, and snoring	American Thoracic Society Berlin Questionnaire

1 Screen for OSA symptoms (snoring, excessive daytime sleepiness (Epworth score >10), witnessed apnea)

2 If OSA symptoms are present, assess if the patient is uncomplicated

- If uncomplicated, order HSAT
- If complicated, order PSG

3 Interpret Sleep Study Results

- AHI <5: OSA unlikely
- AHI 5-15: mild OSA
- AHI 15-30: moderate OSA
- AHI >30: severe OSA

4 Manage Based on Severity

- Mild (AHI 5-15): Lifestyle changes, oral appliance, possible PAP therapy
- Moderate to severe: PAP therapy; consider referral to specialist; evaluate tirzepatide candidacy
  - Moderate OSA (AHI 15-30): PAP therapy or oral appliance therapy
  - Severe OSA (AHI >30): CPAP, BiPAP, or specialist and surgical evaluation

Diagnostic Testing

Uncomplicated patient:

- Lacks conditions that increase risk for nonobstructive sleep disorders (heart/lung disease, neuromuscular weakness, stroke, or chronic opioid use)
- Lacks risks for nocturnal gas exchange problems (eg, hypoxemia, hypoventilation).
- Has no significant nonrespiratory sleep disorders (narcolepsy, parasomnias) that affect evaluation or HSAT accuracy
- Has no environmental or personal barriers to effective HSAT data collection or interpretation

HSAT: For uncomplicated, high-risk patients

- What to know about at-home sleep apnea tests
- In-lab PSG: For complex cases, comorbidities, or inconclusive HSAT
  - Patients with significant cardiorespiratory disease, potential respiratory muscle weakness because of neuromuscular condition, awake hypoventilation or suspicion of sleep-related hypoventilation, chronic opioid medication use, history of stroke or severe insomnia
- HSAT does not rule out OSA. Consider PSG if clinical suspicion for OSA is high.

Management and Referral

- Manage in primary care if patient is adherent and symptoms improve
- Refer to a sleep specialist for treatment failure, severe cases, or suspected central sleep apnea
- **Whether primary care or specialist manages OSA depends on knowledge, resources, scope of practice, and local standards of care**

Monitoring and Follow-up

- Check adherence to CPAP (>4 hr/night, 70% of nights)
- Monitor daytime symptoms, weight, and cardiovascular risks
- Consider alternative therapies if CPAP intolerance persist
- Reassess AHI at intervals of loss of 10% of initial weight

AHI, apnea-hypopnea index; BiPAP, bilevel positive airway pressure; CPAP, continuous positive airway pressure; HSAT, home sleep apnea testing; OSA, obstructive sleep apnea; PSG, polysomnography.

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