

University of Texas Medical Branch Center for Sleep Disorders Policy: Quality Assurance Plan	Effective Date: 4/1/18 Revised Date: 2/19/18 Campus: ADC
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## QUALITY ASSURANCE PLAN

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### PURPOSE

To improve patient care, process and clinical outcomes the facility will be committed to continuous quality improvement.

### POLICY

Quality improvement measures will be evaluated every quarter and reported to staff and institution on a quarterly basis by the facility director. The technical director will be included in the development and reporting of activities as appropriate, and will serve as a resource to the department. Other appropriate individuals may be included in the data gathering and reporting of the quality improvement activities depending on the organizational structure of the facility.

The facility director shall evaluate the effectiveness of the quality improvement program at least on an annual basis to identify other indicators as needed, which may require monitoring as defined by performance review.

The sleep facility QA program will identify outcome and process measures to monitor and evaluate to determine methods of improving patient care and outcomes.

Monitored indicators will minimally include but not be limited to:

1. A process measure for OSA;
2. An outcome measure for OSA;
3. An outcome measure for another sleep disorder (e.g. RLS, insomnia or narcolepsy); and
4. Inter-scorer reliability.

The HSAT QA program will identify two process measures and one outcome measure used to evaluate efficiency of the program and determine methods of improving patient care and outcomes. Monitored indicators for the HSAT program will minimally include but not be limited to:

1. Two process measures
2. One outcome measure

Sleep facilities may utilize the same outcome measure and process measures for OSA as long as data is collected and analyzed from all patients, including patients tested with both in-center testing and HSAT.

The facility director along with the technical director will be responsible for establishing and implementing the sleep facility QA program. Quarterly, the facility director will attest to the effectiveness of all quality improvement efforts and implement remediation for measures for those indicators that do not meet the established thresholds.

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### PROCEDURE

**1.0** The QA plan will monitor indicators that measure sleep facility processes and patient outcomes. Indicators will be identified and chosen through clinical and administrative collaboration and may be selected from the AASM Published Quality Measures.

**2.0 INDICATOR SELECTION—SLEEP FACILITY:** *Detailed indicator descriptions are attached*

- 2.1 Process Measure for OSA—Adult—Assessment of Sleepiness
- 2.2 Outcome Measure for OSA—Adult—Improve Quality of Life
- 2.3 Outcome Measure for Insomnia—Improving Daytime Functioning
- 2.4 Inter-Scorer Reliability

**3.0 INDICATOR SELECTION—HSAT PROGRAM:** *Detailed indicator descriptions are attached*

- 3.1 Process Measure for OSA—Adult—Baseline Assessment of OSA Symptoms
- 3.2 Process Measure for OSA—Adult—Assessment of Sleepiness
- 3.3 Outcome Measure for OSA—Adult—Improve Quality of Life.

### **4.0 Collection and review of the data**

4.1 Monitoring and collection of data will be performed monthly to identify variances from the established criteria:

- 4.1.1 The data will be collected for the individual indicators using a chart audit tool
- 4.1.2 The results will be measured and analyzed.
- 4.1.3 Indicators that have failed, met or exceeded their established threshold will be identified.
- 4.1.4 Further measurement of indicators will be discussed.

### **5.0 Evaluation and reporting**

5.1 The facility director will review and report all measures to determine if minimum expected thresholds are met. Evaluation shall focus on identifying opportunities to improve process and outcomes of patient care and actual identified problem areas that effectuate a negative outcome. Conclusions shall be drawn regarding the evaluation of data presented with recommendations for remediation determined by the facility director.

5.2 Results of the indicators must be tracked at least quarterly, aggregated, and reported to the facility director for review and determination of areas for improvement plans, for remediation of measures that do not meet the established threshold, and decisions regarding recommendations for improvement.

- 5.2.1 Written summary reports of all indicators must be signed and dated by the facility director.
- 5.2.2 Results of the indicators appropriate to the technical staff will be reported at their monthly staff meeting.

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- 5.2.3 Written summary reports will be kept on file for a period of at least five years.
- 5.2.4 Facility director will review and determine the areas requiring improvement.
- 5.2.5 A remediation plan will be created.
- 5.2.6 Actions will be taken as appropriate to implement the resolve.

Other indicators may be chosen as warranted.