

ESRD NETWORK 2018 ANNUAL REPORT

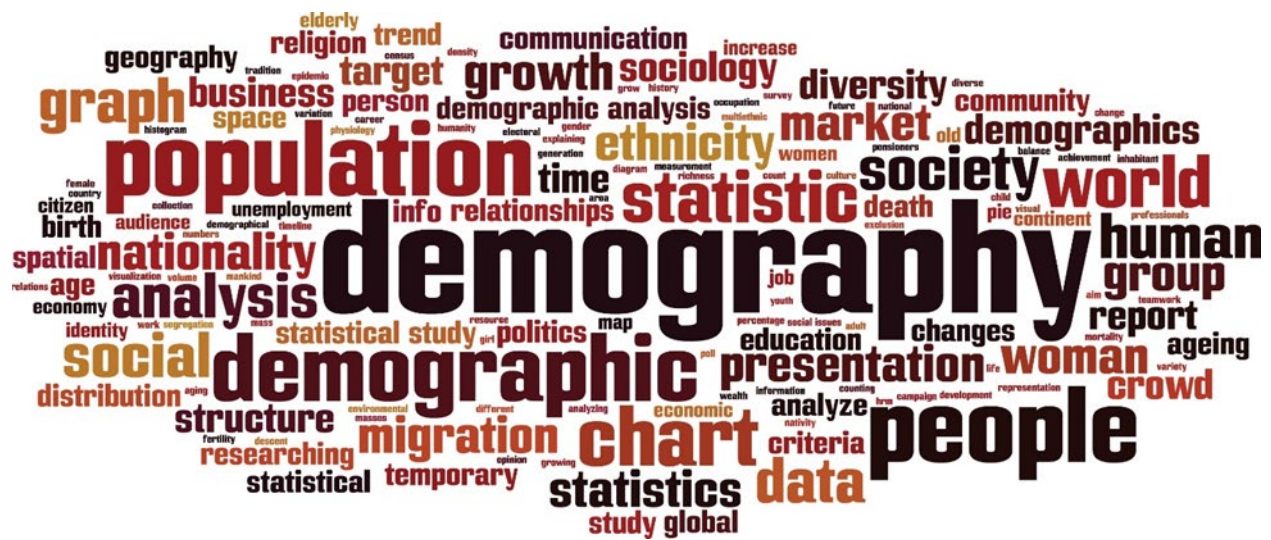
Health Services
Advisory Group
(HSAG): End Stage
Renal Disease
(ESRD) Network 13

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ESRD DEMOGRAPHIC DATA

ESRD Network 13

As part of the HSAG team, Network 13 works with patients, providers, and stakeholders in the states of Arkansas, Louisiana, and Oklahoma to promote the highest quality healthcare, improve patterns of healthcare delivery, and protect Medicare rights for the ESRD patients in our service area. HSAG has held the Network 13 contract since 2013.

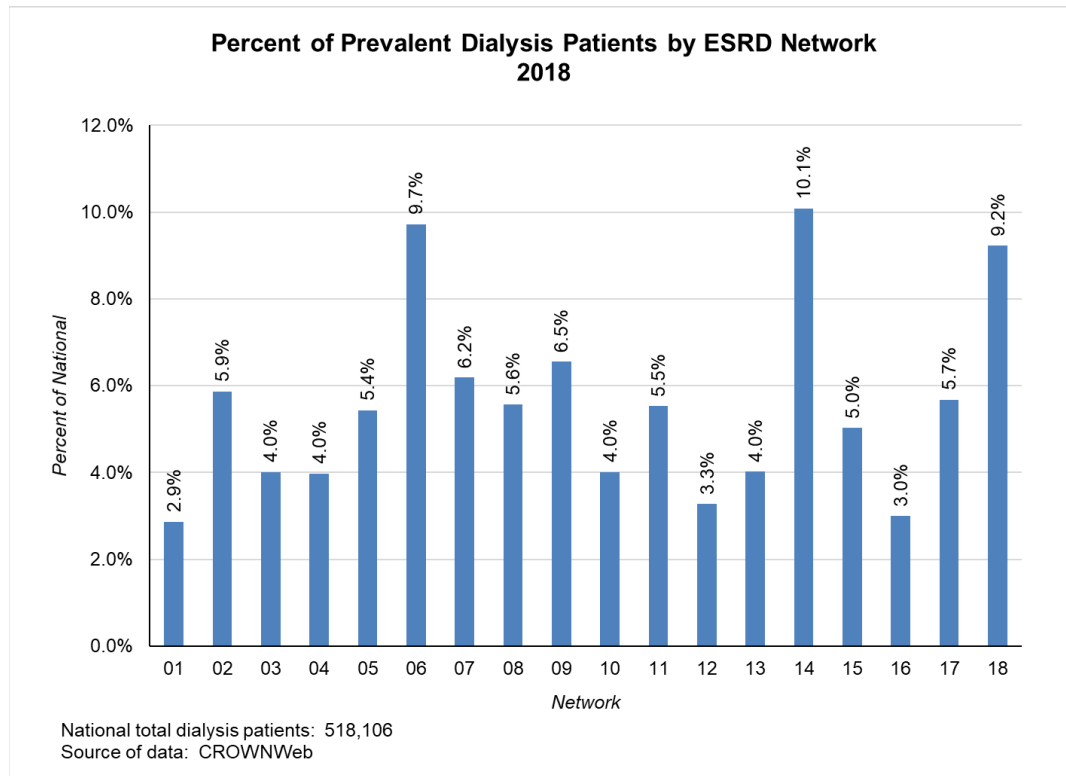
Geography and General Population

The Network 13 service area encompasses three states with a contiguous landmass that covers approximately 165,000 square miles, and includes swamp, coastal marshes, barrier islands, river valleys, forests, sub-tropical forests, lakes, bayous, arid plains, and mountains. Oklahoma contains 10 distinct ecological regions, more per square mile than in any other state by a wide margin. As of July 1, 2018, the Network 13 service area had a combined estimated general population of 11,616,882. This data was obtained from the United States Census Bureau, American FactFinder.

ESRD Population

Network 13 worked in collaboration with the renal community and other key stakeholders to improve the quality of care and quality of life for 26,701 kidney patients in 2018 based on data collected from CROWNWeb. During the reporting period of December 31, 2017 to December 31, 2018, the Network's ESRD patient census increased by 802 patients (4.0%) for a total of 20,808 prevalent patients in the Network's service area, as compared to the national total of 518,106 as of December 31, 2018. In 2018, 5443 individuals with newly diagnosed with ESRD, incident dialysis patients, in the Network service area this number was increased by 404 (8.0%) patients when compared with 2017. (See Chart A)

Chart A: Percent of Prevalent Dialysis Patients by ESRD Network



Race and Ethnicity¹

As of December 31, 2018, the demographics of the ESRD population in the Network 13 service area reflected the following:

- White: 46.4%
- Native American: 3.2%
- African American: 48.5%
- Hispanic or Latino: 4.2%

Gender and Age

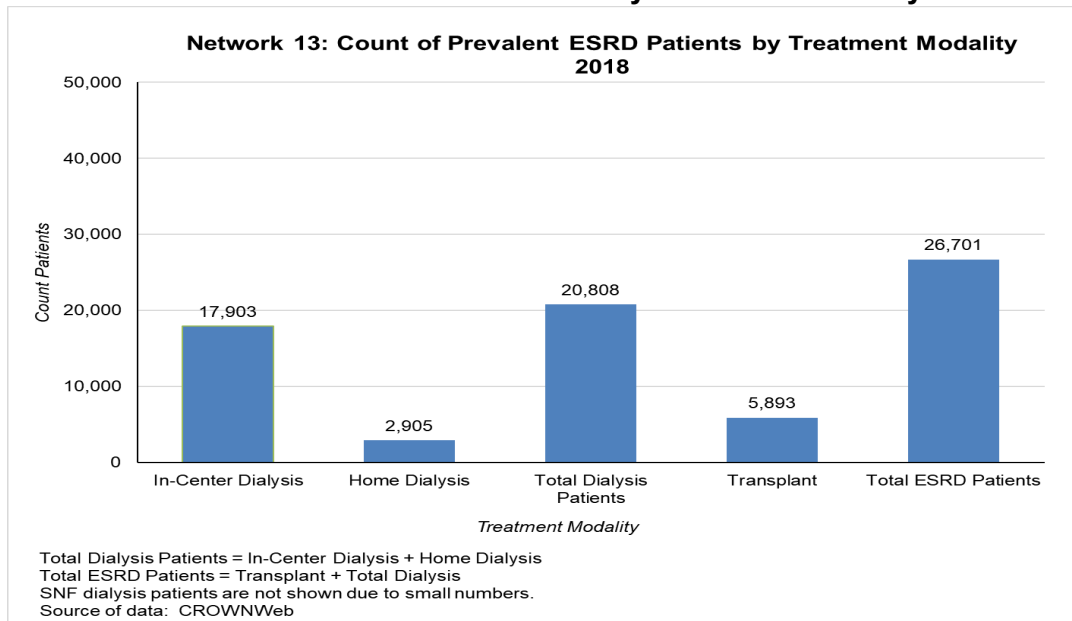
As of December 31, 2018, 45.0% of the Network's ESRD population was female, 55.0% was male, and 42.6% was age 65 or older, as compared to the service area's general population, in which only 15.5% of residents were estimated to be age 65 or older as of July 1, 2018.

Dialysis Treatment Options

According to CROWNWeb data, and as of December 31, 2018, Network 13 had 20,808 ESRD patients on dialysis receiving treatment across the 344 Medicare-certified dialysis facilities and one federal prison across its region. Four main modalities of dialysis treatment were being used (see Chart B):

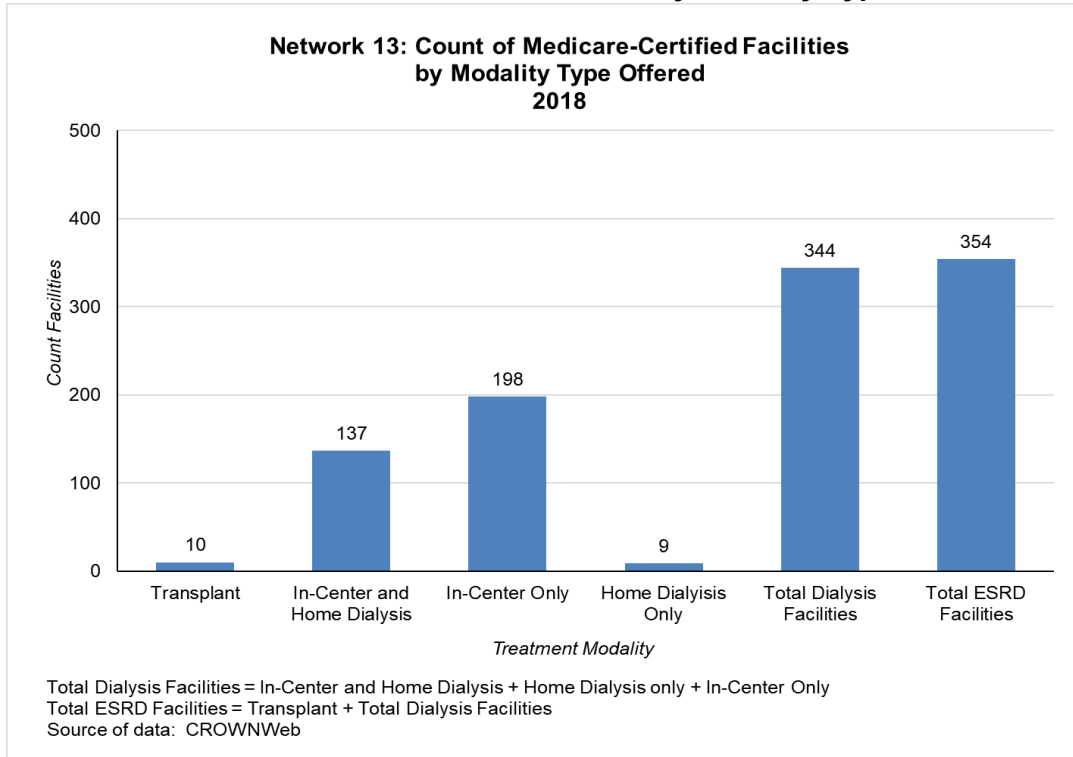
- In-center hemodialysis (ICHD): 86.0%
- Continuous-cycling peritoneal dialysis (CCPD): 10.4%
- Continuous-ambulatory peritoneal dialysis (CAPD): 1.4%
- Home hemodialysis (HHD): 2.1% (see Chart C)

Chart B: Count of Prevalent ESRD Patients by Treatment Modality in Network 13



¹ Data on "ethnicity" and "race" should be interpreted with caution because of the inherent instability of race/ethnicity data.

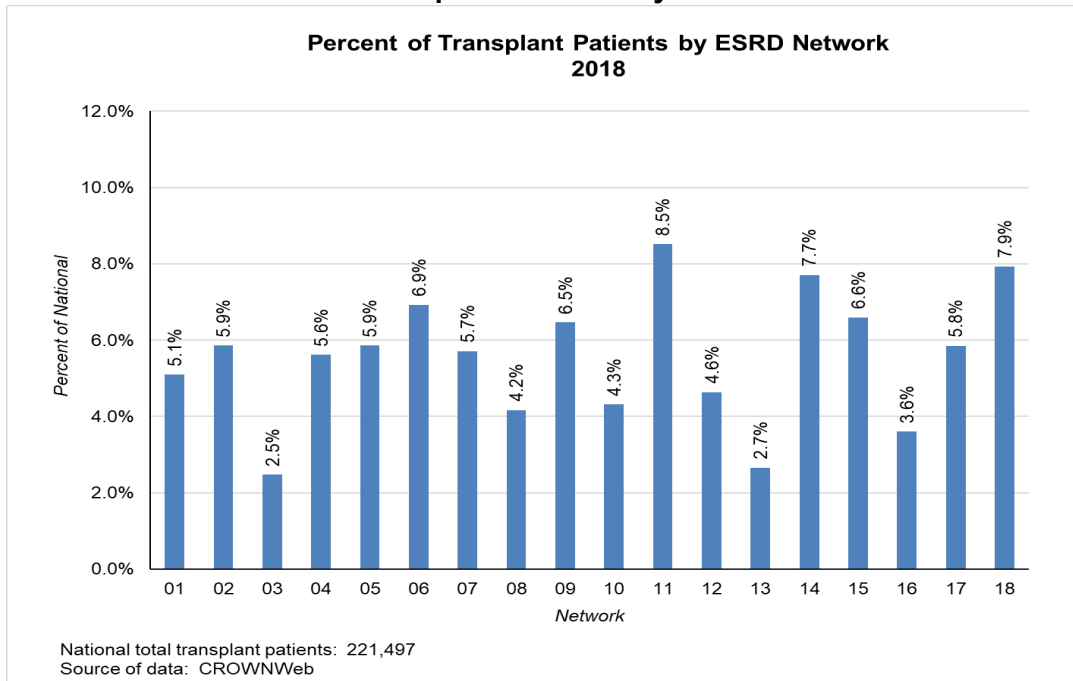
Chart C: Count of Medicare-Certified Facilities by Modality Type Offered for 2018



Transplant

During 2018, 615 kidney transplants were completed by eleven transplant centers in the Network 13 service area. As of December 31, 2018, there were 221,497 transplant patients nationally, of which 2.7% were in Network 13. (See Chart D)

Chart D: 2018 Percent of Transplant Patients by ESRD Network



Providers

As of December 2018, Network 13's service area included a total of 344 dialysis providers, including providers pending Medicare certification and federal/prison facilities, and 10 transplant centers comprising 4.4% of the transplant centers nationwide. (See Chart E)

Chart E: 2018 Percent of Medicare-Certified Transplant Facilities by ESRD Network

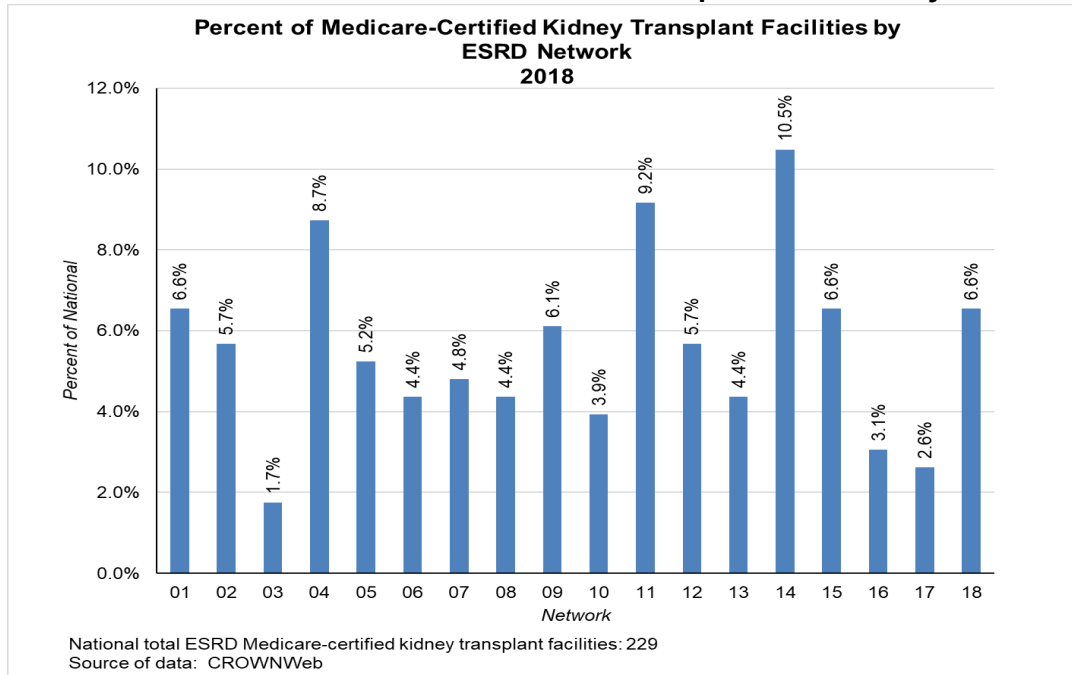


Chart F: Percent of Home Hemodialysis and Peritoneal Dialysis Patients by ESRD Network

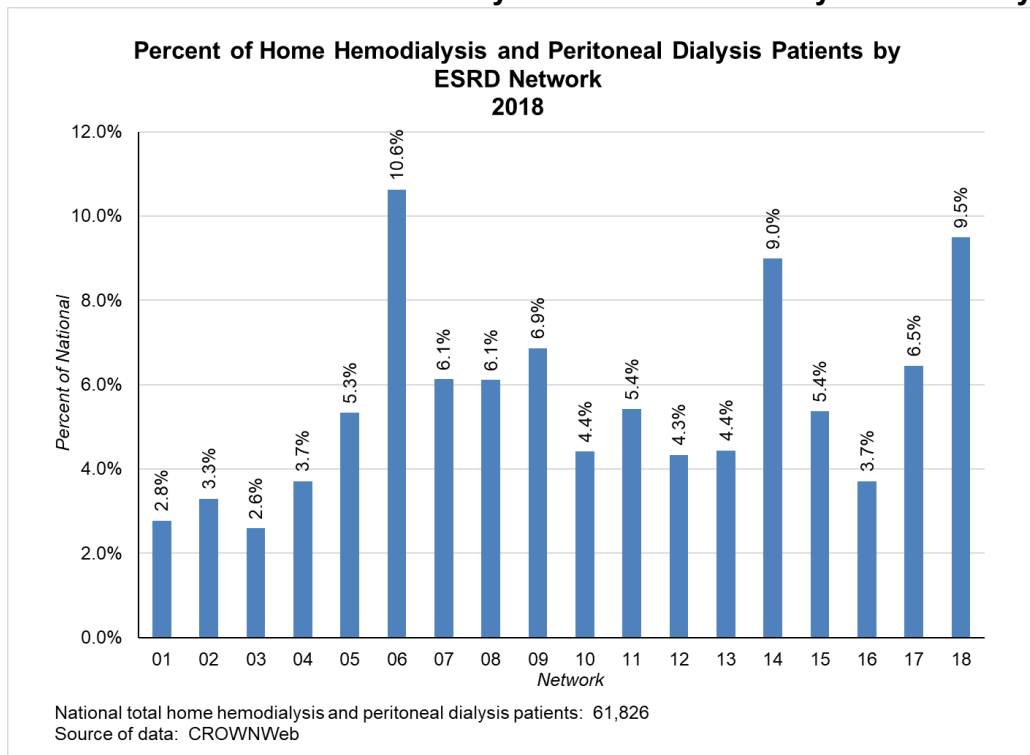
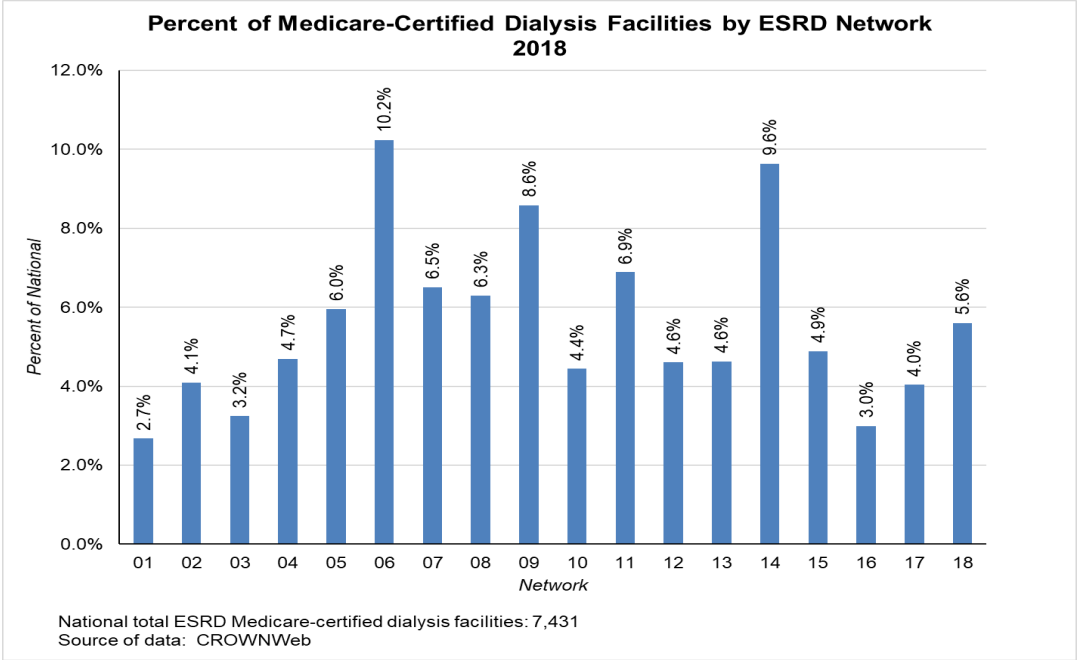


Chart G: Percent of Medicare-Certified Dialysis Facilities by ESRD Network





ESRD NETWORK GRIEVANCE AND ACCESS TO CARE DATA

Improving the Grievance and Access to Care Processes

In April and October 2018, the Network conducted two focused audits to gauge internal and external issues in the areas of grievances and access to care. Additionally, efforts were undertaken to improve the Network's grievance satisfaction scores toward meeting national satisfaction expectations. All quality improvement (QI) activities were carried out with input from patient subject matter experts (SMEs).

Goals and Outcomes

The goals for QI activities in Patient Services were to decrease the number of grievance and access to care cases, while raising the Network's performance in the national grievance satisfaction survey outcomes. General grievances declined from 10% in 2017 to 8% in 2018. Access to Care issues decreased significantly from 50% in 2017 to 36% in 2018.

Interventions

The interventions were designed to assist facilities with using a grievance process to efficiently handle patient concerns related to environmental, interpersonal, and operational issues. Likewise, interventions to improve access to care processes were implemented to facilitate interactions to prevent and/or avert involuntary discharges (IVDs) and/or transfers (IVTs). Technical assistance was provided, as possible, to assist with failure to place (F2P) challenges regarding permanent chronic dialysis unit placement for patients with complex issues. Focused-area interventions included:

- General grievance education for both providers and patients, including:
 - Provision of revised state-specific grievance posters with Network and State Survey Agency contact information to all existing and new ESRD providers.
 - Posting of this information in patient waiting areas is required and verified by onsite visits.
 - Provision of guidance highlighting definitions and responsibilities regarding grievances.
 - Additional resources for ESRD providers.
 - Encouraging facility participation in the Forum of ESRD Networks' May 2, 2018, webinar on *The Grievance Toolkit: Fostering Communication & Improving Quality*.
 - Addressing communication and professionalism concerns through a Network-wide presentation to providers on relationship-centered care.
 - *Patient and Family Engagement: Relationship-Centered Communication* presented by the HSAG Patient Services Directors and Dr. Cooley from the Academy of Communication in Healthcare.
- Implementation of access to care processes, including:
 - Use of an IVD checklist to ensure that all required process steps are addressed by providers when handling IVD/IVT cases.
 - Quarterly interactions between the Network and the State Survey Agencies (SAs), as applicable, specific to access to care cases.
 - Interactions included facility-reported discharge reasons and case-specific outcomes.
 - The Network corresponding with facility administrators and medical directors regarding IVD, with an emphasis on physician discharge.
 - Including an article about IVD and IVT in the Network's patient and provider newsletters that focused on addressing psychosocial interventions.

The Network performed a root cause analysis (RCA) and developed a Plan-Do-Study-Act (PDSA) plan to identify issues and initiate activities to improve the Network's suboptimal grievance satisfaction scores in 2018. Highlights from the PDSA cycle included:

- **PLAN:** The Network determined that sending follow-up notecards to check in with grievants 15 days after case closure would be effective in letting grievants know that they had support, even after their issues had been resolved.
- **DO:** The Network determined that the Forum of ESRD Networks Grievance Toolkit would be better utilized if sent with the grievance acknowledgment letter instead of the case closure letter.
 - Sending at the beginning of the grievance would help patients to navigate the grievance process.
 - Network 13 collaborated with the other HSAG Networks and then made this process change in July 2018.
- **STUDY:** Grievance satisfaction survey scores reflected improvement moving into 2019.
- **ACT:** A critical component of Network 13’s customer service includes ongoing education of patients who file a grievance regarding that which is within the Network’s ability to assist, as well those things that the Network has no control over, including “firing clinicians that they don’t like.”

Best Practices

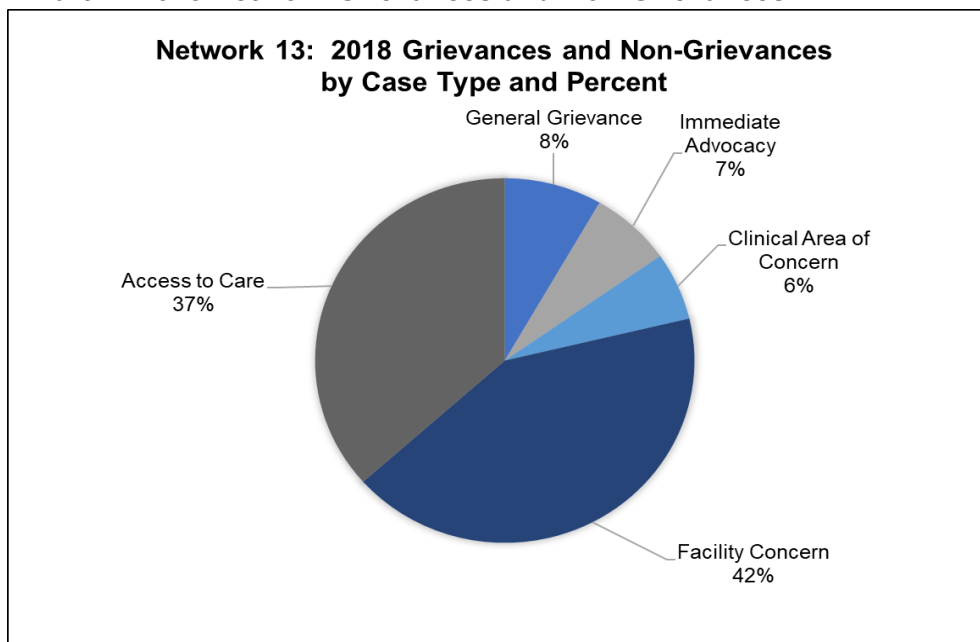
Ongoing education that focuses on the importance of provider staff maintaining a consistent practice of established processes and/or protocols. Use of a sustainability worksheet to reflect on and solidify processes to deal with grievances in a proactive vs. reactive manner remains a go-to best practice.

Barriers

Ongoing barriers to improving patient grievance satisfaction scores include:

- Lack of consistent communication between patients and facility staff related to grievances.
- Staff turnover among the clinicians who generally handle grievances, such as social workers and nurse managers, which leads to knowledge deficits and inconsistencies in practice.

Chart H: 2018 Network Grievances and Non-Grievances



Source of data: Patient Contact Utility (PCU)

ESRD NETWORK QUALITY IMPROVEMENT ACTIVITY DATA

Long-Term Catheter (LTC) Quality Improvement Activity (QIA)

During 2018, the Network conducted a QIA to reduce LTC use (catheter in use for 90 days or longer) from within a cohort of 156 facilities with LTC rates greater than 15.0%. The Network implemented enhanced interventions for a subset of 39 facilities, with approximately 2,475 patients who had the highest LTC rates in the cohort.

Goals and Outcomes

The baseline LTC rate for this activity was 20.6%, generated from June 2017 CROWNWeb data. The goal was to reduce the rate of LTC use by two percentage points from baseline. By July 2018, the group reduced the aggregate LTC rate to 17.5%, a 3.1 percentage point reduction that exceeded goal.

Barriers

The following barriers to reducing LTC use were identified based on facility RCA results:

- Patient refusal for permanent access placement.
- Surgeon issues.
 - Long wait times, limited availability, cancelled surgeries
- High number of new catheter-only admits with difficulty getting the LTCs out within 90 days.

Interventions

Facility interventions for the QIA included:

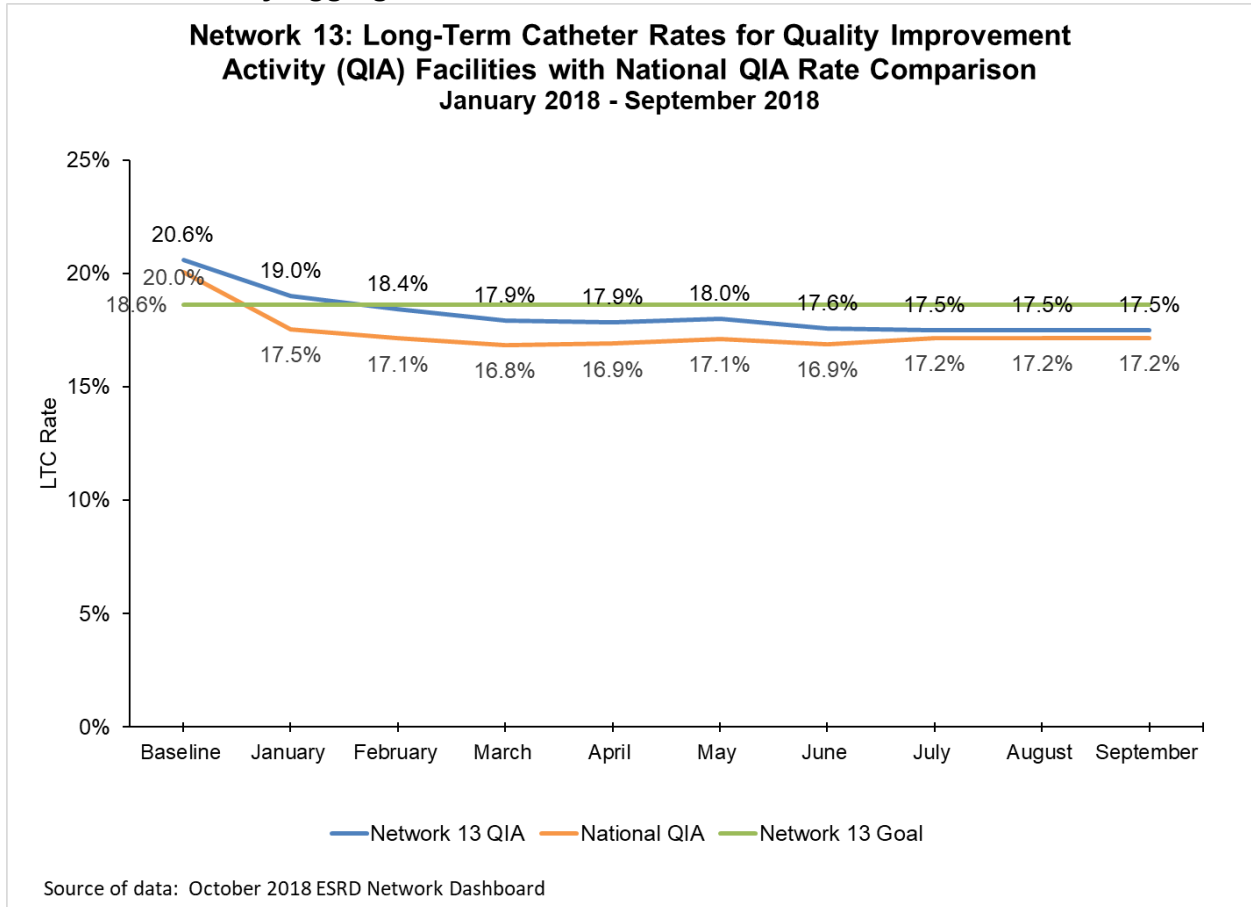
- Initiating an RCA and developing an action plan to decrease LTCs based on findings.
- Attending and participating in the Network 13 vascular access (VA) education activity, *Strategies to Reduce Long-Term Catheter Use*.
- Providing patient education through VA bulletin boards and other resources, such as catheter complication puzzles, which were developed in collaboration with the Network PAC, and Fistula First materials that provided information on permanent vascular access types.
- Assessing patient improvements in knowledge by providing patients with the *Patient Vascular Access Checklist*, an 11-question quiz about VA, at QIA initiation and completion.

Best Practices

Best practices identified by QIA facilities included:

- Providing patient education using a series of catheter complications puzzles focused on low adequacy, infections, stenosis, and hospitalization.
- Assessing patient knowledge using the *Patient Vascular Access Checklist*.
 - Data indicate that mean patient scores on the quiz improved from 78.1% at QIA initiation to 81.1% at QIA completion, which reflected increased knowledge.

Chart I: QIA Facility Aggregate LTC Rates



Bloodstream Infection (BSI) QIA

In 2018, the Network conducted a QIA to reduce BSIs by improving infection control practices. The QIA was designed to support the National Action Plan to Prevent Healthcare-Associated Infections (HAIs) and the Centers for Disease Control and Prevention (CDC) Core Interventions for Dialysis Bloodstream Infection Prevention. The QIA included 62 facilities, impacting approximately 2,773 patients.

Goals and Outcomes

The Network used the National Healthcare Safety Network (NHSN) BSI pooled mean rate per 100 patient-months to target facilities for the QIA. The goal was to demonstrate a 20.0% or greater relative reduction in pooled mean BSI rate and to prevent at least 49 BSIs. By QIA completion, the aggregate BSI rate decreased from 1.48 BSIs per 100 patient-months to 0.698, and 129 BSIs were prevented.

Barriers

Facilities reported the following barriers to further reducing BSIs:

- Patients did not follow hand hygiene practices upon entering and leaving the treatment floor.
- Patients did not wash their VAs.
- Lack of monitoring and/or non-adherence to infection control processes by staff.

Interventions

Interventions implemented during the QIA included:

- Providing facility education on the:
 - CDC's BSI Dialysis Collaborative Core Interventions.
 - Importance of having a front-line clinician completing the annual CDC/NHSN Dialysis Event training.
 - Establishment of a secure health information exchange (HIE) process for sharing blood culture results.
 - CDC BSI Dialysis Collaborative tools and resources.
- Completing monthly performance audits, inclusive of practice issues specific to hand hygiene, connecting and disconnecting catheters, and cannulations for fistulas or grafts.
- Provider and Network staff participation in the HAI Learning and Action Network (LAN) bi-monthly calls.
- Outreach, such as creating a hand hygiene bulletin board and posting the CDC's *Days since Last Bloodstream Infection* poster.
- Assessing and encouraging patient engagement and sharing of the patient perspective on infection control processes by:
 - Recruiting Network Patient Representatives (NPRs).
 - Using a patient access infection control checklist.
 - Educating patients using patient 'preventing infection' pledges, articles, and puzzles.

Best Practices

Based on data from the final patient QIA evaluation, 52.5% of respondents reported that as a result of the educational materials and puzzles provided during the QIA, they learned about the following:

- *Germs and the importance of washing my hands.*
- *How long germs can last on surfaces.*

- *That washing your hands is very important.*
- *Germs can be gotten by just being in a place*
- *Transmission of germs.*
- *Importance of keeping my access clean, plus watch for any changes that could mean infection.*

Chart J: BSI QIA Reduction

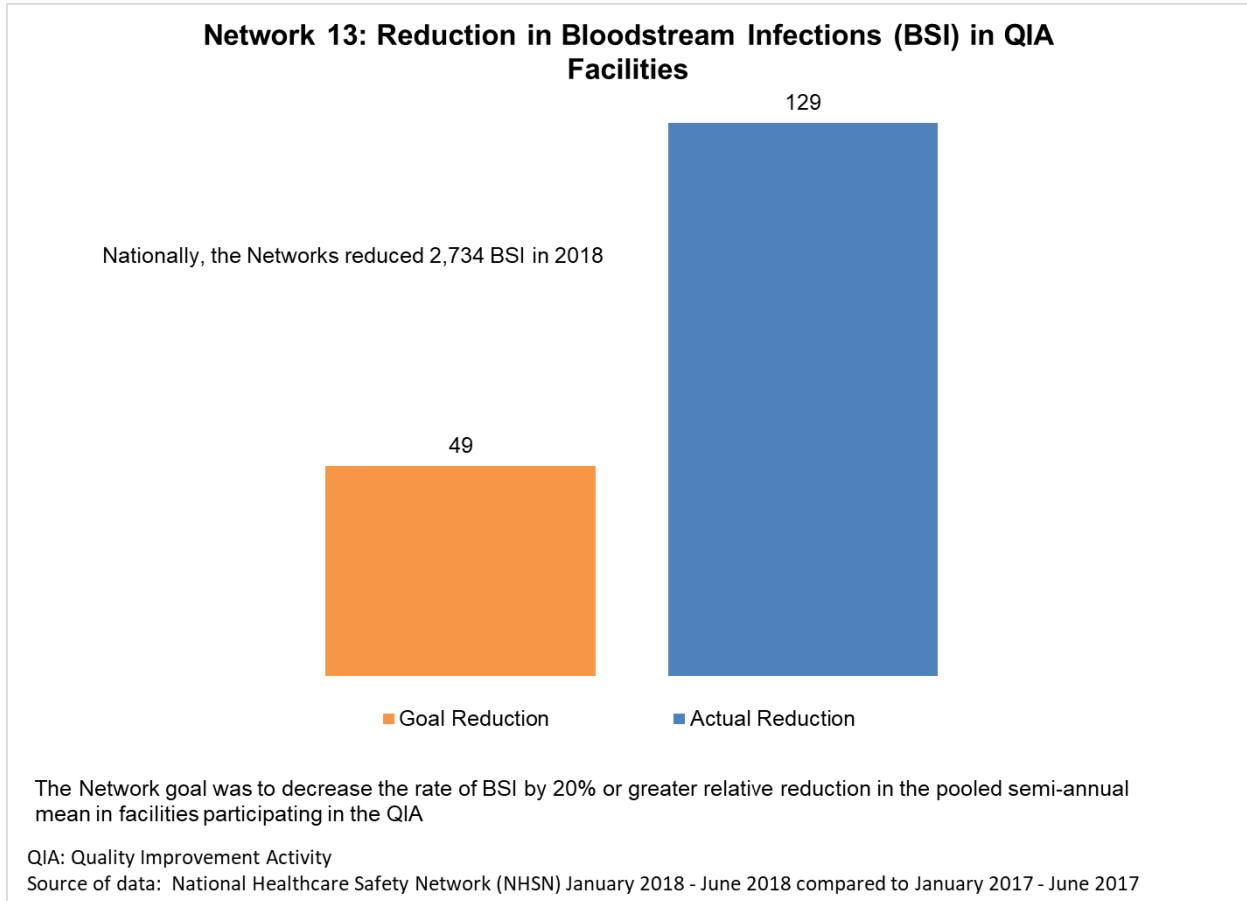


Chart K: Network Facilities Completing NHSN Surveillance Training

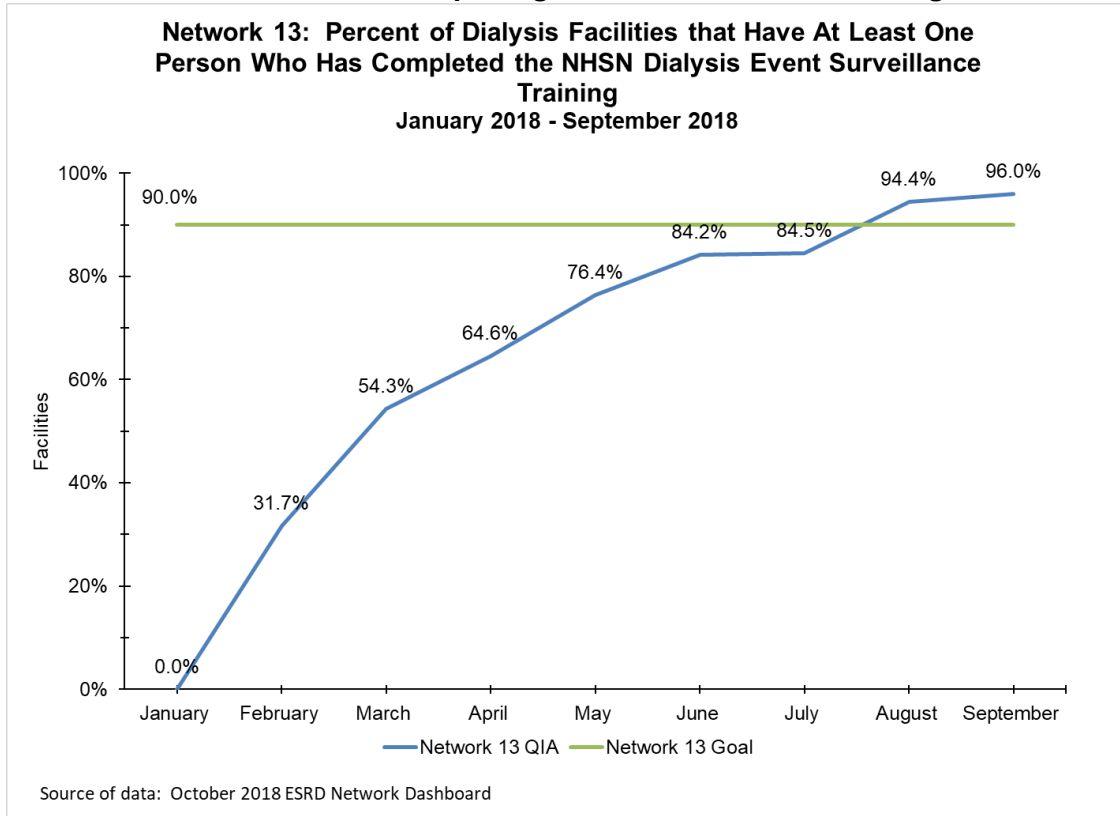
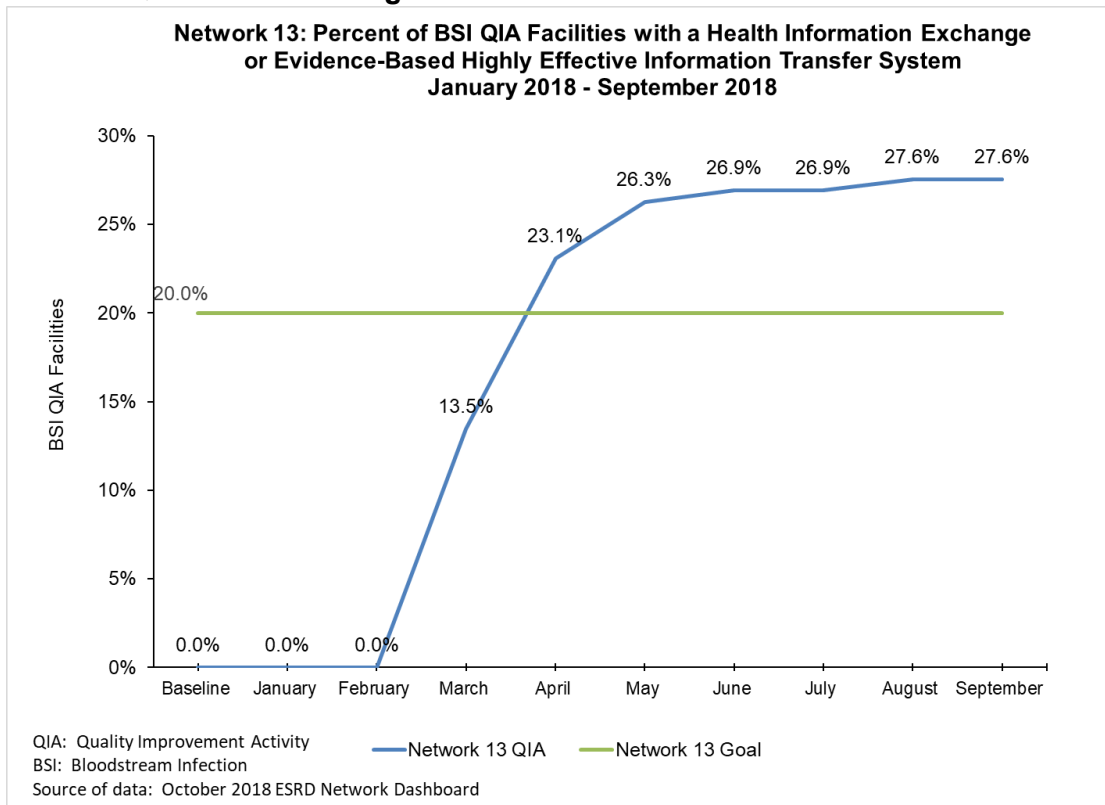


Chart L: QIA Facilities Using an HIE



Transplant Waitlist QIA

In 2018, the Network initiated a QIA to increase the number of adult dialysis patients on a transplant waitlist by adopting a seven-step transplant referral process. Ninety-four facilities (30% of the Network service area's 312 facilities), impacting 5,269 patients, were chosen to participate in the QIA.

Goals and Outcomes

The primary goal of the QIA was to increase the number of patients on the transplant waitlist by 10 percentage points over baseline; baseline waitlist rates ranged from zero (0.0%) to 26.9%. With the Network having the lowest waitlist rate in the nation, it was determined to initiate communications with not only the participating dialysis facilities, but with the 10 transplant centers in the service area. Educating everyone on referral processes and encouraging collaboration between all stakeholders, including ESRD providers and patients, became another primary goal. While the Network's transplant waitlist rate showed some movement both up and down, the final rate was static at 8.4%.

Barriers

Barriers to achieving QIA success identified by the facilities included:

- Lack of two-way communication between dialysis units and transplant centers.
- Knowledge deficits on transplant modality and referral process for both dialysis staff and patients.

Interventions

The Network addressed the barriers indicated above by implementing the following activities with the QIA facilities:

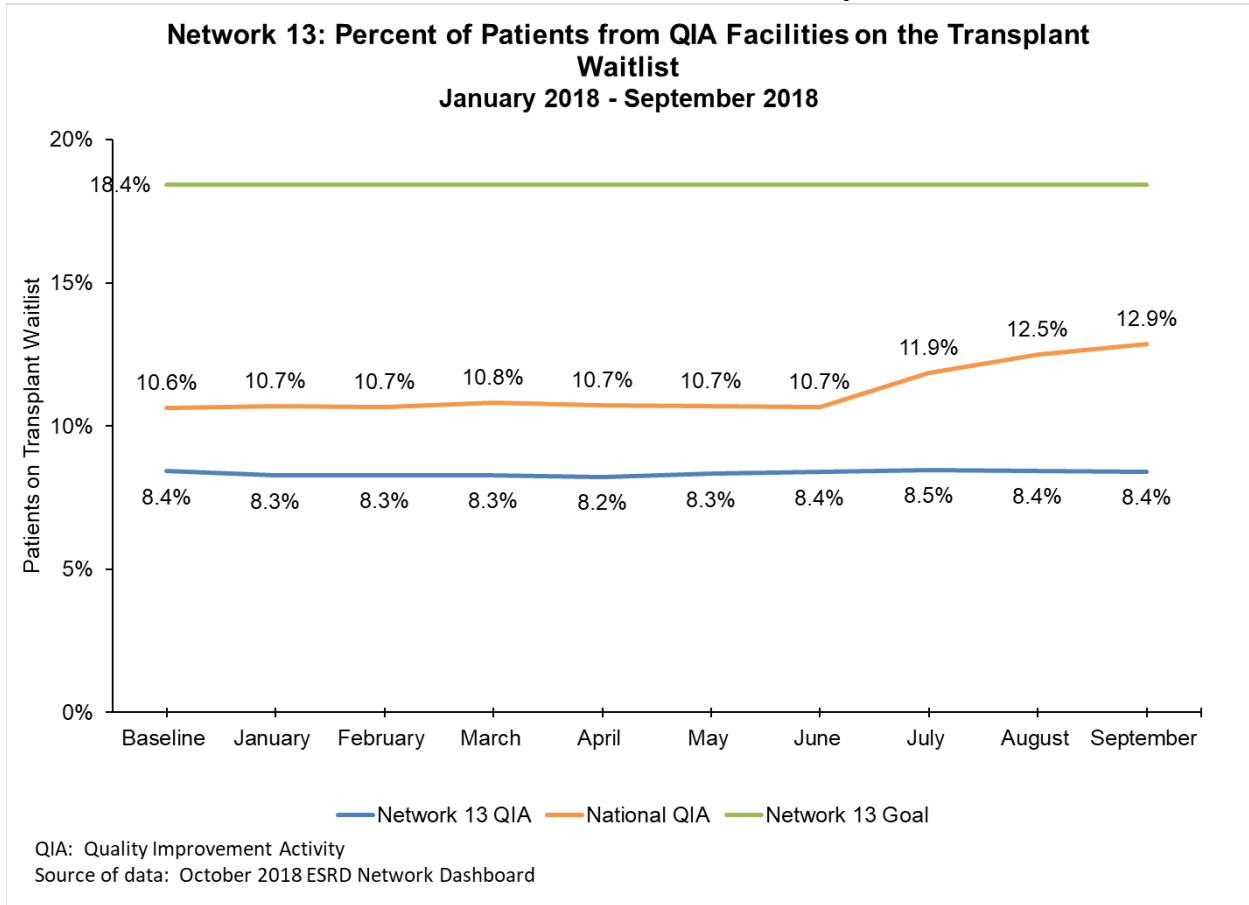
- Participation in bi-monthly NCC Transplant QIA LAN events.
- Establishing/building relationships with transplant personnel within the transplant centers.
 - To facilitate flow of information/education for patients and staff regarding transplant to include Lobby Days, provision of educational materials, assistance with peer mentoring.
- Designation of a patient as an NPR to be involved in QIA activities and help facilitate patient and family engagement (PFE) at the facility level.
- Evaluation of reasons for patient non-interest in transplant modality.
- Incorporating review of the Transplant QIA and interventions into monthly facility Quality Assessment and Performance Improvement (QAPI) meetings.

Best Practices

Best practices identified from the QIA include:

- Building relationships between transplant centers and dialysis facilities to improve communication and mitigate barriers for patients interested in transplant.
- Clearly defining the processes for patient referrals, including defining and documenting medical exclusions, to improve transplant opportunities.
- Determining the reasons for patient non-interest in transplant to identify and address educational/support needs.
- Building better two-way communications regarding patient status between dialysis facilities and transplant centers to strengthen the referral, evaluation, and wait listing processes.
- Continuing to focus efforts to improve waitlist rates.

Chart M: Percent of Patients from QIA facilities on the Transplant Waitlist



Home Therapy QIA

In 2018, the Network conducted a QIA to support the CMS goal of increasing the number of ESRD patients dialyzing at home by 10 percentage points over the baseline for a target group of dialysis facilities. Ninety-three facilities, impacting 6,510 patients, were chosen to participate in the QIA. The facilities' baseline home dialysis rates ranged from zero (0.0%) to 3.2%.

Goals and Outcomes

The baseline home dialysis rate for this activity, identified using CROWNWeb data, was 1.2%. The goal was to increase the number of patents training on home dialysis by ten percentage points, or to 11.2%. As of September 2018, the group increased the aggregate home dialysis rate to 10.9%, a 9.7 percentage point improvement.

Barriers

The following barriers to meeting the QIA goal were identified based on facility RCA results:

- Patient choice.
 - Lack of interest.
 - Patients' socialization needs are met through in-center hemodialysis.
 - Patients want a professional to perform dialysis.
- No partner and/or lack of space for supplies.
- Patients don't feel they can do it on their own.
 - They are fearful, anxious, nervous, hesitant.
- Education level/cognitive skills.
- Lack of family support.
- Patients don't want their families to see their treatment.
- Co-morbidities.

Interventions

Facility interventions for the QIA included:

- Initiating an RCA and developing an action plan to incorporate the top two issues identified as focus areas for improvement.
- Attending and participating on the ESRD NCC Home Dialysis LAN calls, including reporting of changes their facility could make to increase home modality choice.
- Promoting home therapies with an activity, such as a Lobby Day or Discover Home Therapies bulletin board.
- Providing patient education through flyers and educational puzzles on home modalities.
 - Home hemodialysis (HHD) and peritoneal dialysis (PD)

Note regarding effectiveness of educational puzzles: Patient surveys indicated that:

- 50.5% of patients found the puzzles fun
- 42.7% of patients indicated they learned the following by doing the puzzles:
 - *That no blood is exchanged (PD.)*
 - *I can do it (PD) while I sleep.*

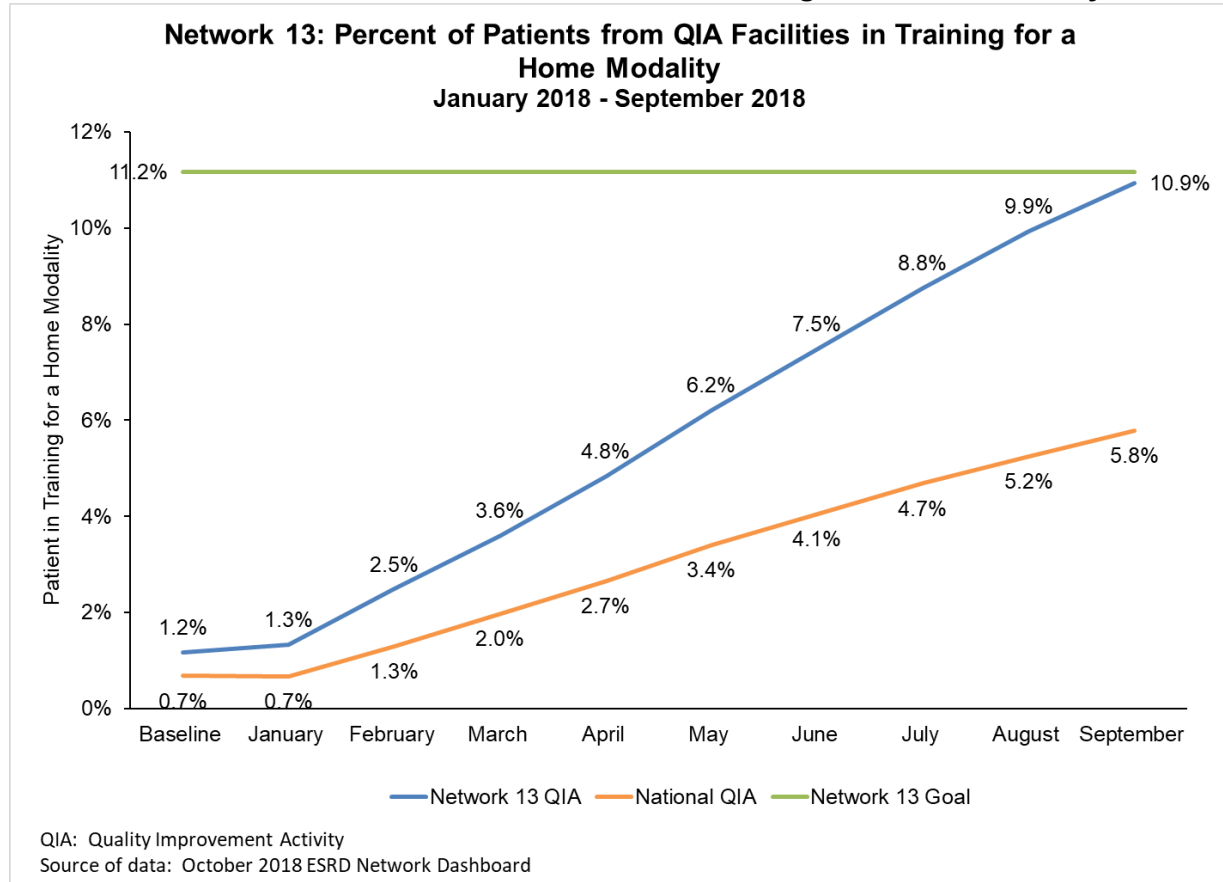
- *I can swim with a PD catheter.*
- *I don't have to get rid of my pets.*
- *About myths.*
- *A lot of information on different dialysis options.*
- *Pros and cons of PD.*

Best Practices

Best practices identified by QIA facilities included:

- Implementing use of transitional care units.
- Using urgent start PD as an alternative to in-center HD.
- Determining barriers to increase patients choosing a home therapy as their modality.
- Using the interdisciplinary team (IDT) to directly support patients and family members through education and re-education.
- Communicating facts to patients.
- Using the Match-D and *My Life, My Dialysis* tools for determining candidates for the home program.

Chart N: Percent of Patients from QIA facilities in Training for a Home Modality



Population Health Focus Pilot Project QIA

In 2018, the Network conducted a QIA focused on improving performance and reporting specific to depression screening for eligible dialysis patients. Clinical depression screenings and documented follow-up reporting for this QIA was done through CROWNWeb. The focus was on CROWNWeb options 3, “screening for clinical depression documented as positive, the facility possesses no documentation of a follow-up plan, and no reason is given” and 6, “clinical depression screening not documented, and no reason is given.” Thirty-two facilities participated in this QIA, impacting approximately 1,672 patients.

Goals and Outcomes

The primary goals of this QIA were to simultaneously reduce the number of patients with CROWNWeb response option 6 to zero (0.0%) from a baseline rate of 76.0%, based on October 2016–June 2017 CROWNWeb data and reduce the number of patients with a positive depression screening and no documented follow-up plan reported from a baseline of 1.3% to 1.2% by project conclusion. By QIA completion in September 2018, the “no screening” rate (option 6) was 17.3%, representing a reduction of 58.7 percentage points and the “positive depression screening and no documented follow-up plan” (option 3) was 0.2%, exceeding goal and representing a 1.1% reduction.

A secondary goal of the QIA was to address/eliminate the identified disparity (age 65+), as compared to a non-disparate population (ages 18-64). By the end of the QIA, data indicated improvement within both populations.

Barriers

The following barriers were identified based on facility RCA results:

- Unclear documentation and reporting process for depression screening.
- Patient lack of knowledge of signs and symptoms of depression.
- Negative stigma/culture around depression.
- Limited resources for patient referrals.
- Patient confusion around screening questions/literacy issues.
- Patients refuse depression screening.

Interventions

Facility interventions for the QIA included:

- Conducting an environmental scan to explore information on how dialysis providers are performing and reporting depression screening.
- Initiating an RCA and developing an action plan to incorporate top-three issues identified as focus areas for improvement.
- Setting clear cohort goals for the two focus areas, such as “no depression screening” and “positive screening without documented follow-up plan.”
- Establishing, with Network assistance, facility-specific depression screening goals for monthly monitoring and reporting using the Network-provided RCA tool.
- Building a resource database, inclusive of the Forum of ESRD Networks’ *Dialysis Patient Depression Toolkit*, introduction of non-pharmacologic therapy for depression (e.g., art/music therapy, yoga/exercise, and cognitive behavior therapy) and the Network-developed, *Shatter the*

Myths of Depression poster with PSME input for increased education and awareness of commonly-identified myths.

- Increasing PFE using NPRs to document “What works for you?”, highlighting successful therapies patients share—all working toward awareness.
- Providing a “Bulletin Board in a Box” focused on “Tools for Good Mental Health”

Best Practices

Best practices identified by QIA facilities included:

- Using the *Patient Depression Toolkit*.
- Using the Patient Resource List with regular updates.
- Having the IDT review screenings and referrals during monthly QAPI meetings.

Chart O: Percent of Patients with no Documentation of a Pain Assessment

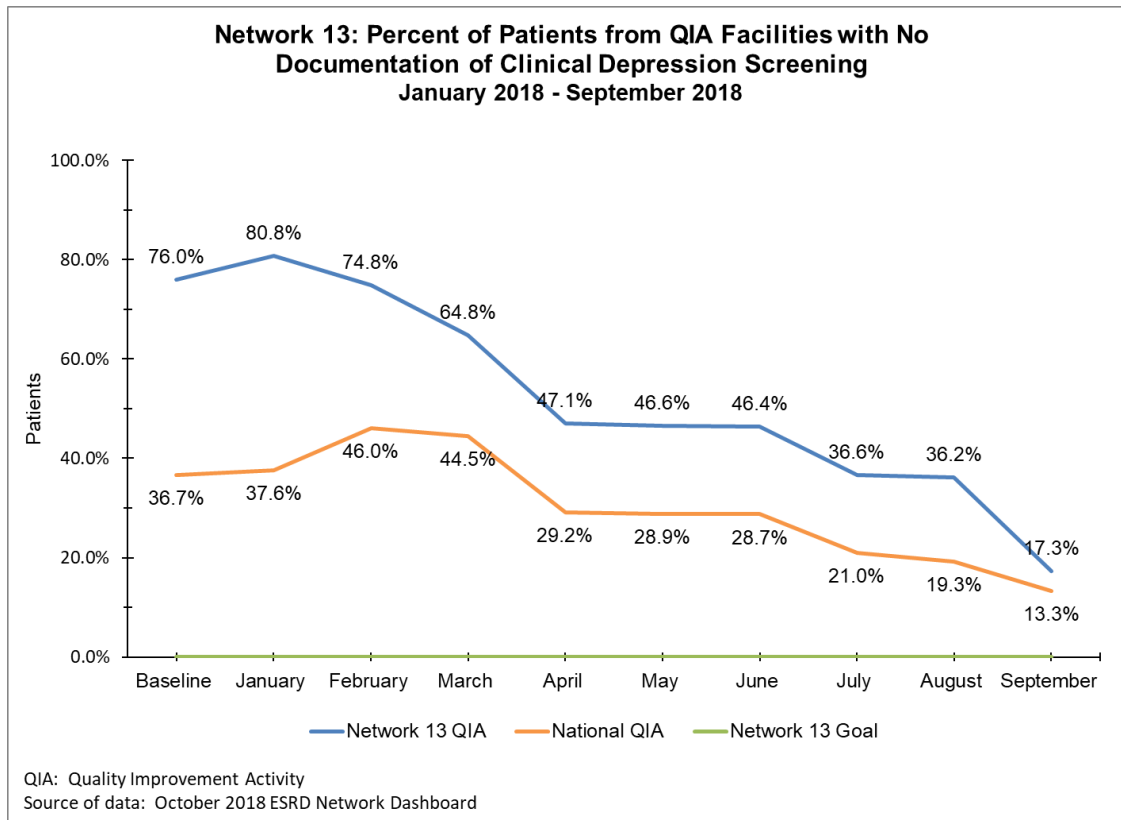


Chart P: Percent of Patients with a Positive Pain Assessment and No Follow-Up Plan

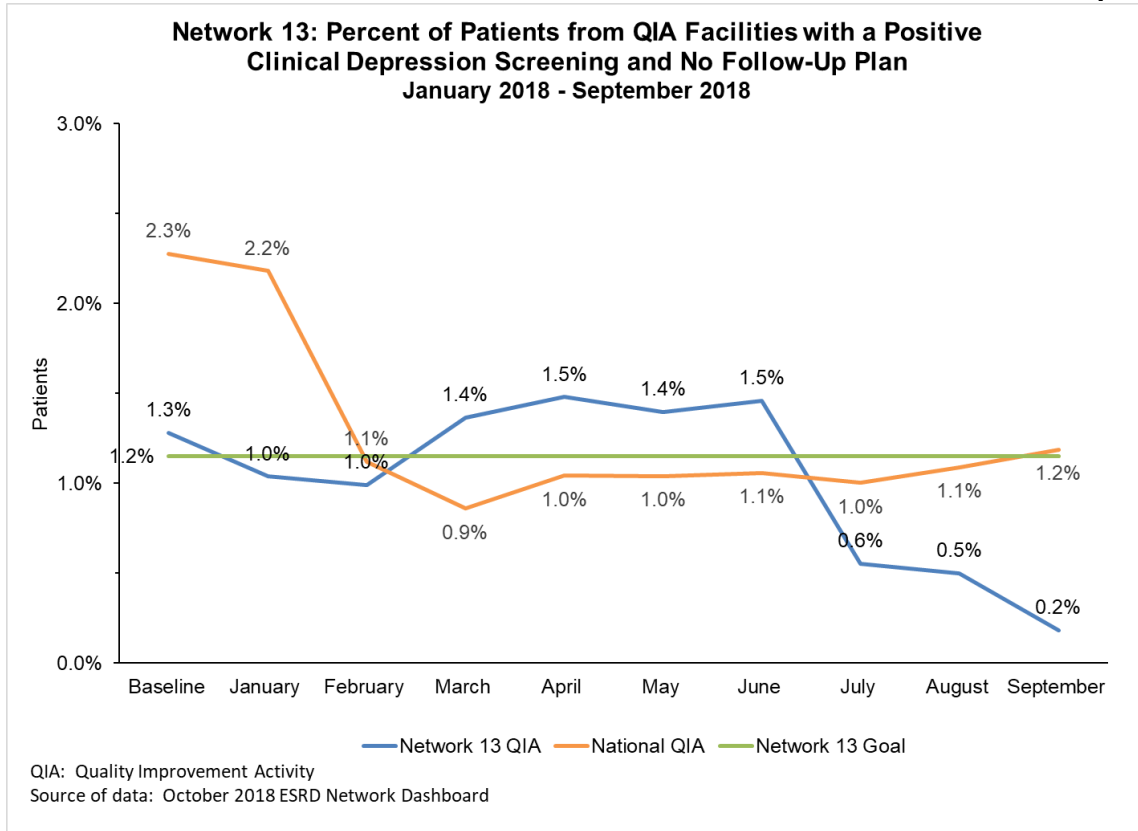
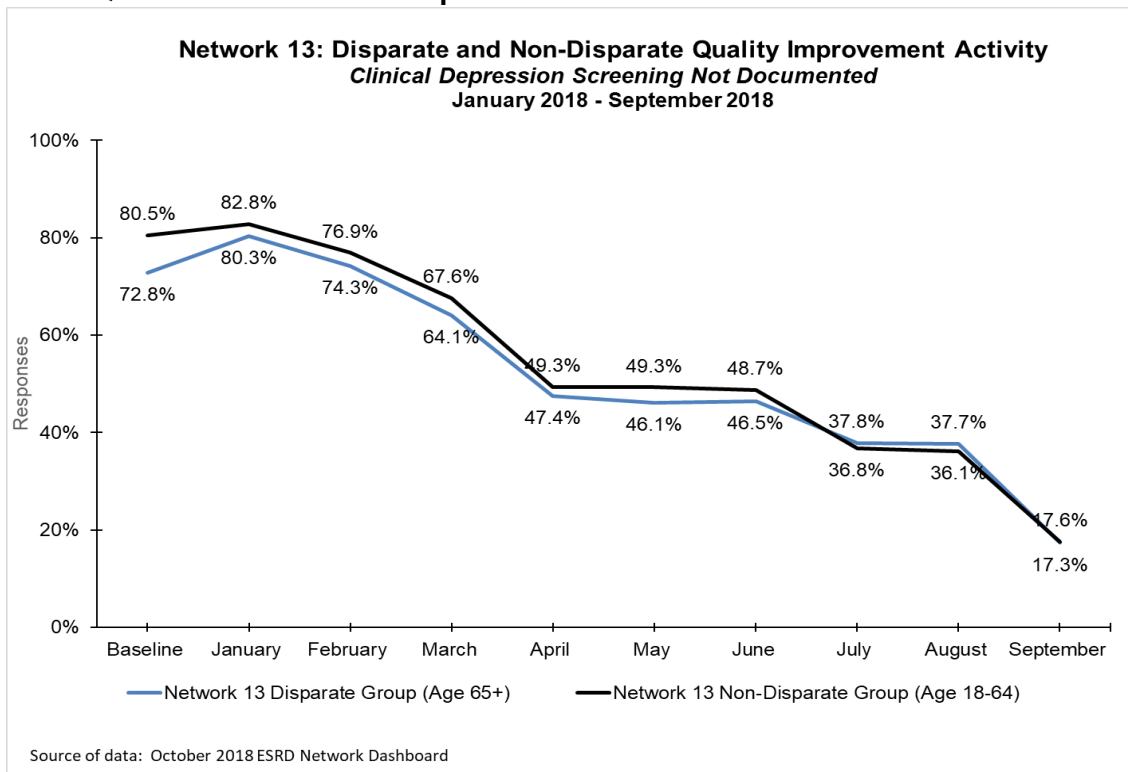


Chart Q: Reduction in the Groups for No Documentation of Pain Assessment



ESRD NETWORK RECOMMENDATIONS

Recommendations for Sanction

The Network strived to maintain a cooperative and collaborative partnership with ESRD providers in all activities in 2018. The Network regularly interacted with facilities regarding QIAs and projects, quality of care issues, patient grievances, data reporting, and the provision of technical assistance and education.

In 2018, the Network did not identify any facilities in its service area that consistently failed to cooperate with Network goals.

Recommendations to CMS for Additional Services or Facilities

There is currently no Certificate of Need requirement for ESRD facilities in the Network's service area. The consensus of our boards and committees is that the competitive market, by its nature, analyzes and identifies areas of need. We share available aggregate data with the SA offices and the CMS Region VI office in Dallas, as requested, for use in conjunction with other factors in their determining prioritization of certification surveys. As generally requested, the information provided to the Regional Office includes number of patients in a given geographic area, as well as facility-related information, including services provided (modalities offered), number of stations, number of shifts, and patient capacity in the immediate geographic area (based on number of shifts and stations at other facilities).

In 2018, the Network did not make recommendations to CMS for addition facilities in its service area.

The special areas of need that the Network believes could be addressed include:

- The number of clinically challenging or disruptive patients, many of whom have been involuntarily discharged from chronic facilities and are without access to another chronic facility.
 - A “unique needs” dialysis facility could allow for higher staff-to-patient ratios and/or employ clinicians with specialized training to enable intensive, individualized services to patients with complex, clinical challenges and/or histories of aggression, mental illness, or substance abuse.
- Dialysis patients with physical conditions (e.g., ventilator-dependent, morbidly obese, antibiotic-resistant infections), or other such needs, which require services that typical chronic facilities for the general dialysis population are unable to provide.



ESRD NETWORK SIGNIFICANT EMERGENCY PREPAREDNESS INTERVENTION

Network Emergency Preparedness

During 2018, two significant weather-related events required Network intervention and assistance for impacts affecting ESRD providers and patients.

Winter Storm Inga

In late January/early February 2018, winter storm Inga brought freezing temperatures that caused water and transportation issues. The Network monitored facility operations throughout the service area, but the primary impact of the storm was in Louisiana, where the water supply infrastructure made it most vulnerable to water issues caused by freezing/refreezing temperatures. Transportation was also an issue for patients and staff, as some roads were impassible. Most problems were caused by bridges icing up vs. overall road conditions. Facilities were proactive, monitoring their water supplies and water quality, providing patient education regarding fluid/diet, and rescheduling treatments based on local conditions. No dialysis unit operations were affected long-term.

Tropical Storm (TS) Gordon

TS Gordon also impacted Louisiana in early September 2018. Dialysis facilities within the projected storm track, as well as throughout the service area, proactively prepared for weather-related events such as heavy rain and tropical storm conditions. Facilities in the immediate TS path in southeast Louisiana opened early where possible, allowing them to close early prior to the storm's arrival. Facilities worked their emergency preparedness plans for both patients and staff.

ACRONYM LIST

This abbreviated acronym list was derived from a more extensive list created by the KPAC (Kidney Patient Advisory Council) of the National Forum of ESRD Networks (Located [here](#)). We are grateful to the KPAC for creating this list of acronyms to assist patients and stakeholders in the readability of this annual report. We appreciate the collaboration of the National Forum of ESRD Networks especially the KPAC.

Acronym	Definition
BSI	Blood Stream Infection
CDC	Centers for Disease Control
CDHE	Colorado Department of Health and Environment
CMS	Centers for Medicare & Medicaid Services
ESRD	End Stage Renal Disease
FDA	Food and Drug Administration
HAIs	Healthcare Acquired Infections
HHS	Health and Human Services
HSAG	Health Services Advisory Group
HIE	Health Information Exchange
KCER	Kidney Community Emergency Response
LAN	Learning and Action Network
LTC	Long Term Catheter
LDOs	Large Dialysis Organizations
PDSA	Plan Do Study Act: A cycle of improvement
PHFPQ	Population Health Focused Pilot
PSME	Patient Subject Matter Expert
QAPI	Quality Assurance and Improvement Program
QIA	Quality Improvement Activity
RCA	Root Cause Analysis
SME	Subject Matter Expert
UNOS	United Network for Organ Sharing