



## Overview of Public-Private Quality Alliances

### Table of Contents

Introduction .....	1
Alliance for Pediatric Quality .....	2
AQA .....	3
Cancer Quality Alliance (CQA)* .....	5
Hospital Quality Alliance (HQA) .....	8
Kidney Care Quality Alliance (KCQA) .....	9
Long Term Care Quality Alliance (LTCQA) .....	11
Pharmacy Quality Alliance (PQA).....	14
Quality Alliance Steering Committee (QASC).....	16
Surgical Quality Alliance (SQA)* .....	18

*\*Information portrayed was obtained from the alliance's web site and other publicly accessible sources rather than direct contact with the alliance staff/representatives.*

### Introduction

The following table provides basic information on the most active health care quality alliances. The information was gathered from the alliances' web sites and follow-up telephone interviews with key contacts in December 2008 and January 2009. Additional detail for some of the content areas is provided in the appendix.

The role of the alliances in the quality enterprise ranges from developing and testing performance measures (or contracting for those activities), to adopting measures for implementation for public reporting and promoting quality improvement initiatives and the use of measures to support these improvement activities. The alliance structures range from formal legal entities (e.g., PQA) to informal partnerships (e.g., Alliance for Pediatric Quality). Most of the alliances are informal coalitions. Financing and membership fees vary greatly among the alliances although those alliances involved in measure development and testing (e.g., KCQA) have the largest budgets. Staffing arrangements include paid staff, in-kind services, paid consultants, and in one case, a joint appointment with a university faculty member (PQA).

The most common suggestion for consideration when establishing a quality alliance made by contacts representing these alliances was to clearly identify and reach consensus on the purpose of the alliance. Other suggestions included ensuring that all relevant stakeholders are invited to participate and that there is adequate funding to support the proposed activities of the alliance near- and long-term.

<b>Alliance for Pediatric Quality</b> Year of Inception: 2006 URL: <a href="http://www.kidsquality.org/">http://www.kidsquality.org/</a>			
<b>Mission</b>	<b>Role in the Quality Enterprise</b>	<b>Organizational Structure</b>	<b>Staffing/ Workgroups</b>
<p>The Alliance exists for the benefit of children and families. Through leadership, alignment, and collaboration, the Alliance partners will take action to:</p> <ul style="list-style-type: none"> <li>- improve the quality of care for children by promoting effective, systematic efforts to improve children's health care; and</li> <li>- ensure that health information technology works for children by developing standards that incorporate pediatric requirements and advocating for HIT that enables systematic improvement.</li> </ul>	<p>The Alliance is focused on spreading improvement initiatives. It no longer sees quality measurement and reporting as a primary activity except in their relationship to quality improvement.</p>	<p>The Alliance is not a legal entity. There is an informal, hand-shake agreement among the four partners (i.e., American Academy of Pediatrics, The American Board of Pediatrics, Child Health Corporation of America, and the National Association of Children's Hospitals and Related Institutions). They do not incur overhead expenses or complications of supporting another organization.</p>	<p>The VPs and designated staff from the four partner organizations conduct the work of the Alliance. They contract with a communications firm to manage the web site and marketing strategy. Initially, there were regularly scheduled calls with the VPs from each organization to engage in discussions about what to do. Gradually, each organization added staff to support the VPs. As time has elapsed, the VPs give less attention to the Alliance. Even though they continue regularly scheduled calls, it can be difficult to schedule VP involvement.</p> <p>One adhoc workgroup was formed - the Improve First Task Force, which is no longer active. There are several work groups associated with various Alliance-endorsed HIT projects but they are really committees "governed" by HIT organizations such as HL7 and CCHIT. The Alliance provides a coordinator on a consulting basis who helps these various pediatric committees work in alignment.</p>

Membership/Member Role	Governance	Financing/Membership Dues	Nursing Presence
<p>There are no members except as represented by the four partners. Together, the Alliance represents 60,000 Board-certified pediatricians, pediatric medical and surgical subspecialists, and 200+ children's hospitals.</p> <p>There are no formal members policies or roles/responsibilities.</p>	<p>Four national organizations, recognized as leaders in pediatrics, formed and run the Alliance for Pediatric Quality (Alliance). These organizations are the American Academy of Pediatrics (AAP), The American Board of Pediatrics (ABP), Child Health Corporation of America (CHCA) and the National Association of Children's Hospitals and Related Institutions (NACHRI).</p> <p>There are no official rules/policies.</p>	<p>Direct costs of a communications firm are shared by the four partners. All other staff functions are donated by the partners. The cost budget fluctuates widely (e.g., ~\$250,000 in 2008, but will be ~\$60,000 in 2009).</p> <p>There are no members except as represented by the four partners.</p>	<p>Nurses do not have separate representation on the Alliance. At the initiation of the Alliance, the four partners thought it was enough of a challenge for them to agree on the alliance and they already knew each other well. All agree that candidate improvement efforts must be multidisciplinary. A recent project for spreading the ICU initiative to hematology/oncology included nurses at the initial expert meeting.</p> <p>If nurses wished to have more voice in the Alliance, the best avenue would be through the two hospital organizations.</p>

**AQA** Year of Inception: 2004 URL: <http://www.ambulatoryqualityalliance.org/>

Mission	Role in the Quality Enterprise	Organizational Structure	Staffing/ Workgroups
<p>The mission of this effort, a large voluntary multi-stakeholder collaborative of physicians, consumers, purchasers, health insurance plans and others, is to improve patient safety, health care quality and value in all settings through a collaborative process in which key stakeholders agree on and promote strategies to implement performance measurement at the physician and other clinician or group level; collect and aggregate data in the</p>	<p>The AQA identifies which measures endorsed by NQF are best suited for ambulatory care and identifies solutions to implementation challenges (e.g., data aggregation, data sources).</p>	<p>AQA is an informal alliance, not a legal entity.</p>	<p>AHIP members wanted AHIP to work with the physician community and AHIP provides staff support to AQA. Each Steering Group member provides staff as needed. AHRQ provides a transcriber for meetings.</p> <p>AQA has established several Workgroups;</p> <ul style="list-style-type: none"> <li>- AQA Steering Group - may appoint committees (e.g., membership, finance)</li> <li>- Data Sharing and Aggregation</li> </ul>

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<p>most appropriate way; and report meaningful information to consumers, physicians and other clinicians, and other stakeholders to inform decision-making and improve outcomes.</p>			<p>- Performance Measurement - reviewing measures to determine alignment with public reporting and quality improvement  - Reporting - physician and consumer groups review and recommend best ways to report/display data for the target audience</p>
<b>Membership/Member Role</b>	<b>Governance</b>	<b>Financing/Membership Dues</b>	<b>Nursing Presence</b>
<p>Members include 80 organizations, 50 of which are medical specialty societies. Member stakeholder sectors include:</p> <ul style="list-style-type: none"> <li>a. consumer organizations;</li> <li>b. public and private purchasers/payers;</li> <li>c. health insurance plans;</li> <li>d. physician organizations;</li> <li>e. other clinician organizations;</li> <li>f. government;</li> <li>g. organizations representing hospitals and other sites of care;</li> <li>h. certification, accreditation and other quality measurement and quality improvement organizations; and</li> <li>i. health care “manufacturers.”</li> </ul> <p>Any AQA member can participate on any workgroup.</p> <p>Voting processes.</p> <ul style="list-style-type: none"> <li>a. For all AQA action items, each AQA member organization has one vote.</li> <li>b. An item is approved if a majority of stakeholder sectors</li> </ul>	<p>The Steering Group consists of at least 16 members representing the following sectors:</p> <ul style="list-style-type: none"> <li>a. 6 members representing physicians;</li> <li>b. 2 members representing consumers;</li> <li>c. 2 members representing purchasers;</li> <li>d. 2 members representing other clinicians;</li> <li>e. 1 member representing health insurance plans;</li> <li>f. 1 member representing the remaining stakeholder sectors; and</li> <li>g. 2 ex-officio, non-voting members representing government.</li> </ul> <p>AQA workgroup chairs are considered Steering Group members during their terms.</p> <p>Incoming Steering Group members are selected by the current Steering Group; the current Steering Group takes nominations from the respective communities/industries. AQA facilitates a process by which the remaining stakeholder sectors may convene to nominate the “stakeholder at large” representative.</p>	<p>AQA has no revenue sources except meeting registration fees (\$35-50/registrant). It now has a Finance Committee for the first time to look at AQA's role in the quality enterprise and how to achieve its goals. It is exploring public/private funding of the quality infrastructure including measure development, implementation, and learning to achieve continuous improvement.</p> <p>No membership fees exist.</p>	<p>Membership is open to any clinician groups. ANA participated initially, and now periodically sends a representative to the AQA meetings. In the most recent call for nominations for two other clinician (non-physician) seats on the Steering Group, no nurses were nominated and the positions were filled by a physical therapist and a social worker.</p>

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<p>votes affirmatively AND at least three of the stakeholder sectors voting affirmatively are consumers organizations, public or private purchasers/payers, health insurance plans, physician organizations, or other clinician organizations. A stakeholder sector has voted affirmatively for an item if a majority of organizations within that stakeholder sector has voted affirmatively.</p>	<p>Each newly appointed Steering Group member serves a three year term. Members may serve two terms. Terms are staggered. On an annual basis, the Steering Group elects a Chair.</p> <p>In April 2008, AQA adopted Rules and Policies Governing AQA Membership and Operations that are available on the web site (see appendix). One motivation for more formal rules was to ensure that non-physician stakeholders were represented and had adequate influence on decisions.</p>		
<p><b>Cancer Quality Alliance (CQA) Year of Inception: 2005 URL: <a href="http://www.cancerqualityalliance.org/CQA/Home/">http://www.cancerqualityalliance.org/CQA/Home/</a></b></p>			
Mission	Role in the Quality Enterprise	Organizational Structure	Staffing/ Workgroups
<p>The Cancer Quality Alliance fosters collaboration among diverse stakeholders to improve cancer care quality. By encouraging the sharing and implementation of measures, tools, and practical programs to improve quality, the Alliance seeks to become a national voice for the quality of cancer care. Members of the Alliance include cancer care providers, patient advocacy groups, certifying and accrediting organizations, public and private payers, federal agencies, foundations, and other national organizations involved in improving the quality of cancer care.</p>	<p>The Alliance activities include: fostering the rapid development and implementation of measures appropriate for quality improvement and accountability; enhancing mechanisms for data collection; promoting the development and adoption of oncology electronic medical records (EMRs); and endorsing a blueprint that describes optimal cancer care.</p>	<p>The information on CQA summarized in this table was gathered from the web site only, which did not provide information for all fields.</p>	<p>The information on CQA summarized in this table was gathered from the web site only, which did not provide information for all fields.</p>

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Membership/Member Role	Governance	Financing/Membership Dues	Nursing Presence
<p>The CQA has 19 alliance members, 2 affiliate members, and 7 liaison members.</p> <p>1. Alliance Members – those with a broad interest in cancer care quality improvement, experience in developing and implementing cancer quality measures, and the ability to contribute to Alliance activities. Alliance Members are expected to have a national membership or have a national focus.</p> <p>2. Affiliate Members –entities that have an interest in cancer care quality or experience in developing or implementing cancer quality measures, but lack a national membership or national focus. Although these organizations are not national entities, they will be eligible for membership only if their involvement in quality improvement affects other practices or have regional or national implications. These entities should be able to demonstrate their commitment to communicate and/or collaborate with others engaged in cancer quality improvement to expand the impact of their own quality initiatives.</p> <p>3. Liaison Members –federal agencies or other organizations that are prevented from paying</p>	<p>The Alliance is co-chaired by Patricia Ganz, MD, a medical oncologist and Chair of ASCO’s Quality of Care Committee, and Ellen Stovall, President and CEO of the National Coalition of Cancer Survivorship.</p>	<p>The information on CQA summarized in this table was gathered from the web site only, which did not provide information for all fields.</p>	<p>The Oncology Nursing Society is listed on CQA’s web site as a member.</p>

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<p>dues to or voting in cooperative organizations. Liaison Members do not pay annual dues. These organizations are encouraged to make inkind contributions. Alliance Members, Liaison Organizations, and Affiliate Organizations.</p> <p>1. Alliance Members are asked to make a commitment to attendance at meetings, leadership of workgroups, and active involvement in the Alliance’s activities. Alliance Members are expected to have the ability to vote on behalf of their organizations on matters relating to CQA membership as well as other CQA activities or initiatives that do not have significant financial or other impact on the member organization. Alliance Members name a representative and an alternate representative to attend Alliance meetings, participate in Alliance consensus-building efforts, and vote on Alliance motions.</p> <p>2. Affiliate Members name a representative and alternate to attend Alliance meetings, and participate in Alliance consensus-building efforts. Affiliate Organizations will not vote on Alliance motions.</p> <p>3. Liaison Members are asked to name a representative and alternate to attend Alliance</p>			
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meetings and participate in Alliance consensus-building efforts. Liaison Members will not vote on Alliance motions. These organizations are encouraged to make inkind contributions.			
<b>Hospital Quality Alliance (HQA) Year of Inception: 2002 URL: <a href="http://www.hospitalqualityalliance.org/">http://www.hospitalqualityalliance.org/</a></b>			
<b>Mission</b>	<b>Role in the Quality Enterprise</b>	<b>Organizational Structure</b>	<b>Staffing/ Workgroups</b>
<p>The HQA is a national public-private collaboration that is committed to making meaningful, relevant, and easily understood information about hospital performance accessible to the public and to informing and encouraging efforts to improve quality.</p> <p>The Hospital Quality Alliance facilitates continuous improvement in patient care through:</p> <ul style="list-style-type: none"> <li>- implementing measures that portray the quality, cost and value of hospital care;</li> <li>- developing and using measure reporting in the nation's hospitals; and</li> <li>- sharing useful hospital performance information with the public.</li> </ul>	HQA adopts measures for implementation and works with CMS on public reporting on Hospital Compare.	HQA is an informal collaboration, not a separate legal entity.	<p>There is a full-time, budgeted position for Managing Director (recently vacated and will be replaced). All other staff are from the principals' organizations. One of the principal organizations provides office space for the Managing Director.</p> <p>HQA has two workgroups. The Measure Workgroup makes recommendations on measures to adopt for implementation. The Communications Workgroup helps with dissemination of information on the measures that are supported.</p>

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<b>Membership/Member Role</b>	<b>Governance</b>	<b>Financing/Membership Dues</b>	<b>Nursing Presence</b>
<p>HQA has 20 members (referred to as “Principals”), including organizations representing hospitals, consumer representatives, physician and nursing organizations, employers and payers, oversight organizations and government agencies.</p> <p>Members review recommendations and agree on which measures to adopt. They work on consensus and everyone agrees.</p>	<p>Principals from all 20 member organizations make decisions through consensus.</p> <p>There are no official rules/policies, but it was a topic for discussion at the December 2008 meeting.</p>	<p>Membership dues are the only source of revenue and are used primarily for the managing director salary, travel, meetings, and conference calls.</p> <p>Dues are tiered by organization size. The range is approximately \$10,000-\$50,000. All members are expected to provide in-kind services.</p>	<p>ANA is one of the principals. Nurses are also involved through the member hospital organizations.</p>

**Kidney Care Quality Alliance (KCQA) Year of Inception: KCP 2003; KCQI 2005; KCQA 2006 URL: <http://www.kidneycarepartners.com>**

<b>Mission</b>	<b>Role in the Quality Enterprise</b>	<b>Organizational Structure</b>	<b>Staffing/ Workgroups</b>
<p>Members of the kidney care community formed a coalition primarily to advocate for policy change. This partnership, referred to as the Kidney Care Partners (KCP), involves patient advocates, care professionals, providers and manufacturers.</p> <p>Their mission, individually and collectively, is to ensure:</p> <ul style="list-style-type: none"> <li>- chronic kidney disease patients receive optimal care;</li> <li>- chronic kidney disease patients are able to live quality lives;</li> <li>- dialysis care is readily accessible to all those in need; and</li> <li>- research and development leads to enhanced therapies and</li> </ul>	<p>KCQA developed measures and is now testing those endorsed by NQF. It has developed pay-for-performance proposals and advocates for measure reporting and pay-for-performance programs.</p>	<p>Kidney Care Partners is a nonprofit 501 (c) (4) organization and parent organization for the Kidney Care Quality Initiative and the Kidney Care Quality Alliance. The KCQI was formed to drive quality improvement in kidney care and to develop a well-designed pay for performance program that meets the needs of patients, other members of the kidney care community, and federal policy-makers. The KCQA was formed to develop and test performance measures that would drive quality improvement and that could be used in a pay for performance program.</p>	<p>KCP does not have staff employees; it is staffed by professional consultants. KCQA has two consultants who are conducting the testing of the KCQA performance measures conditionally endorsed by NQF. These consultants report to the KCQA Steering Committee, but are paid by KCP. The consultants also serve as the convener and administrative arm of the Alliance and the Alliance Steering Committee. KCP consultants may assist with some functions such as webinars.</p> <p>KCQA Work Groups include:</p> <ul style="list-style-type: none"> <li>- Adult Clinical Measures</li> </ul>

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<p>innovative products.</p> <p>KCP formed the Kidney Care Quality Alliance (KCQA) in 2006 to address performance measurement and public reporting, to stimulate quality improvement, and to spearhead measure development and testing related to CMS's Dialysis Center Compare (and future pay-for-performance program). Creation of a separate constituency group that was smaller, more nimble, focused on issues of priorities to health care providers and the medical profession, and that included patient/consumer "voice" was a motivation in forming KCQA.</p>			<ul style="list-style-type: none"> <li>- Pediatric Domain Work Group</li> <li>- Quality of Life/Patient Perspectives Work Group</li> <li>- Implementation and Data Issues Work Group</li> </ul>
<b>Membership/Member Role</b>	<b>Governance</b>	<b>Financing/Membership Dues</b>	<b>Nursing Presence</b>
<p>Membership in the Kidney Care Quality Alliance is open to KCP members and any organization in the health care community, including patient organizations, consumers, providers, health care professionals, and manufacturers. There are 43 members listed on the KCQI web site.</p> <p>All Alliance members in good standing have the opportunity to vote on any consensus proposal. Upon receipt of recommendations, the representatives of the Alliance meet to review the recommendations and to discuss</p>	<p>KCP has a Board of Directors, an Operations Committee, as well as ad hoc workgroups. KCQA is independent of KCP and relies on a Steering Committee.</p> <p>KCP's Board is composed of 33 members – one representing each organizational member of KCP. Regardless of organizational size or dues contribution, each Director has an equal vote. The Board of Directors must vote on all policy positions taken by KCP.</p> <p>KCQA is led by a Steering Committee (named by the KCP Board) that includes physicians, providers, patient</p>	<p>KCQA is funded exclusively out of KCP as a line item in the KCP annual budget (amount not disclosed). The budget varies substantially based on the activities and at present is quite substantial to support testing of the performance measures.</p> <p>There is no cost associated with joining the Kidney Care Quality Alliance. KCP members, however must pay dues. Initially, all KCP members paid the same dues. Over the last few years, significant efforts have been invested in modifying the dues structure to reflect an organizational revenue-based sliding scale formula, with some members on</p>	<p>Gail Wick represents the American Nephrology Nurses Association (ANNA) on the KCQA Steering Committee. As co-chair she serves in a leadership role and has input into initiatives undertaken. However, there is only one nursing organization and several physician organizations devoted to renal care.</p>

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them. All members of the Alliance have opportunities to comment on the recommendations in writing.	advocates, nursing organizations, CMS, and one organizational member not involved in the direct provision of kidney care. The Steering Committee excludes pharmacy representation because of potential conflict of interest.	the Board, regardless of dues contribution. KCP staff indicated that there was no member attrition as a result in this change in dues structure.	
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**Long Term Care Quality Alliance (LTCQA) Year of Inception:** 2008 - Exploring establishment **URL:** [http://www.brookings.edu/events/2008/1217\\_LTCQA.aspx](http://www.brookings.edu/events/2008/1217_LTCQA.aspx)

<b>Mission</b>	<b>Role in the Quality Enterprise</b>	<b>Organizational Structure</b>	<b>Staffing/ Workgroups</b>
<p>Numerous organizations have expressed interest in establishing a Long-Term Care Quality Alliance in an effort to achieve sustainable, high-value, and person-focused long-term care in the United States. Based on a few meetings held during the 2nd half of 2008 and subsequent discussions with a wide range of stakeholders, it appears as if there is consensus to establish an Alliance and to focus its activities on implementing and/or accelerating efforts to improve quality in long-term care and related areas at the person level, regardless of setting.</p> <p>The primary goal of the LTCQA, therefore, will be to support improvements in care quality centered on individuals who need long-term and post-acute care and supportive services regardless of setting. Using existing assessment tools (e.g., Minimum Data Set, OASIS, Care Tool) and other data resources, there are some</p>	<p>The LTCQA will be involved in identifying gaps in measures, data systems, and assessment tools that can support person-centered performance assessment, and devising recommendations to help fill these gaps. However, the LTCQA is not intended to be a national quality measurement advisory body and will be as implementation-focused as possible to support better and more consistent quality measurement pilots, demonstrations, and initiatives that can tangibly improve performance and generate better evidence on reforms that work. Supporting existing efforts or developing new pilots and demonstrations will thus be a core part of the initial stages of the LTCQA.</p>	<p>The Brookings Institution's Engelberg Center for Health Care Reform will continue to facilitate the formation of the LTCQA during its start-up phase, in partnership with the "planning group." This will include providing day-to-day direction, convening stakeholders, supporting the development of an organizational structure, developing materials, and assisting in identifying initial funding sources. However, Brookings' role will transition to serving as an equal among many participating stakeholders in the process once the initial organizational structure and the Steering Committee are established and once initial seed funds are identified that can ensure the early success and sustainability of the LTCQA.</p>	<p>The Engelberg Center for Health Care Reform, Brookings Institution, is hosting the discussions on the formation of a Long-Term Care Quality Alliance.</p> <p>The LTCQA will seek initial funding to support basic operational support, including eventually hiring an Executive Director and a small number of initial staff that may be augmented by consulting support from outside individuals or organizations. The Executive Director and other staff will be selected by the Steering Committee in conjunction with achieving fundraising and other organizational goals. To support tangible next steps, Brookings has proposed contracting with an individual and/or organization with relevant expertise to make specific, short- and medium-term recommendations regarding the development of pilots or</p>

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<p>potential opportunities to identify and develop new quality improvement programs or demonstrations on behalf of individuals with particular needs, such as:</p> <ul style="list-style-type: none"> <li>- those needing assistance with activities of daily living and managing chronic conditions;</li> <li>- those with disabilities; and</li> <li>- those who have specific diagnoses (e.g., advanced dementia), including the nonelderly who need long-term or post-acute care services and supports.</li> </ul> <p>The stakeholder groups that have been meeting about the establishment of LTCQA are contemplating appropriate names that reflect its mission and wide range of stakeholders (i.e., terminology that adequately captures the broad range of long term care settings and services).</p>			<p>demonstrations.</p> <p>The Steering Committee will establish several workgroups that will help advance the major work of the LTCQA. Possible initial workgroups may include:</p> <ul style="list-style-type: none"> <li>- Governance/operations workgroup(s)</li> <li>- Technical workgroups to help develop and support pilots or demonstration projects</li> </ul>
<b>Membership/Member Role</b>	<b>Governance</b>	<b>Financing/Membership Dues</b>	<b>Nursing Presence</b>
<p>The major trade associations representing skilled nursing homes, assisted living facilities and other institutional settings (e.g., American Health Care Association [AHCA], American Association of Homes and Services for the Aging [AAHSA], National Center for Assited Living) of care have been visible contributors. Groups representing home care,</p>	<p>The early stages of the LTCQA have been supported by an initially small and informal group of organizations and convened by the Brookings Institution's Engelberg Center for Health Care Reform. This unofficial “planning group” has gradually expanded to reflect the diverse perspectives of a broader range of stakeholders, including providers, consumer and family advocates, government, and others. As the key</p>	<p>The LTCQA will ultimately become a self-sustaining membership organization. Several groups have ‘pledged’ funds in support of the launch. Additionally, the LTCQA conveners have discussed securing funding from grant-making foundations with a mission to support improvements in quality in long-term care .</p> <p>At this point, no membership fee</p>	<p>To date, nursing participation has been through attendance at meetings or calls. Several nursing groups were in attendance at the December meeting, including American Association for Long Term Care Nursing (AALTCN), National Conference of Gerontological Nurse Practitioners (NCGNP), The John A. Hartford Foundations Institute for Geriatric Nursing.</p>

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<p>Programs of All-Inclusive Care for the Elderly, hospice and palliative care and geriatric service providers (e.g., geriatric nurses) have also been involved in early discussions. A list of participants at the December 2008 meeting was provided.</p> <p>As envisioned, the LTCQA will be a broad-based organization encompassing a range of stakeholders, including those representing individuals, families, caregivers, providers, government leaders, and others. Further, it should focus on supporting quality improvement that is person-centered regardless of age, place of residence, or setting of care.</p> <p>At this stage, membership, governance, and organizational structure have not been determined.</p>	<p>goals and activities of the LTCQA take shape, and as many more stakeholders have become involved, the initial planning committee will help support the development of a more formal Steering Committee structure through a transparent process that will ensure adequate representation from a broad range of stakeholders.</p> <p>At this time no bylaws have been drafted/enacted.</p>	<p>schedule has been established. At the meeting held at Brookings on December 17, 2008 the major nursing home associations (AHCA, AAHSA) pledged \$15,000 in support of launch activities. No specific agreements, however, were made/determined.</p>	<p>There are two opportunities for nursing to get more involved. First, in the next six months, a Technical Advisory Group (TAG) will be addressing the key questions such as what are the gaps and barriers to person-centered measurement and how to move from the conceptual to the practical. Second, a Steering Committee will be established.</p>
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<b>Pharmacy Quality Alliance (PQA)</b> Year of Inception: 2006 URL: <a href="http://www.pqaalliance.org/">http://www.pqaalliance.org/</a>			
<b>Mission</b>	<b>Role in the Quality Enterprise</b>	<b>Organizational Structure</b>	<b>Staffing/ Workgroups</b>
The mission of the PQA is to: improve health care quality and patient safety through a collaborative process in which key stakeholders agree on a strategy for measuring performance at the pharmacy and pharmacist-levels; collecting data in the least burdensome way; and reporting meaningful information to consumers, pharmacists, employers, health insurance plans, and other health care decision-makers to help make informed choices, improve outcomes and stimulate the development of new payment models.	The PQA developed measure concepts and contracted with NCQA (subcontractor Advanced Pharmacy Concepts) to develop measures from prescription drug claims, which were submitted for NQF endorsement. PQA also contracted with AIR to develop a patient questionnaire (like CAHPS). The PQA has five demonstration projects to test the feasibility of creating systems to monitor the quality of pharmacy performance.	AHIP was a founding member that provided infrastructure services, which allowed PQA to get off the ground in an expedient fashion. PQA was "housed" within AHIP with a separate operating budget, for the first two plus years. Now, it is totally separate - PQA, Inc., a Delaware-based non-profit organization and will be seeking 501c3 status.	<p>The Executive Director started at half-time, and is now full-time. They also have a half-time assistant. The Director of Research and Practice Improvement is a faculty position with joint appointment, which is funded half-time by PQA through the university. This has been a very successful arrangement. The position was originally held by Dr. David Nau and now is through Purdue University. The Director of Research and Practice Improvement oversees the demonstration projects.</p> <p>Related work of the PQA is done in four key workgroups:</p> <ul style="list-style-type: none"> <li>- Communications &amp; Education</li> <li>- Quality Metrics</li> <li>- Data Aggregation &amp; Reporting</li> <li>- Research Coordinating Council</li> </ul> <p>Each workgroup is chaired by an appointed member of one of the steering organizations. 350-400 people are participating in the workgroups.</p>
<b>Membership/Member Role</b>	<b>Governance</b>	<b>Financing/Membership Dues</b>	<b>Nursing Presence</b>
The PQA has 60+ members. Members include government agencies, national pharmacy associations, health care provider and practitioner organizations, consumer groups, patient	The PQA is led by a Board of Directors comprised of 16-25 members from the following categories: (a) Academic institution or health care foundation; (b) State and national pharmacist	The PQA operating budget is \$1,000,000+. The PQA received seed money from about 2/3 of the initial Board (\$35,000 each). It is now self-sustaining through dues. Revenues	The only nursing member was the American Academy of Nurse Practitioners. Their membership was initially sponsored through a grant. They were very engaged, but it is uncertain whether they

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<p>advocacy organizations, chain pharmacy corporations, health plans, pharmacy benefit managers, quality improvement organizations, pharmaceutical corporations, generic manufacturers, biotechnology corporations.</p> <p>Workgroups develop recommendations that go to the full membership for review and endorsement. The members endorse through consensus. If there is enough disagreement, and there is no "consensus," the issue (or measure concept) doesn't move forward. The Board makes final decisions (for example, 30 metric concepts endorsed, but the Board will decide which to contract for measure development. They have not had a need to move to votes by "stakeholder" category as AQA has done.</p> <p>Members can appoint representatives to 3 of the 4 workgroups. The Research group is appointed because they want specific expertise, but members can nominate candidates.</p>	<p>practitioners organization;</p> <p>(c) Community/ Ambulatory independent practitioners (or organization representing independent owners);</p> <p>(d) Community/ Ambulatory chain practitioners (or organization representing chains);</p> <p>(e) Managed care practitioners group;</p> <p>(f) Employer or employer coalition representative and/or public or private purchasers/ payers;</p> <p>(g) Consumer advocacy or patient advocacy organization;</p> <p>(h) Health plan (or organizations representing plans and individual plans);</p> <p>(i) Pharmacy benefit management company/claims administrator/data aggregator;</p> <p>(j) Pharmaceutical manufacturer;</p> <p>(k) Generic pharmaceutical organization; and</p> <p>(l) Long term care and/or health system pharmacy practitioners (or organization representing one of these two settings). Directors are elected by a majority vote of the Directors then in office at the annual meeting of the Board or at a special meeting called for such purpose. Each director shall hold office for a four (4) year term and until his or her successor is duly elected or until his or her death, resignation or removal. Directors may serve up to two (2) consecutive terms.</p> <p>Copy of bylaws provided (see appendix).</p>	<p>are entirely from membership dues (no sponsors, no charge for meetings).</p> <p>The fee schedule is on the application form. There is a sliding scale with two structures - non-profit and for-profit.</p> <p>Dues for Non-Profit Organizations (Based on Annual Operating Budget) range from \$1,250 (&lt;\$500,000) to \$25,000 (&gt;\$50 million).</p> <p>Dues for For-Profit corporations (Based on Annual U.S. Based Sales) range from \$1,250 (&lt;\$2 million) to \$25,000 (&gt;\$250 million).</p> <p>Academic Memberships for full-time faculty are \$500.</p> <p>Organizations can apply for a dues waiver, which are evaluated on a case-by-case basis by the Steering Committee.</p>	<p>will be continuing membership.</p>
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<b>Quality Alliance Steering Committee (QASC) Year of Inception: 2006 URL: <a href="http://www.brookings.edu/projects/qasc.aspx">http://www.brookings.edu/projects/qasc.aspx</a></b>			
<b>Mission</b>	<b>Role in the Quality Enterprise</b>	<b>Organizational Structure</b>	<b>Staffing/ Workgroups</b>
<p>The vision of QASC is to advance high-quality, cost-effective, patient-centered health care through the coordination of the various groups that are working to promote public reporting of health care provider information for:</p> <ul style="list-style-type: none"> <li>- improvement directly by providers;</li> <li>- consumer decision-making; and</li> <li>- effective policies, payment policies and consumer incentives that reward or foster better provider performance.</li> </ul>	<p>QASC is not involved in measure development (except where there was a gap in cost-of-care metrics). It coordinates development/creation of a data infrastructure enabling wide-spread availability of performance information. The particular focus is on producing person-centered performance information (e.g., clinical outcomes across the episode of care).</p>	<p>QASC is a coalition; not a formal organization/legal entity.</p>	<p>Staff support is provided by the High-value Health Care Project grant from RWJF. It's difficult to separate out QASC functions from the technical activities of the grant, but approximately .5 FTE of director and .5 FTE of assistant support meetings of the QASC. Brookings staff support and enable the activities of the QASC and its workgroups by:</p> <ul style="list-style-type: none"> <li>- supporting chairpersons in the preparation of meeting agendas;</li> <li>- advising chairpersons on critical issues before the QASC and or workgroups;</li> <li>- conducting relevant background research, compiling materials, devising draft documents, etc.;</li> <li>- managing logistics of meetings and associated travel, lodging, etc.;</li> <li>and</li> <li>- ensuring effective communication about the QASC, web site support, report generation, etc.</li> </ul> <p>The workgroups include:</p> <ul style="list-style-type: none"> <li>- Episodes of Care Work Group</li> <li>- Cost-Pricing Transparency Work Group</li> <li>- Measure Implementation Strategy Work Group</li> <li>- Regional/national Coordination Work Group</li> </ul>

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Membership/Member Role	Governance	Financing/Membership Dues	Nursing Presence
<p>QASC has 33 members. The Quality Alliance Steering Committee is comprised of members who are recognized leaders in critical performance measurement and reporting activities and/or sector- or area-specific quality alliances. Members represent a broad array of key stakeholder groups such as consumers, employers/payers, health plans, health care professionals, hospitals/institutional providers, and others. Members are invited to join the QASC upon recommendation of the QASC agenda group and approval by the QASC.</p> <p>Members serve three-year, staggered terms which are renewable. Members attend QASC meetings and participate fully in its deliberations and assist in implementing QASC recommendations. They:</p> <ul style="list-style-type: none"> <li>- Work to realize the QASC vision through coordinating the activities of their stakeholder group with related QASC activities.</li> <li>- Work collaboratively with other QASC members, quality alliances and the entire quality measurement/reporting</li> </ul>	<p>The QASC is chaired by two individuals. One chairperson shall be the Director of the Agency for Health Care Research and Quality (AHRQ). The other chairperson shall be nominated by the QASC Agenda Group and approved by the QASC. This chairperson serves a three-year term that is renewable. Five to seven individuals from the roster of current QASC members serve on the Agenda Group (i.e., Executive Committee). Members are nominated by the Chairpersons to serve on the Agenda Group. Nominees are subject to approval by the QASC. Members of the Agenda Group shall represent a broad range of stakeholder groups and quality alliances. Members serve three-year, staggered terms which are renewable. The Agenda Group assists the chairpersons in the preparation of QASC meetings and agenda items, the planning and execution of relevant QASC activities and projects, and helps to assure that all relevant QASC issues are appropriately reviewed and guided by QASC members.</p> <p>QASC does not have formal bylaws. It has established Operating Rules and Procedures available on web site (see appendix).</p>	<p>The Robert Wood Johnson Foundation (RWJF) is providing significant funding to the Engelberg Center for Health Care Reform at the Brookings Institution, America’s Health Insurance Plans (AHIP) Foundation, and the American Board of Medical Specialties to work on efforts supporting the vision of the Quality Alliance Steering Committee (QASC). RWJF’s support totals \$15.8 million over 30 months, only a portion of which supports the QASC. Prior to RWJF funding, QASC was supported by AHRQ (staffing, meeting logistics).</p> <p>There are no membership fees.</p>	<p>Mary Naylor represents nursing on the Steering Committee. Nursing has been involved through active participation on the workgroups by representatives of nursing organizations and by nurses in other organizations.</p>

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enterprise. - Publicly represent QASC and its vision and goals.			
<b>Surgical Quality Alliance (SQA) Year of Inception: 2006 URL: <a href="http://www.facs.org/ahp/sqa/index.html">http://www.facs.org/ahp/sqa/index.html</a></b>			
<b>Mission</b>	<b>Role in the Quality Enterprise</b>	<b>Organizational Structure</b>	<b>Staffing/ Workgroups</b>
The mission of the surgical quality alliance is to bring surgical specialties and anesthesiology together to define the principles of surgical patient quality measurement and develop awareness among interested parties about issues related to surgical care and quality in all surgical settings.	The information on SQA summarized in this table was gathered from the web site only, which did not provide information for all fields.	The information on SQA summarized in this table was gathered from the web site only, which did not provide information for all fields.	The information on SQA summarized in this table was gathered from the web site only, which did not provide information for all fields.
<b>Membership/Member Role</b>	<b>Governance</b>	<b>Financing/Membership Dues</b>	<b>Nursing Presence</b>
The membership includes 16 medical specialty organizations.	SQA Leadership Chair: Frank Opelka, MD, FACS Vice-Chair: Bob Haralson, MD, FACS Vice-Chair: Fred Edwards, MD, FACS	The information on SQA summarized in this table was gathered from the web site only, which did not provide information for all fields.	No nursing involvement is indicated.

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