# Pharmacy Software Reveals Patients' Rx Histories

BY JOYCE FRIEDEN
*Associate Editor, Practice Trends*

Want to see all the medications your patient is on before you write that next prescription? A pharmacy trade group is ready to help you . . . if you have electronic health record or e-prescribing software.

New software from SureScripts, a technology offshoot of the National Community Pharmacists Association and the National Association of Chain Drug Stores, will allow physicians to view information on all prescriptions filled by a patient at a wide variety of retailers and pharmacies.

The purpose of the software is to get more physicians interested in e-prescribing, according to Kevin Hutchinson, CEO of SureScripts, which rolls out the new service this month. "By providing a medication history, we start making e-prescribing more attractive to the 75% of physicians who are not using anything today. It gives them a 'business case' to provide an EHR or a stand-alone e-prescribing application."

The service is available initially in select areas of six states—Florida, Massachusetts, Nevada, New Jersey, Rhode Island, and Tennessee. SureScripts hopes to expand the service in the future.

SureScripts was founded in 2001 by the National Community Pharmacists Association and the National Association of Chain Drug Stores. Its goal is to improve electronic connectivity between physicians and pharmacies by providing the behind-the-scenes network that makes the two-way electronic exchange of new prescription and renewal information possible, according to the company.

Its revenues come entirely from pharmacies that become members; any income generated is redistributed to members.

Under the program, which cost $6 million to develop, physicians requesting the medication history of a particular patient will see all the new prescriptions and refills that the patient has obtained at Walgreen's, CVS, Wal-Mart, and other large pharmacy chains.

"The prescribing process doesn't stop at sending the prescription to the pharmacy," Mr. Hutchinson said. "We have to give more clinical information to providers—physicians as well as pharmacists—so they can take better care of patients and know what they're taking that the doctors might not have prescribed themselves. It's really about driving adherence and compliance."

SureScripts is working on getting mail-order pharmacies to sign on to provide data. "We've had expressions of interest and commitment, but they won't be part of the pilot," he said. Other future data sources could include insurers, pharmacy benefit management companies, and pharmacies in hospitals and long-term care facilities.

The good thing about using pharmacy data rather than insurance claims is that the pharmacy data includes the date the patient picked up the medication, not just the date that a claim was approved, Mr. Hutchinson said. That information will help physicians "track their patients' compliance and figure out, for example, how many of their diabetic patients are not taking their medications as prescribed."

Physicians will be able to use this service in two ways, according to Mr. Hutchinson. "Some may prefer to send a request at night looking at their patient schedule for the next day" so that they'll have the medication history in front of them before each patient even gets to the office. For walk-ins, "there will be a button that says 'Get medication history,' which the front desk can do prior to the patient going back to the exam room."

With data coming from many different sources, patient verification is an important part of the process, he noted. The company is using a master patient index from Initiate Systems Inc. to verify records.

"Think of it as a record locator service," Mr. Hutchinson said. Initiate Systems will send SureScripts the patient's demographic information and other distinguishing data elements, and SureScripts will match it up with the pharmacy data and decide whether to send the information on to the physician, based on how confident the software is of the match.

"We set thresholds based on what constitutes a more accurate match than nonaccurate," he explained. "We err on the side of caution, so if any patients may not match who we think they are, we don't send that information. Absent a national patient identifier, this is the only way you can do the matching."

Since many physicians have their own identification numbers for patients, SureScripts is looking at eventually using those numbers to provide accurate prescribing information. This might entail having pharmacies electronically store the patient identifier numbers for each of the different physicians that a patient sees, Mr. Hutchinson said.

Like other medical information, prescribing data falls under the Health Insurance Portability and Accountability Act (HIPAA). Because SureScripts is considered a "business associate" of both the physician and the pharmacy under the law, its data transmission does not present a problem, especially since patients signing the HIPAA form at their doctor's office have given their physician permission to look at this type of data, he added.

Kirk Nahra, a Washington lawyer specializing in health privacy, said the program is a good example of the tension between providing better health care and giving up some privacy rights. "With all of these e-initiatives—e-prescribing, electronic health records—the whole purpose is to give a lot more people access to a lot more information," he said. ■

# Pay-for-Performance Agreement Ruffles Feathers

BY JENNIFER LUBELL
*Associate Editor, Practice Trends*

Specialty organizations are concerned that the American Medical Association is unilaterally setting performance goals that doctors won't be able to meet.

A recent agreement between the AMA and leaders in Congress outlines an ambitious 2-year timeline for establishing performance measures, "to improve voluntary quality reporting to congressional leadership," AMA Chair Duane M. Cady said in a statement.

Dr. Cady signed the pact at the end of last year, although the details weren't publicly disclosed until several months later. The terms were outlined in a Feb. 7 memorandum from AMA Vice President Michael Maves to the state medical associations and national specialty societies.

The agreement was cosigned by Sen. Charles E. Grassley (R-Iowa), chair of the Senate Finance Committee; Rep. Bill Thomas (R-Calif.), chair of the House Ways and Means Committee; and Rep. Nathan Deal (R-Ga.), chair of the House Energy and Commerce subcommittee on health.

If the plan goes through, physician groups will work with the Centers for Medicare and Medicaid Services to agree on a starter set of evidence-based quality measures for a broad group of specialties, with a goal of developing approximately 140 physician measures covering 34 clinical topics by the end of 2006.

The AMA has been working on these quality initiatives for some time, Dr. Cady said. "For the past 5 years the AMA has convened the Physician Consortium for Performance Improvement, which includes more than 70 national medical specialty and state medical societies." To date, the consortium has developed more than 90 evidence-based performance measures, he said.

The consortium has not yet tested the physician measures; it has been working with several groups to do so, including the Ambulatory Care Quality Alliance, said Dr. Nancy Nielsen, speaker of the AMA's House of Delegates, at a press briefing. The alliance is receiving funding from the Agency for Health Research and Quality and CMS to test 26 measures at six clinical sites, beginning May 1. Those measures include some developed by the consortium, among others. The pilot is crucial, as it will bring to the surface any "unintended consequences," Dr. Nielsen said. Then in 2007, doctors who report on three to five quality measures would see increased payments from Medicare. By the end of next year, physician groups should have developed performance measures "to cover a majority of Medicare spending for physician services," the agreement said.

**While primary care quality measures have been written, it's a different story for subspecialties because 'they're starting from ground zero.'**

Other initiatives, such as working on methods to report quality data and implementing reforms to address payment and quality objectives, also were outlined.

As far as Dr. Cady is concerned, nothing in the agreement with the congressional leaders should be a surprise. "It involved only [those] commitments we had previously outlined to our specialty society colleagues."

All of these steps had been documented previously in public letters to Congress and the Bush administration and distributed to medical specialty societies, he said.

Yet some of the members of the consortium said they had no advance notice of the AMA's plans to sign this pact.

"This is an agreement signed with leaders on Capitol Hill on how pay for performance should be laid out, and some groups feel they should have been a part of it," Cynthia A. Brown, director of advocacy and health policy at the American College of Surgeons, said in an interview.

The real problem is not about advocacy or the workings of the consortium. It's about meeting deadlines on clinical measures, Ms. Brown said. "Not everyone is ready for [pay for performance]."

While primary care quality measures have been written, it's a different story for subspecialties, "because their measures haven't even been developed yet. They're starting from ground zero," she said.

With this latest agreement, subspecialties now feel pressured to find their own groups of doctors to propose measures to run through the consortium's process by year's end, she said.

The criteria on performance measurement also will be different by specialty, Ms. Brown said. "Surgeons in particular often like to be judged by outcomes, and primary care doctors don't want to be because they have a bigger problem with patient compliance. One size doesn't fit all."

Dr. Nielsen noted that the specialty societies had been included on the performance measure development from the start. The initial measures won't cover all the specialties, but it was necessary to show Congress that the profession was serious about quality improvement by getting something started.

The American College of Physicians, in the meantime, wants to move even faster than the AMA on measure development, voluntary reporting, and pay for performance, Robert B. Doherty, the college's senior vice president for governmental affairs and public policy, said in an interview.

The key is for all of the stakeholders in performance measurement programs to stay focused on the substance, Mr. Doherty said. "We need to show Congress that the profession is committed to quality measurement and reporting." ■