



Patient ID Now Coalition

Written Testimony for the Record – Hearing: “Review of Coronavirus Response Efforts”

Subcommittee on Labor, Health and Human Services, Education, and Related Agencies

Committee on Appropriations

United States Senate

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On behalf of the [Patient ID Now](#) coalition, thank you for the opportunity to provide written testimony regarding the U.S. Senate’s Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies (Labor-HHS) hearing, “Review of Coronavirus Response Efforts.”

Patient ID Now is a coalition of healthcare organizations that represents a wide range of healthcare stakeholders committed to advancing through legislation and regulations the development and implementation of a national strategy to address patient identification and matching.

The response to the COVID-19 pandemic has highlighted the need to address patient misidentification throughout the health system. Accurate identification of patients is one of the most difficult operational issues during a public health emergency, including the gathering of patient demographic information (e.g. —address, phone, email, etc.) and ensuring such information remains attached to the correct patient. Field hospitals and temporary testing sites in parks, convention centers, and parking lots have exacerbated these challenges.

Without the ability to accurately identify and match patients to their health information, this critical information becomes lost and safe, effective and timely diagnosis and is jeopardized. For example, there are reports of instances where patient specimens are collected for COVID-19 testing in temporary sites and then sent off-site to a public health lab for testing. Once the results were returned, there have been difficulties matching the results to the correct patient given the inconsistent and scant amount of demographic information included with the sample. This has resulted not only in a backlog of COVID-19 results unable to be sent to patients, but even results being sent to the *wrong* patient, increasing the privacy and safety risks to the entire community. Without test results being returned to the correct patients, contact tracing and individuals’ own ability to quarantine effectively is hindered.

Correctly matching patients to their information is not just vital for the initial COVID-19 diagnosis. Ensuring the correct patient medical history is accurately matched to the patient is also critical for future patient care, claims billing, patients’ long-term access to their complete health record, and for tracking the long-term health effects of COVID-19, which the medical community does not currently know.

Furthermore, the nationwide response in the coming months to the COVID-19 pandemic hinges on accurate information. For example, once a vaccine is created, any large-scale immunization programs will depend on accurate patient information to identify who has had the disease, who has been vaccinated, and what their outcomes are. Multiple dose vaccines will rely even more heavily on patient records being complete to ensure the correct timing and dosage for patients to be fully protected. As

public health systems increasingly rely on patient data pulled from electronic health records (EHRs), we must make sure that the patient information within these EHRs is accurate in order to have the best public health response to these emergencies.

The COVID-19 pandemic has also laid bare healthcare disparities in underserved communities and populations. As the coronavirus has disproportionately affected these communities, so has patient misidentification, increasingly putting these patients' health at higher risk. According to OCHIN, a national, non-for-profit, health IT service provider for a national network of more than 500 healthcare delivery sites across the country—

- Black patients make up 13% of their patient population but **21% of duplicate records;**
- Hispanic/ Latino patients make up 21% of the population that OCHIN's members serve, yet they make up **35% of duplicates;**
- The homeless population makes up 4.3% of OCHIN patients, but 12% of its duplicates (**almost three times the expected rate**); and
- Migrant patients make up 2.1% of the OCHIN patient population but **3.6% of its duplicates.**

Failure to accurately identify and match patients to their health information raises serious quality of care and patient safety concerns, which must be a top priority during a pandemic. Difficulties in correctly matching patients to their health information across health information technology systems limits health information exchange, which can result in medical errors, delayed or lost diagnoses, duplicative testing, and wrong patient orders. The problem of patient misidentification is so dire that one of the nation's leading patient safety organizations, the ECRI Institute, named patient misidentification among the top ten threats to patient safety.¹ Patient matching issues can cause everything from delayed or unnecessary care, to adverse drug events, to even death.²

The problem of patient misidentification extends to hospitals and providers that are already overburdened during this health crisis. Approximately 33 percent of all denied hospital claims are associated with inaccurate patient identification, costing the average hospital \$1.5 million each year, and the healthcare system more than \$6 billion.³ Patient misidentification costs the average clinician almost half an hour in wasted time per shift at a time when many providers are already stretched thin.⁴

Finally, patient privacy must continue to be a priority during a pandemic. Without a national strategy addressing patient identification and matching, the healthcare ecosystem faces an "inverse" privacy problem, whereby individuals must repeatedly disclose individually identifiable information to each healthcare provider they see to accurately match the patients to their medical record. Furthermore, each payer still maintains separate proprietary identifiers for patients, increasing the number of identifiers in use. Even more worrying for patient privacy is risk of overlays—i.e.—the merging of multiple patients' data into one medical record, causing patients to have access to other patients' health information, which could result in an unauthorized disclosure under HIPAA.

¹ Top 10 Patient Safety Concerns for Healthcare Organizations, Available at:

https://www.ecri.org/EmailResources/PSRQ/Top10/2017_PSTop10_ExecutiveBrief.pdf

² <http://www.healthcarebusinesstech.com/patient-identification-errors/>

³ <https://www.securitymagazine.com/articles/88999-inaccurate-patient-ids-cost-hospitals-15m-a-year>

⁴ <https://www.imprivata.com/company/press/positive-patient-identification-can-dramatically-improve-patient-care-and-hospital%E2%80%99s>

The issues around patient identification arise due to a narrow interpretation of a two-decade old appropriations restriction included in Section 510 of the Labor-HHS appropriations bill that prohibits the US Department of Health and Human Services from spending federal dollars to promulgate or adopt a unique health identifier for individuals. This archaic ban has had a detrimental impact across the healthcare system to patients, providers, and public health. Striking Section 510 from the Labor-HHS appropriations bill will provide the US Department of Health and Human Services the ability to evaluate a full range of patient matching solutions and enable it to work with the private sector to identify a nationwide strategy that is cost-effective, scalable, secure and one that protects patient privacy.

Accurate patient identification and matching must be a top priority during public health emergencies to protect patient safety, patient privacy, and strengthen the public health response. While Section 510 remains in the Labor-HHS appropriations bill, the ability to address these issues will continue to be stifled.

We appreciate the opportunity to provide comments on the issue of patient identity and matching as it relates to the national coronavirus response. We look forward to working with you and acting as a resource on patient identification. Should you or your staff have any additional questions or comments, please contact Kate McFadyen, Director, Government Affairs, AHIMA, at kate.mcfadyen@ahima.org or (202) 480-6058.