Testimony of the Patient ID Now Coalition
Concerning Fiscal Year 2022 Health and Human Services Appropriations

Written Testimony Submitted for the Record to the Senate Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies

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On behalf of the Patient ID Now coalition, thank you for the opportunity to provide written testimony regarding the US Senate's Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies Fiscal Year 2022 (FY22) appropriations bill.

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.

On behalf of the Patient ID Now coalition, we urge you to reject the inclusion of outdated rider language in Section 510 of the Fiscal Year 2022 Labor, Health and Human Services, and Education and Related Agencies (Labor-HHS) Appropriations bill that prohibits the US Department of Health and Human Services (HHS) from spending any federal dollars to promulgate or adopt a national unique health identifier.

For over two decades, innovation and industry progress has been stifled due to a narrow interpretation of Section 510, included in Labor-HHS bills since FY1999. Even worse, without the ability of clinicians to correctly connect a patient with their medical record, lives have been lost and medical errors have needlessly occurred. These are situations that could have been avoided had patients been able to be accurately identified and matched with their records. This problem 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]

Today, there is no consistent and accurate way to link patients to their health information as they seek care across the continuum. Countless times every day, a patient record is mismatched or is duplicated into multiple disparate records. Medications are prescribed for patients lacking a complete medical history in their record, allergies are missed, diagnoses are lost or delayed, and duplicative tests are ordered. Clinicians and medical personnel across the spectrum must be able to trust that patient records they are using to make vital care decisions are complete and accurate.

The issue of patient misidentification creates additional financial burdens to patients, clinicians, and institutions. A 2018 Black Book market research survey found that the average expense of repeated medical care due to patient misidentification costs an average of $1,950 per inpatient stay and over

[1] Top 10 Patient Safety Concerns for Healthcare Organizations, Available at: https://www.ecri.org/EmailResources/PSRQ/Top10/2017_PSTop10_ExecutiveBrief.pdf

$800 per emergency department visit.[2] According to a study of healthcare executives, misidentification costs the average healthcare facility $17.4 million per year in denied claims and potential lost revenue.[3] The Black Book survey also indicates that denied claims as a result of patient misidentification costs the US healthcare system over $6 billion annually.

Now, more than ever, the COVID-19 pandemic highlights the need to address patient identification and matching. Accurate identification of patients is one of the most difficult operational issues during a public health emergency, including the collection of patient demographic information (e.g. – name, address, phone number) and the implementation of a method to ensure that the information remains attached to the patient. Field hospitals, temporary testing sites, and vaccination sites in parks, convention centers, and parking lots exacerbate these challenges. The fact that most COVID-19 vaccines are currently administered in two doses increases the difficulties of patient identification. There are reports of vaccination registrations causing thousands of duplicate records within a single system, costing some hospitals and health systems at least $12,000 per day to rectify these errors. There are also reports of some vaccination sites being denied more vaccines because patient record systems incorrectly show patients have not received administered vaccinations. Ensuring the correct patient medical history is accurately matched to the patient is critical for future patient care, claims billing, patients' long-term access to their complete health record, and for tracking the long-term effects of COVID-19.

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.***

The current system that lacks a national strategy around patient identification and matching also presents a number of troubling privacy issues for patients. Right now, 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 a patient to have access to other patients' health information, which could result in an unauthorized disclosure under HIPAA.

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[2] https://www.prnewswire.com/news-releases/improving-provider-interoperability-congruently-increasing-patient-record-error-rates-black-book-survey-300626596.html

[3] https://www.imprivata.com/patient-misidentification

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.

For the past two fiscal years, the US House of Representatives has voted in a bipartisan manner to remove the ban from the Departments of Labor, Health and Human Services, Education, and Related Agencies appropriations bill. We urge the Senate to follow the bipartisan will of the House of Representatives to protect patients and ensure that Section 510, the archaic funding ban on a national unique health identifier, is NOT included in the FY2022 Labor, Health and Human Services, Education, and Related Agencies Appropriations bill.

We appreciate the opportunity to provide comments on the issue of patient identity and matching in the FY22 Labor-HHS appropriations bill. 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.