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Patient Linking Hearing
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Thank you for the opportunity to provide testimony today as you examine issues associated with linking and matching patients to their health information, both within healthcare organizations as well as exchanges across healthcare entities.

I am Ken Tarkoff, Senior Vice President and General Manager of the Clinical Solutions group at RelayHealth, a division of McKesson Corporation. For more than 15 years, I have been working in senior management positions of health information technology companies. In my current role, I am responsible for the general management of RelayHealth's clinical connectivity business primarily offered to health systems, independent physician practices, health plans and consumers. RelayHealth Clinical Solutions is also a large player in the community and regional health information exchange space and one of the few solutions in the market that enables active participation of patients in this community exchange.

I am testifying today on behalf of RelayHealth.

In response to some of the questions you have raised, I would like to begin by sharing a brief hypothetical example to illustrate one of the complex challenges that we face in our rapidly evolving world of electronic healthcare.

A husband and wife go to the same physician practice for years. They divorce and the husband remarries a woman with a similar first name who was born the same year as his first wife. A lab result for Wife #2 is delivered to the physician practice online. The record is not an exact match, but the system presented Wife #1 as a reasonable match since they had the same last name, zip and gender, and a close first name and date of birth. The practice staff person who handles the lab record is new and does not know that there is both a former wife and a current wife on record. As a result, the staff person releases Wife #2's record to Wife #1.

While this scenario is conceivably possible in both a paper-based system and an electronic system, it illustrates some of the complexities we face today in patient identity management.

Our industry is currently building a foundation for health information exchange (HIE), and to do so, we must address an exceedingly complex set of issues that has been developing since the inception of health information technology (health IT). In light of all of the changes and concurrent efforts in health IT, we cannot expect to quickly build a foundation and infrastructure for global patient identity matching. Healthcare providers need time to implement health IT solutions and to develop strategies and processes to exchange and best utilize interoperable, accurate and secure patient data, with the ultimate goal of facilitating delivery of high-quality care.

As we construct our solutions and build an interoperable infrastructure across our healthcare system, I offer several principles for your consideration:

1. A local and regional set of challenges requires local and regional solutions.

Healthcare is an industry that is recognized as a local and regional business focused on the provider-patient relationship. As a result of this local and regional approach to healthcare, we believe it is important to have a decentralized approach, with the option for discrete entities to centralize as appropriate.

A decentralized approach would give each care delivery organization the power to determine how health data are managed, matched and presented. By allowing providers to establish the right processes and workflow, decentralization will facilitate organic growth of HIE at the community level, where patients have strong relationships with their providers and providers are personally knowledgeable about each patient's identity.

A decentralized approach also acknowledges that there are emotional and political implications associated with the concept of a national patient identifier. By pursuing a decentralized approach, our healthcare system can move forward with robust healthcare information exchange, while the concept of a national patient identifier is further examined.

2. Facilitate transparency by building on provider-patient relationships.

Transparency should empower patients to be more involved with their care. By building on the foundation of provider-patient relationships, we can create an environment of shared responsibility for patient data. As a result, patients will feel that their Patient Health Record (PHR) is a collaborative, shared effort. In this environment, if a patient or provider sees an error, they can likely correct it before any harm is done.

3. Create patient-centric processes with limited impact on clinician workflow.

Standardized approaches must recognize that a clinician's foremost responsibility is to provide the best possible care for each individual patient. To ensure that we are addressing widespread adoption challenges, we should garner clinician feedback on an ongoing basis to ensure we do not negatively impact workflow.

Recommendations for ONC's Approach to Patient Matching:

In addition to the three principles, I would like to submit two recommendations to guide the development of federal policy in this area.

1. **Enable local and regional approaches to patient matching by standardizing data fields and formats.**

   The use of standard data fields and formats for demographic matching often can introduce the need for human intervention to help prevent or resolve patient identity matching errors.

As an example, many solutions do not support the middle-name field, requiring system users to add a middle name or initial to the first or last name fields. While the additional information may be useful, it will likely inhibit exact patient identity matching and require manual intervention. Similarly, some names include “special” text characters such as a hyphen or an apostrophe. If a system does not support these formats, the users may add a space instead of the special character, potentially creating an entirely new name structure. In both of these examples, human intervention is required to resolve the matching issues.

If the ONC defines demographic data and format standards for patient identity matching, the frequency of these types of human intervention will be reduced. Additionally, other standard identifiers, including a national patient identifier, may also reduce patient matching issues. However, we do not believe that any form of data and format standardization and/or centralized identifier will completely remove the need for human intervention in preventing or resolving incorrect patient matches. Therefore, identifying the appropriate resource to manage these identity issues is very important.

Since local communities of healthcare providers know their patients best, we believe they are the most qualified to prevent and resolve these issues. This approach requires efficient workflow in health IT systems supported by a more comprehensive data and format standard for demographic patient matching.

2. **Implement processes for correcting data.**

   Human error will always be the greatest cause for incorrect matches and bad data. The best way to manage the risk of human error is to have a shared sense of responsibility among all constituents who interact with the data. For example, patients should have functionality that allows them to notify providers by flagging errors on their electronic records. In turn, providers should have both the technical capability and a standard window to correct the issue. Implementing a standard process for identifying and correcting errors will reduce the risk of bad data propagating through multiple connected systems. Additionally, healthcare providers and patients would benefit from a standard transaction set or flag that identifies potentially incorrect data and offers both parties a standard capability to correct that data in their systems.

If the ONC implements these two recommendations, we anticipate a significant reduction in patient identity matching issues that impact the ability for providers to deliver quality care.

I appreciate the opportunity to participate in this dialogue as you address fundamental issues that will enable us to continue to build upon the existing healthcare information infrastructure. We look forward to working with you as you consider the recommendations presented today.

Thank you for your consideration. I would be pleased to answer any questions.