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# 1 Excerpt from Request for Feedback

I am reaching out to you because you provided testimony at the Health IT Policy Committee's Tiger Team hearing on improving the accuracy of matching patients to their health data in December of 2010.

HHS recently released proposed rules setting for the meaningful use and EHR certification rules for Stage 2 of the HITECH incentive program. Stage 2 of meaningful use proposes increased requirements for eligible providers and hospitals to exchange data in transitions of care (through the use of a Consolidated CDA summary of care record standard) and to perform reconciliation of medication, problem and medication allergy lists when information on a patient is sent from one or more different sources. The ability to effectively match patient data when information is sent from another source will obviously be key to the success of these initiatives.

In the proposed EHR certification rule, the Office of the National Coordinator for Health IT (ONC) specifically asks if EHR technology should be tested and certified to its capability to "perform some type of demographic matching or verification" when patient records are received from another source (they pose this comment both with respect the incorporation of a Consolidated CDA as a result of a care transition (page 60 of the draft rule) and with respect to comparing two or more sources of data for reconciliation purposes (page 63 of the draft rule). (Page references are to the initial draft rule posted on the web, not the official federal register notice.)

Do you have any thoughts on this question that you would be willing to share with us as the Tiger Team considers this question?

# 2 Dignity Health (formerly Catholic Healthcare West)

Respondent: Scott Whyte, Vice President, IT Connectivity, Dignity Health

Thanks for reaching out to Dignity Health (formerly Catholic Healthcare West) to gain our input regarding the Stage 2 Certification requirement for EHR technology to be tested and certified to its capability to perform some type of demographic matching or verification when patient records are received from another source. I appreciate you giving me to time to gather my thoughts and confer with my colleagues.

As you'll recall, Dignity Health is the fifth largest not-for-profit hospital system in the country. In addition to 40 hospitals in Arizona, California and Nevada, Dignity Health has a network of over 10,000 affiliated physicians and over 55,000 employees. Given our regular and extensive engagement with community providers, we're actively working on patient and provider matching. Since 2007, Dignity Health has developed a large and successful private HIE solution that connects over 4,300 independent physicians, integrates with over 20 different acute and ambulatory EMRs and maintains over 4.1 million unique patient records. Dignity Health is also engaged in a number of local and community HIOs.

Dignity Health supports a certification requirement for patient matching for transitions of care and reconciliation functions, as long as it is aligned with the meaningful use requirements for providers. As the ONC finalizes this and other regulatory requirements for Stage 2 Meaningful Use and EHR Certification, Dignity Health urges the ONC to recognize the complexity of performing matching, and the continued need for human intervention. Specifically, Dignity Health provides the following thoughts to the Tiger Team for your consideration:

- Workflow and Human Intervention. Many ambulatory EMRs have some level patient matching functions to facilitate results delivery from an outside source (i.e. lab results, imaging, etc.). However, the exchange of information through the use of Transition of Care documents or Consolidated CDA Summary of Care Records, is not currently used throughout the health care community. The move toward the accurate exchange of this type of information can occur through technology, but will also require significant workflow changes and human intervention. The health care community has to be given the opportunity to build both the technology and the workflow changes.
- Standardized Matching Criteria. In addition to the certification requirement, the ONC should establish a minimum set of demographic information to accurately match patient records. Dignity Health has invested significant resources to implement an enterprise master patient index to reconcile patient identity across the acute and ambulatory setting. Despite these investments, there remains variability in matching within Dignity Health and matching with our data partners throughout the health care community. A standardized set of matching criteria (e.g., first name, last name, DOB, gender, zip) would help mitigate this variability, and would help build a trust framework that will facilitate patient matching at a larger scale.
- Flexible and Scalable. The technology necessary to implement patient matching should be both flexible, so the health care community can develop and evolve solutions, and scalable, so the solution can translate throughout the industry.
- Provider Matching. Policies and technologies developed to support patient matching should be leveraged to also support provider matching. In our experience, provider matching is equally important as patient matching, especially in a "push model" environment. This will support a transition into accurate and true health information exchange throughout the industry.

I hope these thoughts are helpful to the Tiger Team as you move forward with discussions around the patient matching certification requirement. Please let me know if you need additional information, or if you'd like for me to arrange for a phone conversation with the Dignity Health team. Thank you again for reaching out to us.

# 3 IBM Software Group

Respondents: Dr. Scott Schumacher and Lorraine Fernandes, RHIA, IBM Software Group, Information Management

Thanks for seeking our reaction to the NPRM section that addresses data exchange and patient matching.

Question:

In the proposed EHR certification rule, the Office of the National Coordinator for Health IT (ONC) specifically asks if EHR technology should be tested and certified to its capability to "perform some type of demographic matching or verification" when patient records are received from another source (they pose this comment both with respect the incorporation of a Consolidated CDA as a result of a care transition (page 60 of the draft rule) and with respect to comparing two or more sources of data for reconciliation purposes (page 63 of the draft rule). (Page references are to the initial draft rule posted on the web, not the official federal register notice.)

Response:

Certified EHR technology should NOT include a requirement for performing demographic matching

Rationale:

- The patient matching function should be external to the EHR, as specialized technologies are used for this. One danger with having "some type" of demographic matching as part of the EHR is that organization may come to rely on this as their "only type" of matching and thus ignoring the other functions critical to identity management.
- Key among these functions are data stewardship and early patient identification. Correct identification of the patient occurs in advance of the clinical data capture or creation, typically at the point of registration. Best practices require that ambiguities be resolved before clinical treatment thus many institutions develop patient identity solutions prior to implementing an EHR.
- And, many business processes are used in managing the data stewardship function, and clearly business processes aren't part of certification.
- Lastly, exchange of a CCD (or other discrete data) is generally handled through a gateway and other specialized approaches such as Direct, not in the EHR itself. Matching these records, whether through technology or business processes, therefore happens outside the EHR in the same manner as patient-presented information.

Thus imposing a certification requirement in the EHR doesn't make sense from a technology or business process perspective. The functionality shouldn't be there.

# 4 RelayHealth

Respondent: Kenneth A. Tarkoff, SVP/GM, Clinical Solutions, RelayHealth

Sorry for the delay. We had a chance to get together and wanted to give you a quick response on our thoughts here. In response to your question about requiring EHRs to have demographic matching, our simple response would be that we do not think that would be a good idea. Instead, we believe that the ONC should certify on the ability to send and receive a normalized set of demographic identifiers on all certified workflows (e.g., transition of care, sending and receiving laboratory data, public health, patient download and transmit). Ideally, ONC would also certify on the ability to send those demographic identifiers via a common standard (e.g., HL7 ADT or one of the NwHIN standards) to enable record locator and identity management services for a variety of workflows (transition of care, transactional, and longitudinal record services). The rationale behind this perspective is that we believe the more important element here to ensure is that all certified EHRs are exchanging the minimum data required to do demographic matching. EHRs may decide to build demographic matching capability into their EHR or they may decide to rely on third party capabilities. Both of these options will work effectively. At a minimum, we should make sure that the EHRs are providing the data necessary to match patients and allow the market to decide who offers these capabilities.

I hope this information is helpful and we would be happy to discuss in more detail if necessary.

# 5 HIMSS

Respondents: Lisa A. Gallagher, BSEE, CISM, CPHIMS, Senior Director, Privacy and Security, HIMSS on behalf of the HIMSS Patient Identity Integrity (PII) Work Group

*Submitted with the understanding that the comments have been compiled by the HIMSS Patient Identity Integrity Work Group, and is being vetted through the HIMSS Standard Operating Procedures before the official HIMSS comments are submitted to the government.*

HHS recently released proposed rules setting forth the meaningful use and EHR certification rules for Stage 2 of the HITECH incentive program. Stage 2 of meaningful use proposes increased requirements for eligible providers and hospitals to exchange data in transitions of care (through the use of a Consolidated CDA summary of care record standard) and to perform reconciliation of medication, problem and medication allergy lists when information on a patient is sent from one or more different sources. The ability to effectively match patient data when information is sent from another source obviously will be key to the success of these initiatives.

In the proposed Standards and Certification Criteria (S&CC) Rule (EHR certification rule), the Office of the National Coordinator for Health IT (ONC) specifically asks if EHR technology should be tested and certified to its capability to "perform some type of demographic matching or verification" when patient records are received from another source. This question is posed with respect to the following activities:

1) The incorporation of a Consolidated CDA as a result of a care transition (page 60 of the draft rule) and,
2) Comparing two or more sources of data for (medication) reconciliation purposes (page 63 of the draft rule).

In reference to these items:

1) The incorporation of a Consolidated CDA, the following information is provided in the NPRM.

**MU Objective**

The EP, EH, or CAH who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.

**2014 Edition EHR Certification Criteria**

§ 170.314(b)(1) (Incorporate summary of care record)

§ 170.314(b)(2) (Create and transmit summary care record)

**Standards**

§ 170.205(a)(3) (Consolidated CDA); § 170.207(f) (OMB standards for the classification of federal data on race and ethnicity); § 170.207(j) (ISO 639-1:2002 (preferred language)); § 170.207(l) (smoking status types);

§ 170.207(a)(3) (SNOMED-CT® International Release January 2012); § 170.207(m) (ICD-10-CM); § 170.207(b)(2) (HCPCS and CPT-4) or § 170.207(b)(3) (ICD-10-PCS); § 170.207(g) (LOINC version 2.38); § 170.207(h) (RxNorm February 6, 2012 Release); and § 170.202(a)(1) (Applicability Statement for Secure Health Transport); § 170.202(a)(2) (XDR and XDM for Direct Messaging); and § 170.202(a)(3) (SOAPBased Secure Transport RTM version 1.0)

HIMSS Patient Identity Integrity (PII) Work Group Feedback:

The NPRM request for comment refers to the MU measure and associated certification requirement in the table above. That is, the EP, EH, or CAH will be required to provide a summary care record for each referral or transition of care. Thus, the supportive Certified EHR will be required to Incorporate, Create and Transmit the summary care record.

The HIMSS PII Work Group (WG) members note that there are three EHR capabilities required to accomplish this requirement: Create (a summary record) ➔ Transmit/Transport ➔ Consume.

The S&CC NPRM explicitly asks "whether ONC should require, as part of the 'incorporate summary care record' certification criterion proposed at § 170.314(b)(1), that EHR technology be able to perform some type of demographic matching or verification between the patient in the EHR technology and the summary care record about to be incorporated. This would help prevent two different patients summary care records from being combined."

The WG members wish to point out that this will not prevent patient "overlays" but might have some limited impact on reducing the incidence of erroneously combined records. The WG members observe that there are several vendors that can create CCD/CCR records, but few are successful in creating the transmit transaction and virtually none with the ability to "consume" it. By "consume" we mean that the CCD/CCR populates into a foreign receiving EHR in a form that can be written (saved). Given that the majority of EHRs currently cannot "consume" the summary care record, they are therefore not able to read/process the related data fields in the summary care record that would be required to perform any type of matching or verification.

At present healthcare organizations are best served to keep all of these files in separate records and not merge until the technology can catch up. Through the certification process, vendors

would be required to address these new, additional functionalities. Therefore, the WG members agree that automated matching and verification may be a stretch for the year 2014.

Each organization has a responsibility relating to the stewardship of the data they are sharing. Passing information through health information exchange mechanisms requires filtering of some sort in what transactions may pass. "Mary Gonzales" may be found in records across multiple states and may produce hundreds of records to match. This is overwhelming at the local EHR level. There is neither staffing nor expertise to perform adequate accurate matching. At the local EHR level, it also may violate the individual's privacy by returning too much information on too many individuals with similar attributes.

Given the current state of capability, the HIMSS PII WG recommends that:

- EHR vendors be required to provide certain specific functionalities and meet certain criteria for the creation, transfer/transport, and consumption of summary care records.
- EHRs have capability to match records at a basic level to advance EHR solution capabilities.
- Outside of certification process, but within the regulatory process, establish thresholds for patient identity integrity within an entity's EHR. Data stewardship starts at home. Data integrity requires a proactive approach for identity management not just technical functionalities.

2) Comparing two or more sources of data for (medication) reconciliation purposes (page 63 of the draft rule).

The S&CC NPRM requests public comment "on whether as part of this certification criterion we should require EHR technology to perform some type of demographic matching or verification between the data sources used. This would help prevent two different patients' clinical information from being reconciled. We propose to adopt this revised certification criterion at § 170.314(b)(4).

**MU Objective**

The EP, EH, or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.

**2014 Edition EHR Certification Criterion**

§ 170.314(b)(4) (Clinical information reconciliation)

HIMSS PII WG Discussion:

The HIMSS PII WG observes that medication reconciliation is currently a challenge to execute in the hospital environment. We are not even close to being able to do it within an HIE, and certainly not within the next two years. The process of coordinating medications across the continuum of care is not straightforward. Some of the reasons are: 1) due to large variations in the process to gather medication history, 2) four types of staff are required to participate based on their role: physician, pharmacist, nursing and clerical staff. Information can be stored in different places in the chart. Clinical staff rarely compares or resolves discrepancies between physician and nursing notes. It can be argued that true reconciliation belongs at the pharmacy level in their role as keeper of evidence-based information related to medication reconciliation.

Although the clinician may write an order, patient compliance is difficult to measure at the provider level.

We agree there should be verification of current medications, however, that is different from reconciliation within the EHR. The receiving organization should verify with the patient their current medication regime. Patient acuity becomes a factor. Medication reconciliation should be done at the source, not at the receiving organization EHR. Medication history should remain intact.

Medication reconciliation requires substantial backend clinical business intelligence. It must be done by highly trained and knowledgeable staff (drugs not being discontinued and still appearing as active, et.al.) It requires equal parts machine and human reconciliation and access to substantial amounts of information.

The Work Group recommends that:

- EHR should contain functionality based on certifiable criteria for verification of current medications (as opposed to reconciliation of medications within the EHR.)
- Medication history should remain intact at receiving care setting.
- ONC promote process standardization for medication management and reconciliation.

The HIMSS PII Work Group appreciates this opportunity to provide input into this important process.