

Patient ID: Rocky terrain

By Rachel Z. Arndt

It makes sense that, when you walk into any healthcare setting, your doctors know who, exactly, you are. But the industry has long struggled to find a fail-safe way to match the flesh-and-blood patient to the patient that exists in the medical record. One solution—one that’s been whispered about for nearly two decades—is a national unique patient identifier, a number assigned to each person to keep her medical identity sorted out. Proponents of such an identifier say it would improve patient safety. Naysayers say it would infringe on privacy. The whispers behind a patient identification solution have, in recent years, grown, but they still aren’t loud enough to drive universal change. Here, we trace the national patient identifier’s uphill battle since it was first mentioned in the Health Insurance Portability and Accountability Act of 1996.

UNMARKED TRAIL AHEAD

2018

CMS will issue Medicare cards with new ID numbers instead of Social Security numbers.

2017

Although the 2017 HHS appropriations bill still prohibits the department from spending money on a patient ID, it includes a section that encourages the ONC to give technical help to the private sector in its patient-matching efforts—which are, technically, different from a unique patient ID.

2016

The College of Healthcare Information Management Executives launches its \$1 million National Patient ID Challenge. The goal: use crowdsourcing to find a solution that will ensure accurate patient identification all of the time.

CHIME calls off its patient identification challenge, replacing the effort with the Patient Identification Task Force.

1999

In budget legislation, Congress banned HHS from spending money on developing a patient ID. The language has been in every appropriations bill since.

1996

The Health Insurance Portability and Accountability Act instructed the government to create unique identifiers for patients, employers, health plans and providers.

Discussions about a national patient ID are muted, if not non-existent. “Early, there weren’t enough EHRs to generate interest,” said David Muntz, principal at health IT consultancy StarBridge Advisors and former principal deputy at HHS’ Office of the National Coordinator for Health Information Technology.

Then, Muntz said, conversations trickled to a halt because of the appropriations language.