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Importance of EHR Systems in Health Care

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Introduction

With the advent of Health Care Reform adopted by Congress in 2010, accessible health care will be provided for previously uninsured populations. The daunting challengefor health care providers to meet this Federal mandate will beto deliver comprehensive, cost effective, quality care. Fundamental to successfully achieving this mandate is to establish an efficient documentation and reimbursement reporting system. The use of an Electronic Health Record (EHR) system and other Health Information Technology (HIT)can providethe infrastructure needed to efficientlyand seamlessly document care while supporting apayer based medical record (PBR) system [1]. For example, accurate and appropriate documentation should clearly identify general complications as well as comorbidities (MCC).Identification of general complications and comorbidities (CC) should produce an accurate Case Mix Index (CMI) significantly correlates with the level of provider reimbursement [2].

According to a 2012 survey conducted by the Department of Health and Human Services, hospitals are making major strides implementing the useof health information technology for documentation. The survey also indicated that 2000 hospitals and 41,000 doctors have received 3.1 billion dollars in payments after effectively using an EHR system. Not only does the EHR system support accurate and comprehensive provider documentation of MCC and CC reimbursements, but it also monitors the quality of care delivered. As a necessary requirement and in compliance with the Center for Medicare and Medical Services (CMSs), the EHR can be effectively used to validate quality, comprehensive and appropriate care.

A clinical decision support intervention system can also be incorporated with the EHR to facilitate evidence based practices for quality and efficient care. Such a system can actively support appropriate provider decision making while providing an efficient method for documenting care [3,4]. Ultimately, a hospital's economic viability is dependent on comprehensive provider documentation. This documentation should incorporate appropriate diagnoses, treatments and best outcomes. It is anticipated that CMS will standardize all EHRs for providers.

Prophetically, the Center for Medicare and Medicaid Services in 2008 made a preempted move to enhance health care outcomes by adding Medical Severity (MS) to the Diagnostic Related Groups (DRGs), now known as MS-DRG. This new value based initiative will facilitate quality care by influencing acute care hospitals to render prescriptive care to receive comparable provider reimbursement. Consequently, hospitals will be rewarded by reimbursement for best practices and penalizedwith less reimbursement for not adhering to standardized guidelines.MS-DRG guidelines can be a useful provider data system to effectively to analyze and measure a provider's clinical outcomes. These outcomes are reported by the CMS as summarized quality measures. This report is made available to the general public. This hospital report card and can be viewed on the "Hospital Compare" website at www.hospitalcompare.hhs.gov.

In conclusion, the American Recovery and Reinvestment act of 2009 and the US health policy are aiming for 100% provider adoption of a comprehensive EHR system by 2015. Rendering appropriate quality care and providers getting equitably reimbursed for the care they give are of paramount important. The suitable use of Health Information Technology (HIT) and the integration of a payer based system for reimbursement is necessary.Given the new health care mandatesas outlined by the federal government, the use of HIT is needed to effectively care for and manage the influx of approximately one million newly insured persons.

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