Electronic Health Records and Ambulatory Quality

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The Authors' Reply—We appreciate Dr. Berger's comments related to our article on electronic health records (EHRs)¹ and ambulatory quality of care.² We agree that health care quality is much broader than adherence to recommended processes of care. We have previously noted that many of today's quality measures represent only the subset of measures that can be feasibly captured from administrative claims or manual review of paper medical records.³ We have also written about how EHRs can potentially expand what is feasible to measure, by enabling clinically nuanced measurements of care for large numbers of patients.³

EHRs and other types of health information technology (such as health information exchange and mobile devices) can advance quality measurement by: 1) allowing more consistent assessment of patient outcomes (such as functional status), in addition to health care processes; 2) enabling quality measures that more directly take into account patients' comorbidities, medications and laboratory results, and how those may affect appropriateness of care; 3) facilitating risk adjustment that is more clinically detailed; and 4) explicitly incorporating patients' preferences.

Our view is consistent with recent calls to develop novel measures of ambulatory care quality, including measures that would be generated from EHRs.⁴ However, we have

also found that automated reporting of quality from EHRs is not always accurate and needs to be improved.⁵ Measuring quality is challenging, and opinions about what constitutes high-quality care continue to evolve, particularly in this emerging era of electronic data. Despite the challenges, EHRs are likely to generate a more complete picture of quality than claims data for a larger number of patients than is feasible on paper.

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REFERENCES

1. **Berger Z.** Electronic health records and ambulatory quality. *J Gen Intern Med.* 2013, doi:[10.1007/s11606-013-2474-5](https://doi.org/10.1007/s11606-013-2474-5).
2. **Kern LM, Barron Y, Dhopeswarkar RV, Edwards A, Kaushal R.** Electronic health records and ambulatory quality of care. *J Gen Intern Med.* 2013;28:496–503.
3. **Kern LM, Kaushal R.** Interoperable electronic health records and quality of care. In: Agency for Healthcare Research and Quality's National Quality Measures Clearinghouse Expert Commentaries, June 2010. Accessed April 9, 2013, at: <http://www.qualitymeasures.ahrq.gov/expert/expert-commentary.aspx?id=23789>.
4. **Bishop TF.** Pushing the outpatient quality envelope. *JAMA.* 2013;309:1353–4.
5. **Kern LM, Malhotra S, Barron Y, et al.** Accuracy of electronically reported "meaningful use" clinical quality measures: a cross-sectional study. *Ann Intern Med.* 2013;158:77–83.