

Health Services Accreditation Standards for Information management in Canada, New Zealand and USA: A Comparative Study

** Safdari R. PhD, ** Meidani Z. MSc*

**Dept. of Medical Record, School of Allied Health Professions, Tehran University of Medical Sciences, Iran*

***Dept. of Medical Record, School of Nursing and Allied Health Professions, Hormozgan University of Medical Sciences, Iran*

(Received 17 Mar 2006; accepted in revised form 23 Nov 2006)

Abstract

Background: In a variety of industries, accreditation is recognized as a symbol of quality indicating that the organization meets certain performance standards. In this regard, health records are among the primary documents used by health care facilities to evaluate compliance with the standards set by the accreditation agencies. This study compares the strengths and weaknesses of Information management(IM) standards of three well-established national accreditation agencies in Canada, USA and New Zealand.

Methods: This was a comparative–descriptive study in which the IM standards for the national accreditation agencies of Canada (CCHSA), USA (JCAHO) and New Zealand (QHNZ) were collected and investigated through the internet, and e-mail.

Results: All of the accrediting agencies have accepted reliability, accuracy, and validity as data quality. JCAHO and CCHSA have adopted maximum standards related to evidence-based decision-making. Achieving positive outcomes was adopted by CCHSA and QHNZ, and is among the strongest points of their standards.

Conclusion: These review findings revealed that the CCHSA and QHNZ had adopted the same standards with emphasis on information management planning, achieving positive outcomes and making improvement. While the strong points of JCAHO's standards are patient specific information and evidence-based decision-making.

Key words: *Standards, Accreditation, Information Management, Evaluation*

Introduction

As the health care market becomes increasingly consumer oriented, cost and quality are two major criteria that will differentiate competing organizations (1).

Health care organizations are turning to quality as a means to gain a competitive advantage. This emphasis on quality, results from the need to reduce costs while simultaneously improving the quality of care and customer satisfaction (2). Therefore, obtaining and maintaining qual-

Correspondence: Dr Safdari, Fax: +98 21 88965608, E-mail: safdari@hbi.ir

ity in health care has become the main focus (3); quality generation is the only way to get the desired success (4).

In this climate, health care organizations' efforts to achieve excellent quality health care is evidenced by the plethora of partial and incoherent measures and the lack of a systematic approach to the quality(5).

Now, most health care managers and policy makers view evaluation and control of quality, and improvement in quality, as an imperative (6). Therefore, with this demand for improved quality, a growing interest and expansion in accreditation programs has occurred worldwide during the past decade (7).

In a variety of industries, accreditation is recognized as a symbol of quality indicating that the organization meets certain performance standards (8), and provides an opportunity for that organization to evaluate their operation against national standards (9). In this regard, for health care organizations, health records are among the primary documents used by health care facilities to evaluate compliance with the standards set by accreditation agencies (10).

The literature substantiates that the quality of medical records reflects the quality care provided by physicians (11). As the review of health information data is a major part of the accreditation process (12), this study compares strengths and weaknesses, and the general functionality of IM standards of three well-established accreditation agencies in Canada, USA and New Zealand.

Materials and Methods

In a comparative-descriptive study conducted during 2003-4, the IM standards of Canada, USA and New Zealand were collected and investigated through the internet, and e-mail. Collecting IM standards were done by contribution of some facilitators in each accredi-

tation organization that researchers have communicated with them through the e-mail.

The research sample has included the IM standards of three accreditation agencies, Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Canadian Council on Health Services Accreditation (CCHSA) and Quality Health New Zealand (QHNZ), comprising information management planning, patient specific information (client records), achieving positive outcomes, being a learning organization, education development standards, evidence based decision making, and confidentiality. As, these study conducted under direct supervision of those coordinators, designed comparatives tables have been sent to these agencies in order to ensure the correctness of results and providing a feedback to them and their organizations to compare their functionality of IM standards .

Results

JCAHO has considered the most complete standards related to Patient-Specific Information Standards that enclose medical record content. All of the accrediting organizations have developed some similar standards in confidentiality area.

Supporting Evidence-Based Decision Making, comprise organizational processes to effectively manage information, including the capturing, reporting, processing, retrieving, disseminating, and displaying of clinical/ service and non clinical data and information. As Table 1 indicates, JCAHO has adopted maximum standards in this area.

Table 1: Comparison of Supporting Evidence-Based Decision Making Standards

Organizations Standards	JCAHO	CCHSA	QHNZ
Monitoring the quality of data, including data reliability, accuracy and validity	√	√	√
The information management system allows the organization to gather data from various sources,	√	√	√
Staff, service providers, clients and families have access to information to support decision making and improve knowledge	√	√	—
The organization's information management processes support the collection	√	√	—

analysis and reporting of data

Those responsible for collecting and reviewing the data are accountable for information accuracy and completeness √ — —

Being a Learning Organization covers those standards that IM processes support managerial and operational decisions, performance improvement activities, patient care, treatment, and services decisions. In this section, all of the accreditation agencies have regarded same standards (Table 2).

Table 2: Comparison of Standards Related to Being a Learning Organization

Organizations	JCAHO	CCHSA	QHNZ
Standards			
Evaluating and improving information management process	√	√	√
Evaluating IM processes and results by selecting and monitoring indicators, collecting and analyzing data and information	√	√	√
Incorporating research and benchmarks into information management processes	√	√	√
Using the evaluation information to make decisions, improvement	√	√	√

Achieving positive outcomes covers the topics of best result, and according to table 3, most complete standards has been adopted by CCHSA and QHNZ, and is among the strongest points of related standards.

Table 3: Comparison of Standard Related to Achieving Positive Outcomes

Organizations	JCAHO	CCHSA	QHNZ
Standards			
The organization's information management processes achieve the best possible results	—	√	—
There is evidence that the goals an expected results of information management activities are achieved	—	√	√
There is evidence that users are satisfied with the organization's information management processes and services	—	√	√

Table 4 indicates that CCHSA have regarded most complete and suitable standards related to educational and staff development standards.

Table 4: Comparison of Education Development Standards

Organizations	JCAHO	CCHSA	QHNZ
Standards			
Access to knowledge based resources	√	√	√
Managing education material, relevance and research information	√	√	√
Tailoring education, training and support to user's need and responsibilities	—	√	√
Obtaining feedback from user's, client and families to improve resources	—	√	√

There is evidence that the education, training are effective	—	√	—
The education, training support the user's skills	—	√	√

Discussion

As findings of research indicate, all types of standards have considered by three accreditation organizations, support the medical record and IM processes according to their health care systems needs and requirements. Because, the challenges of today's market place and the interest in objective performance data, the concurrent use of information for decision making has become critical for managers to make accurate cost outcome decisions (13). The patient record is the information center-piece of the health care decision making process both for individual patient treatment and for its potential to collect or aggregate data for research. Nevertheless, poor quality records cannot be used as a reliable source for making decisions about health care (14). It has often been said that an adequate medical record indicates adequate care (15). Such consolidation is important for current and continuing care purposes, utilization management, and quality assessment and improvement activities. Although the medical record is kept for the benefit of patient, the physician and health care health care institution, it is the property and responsibility of the health care institution to safeguard and preserve its content (16).

As finding of study shows JCAHO has made the most complete standards related to medical record content and some similar standards in order to preserving its confidentiality and security.

The decision maker must have timely, accurate and cost effective information on which a sound decision can be based. Actually, the increased probability of making good decisions depends on the quality of the information (17). Moreover, data quality is one dimension of the overall information integrity challenge that, in the context of today's information systems, is defined as the accuracy, con-

sistency, and reliability of information (18). So, data quality activities have been a priority for the HIM professionals and these functions have had an even sharper focus with the advent of computerized patient records. Validity, reliability, completeness, readability, timeliness, relevance, accessibility, security, and legality have all been accepted as the data quality characteristics with computer applications.

However, the findings of this comparative study showed that all the accrediting agencies only adopted reliability, accuracy and validity as their characteristics of data quality.

In health care there are many users, both individuals and groups, who rely on health data and who demand quality in the data collected, analyzed, interpreted and reported. This includes health departments that use information related to vital statistics, disease incidence and prevalence, and so on, to provide aggregate data for public policy development. Nevertheless, the effective use of health information depends on the systems that can create, analyze, disseminate and utilize it. So, an important skill for the health information manager is the ability to analyze the processes that create and handle health information to be sure that they are functioning in the most effective and efficient manner. Given the importance all the accreditation agency JCAHO, CCHSA, QHNZ, have adopted complete and suitable guidelines related to making improvements in being a learning organization standards.

Moreover, processes are important because, outcomes are the end result of specific processes. Favorable outcomes include the achievement of defined goals. Health care providers must set goals that serve as benchmarks for health outcomes achievement (19). These benchmarks can be used to compare an organization or a process to others, and also allows

for external or sequential comparisons (20). So, health care providers can test the effect of their interventions on goal attainment. Actually, collecting and tracking benchmark information for use in improving performance can take a great deal of effort (21).

Achieving positive outcomes is embraced by CCHSA and QHNZ, and is among the strongest points of their standards, while JCAHO have no standards in this area.

Handling all of these activities in a health information department, with all of the technological advances that occur in today's health care environment and the continuous updating and replacing of equipment and computer software, typically requires training and education (22). Training involves orientation, education, and practice and development of employees, and often occurs in the beginning of employment, as procedure and policies change, and as processes, technology, and equipment are improved. As finding of study, shows CCHSA have regarded most complete and suitable standards related to educational and staff development standards.

All together, the findings of this comparative study revealed that the CCHSA and QHNZ have adopted the same standards with emphasis on information management planning standards, achieving positive outcomes, while the strong points of JCAHO's standards are patient specific information and evidence-based decision-making.

These agencies with emphasis on Information Management (IM) standards not only improve the quality of health services and information management processes, but also provide a subtle push toward the adoption of the Electronic Health Record systems EHRs (23).

Regardless of all this importance Hajavi in his study titled "Medical Records Standards In selected Countries& Iran: Comparative Study" revealed that in comparison with other countries', Iran not only has the minimum standards, related to medical records- the core

component of health information-but also there is an incompatibility between these minimum standards and existing identified problematic areas. Overall, these study findings indicate that Iran's Ministry of Health standards for medical record departments have a lot of shortcomings and deficiencies. That, plus the absence of a custodian organization to formulate standards related to documentation, confidentiality, access, security, and retention and destruction of medical records, necessitates a standardization movement in Iran's medical record departments (24).

Standardization in Iran health Care System like other its industry is still in its infancy, we have much to do. Now in the field of medical records it now started. A model of medical records standards is presented and is going on under supervision of Teheran University of Medical Sciences and among 17 university's medical record professors and Health Deputy's expert's evaluation of medical record departments as a national project. The following is its characteristics which has been developed through the reviewing standards of USA, Australia, Canada, New Zealand, Lebanon, Zambia, Southern Africa and of course in practice Iran Ministry of Health 's standards and future needs of medical record departments:

- Organization and Administration
- Staffing and Direction
- Policies and Procedures
- Staff Development and Education
- Facilities and Equipment
- Health Information System

Acknowledgements

The authors wish to express their gratitude to the following individuals, who we are indebted to for their invaluable support and contribution: Shirley Pilon, CCHRA(C), IF-HRO Director, Canada, as editor, guide and facilitator. Canada: Paula Greco, CCHSA, Dr. Mukarram Ali Zaidi, Research and Prod-

uct Development Specialist (CCHSA), USA: Susie McBeth, JCAHO, Jean Clark, IFHRO Vice-President, New Zealand: Deirdre Cuff, QHNZ

References

1. Siewicki BJ, Hess J, Ernst LLP, et al. Integration challenges in managed care organization. *J AHIMA*. 1997; **68(3)**: 30-32.
2. Prybuto VR, Spink A. Transforming a health care information management system. *J Top Health Inf Manag*. 1997; **18(2)**: 1-11.
3. Aghazadeh SM. Implementing of total quality management in the managed care industry. *TQM Mag*. 2002; **14(2)**: 79-91.
4. JHA S. *Hospital Management*. Publishing House, Mumbai: Himalaya, 2001: p. 66.
5. Ritoja S, Hocever Z. Redesign of healthcare processes classification to improve the processes of gathering information and data processing on professional and organizational quality in healthcare. *Int J Health Care Qual Assur*. 2001; **14(6)**: 245-9.
6. Rooney A, Ostenberg PR (1999). Licensure, accreditation and certification: approaches to health services quality. Available from: www.qaproject.org/pub/pdf/accreditation.pdf
7. Nicholas D (1999). Using accreditation to improve quality. Available from: www.qaproject.org/pub/engv.pdf
8. Whittaker S, Rooney A (1999). Quality improvement in South Africa: the COH-SASA accreditation initiative. Available from: www.qaproject.org/pub/engv.pdf
9. Peden A. *Comparative records for health information management*. Delmar publisher, Albany, 1998: p144.
10. Davis N, LaCour M. *Introduction to health information technology*. W.B Saunders Company, Philadelphia, 2001: p. 205.
11. Dra G. Some related factors associated to the quality of cesarean section performance in Haraponkita children & maternity hospital in Jakarta. *The 13th International Health Record Congress in conjunction with the 21th Conference of HIMAA, Melbourne*, 2000: p.1-7.
12. Abdelhak M, Grostick S, Hanken M, et al. *Health information: management of a strategic resources*. W.B. Saunders Company, Philadelphia, 2001: p.15, p. 152, p.76, p.518.
13. Kohli R, Tan JK, Piontek FA, et al. Integrating cost information with health management support system: an enhanced methodology to assess health care quality drivers. *J Top Health Inf Manag*. 1999; **20(1)**: 80-95.
14. Bermeo AM, Romero P (2002). Redesigning hospital documentation systems to improve patient records in Ecuador. Available from: www.qaproject.orh/pub/pdf/ecuadorobsk.pdf
15. Huffman EK. *Health information management*. 4th ed. Physician's Record Company, Berwy, Illinois, 1994: p.106.
16. Skurka M. *Health information management*. Health Forum Inc, San Francisco, 1998: p.57.
17. Kloss L. Information integrity: our achilles' heel. *J AHIMA*. 2002; **73(10)**: 23.
18. Schmitz H. Matching system requirements to organizational function. *J Top Health Inf Manag*. 1999; **19(4)**: 75-83.
19. Wojner A. *Outcome management*. A Harcourt Publishers, St Louis, 2001: p. 6.
20. Wolper L. *Health care administration*. Jones and Bartlett Publishers, Boston, 2002: p. 621.

21. Berry TB. Using benchmarking to support performance improvement efforts. *JAHIMA*. 1998; **69(10)**: 26-8.
22. Davis N, LaCour M. *Introduction to health information technology*. W.B Saunders Company, Philadelphia, 2001: p. 400.
23. Englebardt S, Nelson R. *Health care informatics*. Mosby Inc, St .Louis, 2002: p. 225.
24. Hajavi A, Ebadi Far F, Meidani Z. Medical records standards in selected countries & Iran: comparative study. *New J Inst Health Rec Inf Manag*. 2005; **46(1)**: 4-6.