

Joint Commission International accreditation: relationship to four models of evaluation

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Abstract

Objective. To describe the components of the new Joint Commission International (JCI) accreditation program for hospitals, and compare this program with the four quality evaluation models described under the ExPeRT project (*visitatie*, ISO, EFQM, organizational accreditation).

Results. All the models have in common with the JCI program the use of explicit criteria or standards, and the use of external reviewers. The JCI program is clearly an organizational accreditation approach with evaluation of all the 'systems' of a health care organization. The JCI model evaluates the ability of an organization to assess and monitor its professional staff through internal mechanisms, in contrast with the external peer assessment used by the *visitatie* model. The JCI program provides a comprehensive framework for quality management in an organization, expanding the boundaries of the quality leadership and management found in the EFQM model, and beyond the quality control of the ISO model. The JCI organizational accreditation program was designed to permit international comparisons, difficult under the other models due to country specific variation.

Conclusion. We believe that the organizational accreditation model, such as the international accreditation program, provides a framework for the convergence and integration of the strengths of all the models into a common health care quality evaluation model.

Key words: accreditation, international standards, quality control, quality evaluation

This paper compares the new Joint Commission International (JCI) accreditation program for hospitals with the four external quality mechanisms for the improvement of health care described under the ExPeRT project. A description of the JCI standards development project provides the platform from which comparisons with the quality evaluation models can be made.

The JCI standards development project was funded by Joint Commission Resources, Inc. (JCR), a not-for-profit subsidiary of the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission), over a 16-month period from June 1998 through September 1999. The aim of the project was to meet a need for a set of international accreditation standards, specifically for hospitals, where none existed. The ultimate aim was, and continues to be in concert with JCR's mission, to improve the quality of care in the international community through accreditation and consultation.

Program development

JCR staff managed the project. An International Principles and Standards Development Task Force (see Appendix), was appointed with members from seven world regions and two members representing the International Society for Quality in Healthcare (ISQua). The charge to the Task Force was to guide the process of developing a truly international set of standards and provide advice to the JCR Board on the framework of the international accreditation program within which the standards would be applied.

A set of JCI Principles for Standards was formulated to guide the standards development process. These principles were in harmony with the then draft principles for standards as set forth by the ISQua. Staff reviewed the ISO and EFQM approaches. The standards of established national accrediting bodies were evaluated regarding patient focus, departmental or functional organization, balance of structure, process and

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outcome standards, quality management focus, and actual requirements (e.g. minimal or optimal). The Joint Commission national standards for hospitals were included in the evaluation process and ultimately provided the standards framework endorsed by the Task Force. This framework provides a patient and family focus for a mixture of structure, process and outcome standards organized around the principle functions and systems found in health care organizations.

The Task Force first met in June 1998. The first draft of standards was sent, by mail and e-mail, to health care accreditation and quality experts in each of the seven World regions for review and comment. In addition, focus groups were held in each World region to obtain direct evaluation of the standards by key stakeholders in the respective countries. Finally, the practical applicability of the standards was evaluated in four test surveys in four different countries. The standards were revised based on findings in each phase of review, were finally endorsed by the Task Force, and approved by the JCR Board in September 1999. The first edition of the standards was published in November 1999 [1]. The first accreditation surveys occurred in the last quarter of 1999.

The standards will be made available on the Joint Commission and JCR web sites. Consistent with the principles of continuous quality improvement, the JCI accreditation standards for hospitals will continue to evolve with experience, new scientific and technical knowledge, the opinion of experts and the advice of an international advisory body.

Observations related to the JCI accreditation standards and four models for quality assessment

An international accreditation program is more than its standards. The survey process, scoring method, decision process and standards interpretation all contribute to the 'essence' of the program. Thus the observations offered reflect program components beyond that of the international standards alone.

The JCI accreditation program was, from the beginning, designed to take into consideration the social, political and economic realities in the host country. The strongest demand for accreditation standards exists in the growing number of countries where legislation has been enacted aiming to improve health services and manage their cost. Increasing demands for accountability, access, improved quality of health care and better cost management are driving the development of external peer review mechanisms. Indeed JCI, in the last 6 years, has observed the number of countries with established or fledgling standards-based accreditation systems grow to about 26 [2]. The JCI accreditation standards were developed to accommodate the legal and regulatory context of each health care organization evaluated. Over 40 standards defer to the expectations set forth in the laws and regulations of the country, when such laws and regulations set a higher expectation than the standard. The Patient and Family Rights standards are a good example. These standards address six

fundamental processes. How these processes are carried out in an organization depends on its country's laws and regulations and any international conventions, treaties, or agreements on human rights endorsed by its country. The summary observation is that the JCI standards and accreditation process provide a framework into which the social, legal, regulatory, and cultural details can be integrated.

The four models of external quality evaluation described under the ExPeRT project were that of *visitatie*, organizational accreditation, the European Foundation for Quality Management (EFQM), and ISO certification. All these models have in common with JCI the use of:

- Explicit criteria or standards – pre-established sets of expectations, stated as standards or evaluation criteria, which are reviewed, approved or at least sanctioned by a respected authority.
- External reviewers – surveyors/evaluators sent from an established, sanctioned entity which has the authority to provide assessment or survey against pre-established or explicit sets of criteria or standards; or they may be consultants invited into the organization on an informal basis to apply the criteria desired by the organization.

The JCI program is clearly an organizational accreditation approach. As such it evaluates the capability of an entire health care organization to produce good results. The evaluation considers a full range of functions and systems including those that support the provision of patient care (access to care, patient assessment, patient care, patient and family education, etc.) and those that support the operation and management of the organization (leadership, information management, infection control, facility management, etc.). This 'systems' approach recognizes that the capability to produce good results is dependent, only in part, on the competence (knowledge, skills, experience and behaviors) of the professional staff. Thus, the focus of accreditation standards is on the internal capacity of an organization to create and sustain systems and processes needed to evaluate and monitor the competence of its health professional staff. This is in contrast with an assessment of professional competence by external peers as in the *visitatie* model. In accreditation, peer evaluation fits within the larger quality evaluation system as a tool that may be appropriate in some cases of variance analysis.

The organizational accreditation approach of JCI also provides the framework for effective quality leadership and quality management systems as in the EFQM model, and in addition provides the framework for quality control as in the ISO model. Thus, the JCI accreditation program, as with other organizational accreditation models, provides a comprehensive framework within which other models can be accommodated. Such a combined or integrated approach places quality management (EFQM), quality control (ISO) and peer assessment (*visitatie*) as integral components of an organization's quality systems. This combined or integrated approach has the potential to provide the added process level specifications that can enrich the traditionally more generic framework of organizational accreditation.

The development of the JCI standards followed the principles for standards as developed by ISQua. This developmental path is distinct from the other four models of quality evaluation. Thus, the JCI standards focus on the patient, and the standards describe the interface of good clinical care and good organization management, and embrace (rather than require) the use of practice guidelines and other tools for the reduction of variation in clinical practice. The JCI standards are organized along the patient pathway through a health care organization from entry through discharge, with modest pre-entry and post-discharge requirements. The standards development model used by JCI was to gain as broad a consensus as possible in the international community. It was recognized from the outset that the standards development process was never-ending and thus must continue to glean expert advice, new evidence, etc. Finally, the content of standards and thus the focus of the accreditation process is on reducing risks to patients (and staff, visitors, etc.) from the facility environment, from critical junctures in the care process, and from behaviors that fail to protect human rights and individual dignity. While some elements of the development process are common to all the quality evaluation models, the developmental process for the JCI accreditation standards was designed to produce a more comprehensive and universally applicable evaluation model focused on the unique aspects of health care settings.

One important element of the JCI standard development and testing process was the eventual use of the results of accreditation to compare the performance of JCI accredited health care organizations. International standards applied in a standardized evaluation and decision process will produce results that are comparable within countries as well as between countries. This is in contrast to:

- the *visitatie* program in which the standardization of peer evaluation is difficult, even within a country;
- ISO certification in which country specific variation in the criteria and evaluation process can and does occur;
- the EFQM model in which the criteria were designed primarily for application in the European community.

The JCI standards were shown in testing to have applicability in different cultures, and with different country specific laws and regulations. This is due to the focus of each standard on the principle involved, not on the particular structure or process in the health care organization. For example, the principle that, 'in the event of a fire emergency all staff and patients have safe exit as there is early detection, available fire suppression mechanisms, and unblocked exits' can be met by a variety of 'equivalent' equipment and processes ranging from a fully sprinkled building to portable fire hoses. Thus, country specific modification of the standard itself, as is frequently found in the other models, is not necessary. Rather, the key to accommodating cultural and other differences lies in the use of standard equivalencies, which still require the 'spirit' or 'intent' of the standard be met.

The accreditation decision for JCI is based on the results and successful follow-up to an on-site standards based survey of the health care organization. This does not preclude organization self-assessment to prepare for accreditation. In fact, the JCI standards require self-assessment as a fundamental element of any approach to quality management using the measure, assess, and improve cycle. JCI however, does not make known to the surveyors the findings from such self-assessments, other than those related to quality improvement efforts, and does not consider self-assessment results in the final accreditation decision. In addition, the on-site survey uses a convergent validity approach. All three surveyors evaluate all standards, and use interviews, document review, and observation to reach a team conclusion regarding the organization's compliance with a standard. It could be argued that this evaluation approach appears to be stronger than the other evaluation models in that it provides more substantial, objective, externally validated data, useful for comparative purposes, than the 'triangulation' of evaluation responsibility found in the site visits of the other models.

The JCI reporting and report evaluation process is consistent with the other models in that there is a preliminary report provided to the organization at the close of the survey, and the surveyor findings are validated prior to making the accreditation decision and releasing the final report to the evaluated organization. The accreditation decision process applies a set of rules to the findings to reach uniform and reliable final accreditation decisions. A singular set of rules, rather than country specific rules or decision processes is one more step to ensure the comparability of the JCI accreditation results from country to country.

The JCI on-site evaluation is performed by trained surveyors. The surveyors are also peers (physician, nurse, administrator), and we believe these peer surveyors must also have specialized knowledge and skills to perform the evaluation of standards. As noted above, all surveyors survey all the standards, not just those most associated with their career experiences.

We concur with the previously expressed conclusion that the four models evaluated by the ExPeRT project are converging. This convergence is the result of multiple factors such as the publication of the Principles advanced by ISQua, greater sharing of information among quality evaluation programs and the need for all quality evaluation programs to address the needs and expectation of increasingly more common user and stakeholder groups. The JCI program has drawn from the strengths of each model while attempting to avoid the country specific variations inherent in the models.

In addition, there continues to be a need to evaluate the extent to which a quality evaluation program (e.g. *visitatie*, ISO, JCI, EFQM) separates consultation and self-assessment activities from the final objective evaluation of the organization. Self-assessment, for example, is a proven powerful tool to help organizations improve, but is an unproven tool for gathering information for incorporation into an external decision making process. We would agree that with proper information 'fire walls', the preparation for external evaluation via self-assessment and the actual external evaluation phases

of the models could be further integrated. For JCI the most important element of any information 'fire wall' is that the external evaluators have no prior knowledge of the organization, and thus can evaluate standards compliance through an unbiased, valid and reliable process. Nationally, as well as internationally comparable accreditation decisions demand nothing less.

Trends and conclusions

JCI's worldwide experience to date points to a common desire among countries for improved access and quality with better management of health care costs. Health care system stakeholders are demanding more accountability and better-trained health care professionals. Country health care systems are looking to other countries for clinical practice guidelines and other tools to promote the practice of evidence based medicine, implying opportunities for international knowledge exchange and the potential for increasing consistency in the practice of medicine and overall health care delivery. The growing interest in the development and use of viable and valid indicators (performance measures) will lead to a need for internationally comparable data. The rapidly increasing use of technology has the potential to support all these trends.

Accreditation, with its 'systems' approach, quality monitoring and management framework, and total organization evaluation, could serve as the best tool to facilitate the convergence of the strengths of a variety of quality evaluation models into a common, multipurpose model. However, we agree that further descriptive research must be done to

facilitate this convergence. A common model for evaluation of health care organizations could better serve the European Union, as well as other regions of the world, in the movement toward harmonizing improvement in health care delivery.

References

1. Joint Commission on Accreditation of Healthcare Organizations. *Joint Commission International Standards for Hospitals*. Joint Commission on Accreditation of Healthcare Organizations: Oakbrook Terrace, 1999.
2. vanOstenberg P, Rooney A. *Licensure, Accreditation and Certification: Approaches to Health Services Quality*. Center for Human Services: Bethesda, MD, 1999.

Appendix

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