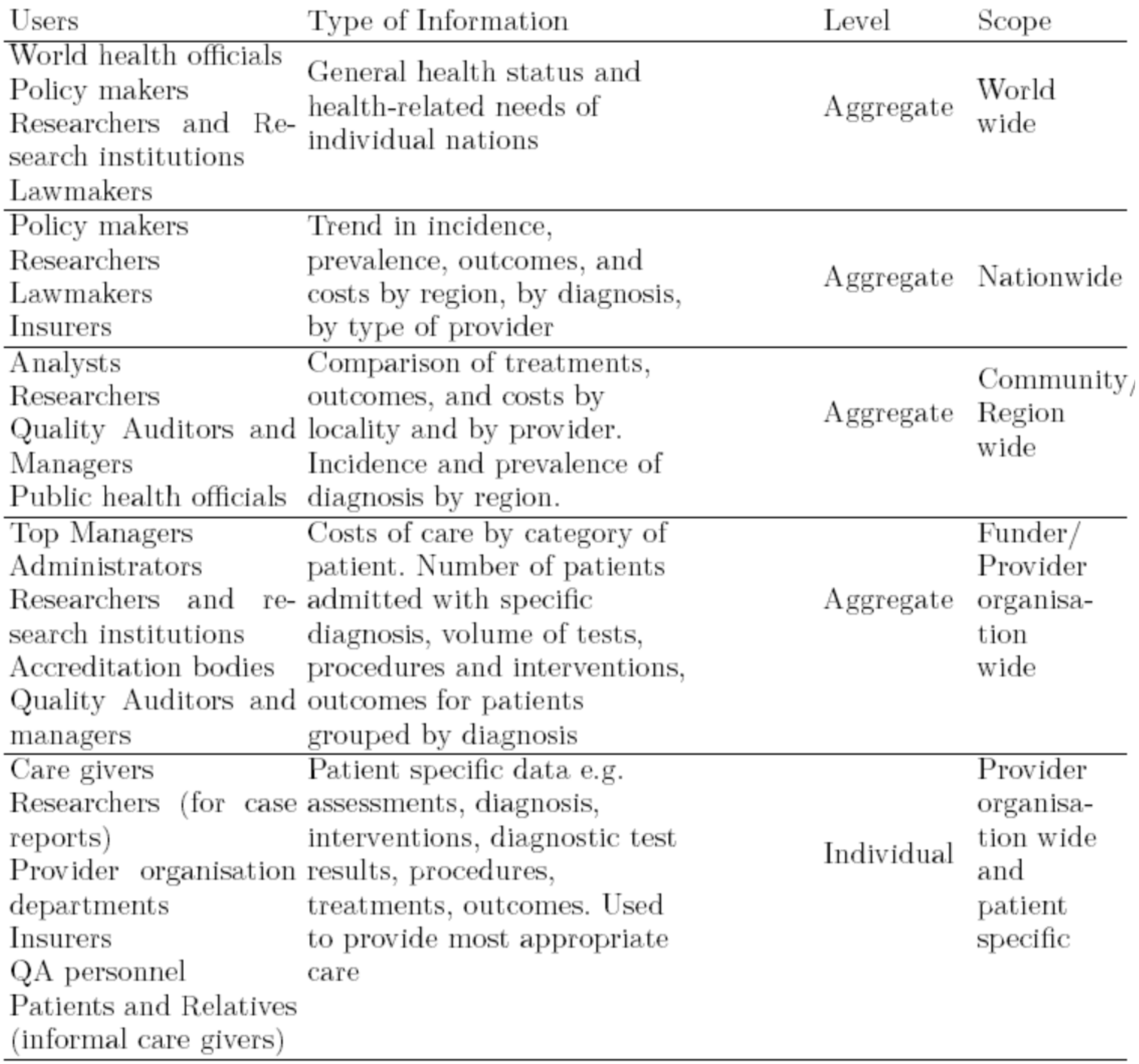
C. Batini & M. Scannapieco
Data and Information Quality Book Figures

Chapter 13: Information Quality in Healthcare

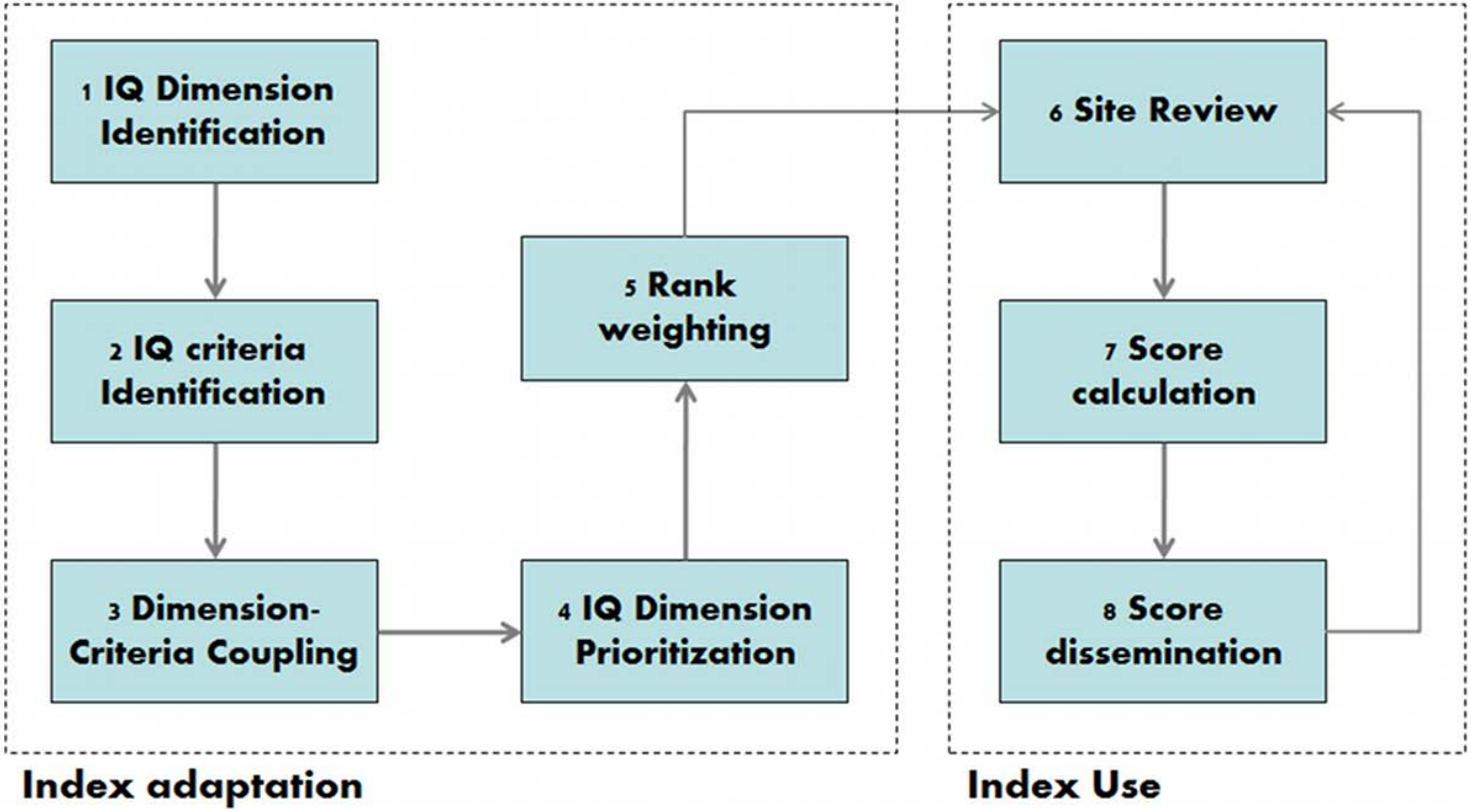
The patchwork of medical records and health information systems "in the wild" (a radiological outpatient office)

Users, Scopes and Types of Health Information. Adapted from [363]

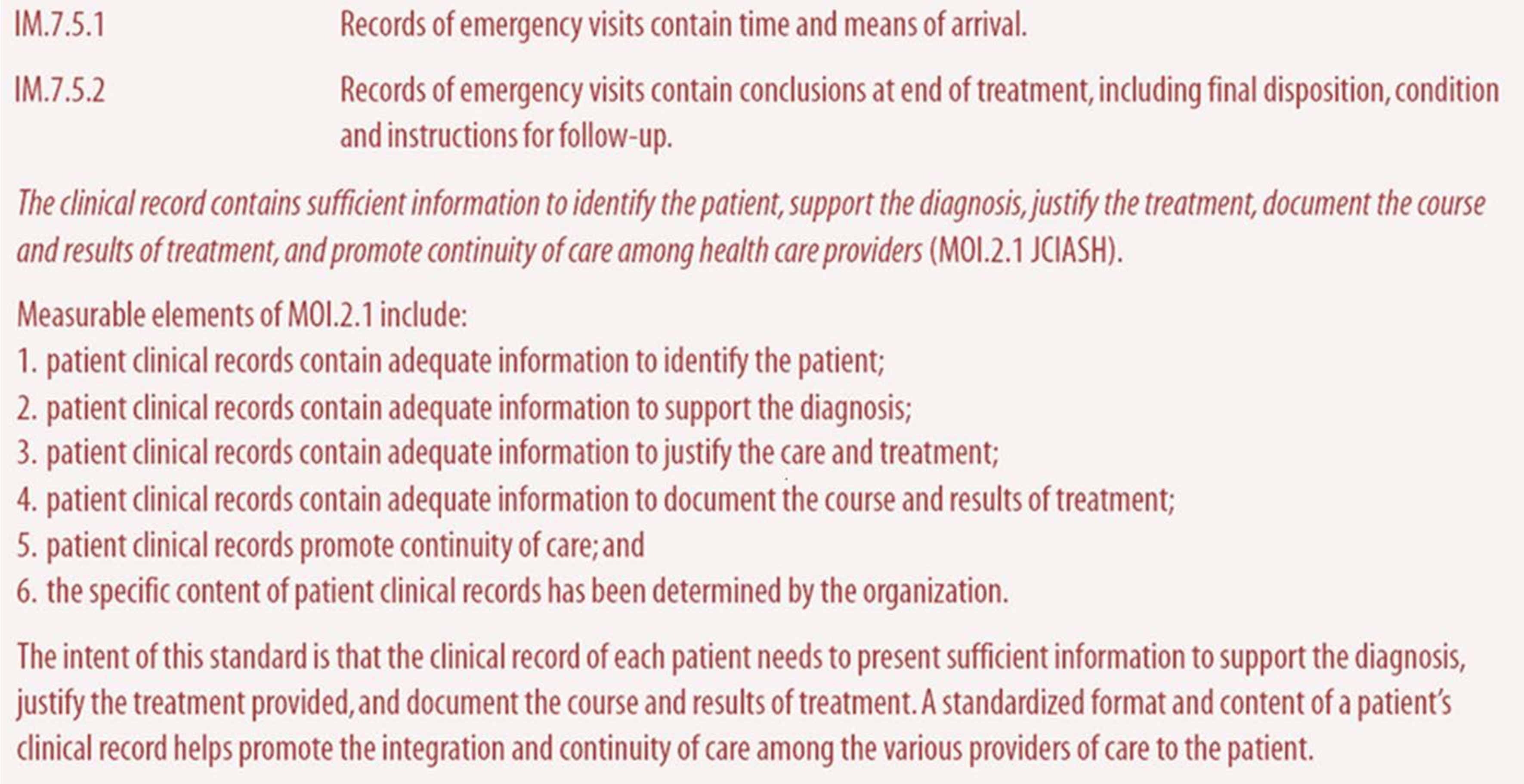


Users	Type of Information	Level	Scope
World health officials Policy makers Researchers and Research institutions Lawmakers	General health status and health-related needs of individual nations	Aggregate	World wide
Policy makers Researchers Lawmakers Insurers	Trend in incidence, prevalence, outcomes, and costs by region, by diagnosis, by type of provider	Aggregate	Nationwide
Analysts Researchers Quality Auditors and Managers Public health officials	Comparison of treatments, outcomes, and costs by locality and by provider. Incidence and prevalence of diagnosis by region.	Aggregate	Community/ Region wide
Top Managers Administrators Researchers and research institutions Accreditation bodies Quality Auditors and managers	Costs of care by category of patient. Number of patients admitted with specific diagnosis, volume of tests, procedures and interventions, outcomes for patients grouped by diagnosis	Aggregate	Funder/ Provider organisation wide
Care givers Researchers (for case reports) Provider organisation departments Insurers QA personnel Patients and Relatives (informal care givers)	Patient specific data e.g. assessments, diagnosis, interventions, diagnostic test results, procedures, treatments, outcomes. Used to provide most appropriate care	Individual	Provider organisation wide and patient specific

A step-wise methodology for the assessment of HIQ in the domain of unstructured (Web) content, adapted from [101]



Examples of standards issued by the The Joint Commission (2000). Adapted from [679]



IM.7.5.1	Records of emergency visits contain time and means of arrival.
IM.7.5.2	Records of emergency visits contain conclusions at end of treatment, including final disposition, condition and instructions for follow-up.

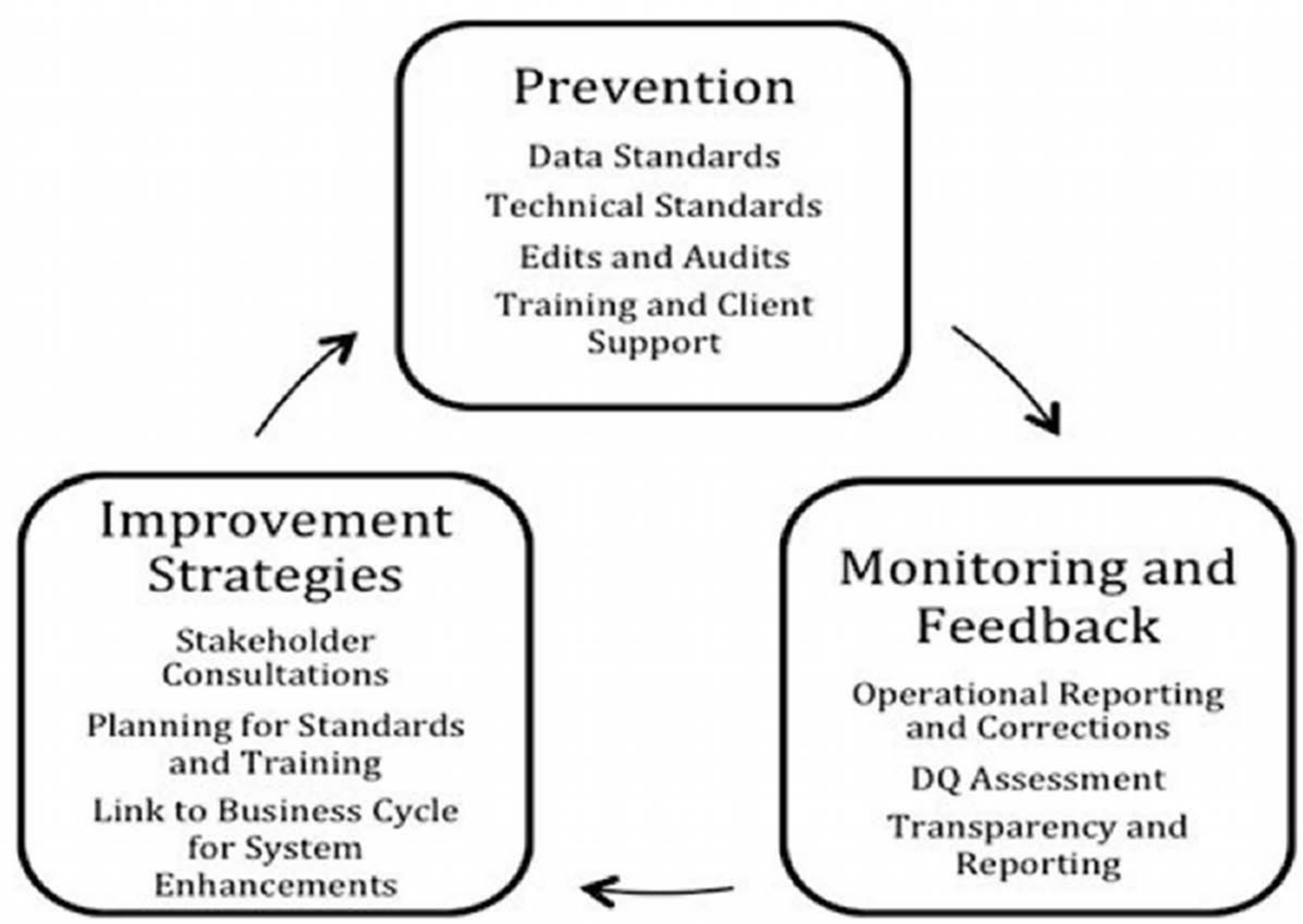
The clinical record contains sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results of treatment, and promote continuity of care among health care providers (MOI.2.1 JCIASH).

Measurable elements of MOI.2.1 include:

1. patient clinical records contain adequate information to identify the patient;
2. patient clinical records contain adequate information to support the diagnosis;
3. patient clinical records contain adequate information to justify the care and treatment;
4. patient clinical records contain adequate information to document the course and results of treatment;
5. patient clinical records promote continuity of care; and
6. the specific content of patient clinical records has been determined by the organization.

The intent of this standard is that the clinical record of each patient needs to present sufficient information to support the diagnosis, justify the treatment provided, and document the course and results of treatment. A standardized format and content of a patient's clinical record helps promote the integration and continuity of care among the various providers of care to the patient.

The CIHI continuous data quality improvement process. Taken from [526]



Prevention

Data Standards

Technical Standards

Edits and Audits

Training and Client Support

Monitoring and Feedback

Operational Reporting and Corrections

DQ Assessment

Transparency and Reporting

Improvement Strategies

Stakeholder Consultations

Planning for Standards and Training

Link to Business Cycle for System Enhancements