A BC First Nations Perspective on Accreditation and Quality Improvement: Experience, Impacts and Lessons Learned

First Nations Health Authority

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Health through wellness

RECIPROCAL™ CONSULTING

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Executive Summary[1]

This section provides a high-level summary of findings gathered as a part of an evaluation process led by the First Nations Health Authority's (FNHA) Community Accreditation and Quality Improvement (CAQI) program. The purpose of this assessment was to identify the impacts of the accreditation and continuous quality improvement efforts of First Nations health services and addictions recovery and healing services on patient safety, quality of care and continuity of care (among other impacts).

Methodologies

Findings are based on a mixed-method approach, using both primary and secondary data sources. Primary data was gathered through interviews and surveys. See Appendix A for tools used for primary data collection. Secondary data was provided by the First Nations and Inuit Health Branch (FNIHB) and the FNHA. This report builds on a recent cross-Canada project delivered in partnership by the FNIHB and the FNHA: the Report on the Analysis of Accreditation in First Nations Health Services. The second phase of research in this report is a BC-specific evaluation conducted through the lens of BC First Nations self-determination.

Findings

The following section summarizes the key report findings of the themes that emerged from the analysis and identifies differences based on the various lenses, including whether organizations had different experiences based on location (i.e., rural, urban), service type (i.e., health centre, addictions service or both) or the number of years they have been accredited for.

A number of themes and similarities emerged across all lenses and from both the interview and survey participants regarding the impacts of accreditation and/or continuous quality improvement (CQI) processes. A brief discussion related to the shared impacts of accreditation described by organizations is provided below.

Self-Determination

The majority of organizations interviewed in BC shared that, ultimately, accreditation and/or CQI did support First Nations with self-determination, noting the flexibility First Nations have in determining how to address gaps in services and the community's involvement in determining accreditation priorities and/or processes. Participants felt that the accreditation and/or CQI process also contributed to increasing the quality of care in their community and their ability to develop relevant policies to meet the needs of their people. The involvement of First Nations governments in the accreditation and/or CQI process was another important aspect contributing to self-determination. Working with the FNHA on accreditation and/or CQI was identified as one step toward self-determination. For the few participants who stated that accreditation and/or CQI did not contribute to self-determination, the funding structure for their organizations dictated much of the decision-making of who received their services. These funding limitations hindered their ability to make service decisions, further highlighting the need for decision-making processes that are more self-determined and led. Overall, accreditation and/or CQI was found to support informed decision-making because it led to updated policies and procedures that enabled staff to work in a more fluid and trauma-informed manner, and to use the gathered information in health advocacy on behalf of their community.

[1] For the most part, when findings refer to **accreditors**, they are referring to surveyors or those supporting with the accreditation process within the accrediting body they worked with. When possible, we denote if the participant is speaking about an accrediting body.

Client Safety

In general, participants reported that accreditation and/or CQI supported increased client safety and quality of care. Training opportunities, as well as the implementation of client feedback systems, were key tools in increasing client safety and quality of care. Improvements in cultural and physical safety were noted. New and enhanced confidentiality standards resulted in robust electronic documentation systems for client consent, enhanced staff awareness and greater consistency. In one case, the need to align confidentiality procedures with local cultural protocols was mentioned. For those few organizations that did not notice an impact, accreditation and/or CQI either affirmed their current practices of patient safety or they had not yet met the standards and could not comment. Improved quality of care was noticed as the result of accreditation and/or CQI due to more training for staff, improved standards, more uniform care and greater confidentiality. Increased quality of oversight and accountability resulted from accreditation, and organizations said they were able to attract better quality staff to job postings. The improved information sharing, increased staff capacity and decreased staff turnover positively impacted the continuity of care clients received at many organizations. Accreditation and/or CQI had a substantial positive impact on client safety and quality of care for the majority of organizations.

Improved Health Outcomes

The majority of organizations in BC found that accreditation and/or CQI did contribute to improved health outcomes in their communities. In particular, improvements in health outcomes were noticed in the areas of maternal child health, child immunization rates, mental health, wound care, prevention and education. Organizations also noted an increase in community pride and trust. Others stated that although accreditation and/or CQI contributed to improved health outcomes, attribution was difficult to measure due to the complexity of factors that impact the holistic health of individuals and communities.

Unintended Outcomes

With regard to unexpected outcomes, many organizations spoke to the increased credibility and reputation that their organization experienced as a result of being involved in accreditation and/or CQI. Organizations were surprised by the strong relationships built through the process. Also unexpected was the non-judgmental and kind support from accreditors and how much the process improved staff morale. Other unexpected outcomes were the creation of a new department focused on quality improvement within the organization, and improvements to the physical cleanliness of the space through janitorial staff involvement in the process. Several organizations were not expecting the accreditation process to provide organizational protection to the community and staff.

Changes to Policy, Processes or Plans

For many organizations, the accreditation process led to the development of policies, processes and procedures. They found it helpful in generating and formalizing policies to reflect their actual processes, as well as articulating policies for practices they do not do (i.e., restraint).

Discussion

In general, few differences in experiences were identified between the national report and this province-specific report. The lack of difference could in part be explained by the fact that the majority of the organizations included in the national report were located in British Columbia and shared similar demographics of being located in rural regions and having been accredited for a number of years. The differences that were identified are described below.

Rural and remote regions more frequently reported that they were required to undergo accreditation to maintain continued funding and demonstrate the value and credibility of their work. Rural and remote regions reported that the accreditation and/or CQI process identified their centres as credible and quality

organizations that match national standards. This was reported by both health centres and addictions centres within BC. Meanwhile, an urban centre reported that they gained increased autonomy to innovate with the accreditation and/or CQI process.

Rural centres reported increased confidentiality and consent practices, particularly around sharing of information, use of electronic consent processes and the development of policies around safe record-keeping. Health centres reported that the required shift to online processes during the pandemic impacted their accreditation and/or CQI process, but accreditors were very accommodating. Others noted that the shift to online impacted service delivery. For one newly accredited rural health centre, the accreditation process helped them through COVID-19 as they had a system to follow to stay on track.

Rural health centres in British Columbia reported that the process of accreditation and/or CQI was more time consuming for the organization than anticipated and took staff away from their hired tasks. Despite the time-consuming nature of accreditation and/or CQI, some rural health and addictions centres reported that the accreditation process led to strengthened trust between the community and the health system. Rural health centres voiced their appreciation for the accreditation and/or CQI support system as much of the terminology was initially unfamiliar. Urban health centres appreciated the face-to-face support offered by the accreditors as well as the ability to connect with other First Nations who had gone through the process before them. Finally, rural health centres explained that the accreditation and/or CQI process led to improvements within their centre. They mentioned examples such as files being better organized and easier to access and share as needed, as well as increased staff support in the form of increased meetings, training and reporting, as well as the establishment of processes to continue providing care during staff transitions.

The accreditation and/or CQI process sparked new opportunities for organizations, but some of the specifics of those opportunities varied by location and organization type. Urban health, rural health and rural addictions centres all noted new funding opportunities that became available once they were accredited. For rural health centres, the accreditation and/or CQI process resulted in the ability to attract more qualified applicants during staff recruitment. New opportunities for urban health centres were described as improved processes in service provision and increased autonomy for innovation. Urban health and addictions centres found an increased capacity for collaboration across programs, access to increased funding, greater value with their funders and increased morale of nurses.

With one exception, organizations that had been accredited for more than five years found value in the Peer Support Network, whereas organizations accredited within the last two years had not used the network. Organizations that found the network valuable were all health centres, both rural and urban. Those who found it helpful noted the network was useful for identifying goals and helping one another meet those goals, sharing successes and challenges, and identifying areas for improvement.

Organizations stated that they were overwhelmingly satisfied with the support provided by the FNHA. Rural health centres, rural addictions centres and urban health centres described the FNHA's support through the accreditation and/or CQI process as "helpful" and "amazing," and they expressed great appreciation for the FNHA's availability to receive phone calls, listen and answer any questions. This sentiment of gratitude and appreciation was consistent irrespective of the length of time the organization had been involved in accreditation and/or CQI.

Moving forward, organizations suggested opportunities for making the accreditation and/or CQI process better for First Nations health and wellness services. Rural addictions centres expressed the need for cultural safety and flexibility to be incorporated into the standards as some felt the accrediting process was micromanaging their organization. They wanted to ensure they were able to keep their uniqueness as an addictions centre while still operating to the standards. A newly accredited rural health centre noted the benefits of having a strong, cohesive team within the organization and to focus on team-building and addressing lateral violence internally throughout the process. Another rural health centre emphasized that the accreditation process should be needs-based and fit the community rather than a one-size-fits-all

approach. Recommendations from urban health centres included engaging staff in the process in a light-hearted way (i.e., handing out prizes along the way) and making accreditation mandatory if requesting funding, at the risk of not receiving adequate buy-in.

Summary

Ultimately, participants found the accreditation process and/or CQI to be impactful, leading to a multitude of positive outcomes for health and addiction centres across British Columbia. These outcomes are related to improved client safety, quality of care, continuity of care and health outcomes, and they ultimately support the self-determination of First Nations. As noted by participants, although there are areas for growth in the accreditation and/or CQI process, organizations in British Columbia have witnessed the overarching and positive impacts that this process has had on their health and addiction services and, therefore, the communities that access these essential services.

Areas of Future Study

Future studies related to the accreditation and/or CQI of First Nations health centres and addiction centres in British Columbia may consider exploring the following topics identified by participants as areas for improvement:

- ⇒ Redundancies in the process
- ⇒ Organizational buy-in
- ⇒ Time commitment and organizational capacity
- ⇒ Culturally relevant approaches when working with communities and developing standards
- ⇒ Increased personnel support for those going through the accreditation process (i.e., focus on relationship building)

1.0 Accreditation of First Nations Health Services

This section provides background information on the accreditation of First Nations health services and addictions recovery and healing services, including the First Nations Health Authority's (FNHA) Community Accreditation and Quality Improvement (CAQI) program. This section also provides information about some of the main health service accreditation bodies in Canada.

FNHA Community Accreditation and Quality Improvement Program[2,3]

The CAQI program partners with community health and addiction recovery healing services to strengthen the quality and safety of health and wellness services by and for BC First Nations.

The CAQI program furthers the FNHA's mission and vision and aligns with four of the 7 Directives:

⇒ Community-Driven, Nation-Based

⇒ Improve Services

⇒ Foster Meaningful Collaboration and Partnerships

⇒ Function at a High Operational Standard

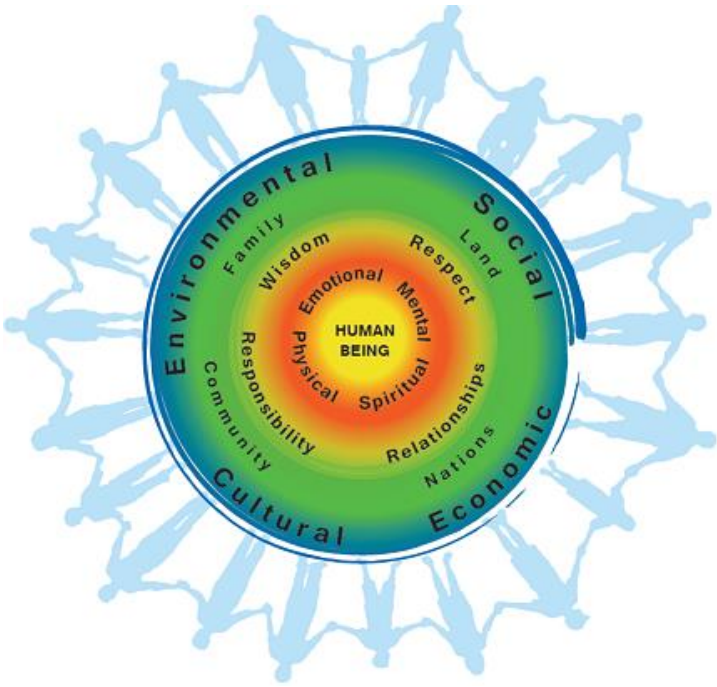
The program collaborates with related FNHA services and teams to further the FNHA's quality agenda, including initiatives such as Nursing, Occupational Health and Safety, Community Health and Wellness Programs, Policy, and Planning Services. In addition to cross-departmental and team initiatives, the CAQI program has active external partnerships. Federally, CAQI works with the First Nations and Inuit Health Branch's (FNIHB) Quality Improvement and Accreditation program to support contract deliverables with accrediting bodies, funding formula maintenance and national Continuous Quality Improvement (CQI) initiatives. Provincially, CAQI works with the BC Patient Safety and Quality Council (BCPSQC) to influence mandates that further provincial conversations on quality as well as collective actions towards cultural safety and humility. The FNHA has supported BC First Nation Health Directors and accreditation and quality leads to participate in BCPSQC priorities, including First Nations representation at annual quality forums, showcasing community-led quality improvement projects and contributing to the newly launched BC Health Quality Matrix.

Guided by the First Nations Perspective on Health and Wellness, shared leadership and a community-based approach, the CAQI program supports accreditation goals and quality improvement actions that enhance health systems and service outcomes. This effort:

- REQUIRES *shared commitment and ongoing funding*
- IMPROVES *quality of services and culturally safe care*
- SUPPORTS *sustainable and sufficient health and human resources*
- BUILDS *Indigenous-led health systems development, management and evaluation*

[2] Information from this section was sourced from: FNHA. (2009). *Community Health Services Accreditation & Quality Improvement.* Retrieved from https://www.fnha.ca/what-we-do/health-and-wellness-planning/accreditation.
[3] FNHA. (2020). *FNHA Community Accreditation and Quality Improvement Program: Participant Survey*. Vancouver, BC: FNHA.

Figure 1. First Nations Perspective on Health and Wellness



The CAQI program supports communities to pursue and maintain health services accreditation status by providing funding to Nations to partner with a recognized Canadian accreditation body. Participation in the program is voluntary. Eligible program participants receive $30,000 in base funding and up to $25,000 for the accrediting body invoice amount. Some additional funds are available to communities depending on the size of their operations and the population they serve, as well as the location of their services. BC First Nations pursue accreditation status either through Accreditation Canada, the Canadian Accreditation Council or the Commission on Accreditation of Rehabilitation Facilities. Currently, CAQI is supporting 41 First Nations health organizations across BC to engage in accreditation. Key program approaches and activities include:

- ⇒ Being guided by the BC First Nations Perspective on Health and Wellness for all program development, implementation and evolution;
- ⇒ Leading with cultural safety and humility when furthering culturally safe care and quality health services;
- ⇒ Promoting the awareness, understanding and benefits of accreditation and quality improvement through the understanding and application of an Indigenous lens;
- ⇒ Linking accreditation and quality improvement to related health service priorities, practices and processes such as leadership development, community health and wellness planning, and evaluation;
- ⇒ Partnering with participating quality champions to engage in ongoing opportunities for leadership, resource sharing, learning and mentorship;
- ⇒ Providing funding, consultation and support to program participants who are participating in continuous quality improvement efforts; and
- ⇒ Evolving a BC First Nations-led approach to accreditation and quality improvement.

The FNHA has been exploring interest in a BC First Nations-led accreditation approach since 2013 and has been facilitating the First Nations-led Accreditation and Quality Improvement Framework Working Group. This collective effort is a response to a long-standing request for more reflective, relevant and responsive accreditation and quality improvement, designed by and for BC First Nations health organizations. The intention is to offer key principles and guidelines that offer an Indigenous approach to continuous quality improvement that is in better alignment with culturally rooted, respectful and community-led ways of providing quality and safe health services. Participating in service improvement is not new for BC First Nations; however, advocacy for defining quality and service standards by and for Indigenous health services is.

The framework incorporates the following elements:

- ⇒ a BC First Nations lens on health and wellness;
- ⇒ Nation-building principles aligned with community development practices; and
- ⇒ two-eyed seeing approaches to strengthen both the quality and the holistic safety of services.

The framework has evolved into the First Nations Perspective on Quality. It depicts a vision for quality care in community-based health and wellness services. It creates a shared focus to guide efforts for community, its partners, and service providers to support safer care, strengthen organizations and enhance partnerships. The perspective can be applied to diverse Nations, communities, and organizations to better integrate community priorities, values, and cultural ways of doing, and knowing.

Quality Improvement and Safety Network

Hosted by the CAQI program, the FNHA Quality Improvement and Safety Network is a province-wide peer network whose approach to quality improvement initiatives is rooted, defined and led by community and culture and where "Indigenous teachings lead Indigenous practices." The network of 41 member organizations includes 32 First Nation health services, of which 28 are accredited, and nine First Nation addiction recovery services, of which all are accredited.

In addition to receiving support to partner with a Canadian accreditation body, the CAQI program and network activities provide opportunities for health leaders to connect with fellow colleagues, access new learning opportunities, share leading practices and build supporting resources.

FNHA Quality Improvement and Safety Network

Accreditation in Canada

Canada has several accreditation bodies that assess health organizations. Currently, BC First Nations health organizations work with one of the following three accreditation bodies: Accreditation Canada, the Canadian Accreditation Council and the Commission on Accreditation of Rehabilitation Facilities.

Accreditation Canada[4]

Accreditation Canada is an independent, not-for-profit organization that delivers customized assessment programs for health and social service organizations. The organization has been in operation for over 60 years and delivers accreditation services nationally in all 13 provinces and territories in Canada, and internationally, serving clients in 38 countries. Accreditation Canada clients include government, regional health authorities, hospitals, community-based programs and services in both the public and private sectors. The organization takes a person-centered approach in its efforts to transform health care and has a *people-powered health philosophy* that brings together diverse experiences and perspectives to foster positive change. Accreditation Canada is accredited through the International Society for Quality in Healthcare (ISQua) and the Asia Pacifica Accreditation Cooperation.

Canadian Accreditation Council[5]

The Canadian Accreditation Council (CAC) is a not-for-profit organization that has been in operation for over 40 years and provides accreditation services to a range of health and human service programs. CAC has provided accreditation services across Canada, including in British Columbia, Saskatchewan, Manitoba, Ontario and the Atlantic region. CAC's vision is to be *a nationally recognized leader for setting standards of excellence* and its mission is *dedication to promoting service excellence by using a peer review process based on best practice standards*. CAC has a variety of standards to help support various health contexts. Additionally, CAC has Indigenous-specific services and offers enhanced designations for Indigenous or cultural programs. CAC works collaboratively with First Nations to enhance programming through accreditation and has standards to support ongoing learning about Indigenous history and culture, access to Indigenous resource people, and the provision of positive role models through recruitment and retention of Indigenous staff. CAC has also been accredited through ISQua.

Commission on Accreditation of Rehabilitation Facilities International[6]

The Commission on Accreditation of Rehabilitation Facilities (CARF) International, founded in 1966, is an independent, not-for-profit organization that provides accreditation services. CARF's mission is to *promote the quality, value, and optimal outcomes of services through consultative accreditation process and continuous improvement services that center on enhancing the lives of persons served*. CARF's vision is *through responsiveness to a dynamic and diverse environment, CARF serves as a catalyst for improving the quality of life of the persons served*. CARF supports service providers to meet internationally recognized organizational and program standards. CARF provides accreditation services in the following areas: aging services, behavioural health, child and youth services, employment and community services, vision rehabilitation services, medical rehabilitation, and opioid treatment programs. The accreditation process includes an in-person survey, a report that includes strengths and areas of improvement for the service provider, as well as the development of a quality improvement plan by the service provider. CARF Canada is governed by a board as well as community advisors.

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[4] Accreditation Canada. (2020). *About Accreditation Canada*. Retrieved from https://accreditation.ca/about/
[5] Canadian Accreditation Council. (2020). *About the Canadian Accreditation Council*. Retrieved from http://www.canadianaccreditation.ca/canadian-accreditation-council/.
[6] CARF International. (2020). *CARF International*. Retrieved November 3, 2020, from http://carf.org/home/.

2.0 Approach and Methodology

This section identifies key aspects of the scope and approach as well as the methodology that was used for the accreditation analysis.

Scope and Overarching Questions

The purpose of this assessment was to gain an understanding of the value of accreditation in First Nations health services, specifically considering whether and how it supports increased First Nations ownership and control of health services and whether and how it leads to improved health outcomes. The overarching areas of inquiry that framed the assessment include:

1. **What are the accreditation/CQI outcomes and impacts?**
    a. To what extent does accreditation/CQI increase the self-determination of First Nations in health care?
    b. To what extent does accreditation/CQI increase First Nations client safety?
    c. To what extent does accreditation/CQI increase First Nations quality of care?
    d. What impact does accreditation/CQI have on continuity of care?
    e. Does accreditation/CQI lead to improved health outcomes for First Nations?
    f. What are the unintended outcomes and impacts of accreditation/CQI for key stakeholders? (i.e., organizational leadership, staff, partners)
    g. What changes to policy, processes and/or plans have been made as a result of accreditation/CQI?
2. **What is the overall satisfaction with the CAQI program?**
3. **What are wise practices and lessons learned?**
    a. What are opportunities and lessons learned related to accreditation/CQI?
    b. What are some success stories and promising models?

Approach

Our research approach is guided by the four Rs of *Respect, Relevance, Reciprocity* and *Responsibility*.[7] As Indigenous women and allies, we are committed to research that lifts up the work of our communities and holistically supports the self-determination of Indigenous peoples. Reciprocal Consulting takes a collaborative, participatory and strengths-based approach to the assessment to ensure that the objective, scope, methodology and approach are appropriate and relevant to the needs of the FNIHB, the FNHA and other key stakeholders. The work of Reciprocal Consulting is grounded in the following:

⇒ *An Indigenous worldview*
⇒ *Strengths-based*
⇒ *Participatory methods*
⇒ *Culturally relevant and responsive*
⇒ *Developmental*
⇒ *Social justice*

[7] Kirkness, V.J, & Barnhardt, R. (2001). First Nations and Higher Education: The Four R's—Respect, Relevance, Reciprocity, Responsibility. *First Nations & Higher Education.* Retrieved from https://uaf.edu/ankn/publications/collective-works-of-ray-b/Four-Rs-2nd-Ed.pdf.

Data Collection Methods

The evaluation used both primary and secondary data sources and gathered both qualitative and quantitative data. For the purposes of this assessment, evidence was defined as "locally relevant information, experience, and culturally based information in addition to scientific research"[8] (Davey et al., 2014, p.317). Table 1 below identifies primary and secondary data sources used to address each of the overarching areas of inquiry.

Table 1: Primary and Secondary Data Collection by Area of Inquiry

Target Group	Information	Method
Key informants from health services and addiction recovery services that have been funded through FNHA	✓ Role in accreditation (i.e., accreditation and quality improvement lead, health director, surveyor) ✓ Information about organization (i.e., service type, location, number of years in accreditation program) ✓ Extent that accreditation increases self-determination of First Nations ✓ Extent that accreditation increases First Nations client safety ✓ Extent that accreditation increases First Nations quality of care ✓ Extent that accreditation improves continuity of care ✓ Improved health outcomes as a result of accreditation ✓ Unintended outcomes and impacts of accreditation ✓ Changes made as a result of accreditation ✓ Satisfaction ✓ Opportunities and lessons learned ✓ Wise practices (i.e., promising models and success stories)	Key informant interview
Health services and addiction recovery staff	✓ Information about organization (i.e., service type, location, number of years in accreditation program) ✓ Extent that accreditation increases First Nations client safety ✓ Extent that accreditation increases First Nations quality of care ✓ Extent that accreditation improves continuity of care ✓ Unintended outcomes and impacts of accreditation ✓ Changes made as a result of accreditation ✓ Wise practices (promising models and success stories)	Online survey
Secondary sources	✓ Impact of accreditation	Literature and document review

[8] Davey, C.J., Niccols, A., Henderson, J., Dobbins, M., Sword, W., Dell, C., Wylie, T. et al. (2014). Predictors of research use among staff in Aboriginal addiction treatment programs serving women. Journal of Ethnicity, 13, 315-336.

Indicators

Table 2 below identifies the indicators related to the areas of inquiry that our team endeavoured to measure.

Table 2: Areas of Inquiry and Indicators

Areas of Inquiry	Indicators
1. To what extent does accreditation and CQI increase the self-determination of First Nations in health care?	1.1 % of participating services indicating that accreditation supports First Nations to make informed decisions with regard to planning and policy development 1.2 % of participating services indicating that health services have flexibility in determining how to address gaps in services 1.3 % of participating services indicating that accreditation provides First Nations health services with knowledge to support health advocacy work 1.4 % of participating services indicating increased self-determination as a result of accreditation 1.5 % of participating services indicating that the community is involved in helping to determine accreditation priorities and/or processes
2. To what extent does accreditation and CQI increase First Nations client safety?	2.1 % of participating services indicating training and professional development opportunities related to client safety identified through accreditation and implemented 2.2 % of participating services indicating mechanisms for client feedback are in place and contribute to service improvement 2.3 % of participating services indicating policies and procedures related to client safety are put in place as a result of accreditation (i.e., managing health information) 2.4 % of participating services indicating increased cultural safety as a result of accreditation
3. To what extent does accreditation and CQI increase First Nations quality of care?	3.1 % of participating services indicating improved facilities and equipment since beginning accreditation process 3.2 % of participating services indicating training and professional development opportunities related to quality of care identified through accreditation and implemented 3.3 % of participating services indicating policies and procedures related to quality of care of put into place as a result of accreditation 3.4 % of participating services indicating increased quality of care as a result of accreditation
4. To what extent does accreditation and CQI increase continuity of care for First Nations?	4.1 % of participating services indicating increased continuity of care as a result of accreditation
5. Does accreditation and CQI lead to improved health outcomes for First Nations?	5.1 % of participating services indicating increased access to health and wellness services for First Nations 5.2 % of participating services indicating improved health outcomes as a result of accreditation
6. What are the unintended outcomes and impacts of accreditation and CQI for key stakeholders?	6.1 # and type of unintended outcomes 6.2 % of participating services indicating meaningful relationships have been built between accreditors and First Nations organization/community members

Areas of Inquiry	Indicators
	6.3 % of participating services indicating impacts on relationships with health services partners, initiatives or systems
7. What changes to policy, processes and/or plans have been made as a result of accreditation and CQI?	7.1 # and type of policy changes and types as a result of accreditation 7.2 # and type of processes changed and types as a result of accreditation 7.3 % of plans that incorporated findings from accreditation
8. What is the overall satisfaction with the CAQI program?	8.1 # and type of challenges that result from being involved in accreditation 8.2 # and type of opportunities that result from being involved in accreditation 8.3 % of participants who indicated the peer support network was valuable 8.4 % of participants who shared a level of satisfaction with support received
9. What are wise practices and lessons learned?	9.1 % of participating services indicating that organizational structure supports service delivery 9.2 % of participating services who engage in monitoring and/or reflection practices that lead to change 9.3 # and type of opportunities for improving accreditation process

Data Collection and Management Processes

Reciprocal Consulting is compliant with British Columbia's *Freedom of Information and Protection of Privacy Act*. Free, prior and informed consent is sought before any data is gathered. All data is stored on password-protected computers with two-factor authentication. Any data not stored electronically is kept within a locked cabinet in the Reciprocal Consulting office. Data is cleaned of identifying information.

Furthermore, Reciprocal Consulting embraces the OCAP principles of ownership, control, access and possession with regard to research and evaluation with First Nations organizations. OCAP principles were included in this project to protect the cultural and intellectual properties of our communities. We further advocate for the inclusion of the Tri-Council Policy Statement for research (and evaluation work) with Indigenous people in Canada.

For interviews, a live transcription method was employed. This involved two members of the Reciprocal Consulting team joining an interview, with one team member facilitating and the other team member transcribing the conversation. One or two members attended key informant interviews depending on the comfort level of live-transcribing while interviewing. In keeping with the principles of OCAP, Reciprocal Consulting returns interview data to the interviewees. This process also serves as a way of verifying and validating the data as it provides participants with opportunities to share additional information or retract data.

Data Analysis Techniques[9]

Qualitative data was categorized through content analysis, using a team approach for enhanced rigour. Data analysis included several rounds of open coding, grouping and thematic categorization of interview and survey responses. The evaluation team participated in a group coding procedure, allowing for discussion around the essence of each data point and creating a group consensus around the generation of

[9] Please note that interviews with organizations may or may not include multiple participants. However, when calculating the number counts (n) organizations were not counted twice to ensure consistent representation throughout the report.

emergent codes. Following this initial procedure, team members coded individual portions of the data, with ongoing discussion around nuanced or complex data.

With regard to quantitative data, descriptive statistics were used to describe trends within the data, such as measures of central tendency (e.g., mean, median, mode).

Once the data had been analyzed, data sources and all of the lines of evidence were triangulated to identify common themes across target groups as well as divergent themes from different target groups. This process of triangulation assisted in identifying key findings.

About the Participants

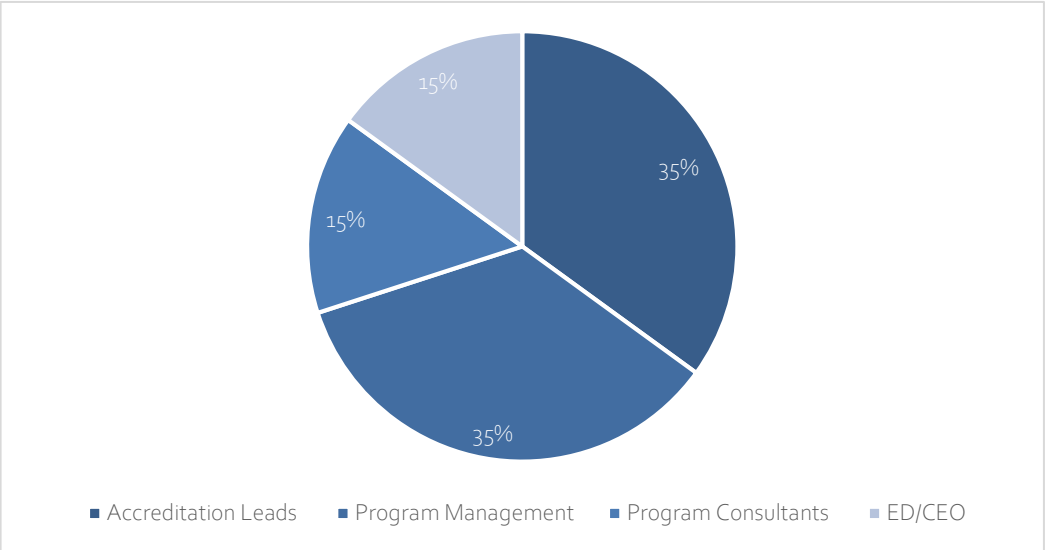
In-depth qualitative interviews were conducted with 20 participants from 16 accredited organizations within British Columbia. Surveys were completed by 30 participants within British Columbia, with 23 respondents identifying that they were from an accredited organization. Of the seven participants who did not respond "yes" when asked if their organization was currently accredited, four indicated that they were in the process of going through accreditation. Two participants reported that they were not accredited, while one participant did not respond to this question, but went on to report that their organization has been accredited for one to three years. As a result, responses from all 30 survey participants are included in the findings.

Below is a breakdown of demographic information related to both interview and survey participants.

Participant Roles

Interview participants included seven accreditation leads, seven program management staff, three program consultants and three executive directors/CEOs. Figure 2 shows the proportion of participants speaking from the perspectives of these unique roles within each organization.[10][11]

Figure 2. Interview Participant Roles (Percentage)

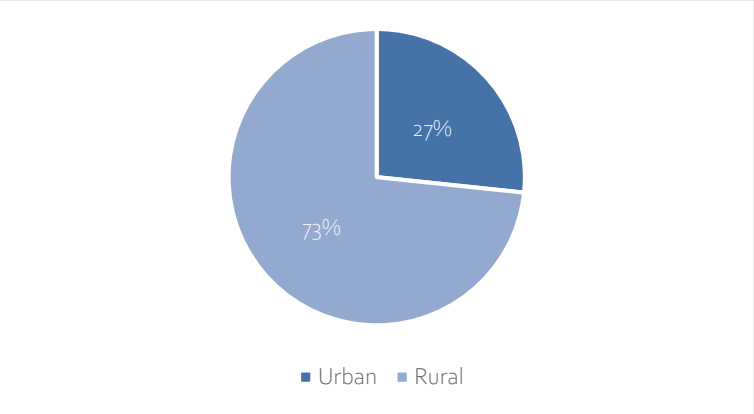


[10] Please note roles were not gathered for survey participants.
[11] Note that interview participants could identify multiple roles (i.e., management and accreditation lead).

Geographic Distribution

Most organizations that were interviewed were located in rural communities (n = 11), with only a few located in urban centres (n = 4).[12] Survey participants were not asked whether their organizations were located in urban or rural areas.

Figure 3. Urban and Rural Region

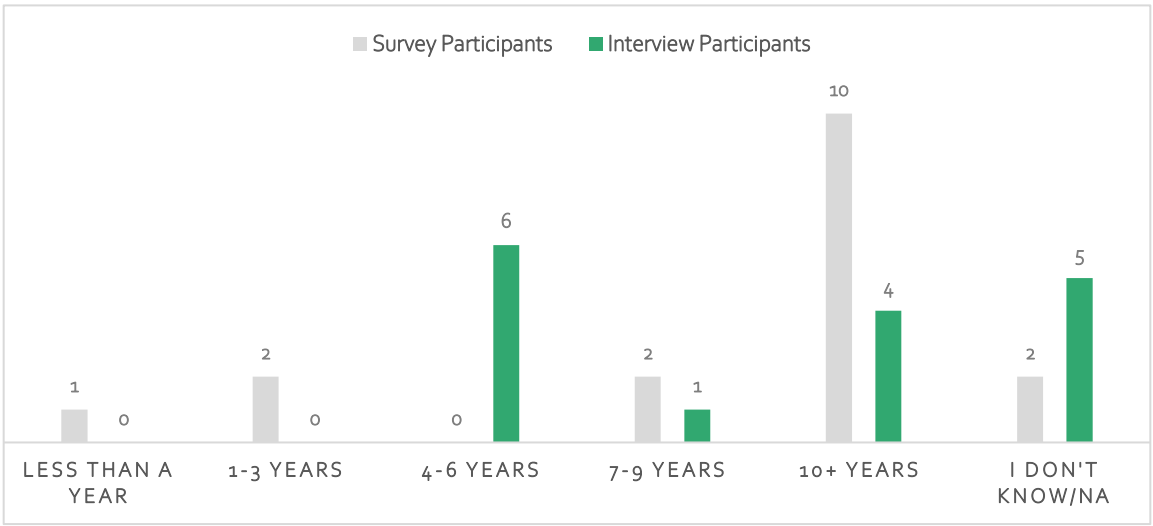


Years Accredited

The amount of time organizations have been accredited and/or pursuing CQI improvement efforts was gathered from interview participants and survey participants. Interview participants reported that their organizations had been accredited between **five and 15 years**.

Survey participants reported that their organizations had been accredited and/or CQI certified between a range of less than one year to 20 years. As with the interview participants, survey participants most frequently reported that their organization had been accredited and/or pursuing CQI improvement efforts for **10+ years** (n = 10, 59%). Four of the survey participants indicated that their organization was currently in the process of becoming accredited and/or CQI certified. Figure 4 below illustrates how many years organizations reported being accredited and/or CQI certified.

Figure 4. Number of Years Accredited



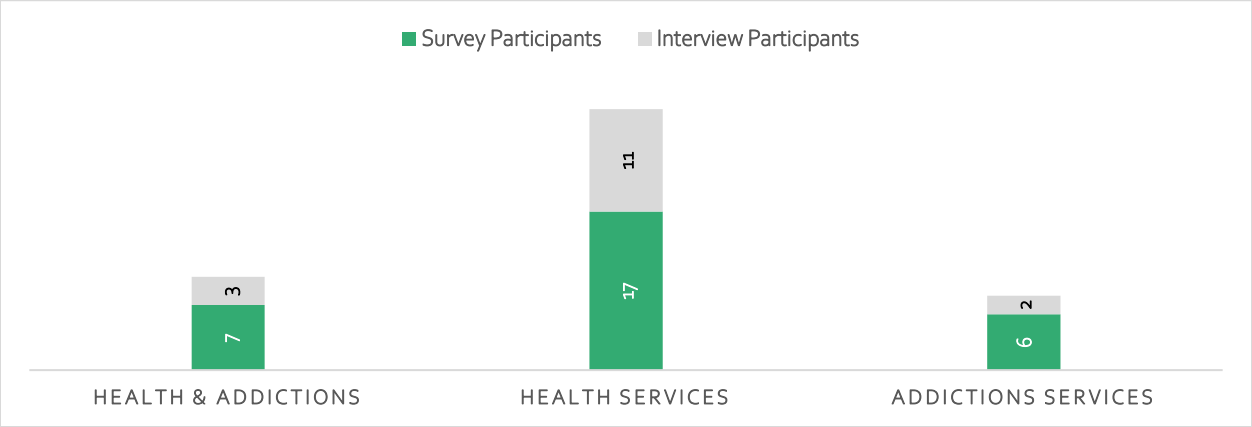
[12] Please note that rural and urban data was not gathered for survey participants.

Services Offered

Participants in this analysis were representatives of organizations that offered health and/or addictions services. Organizations who participated in key informant interviews most frequently offered either **health services** (n = 11, 69%) or **health and addictions services** (n = 3, 19%), with some organizations offering solely **addictions services** (n = 2, 13%).

Survey participants most frequently reported that their organizations offered **health services** only (n = 17, 57%), followed by both **health and addictions services** (n = 7, 23%) and **addictions services** only (n = 6, 20%). Figure 5 below illustrates the breakdown by service type.

Figure 5. Service Type (Number)



3.0 Findings

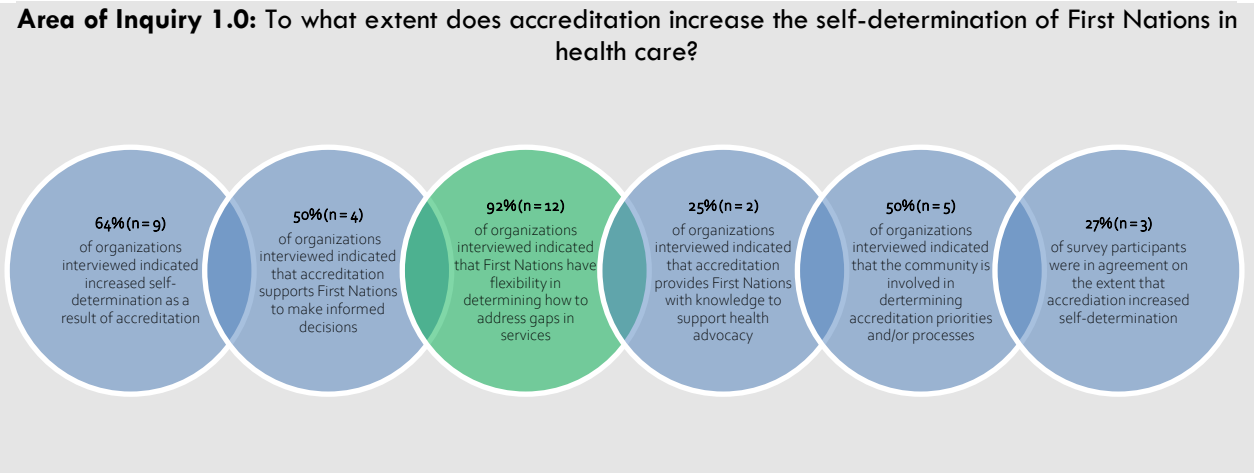
This section provides a synthesis of analysis findings from both interview and survey participants. Each section provides a summary of findings related to the areas of inquiry and corresponding indicators included in section 2.0.

3.1 Impacts and Outcomes

The following section provides findings related to outcomes and impacts of accreditation and/or CQI related to the self-determination of First Nations, client safety, quality of care, continuity of care, improved health outcomes for First Nations, and organizational changes.

Self-Determination

Figure 6. Outcomes and Indicators Related to Self Determination



Accreditation Supporting Self-Determination

When interview participants were asked whether accreditation and/or CQI has contributed to self-determination, many **agreed** that it has (n = 9). Some participants spoke about how having a healthy Nation is part of self-determination and through accreditation and/or CQI, they were able to increase quality of care for the community. Additionally, they were able to develop policies that fit their people and focus their programming on the health challenges relevant to their communities. One community explained that through accreditation, the community increased their skills, autonomy and leadership, gaining skills and capacity in writing their own policies, risk assessments and continuous improvement practices. Additionally, individuals in the community have greater control over their own care planning, and health care planning is done with people not for them. Another participant shared that accreditation and/or CQI contributed to self-determination as First Nations governments were involved and oversaw the process. They were involved in integrating their vision for services and there are policies in place to keep them involved through the accreditation. Others noted that accreditation and/or CQI was a contributor to self-determination, but not the be all and end all. Two participants shared that while self-determination is their ultimate goal, it will take a while to work to get there, and that working with the FNHA on accreditation CQI is a step toward self-determination.

Some participants **did not find** that accreditation contributed to self-determination (n = 3). One explained that their Nation does not get to decide who gets their services, and that this is mostly determined by their

funding structure. Another shared that while accreditation does not support self-determination, it does validate processes that support it. Finally, two participants were not able to answer.

Accreditation Supporting Informed Decision-Making

Nak'azdli Whut'en Centre

When asked how the information that was received through accreditation and/or CQI has been used for informed decision-making, several interview participants spoke about **policy and procedure updates** (n = 6). This included standardizing current policies and procedures, adding new policies to back up the work they were already doing, adding new policies where there were gaps and improving their work to meet the new set of policy standards. The information provided helped to update policies in a timely and organized manner. One participant noted that **updating policies and procedures was beneficial** for their organization because it allowed them to work in a more fluid and trauma-based way that is more in line with what they do.

Other interview participants used the information received for **health advocacy** (n = 3). For example, one participant explained that through the accreditation and/or CQI process, they identified a service they wanted to provide in the community, used this process to conduct program planning and were able to provide more services. Two participants responded that they have **not yet done anything with the information**.

First Nations Autonomy in Designing and Delivering Services

Assessing if accreditation and/or CQI increases self-determination for First Nations included asking interview participants about the flexibility of their organizations to implement changes when gaps or areas of improvement were identified. Most participants felt they had the **flexibility to address any changes** (n = 10). A participant noted that through dialogue with the FNHA, they were able to make adjustments and felt the FNHA understood why they were asking for certain things. Another participant explained that they felt they were able to make changes that were relevant to their community. This was echoed by another participant who felt they were able to make changes that were more aligned with how their organization ran as an Indigenous organization. Further, one participant similarly noted that they were able to incorporate survey feedback from the community on policy and procedure changes. Some barriers to making changes identified by participants included **internal dynamics of the team** (n = 3). One participant explained that while their team had the flexibility to address gaps, they needed to come to consensus on what the gaps were, so change could be slow for addressing challenging problems. Another participant noted that it is up to the teams, but they are often too busy.

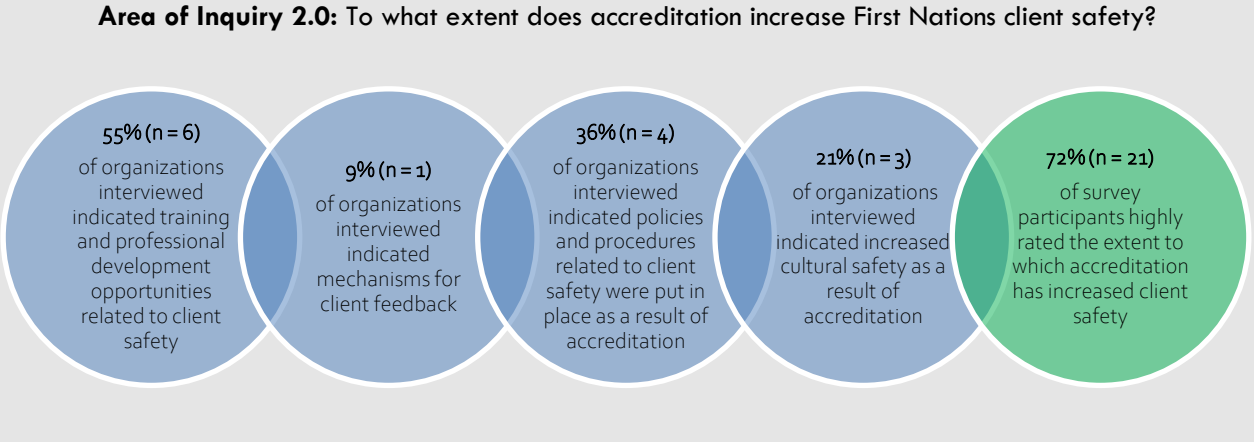
Community Involvement in Determining Accreditation Priorities

Finally, participating interviewed organizations were asked whether their community had been engaged and involved in determining accreditation priorities. Many responded that they **had been** (n = 10). In explaining how they were consulted, participants shared community engagement practices such as Elders committees that provide cultural guidance, a board of directors that includes community members from each community and a client satisfaction survey. Participants also mentioned community engagement with the community health plan, client feedback on accreditation requirements and holding World Cafes for community input on what services are lacking.

Additionally, some participants noted that they **already had community engagement** before accreditation, so re-engaging would be duplicating those efforts. Another explained that they had engagement before accreditation (n = 2).

Client Safety

Figure 7. Outcomes and Indicators Related to Client Safety



Accreditation Impact on Client Safety

Regarding client safety, participants spoke about the changes they have made to their operations and services because of accreditation. First, participants highlighted increased **training** related to safety (n = 3) to address gaps in their training for client safety, workplace safety, suicide prevention and respectful relationships. Additionally, changes were made regarding **cultural safety** (n = 3). This included increasing cultural competency, hosting presentations from scholars on racism in health care, adding a culture and language department, and offering training developed by Elders for those onboarding with their organization. Further, participants noted that they have **increased client reporting** (n = 3). This included implementing mechanisms for reporting incidents, encouraging clients to provide feedback about a service they received and adding more signage informing clients of their rights. Other participants discussed improvements to **physical safety** (n = 2). This included installing security cameras and having systems in place for prevention maintenance. One participant noted they have a new standard on confidentiality, which was previously a challenge given the set-up of the health centre and the size of the community. Finally, one participant noted they have **not yet** complied with standards that would improve client safety, but note that pressure from the FNHA to comply would help them in this area.

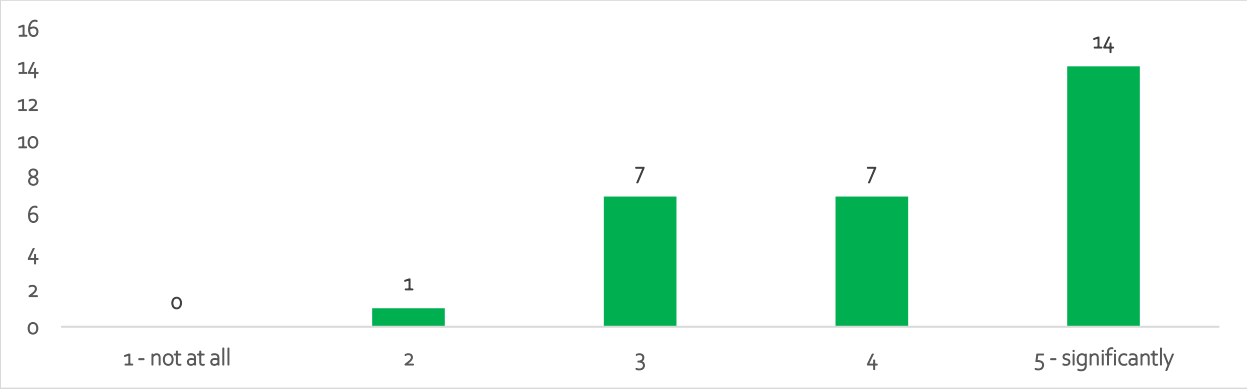
In sharing the impacts of being involved in accreditation on client safety, many participants spoke about improvements made to **consent and confidentiality** (n = 8). In explaining these improvements, participants shared that they have moved to electronic documentation systems for consent forms. Others spoke about developing policies and procedures regarding client information sharing. It was also shared that staff are more aware of confidentiality and more consistent with documentation and information sharing. One interview participant noted that while they now had a more consistent and unified documentation system, it did raise some concerns in one community about the cultural safety of documenting the ceremonies clients access as this could potentially violate Indigenous protocols. Other impacts on client safety identified included new policies put in place to empower clients to give feedback and know their rights, as well as becoming more aware of prevention and risks to give guidance to clients accessing services to ensure they feel safe.

Snuneymuxw First Nation – Health Department

Other interview participants shared that there was **no impact** (n = 4) on client safety, as they were already doing well in this area. One participant explained that while they already had client safety practices in place, the accreditation confirmed the value of their practices. Another noted that although they do not have an official cultural safety policy, safety is at the core of how they do their work. Finally, one participant shared that there was no impact because their community had not yet met many of the standards.

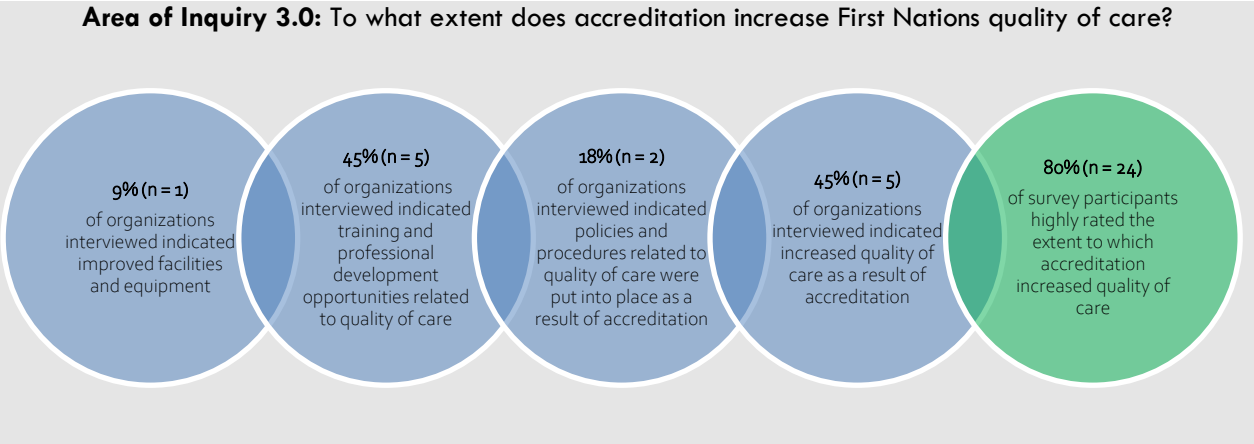
Survey participants were also asked to rate the extent to which accreditation has helped increase client safety in their organization on a scale from 1 to 5, were 1 is *not at all* and 5 is *significantly*. The vast majority shared that the accreditation had **significant impacts** on client safety (rating 5, n = 14). Survey participants rated their responses below.

Figure 8. Survey Ratings: Accreditation Impact on Client Safety (Number)



Quality of Care

Figure 9. Outcomes and Indicators Related to Quality of Care



Accreditation Impact on Quality of Care

Interview participants were asked to share the impact that accreditation has had on quality of care. Interview participants identified several ways that accreditation has **increased** the quality of care (n = 8). Some participants explained that staff have more training, which has a positive impact on clients. Other participants explained that the improved standards through accreditation have improved client care as they now know what standards have to be met. Similarly, one participant shared that clients now have a standard in place to submit complaints. Additionally, because of new standards, clients now receive more uniform care between staff teams that work in cycles with clients, and standards for confidentiality are now in place. One participant noted that their client survey has shown that clients are happy with the care quality.

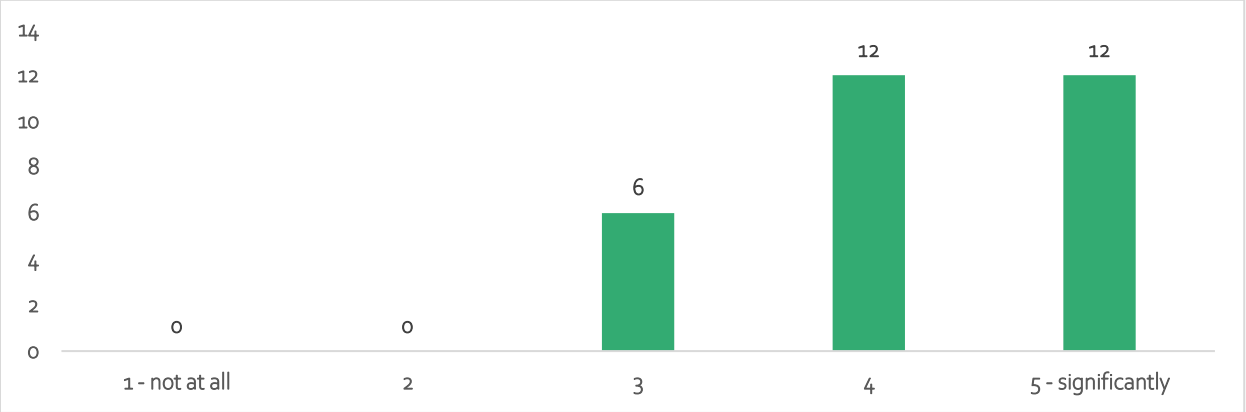
- "*Many changes and standardization of policies/procedures have been completed for the better of the health centre and the community.*"

- "*Accreditation compliance is of utmost importance to our organization as it is like a blueprint for quality service, keeping checks and balances in place to ensure the best and most up-to-date quality of service possible. All of the above examples are a part of the checks and balances that I speak of.*"

Two participants spoke about how their organization was **already providing quality care** prior to accreditation and how they already had professional standards in place. One participant had not yet noticed any impact of accreditation and/or CQI as they do not yet have the accreditation and/or CQI standards in place.

Survey participants were also asked to rate the extent to which accreditation and/or CQI has helped increase quality of care in their organization, on a scale from 1 to 5, where 1 is *not at all* and 5 is *significantly*. As shown in the figure below, most survey respondents shared **that there were significant impacts** (rating 5, n = 12).

Figure 10. Survey Ratings: Accreditation Impact on Quality of Care (Number)



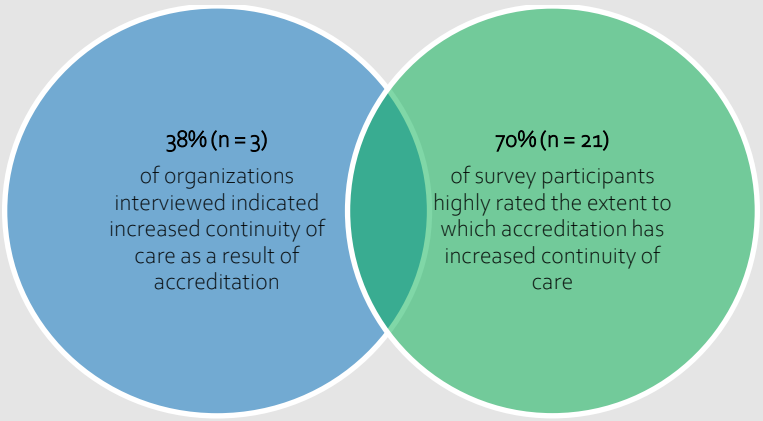
Policies and Procedures Related to Quality of Care

When asked what changes have been made to their operations or services regarding quality of care because of accreditation and/or CQI, participants said that there was **increased quality of oversight and accountability** (n = 9). For example, several participants explained that they made changes to their documentation and reporting. This improves care for clients as there are now mechanisms in place to report incidents, have incidents addressed by management, improve patient charting for consistent care, and enhance co-operation with other organizations. There were also changes to the **quality of the staff** (n = 5). Staff had new professional development and training opportunities through the accreditation and/or CQI process. For example, they had lunch and learns, heard from scholars on racism in health care, and/or took quality improvement training. It was also shared that one community was able to attract more qualified candidates to their organization because the job posting noted that the organization was accredited. Some other changes that impacted quality of care included changes to the equipment and facility, and increased patient empowerment through new policies that emphasize patient control over their own health care. Finally, some participants reported making **no changes** (n = 3) to their operations or services regarding quality of care. One explained it was too soon to tell and another explained that the changes were minor and did not impact client care.

Continuity of Care

Figure 11. Outcomes and Indicators Related to Continuity of Care

Area of Inquiry 4.0: To what extent does accreditation increase continuity of care for First Nations?



Accreditation Impact on Continuity of Care

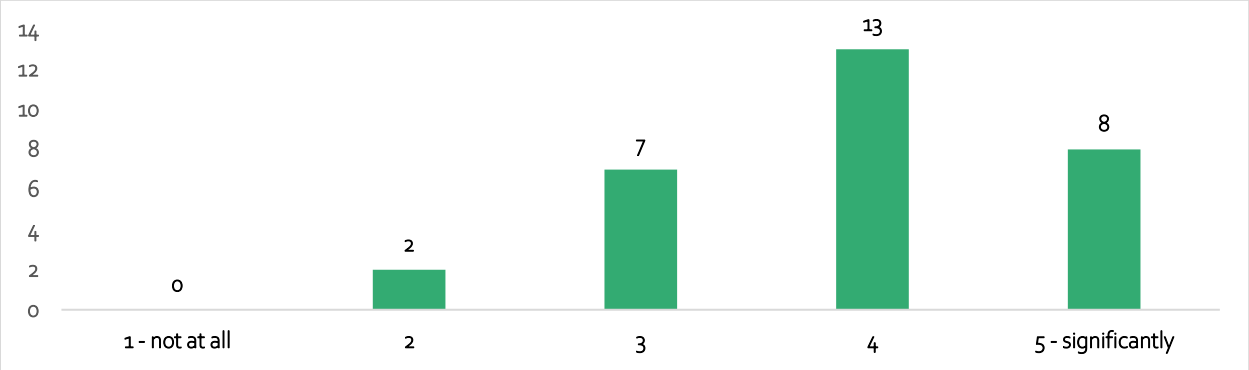
When looking at the impact of accreditation on continuity of care at their organization or in their community, participants explained that they have **improved information sharing** (n = 5). That is, files are better organized and easier to share and access. They also explained that referral systems were updated, making it easier to manage referrals without disruptions for clients.

Further, participants shared that **staff have increased capacity and support** for continuity of care (n = 3). Staff have had trainings on how to fill out documentation and reporting. Staff turnover has reduced, which also positively impacts continuity of care. One participant explained that more consistent policies help ensure continuity of care when non-local staff come and go from the community.

Finally, some participants noted that they have made **no changes** in this area (n = 2). One noted they were already strong in this area as it is a founding belief of their organization, while another explained that they operate in a way where clients just see one person.

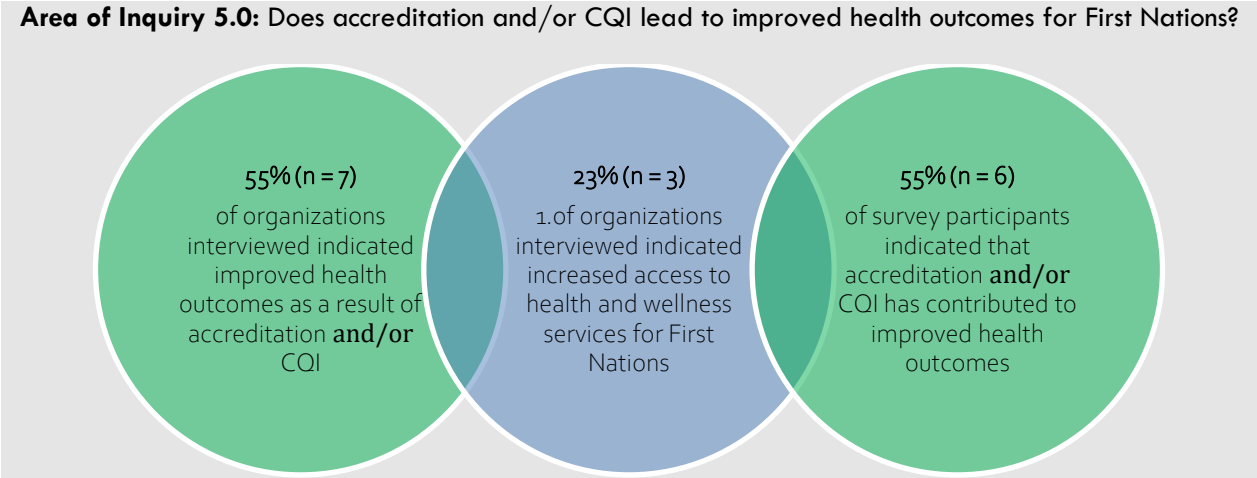
Survey participants were also asked to rate the extent to which accreditation and/or CQI helped increase continuity of care in their organization, on a scale from 1 to 5, were 1 is *not at all* and 5 is *significantly*. As shown in the figure below, survey respondents most often reported that the accreditation process and/or CQI did impact continuity of care (4 rating, n = 13).

Figure 12. Survey Ratings: Accreditation and/or CQI Impact on Continuity of Care (Number)



Improved Health Outcomes

Figure 13. Outcomes and Indicators Related to Improved Health Outcomes



Accreditation and/or CQI Impact on Health Outcomes

When interview participants were asked whether **accreditation and/or CQI leads to improved health outcomes,** participating organizations stated that accreditation has **contributed positively** to improved health outcomes for their communities (n = 9). They identified the following health outcome areas:

- ⇒ Improved maternal child health
- ⇒ Increased child immunization rates
- ⇒ Improved mental health
- ⇒ Improved wound care
- ⇒ Increased focus on prevention and education
- ⇒ Increase in community pride and trust

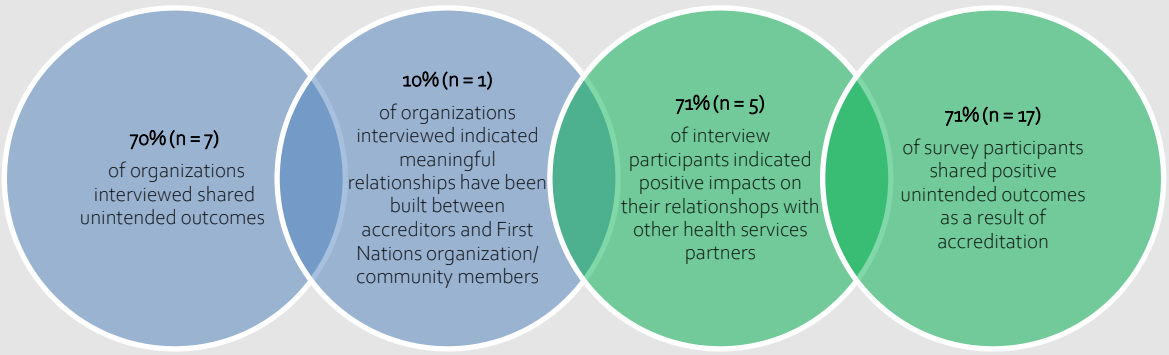
Some participants were **unsure or felt it was too soon** to identify the impacts on health outcomes (n = 4). One participant explained that it was hard to measure or quantify the impacts. Similarly, it was shared that while accreditation and/or CQI has contributed to health outcomes, it was not the "be all and end all." For other participants, it was too early to tell as they were still early in the process or had not yet put

the standards in place. Finally, one participant said that their community had no improved health outcomes to report as they were already operating at a high level before accreditation and/or CQI.

Unintended Outcomes

Figure 14. Outcomes and Indicators Related to Unintended Outcomes

Area of Inquiry 6.0: What are the unintended outcomes and impacts of accreditation and/or CQI for key stakeholders?



Unintended Outcomes

Participants shared a variety of unexpected impacts from accreditation:

- ⇒ **Staff morale** (n = 2): Staff morale improved throughout the process
- ⇒ **Time consuming** (n = 2): The accreditation process was more time consuming than they originally thought and took away from other work staff are supposed to do
- ⇒ **New department** (n = 1): A new department was formed within the organization to focus on quality improvement
- ⇒ **Positive support from accreditors** (n = 1): While apprehensive at first, staff were surprised to find the accreditors to be non-judgmental and kind
- ⇒ **Physical improvements** (n = 1): Cleanliness of the space improved as janitorial staff engaged with the process of implementing new standards

When survey participants were asked whether accreditation and/or CQI had resulted in any other impacts, participants most frequently shared examples of positive unintended outcomes as a result of accreditation. Participants noted that an increase in training positively impacted client care and supported their organizations with continuous improvement. Fewer participants shared that they did not have positive outcomes related to accreditation and/or CQI, with one participant noting that the process did not account for small, rural communities and had similar sentiments about the time-consuming nature of accreditation and/or CQI.

Relationship Building

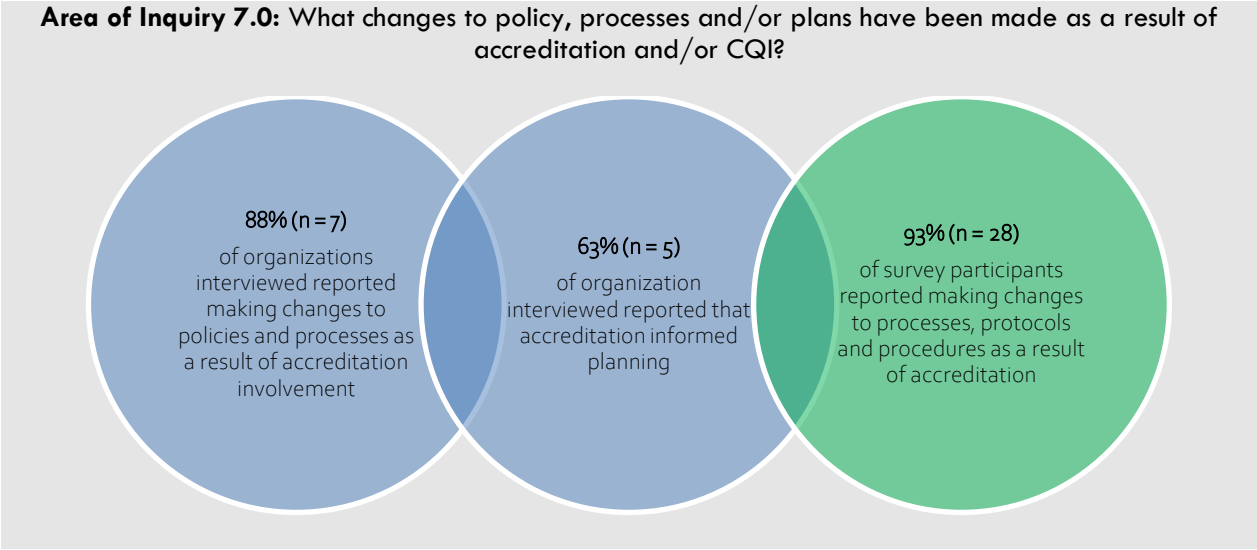
In sharing their experience about the organization's involvement with accreditation and CQI, participants spoke about the following impacts on their relationships with other health service partners, initiatives and systems. First, interview participants reported that their involvement with accreditation is giving the organization a **positive reputation** (n = 3). Participants explained that accreditation provides credibility as it shows that the organization is following and meeting standards of practice for policies and procedures. Other participants reported **continued and strengthened relationship building** as a result of accreditation (n = 2). Participants spoke about continuing relationships with funders and accreditation leading to trust from other health service partners because standards are in place.

Additionally, one participant noted that it is **too early** in their accreditation process to measure an impact and another participant reported no change or impacts to their relationships as no one else in their region is accredited.

Seabird Island Health Centre

Changes to Policy, Processes or Plans

Figure 15. Outcomes and Indicators Related to Changes in Policy, Process and Plans



Accreditation-Related Policy and Process Changes

Participants said the information received through accreditation has been used to **improve policies, processes and plans** (n = 6). This included formalizing policies and processes that were previously in place as unwritten expectations and would not have otherwise been formalized without going through accreditation. Another participant explained that it gave them an opportunity to create policies for practices they do *not* do; that is, for example, they do not use restraint, so they now have a policy in place saying they do not do it. Other specific policy improvements mentioned include adding succession planning and after care planning. Participants also discussed using the information received to plan service improvements. For example, one participant explained that they are now planning to offer services for dental health, mental health and addictions, and a continuum of care team model because the quality improvement and accreditation keeps them attuned to the community's feedback.

The majority of survey participants also reported that accreditation and/or CQI contributed to the **development of policies, processes and procedures,** particularly in the areas of client safety, quality of care and continuum of care.

- *"The changes to policy were to include the whole organization and not only the health department. There has been a shift of thinking from all staff to take responsibility at all levels."*

- *"We have Occupational Health & Safety as well as WorkSafeBC guidelines to follow. We currently are working on all policies, annual training of staff in all areas, including first aid."*

See Table 3 for specific policy and process areas mentioned by interview and survey participants.

Table 3: Topic Areas for Policies and Processes Put into Place through Accreditation and/or CQI

Interview Participant Responses	Survey Participant Responses
Client Safety	
✓ Client safety - general ✓ Emergency response ✓ Informed consent ✓ Incident reporting ✓ Preventative maintenance	✓ Client safety - general ✓ Clients' rights ✓ Complaint protocols ✓ COVID-19 protocols ✓ Occupational Health & Safety ✓ Protocols for treating staff and clients with dignity and respect ✓ Confidentiality
Quality of Care	
✓ Evaluation and surveys ✓ Hiring and job descriptions ✓ Staff training ✓ Succession planning	✓ Financial policies ✓ Operational protocols ✓ Staff safety ✓ WorkSafeBC ✓ Required Organizational Practices (ROPs) for each team ✓ Feedback processes
Continuity of Care	
✓ Client identification	✓ Client access to services ✓ Data management processes

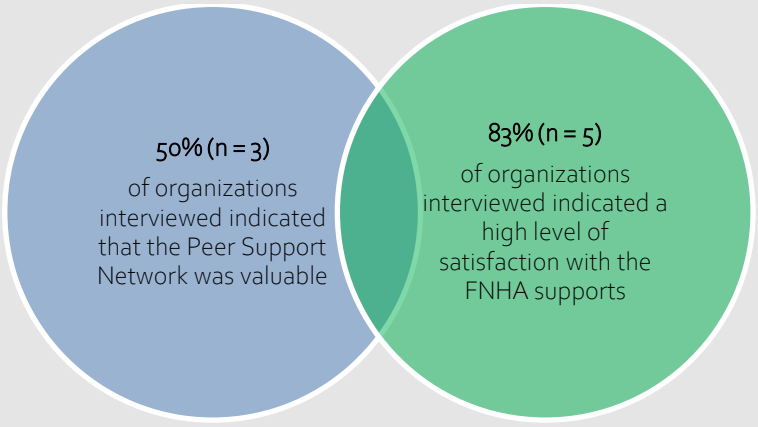
3.2 Satisfaction

The following section provides findings related to overall satisfaction with the CAQI program, as well as feedback on the Peer Support Network.

Satisfaction

Figure 16. Outcomes and Indicators Related to Overall Satisfaction

Area of Inquiry 8.0 What is the overall satisfaction with the CAQI program?[13]



Satisfaction

Of those participants who were asked (n = 7) to rate their satisfaction level with the FNHA's support on a scale from 1 to 5, where 1 is *not at all* and 5 is *significantly* satisfied, participants provided an average rating of **4.4 out of 5.** In explaining their ratings, those who were significantly satisfied said they felt heard by the FNHA (n = 3), noting that the FNHA was willing to listen and provide answers by phone if any support or information was ever needed. Participants who gave significantly satisfied ratings also remarked that the FNHA was amazing and "wonderful to deal with."

Those who provided a rating of **4 out of 5** explained their rankings by sharing that there is always room for improvement, but that the FNHA was very supportive and they had no issues. Finally, one participant who provided a ranking of **3 out of 5** explained their ranking by stating that they had to hire a consulting company to get through the accreditation process and that they would not have been able to do it on their own.

Peer Support Network

Of those participants who were asked, over half felt that the Peer Support Network **was helpful and valuable** (n = 3). They explained that it was an opportunity to share successes and challenges, to improve, and to identify goals and help each other meet those goals. The remainder of the participants (n = 3) did not access the Peer Support Network and therefore were **unable to comment** on it.

[13] Please note that quantitative data was only collected from the previous iteration of this report. However, the qualitative data is inclusive of all respondents.

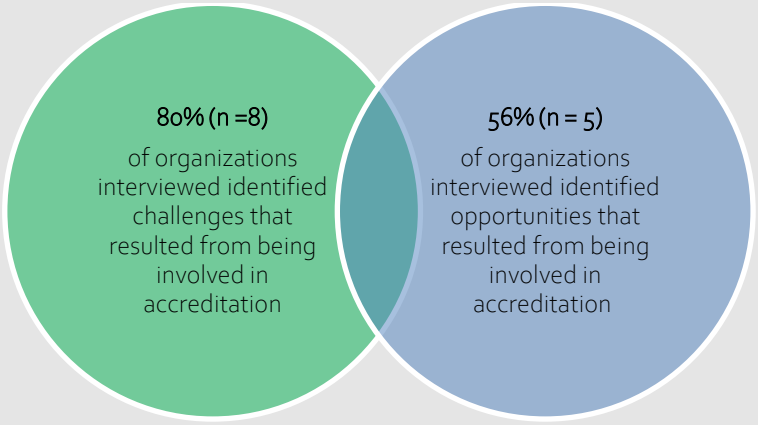
3.3 Wise Practices and Lessons Learned

The following section provides findings related to wise practices and lessons learned, including opportunities for improvement to the CAQI program, as well as success stories and lessons that others can learn from.

Lessons Learned

Figure 17. Outcomes and Indicators Related to Challenges and Opportunities

Area of Inquiry 8.0 What are the challenges and opportunities associated with accreditation?[14]



Lessons Learned for Improvement

When asked if their organization experienced any challenges with the accreditation process, some participants spoke about **redundancy** (n = 3). Participants explained that it was a challenge to prepare policy documents that already existed and were functional. Additionally, there were issues when working with nurses who had to follow two sets of standards throughout the process, one through the FNHA and one through the regional health authority. Another identified challenge was the **time commitment** (n = 5). Participants discussed that the work was being done off the side of their desk. Another explained that the time spent doing paperwork took away from time with clients. Some participants also thought that the process applied a one-size fits all approach, rather than an approach that was **culturally relevant to each community** (n = 4). One participant explained that they did not feel the process was reflective of their organization size, and did not fit the circumstances of their small health centre. Another shared that the accreditors did not understand the context of their First Nations community and organization. Finally, it was noted that the accreditors did not have an Indigenous lens. Some participants spoke about lack of buy-in from their organization or community as a challenge (n = 4). Finally, one participant felt that the approach and skills of accreditors were inconsistent, with some not being knowledgeable about First Nations community contexts.

In sharing opportunities for making the accreditation process better for First Nations health and wellness services, participants spoke about **standards** (n = 2). One participant shared that some standards felt like micromanaging and lacked the flexibility they were looking for to ensure they do not become a "cookie-cutter" treatment centre. Another participant noted that the standards lacked some attention to cultural

[14] Please note that the quantitative data was only collected from the previous iteration of this report. However, the qualitative data is inclusive of all respondents.

safety, as they wanted their organization to document spirituality and Indigenous ceremonial practices, which does not fit with protocols. Participants also spoke about opportunities related to **personnel support** (n = 2). That is, it would be helpful to have face-to-face support where relationship building could take place. Additionally, it was noted that it would be good to have access to other First Nations organizations that have gone through this process and can share their policies. Furthermore, participants shared opportunities regarding **staff mobilization** (n = 2), highlighting the need to engage and team-build with the staff to bring them along in the process. Other opportunities shared were related to updating resources to add more visual representations, not taking a one-size fits all approach, and making the process mandatory to get more buy-in.

Accreditation Opportunities

Organizations that participated in an interview spoke about the new opportunities that arose from accreditation, including:

- ⇒ **Funding retention** (n = 3): One reason they underwent accreditation was to retain their funding sources.
- ⇒ **New funding** (n = 3): Another reason some participants got accredited was to access new funding sources, as some government sources see accredited organizations as more worthy of certain funding opportunities.
- ⇒ **Collaboration** (n = 2): There were increased opportunities for collaboration both within communities and across programs. The process allowed for more community autonomy, which resulted in communities coming together to make changes in their own ways as well as increased capacity to collaborate across programs.
- ⇒ **Staff recruitment:** After accreditation, there were more qualified applicants interested in working for their organization.
- ⇒ **Service improvements**: Accreditation and/or CQI led to trying new things such as software that makes processes easier.
- ⇒ **Reputation:** Having accreditation and/or CQI has increased the organization's reputation as they are able to say they follow certain standards.
- ⇒ **Staff morale:** It has improved staff morale.
- ⇒ **No benefit:** For one participant, there were no new opportunities from accreditation and/or CQI.

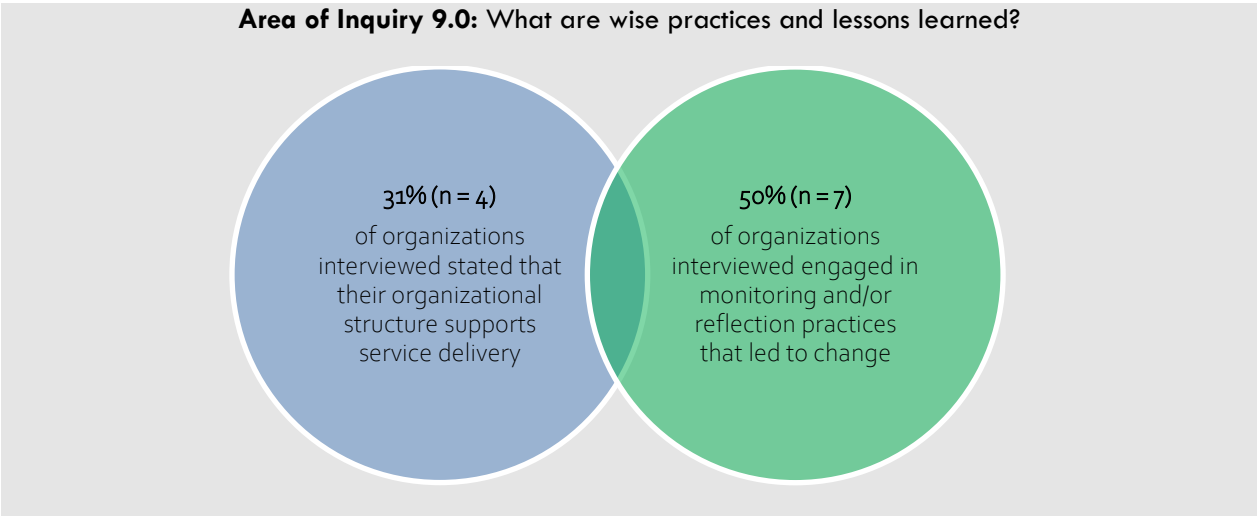
Survey participants reported how to make the accreditation and/or CQI process better for First Nations health and wellness services moving forward. These opportunities are listed in Table 4.

Table 4: Opportunities to Improve the Accreditation Process for First Nations Health and Wellness Services

Services Enabled by Accreditation	n (%)
Training - training made available and ability to participate	8 (73%)
Staff mobilization - mobilizing staff teams to do quality improvement activities	7 (64%)
Standards – content and format	7 (64%)
Resources available – manuals and online information provided by the accrediting body	6 (55%)
Onboarding – getting ready to engage in the process	4 (36%)
Follow-up – meeting any post-survey recommendations	4 (36%)
Surveyors – surveyor approach during onsite survey	3 (27%)
Report – learning from outcomes for continuous quality improvement	3 (27%)
Personnel support – ensuring a supportive partnership with your accrediting body	3 (27%)
Survey process – completing an onsite survey	2 (18%)
Award – celebrating and communicating achievements	1 (.9%)
Other	1 (.9%)

Wise Practices and Lessons Learned

Figure 18. Outcomes and Indicators Related to Success Stories and Promising Models



Success Stories

Participants shared a number of **success stories** that came out of their organization's journey with accreditation and/or CQI:

- ⇒ **Updated technology** (n = 2)**:** One participant successfully moved their policies from paper to an online database, making them easier to access. Another updated to an electronic case management system.
- ⇒ **Patient navigator role** (n = 1): Through the accreditation and/or CQI process, a participant realized there was a gap in patient navigation, so they created a new position so patients could talk to someone about their needs and be put in touch with the right services.
- ⇒ **Helped get through COVID-19** (n = 1): They had systems in place through this process that they could follow.
- ⇒ **Enhanced reputation** (n = 2): Sharing that they are accredited has enhanced their reputation in the community.
- ⇒ **Human resources**: One organization said they were able to create a more unified and efficient HR system.
- ⇒ **Improved communications** (n = 1): One organization began using social media to improve the reach of their communications.
- ⇒ **New benchmark** (n = 1): The accreditation and/or CQI process provided a new benchmark to track progress and change over time and offers a valuable lens on how to improve.

Three survey participants shared their own success stories, which included:

- "*We have had great success and a good deal of feedback from community members about our parenting program as well as our nutrition program.*"
- "*We were able to secure multimillion-dollar funding for an expansion of our Child Development Resource Centre.*"
- "*Accreditation has helped bring together programs that were otherwise siloed. We are working on accreditation with multiple program areas, and we have had them working together in developing process, procedures and policies. It has also worked to help create consistencies across programs.*"

Wise and Promising Practices

Wise and promising practices reported by organizations who were interviewed included **engaging staff** (n = 8). Some ideas shared about this include offering incentives and prizes for staff to get involved with policy updates. Additionally, organizations recommended focusing on team building to get buy-in from staff. It was explained that it is helpful to make sure all staff share the same understanding at the beginning and are all working toward to accreditation and/or CQI. Another idea was to ensure staff know how policies will benefit them and keep staff safe.

Organizations also shared the need for **community education and engagement** (n = 5). It was explained that accreditation and/or CQI are not just about your health centre but about the whole community. Thus, it is important to reach out and engage with the larger community, including the chief and council. It was shared that it is important for communities to be informed on whether accreditation and/or CQI is right for them.

Moreover, it was also shared that **incorporating a First Nations lens** was important (n = 5). This included having philosophies on First Nations health included in accreditation and/or CQI, combining Western and Indigenous models, and choosing an accreditation body that understands the complexity of First Nations. Examples provided by an organization included:

- ⇒ **Breastfeeding program:** Because of accreditation and/or CQI, they were able to provide information so clients could make informed decisions, which resulted in an increase in breastfeeding and duration of breastfeeding.
- ⇒ **Tobacco reduction program:** There was an increase in the amount of information sought out about tobacco reduction through their program that focused on the culture and tradition around tobacco.

Additionally, it was shared that those undertaking accreditation and/or CQI should **do their research** (n = 1). One participant explained that it is important to read and reread the standards to see where your organization fits in. Moreover, they shared that you should research what accrediting body fits your services best.

Finally, **networking and collaboration** were found to be helpful (n = 1). There is a lot that can be learned from other First Nations involved in accreditation and/or CQI as well as by accessing the support provided by the accreditors.

Survey respondents were also asked to share wise and promising practices, and they mentioned the following:

- ⇒ **Keep up with standards and procedures:** It is important not to wait until the last minute, but rather try to keep up with all procedures and process throughout the year while also seeking assistance when needed.
- ⇒ **Share the workload** and include all staff in Accreditation Canada's Required Organization Practices (ROPs).
- ⇒ **Have the right skills and supports**: Each community needs someone who can write polices, a great accreditation lead who can teach the staff the importance of the process, and competent nursing staff to help guide the work from a practitioner's perspective.
- ⇒ **Prepare for the process:** Hold regular meetings on policies and procedures before accreditation and/or the CQI process begins.
- ⇒ **Encourage buy-in, collaboration and participation:** There is a need for the accreditation process and/or CQI to be a shared and participatory process, with buy-in from the entire organization, rather than just from the leadership. This will result in the larger body of staff being confident in the knowledge specific to their organization. Staff should be familiar with all organizational policies and review them annually, and new staff should be provided time for questions.

- "*It is important that management be supportive of the process and get on board; otherwise, there will be complaints from everywhere on the work entailed relating to accreditation. The faster it is embraced, and the more people work on it, the better the experience will be for the organization.*"

- ⇒ **Consider the opportunity to offer 24-hour services.**

- "*I think 24 hrs support is a good one. I like that about our centre because you never know when someone is going through things and just needs your help.*"

- ⇒ **Align the policies and procedures with the same framework and numbering as the standards**, for simplicity in updating policies and procedures when standards are changed.
- ⇒ **Have an accreditation co-ordinator whose only job is dedicated to the accreditation process.** Specifically, this role should focus on planning, co-ordinating staff involvement, communication and implementing accreditation policies and procedures.
- ⇒ Accreditation Canada should help to improve standards in the context of **small rural communities.**

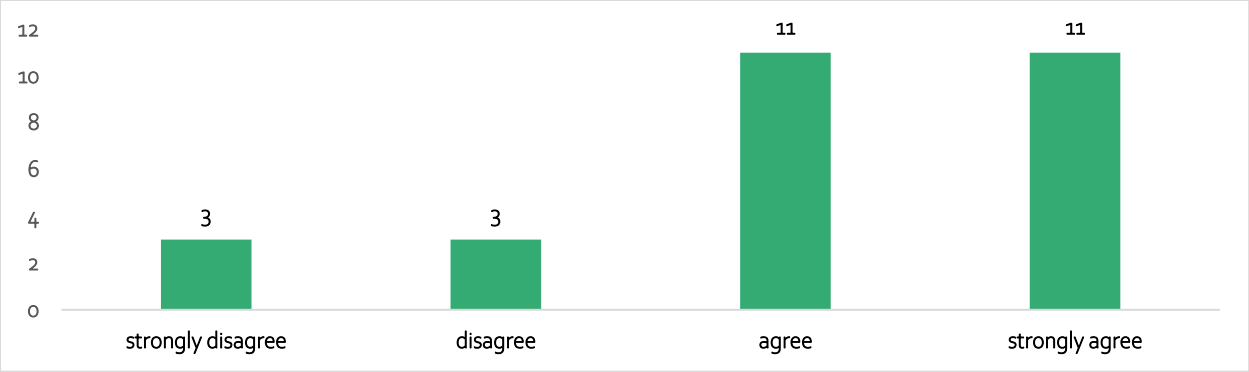
3.4 COVID-19 Response

An additional area of interest was hearing about how the experience of being accredited enabled an organization's response to COVID-19. Findings regarding the impact and experience of organizations during the pandemic as it relates to accreditation are provided below.

Some organizations that participated in an interview spoke about how the pandemic **impacted in-person relationships** (n = 3). It was shared that it was necessary to adapt to phone and online interactions with the accreditors. However, it was noted that the accreditors were very accommodating.

The majority of survey participants **strongly agreed** (n = 11, 39%) and **agreed** (n = 11, 39%) that their organization was better prepared for responding to COVID-19 as a result of accreditation. Please see Figure 19 below for further survey ratings.

Figure 19. Survey Ratings: COVID-19 Response Improved as a Result of Accreditation (Number)



Survey participants were also asked if their organization has utilized accreditation experiences and processes during the COVID-19 pandemic (i.e., standards, policies, plans, partnerships, etc.) to help provide and support the continuation of services and actions. Areas supported by accreditation during the pandemic are listed in Table 5 below.

Table 5: Services Enabled by Accreditation during COVID-19

Services Enabled by Accreditation	n (%)
Implementing infection prevention and control measures	18 (100%)
Accessing health services sites	16 (89%)
Utilizing a pandemic and/or emergency plan	15 (83%)
Providing communication	15 (83%)
Providing services	15 (83%)
Accessing traditional medicine and healing	13 (72%)
Accessing Tele-Health	13 (72%)
Providing medication management	12 (67%)
Ensuring transition of care	12 (67%)
Implementing strategic and operation plans	12 (67%)
Implementing decisions	11 (61%)
Other	1 (.6%)

When survey respondents were asked to give examples of how their organizations have been able to respond to the COVID-19 pandemic as a result of their participation in the health services accreditation process, most organizations spoke of the improvement of **safety procedures and guidelines**. For example, they noted the ability to nimbly adapt safety procurers as well as the ability to come to decisions in a more streamlined way through the support and framework provided by accreditation. In addition, the frameworks and guidelines acquired through accreditation allowed for a sense of process and options when working to develop solutions during the uncertainty of the pandemic.

3.5 Case Study

Adams Lake Indian Band – Sexqeltqin Health & Wellness Centre

Adams Lake Indian Band operates the Sexqeltqin Health and Wellness Centre (SHWC), which is located near Chase, BC. The SHWC offers a range of services to close to 500 on- and off-reserve members of the band. Programs include community health, diabetes, homecare, prenatal, post-natal, maternal child health, children's oral health, early years programming, Aboriginal Head Start on Reserve, home care, Elders' activities, social development and medical transportation.

The SHWC was an early participant in the accreditation process, when it was uncommon for communities without a treatment centre to pursue accreditation. This meant that both Adams Lake Indian Band and Accreditation Canada had to be flexible about how to apply the accreditation process.

The SHWC spent two years preparing for accreditation and received their accreditation status on their first survey. When the second survey took place four years later, it was quite a different experience. There were new surveyors involved who had different expectations regarding treatment programs that were not part of the Health Centre. This was a challenging situation for SHWC to manage, but as a result of SHWC's perseverance and advocacy to Accreditation Canada, they were successful in receiving their second round of accreditation. This led to discussions that weighed the value of the accreditation process against potential challenges, and the resulting decision was made to continue on with accreditation.

One of the values that SHWC achieved from accreditation was formalizing policies and procedures that were already in place.

- *We took our policy and procedure approach to a new level, which is very comprehensive. We wouldn't have achieved that without the accreditation procedure.*

Accreditation also dramatically changed SHWC's training program.

- *We did a tremendous amount of training, particularly for the first accreditation survey.*

Adams Lake Indian Band

Through the accreditation process, SHWC made significant strides in client safety and security and improved confidentiality, consent processes and information-sharing processes. Involving clients in the planning and evaluation of service provision was also strengthened, and continuity of care was improved through documentation, data collection and software systems.

- *We made many strides in continuity, consistency and connectedness of care throughout the health care system.*

Process improvements have also been demonstrated through outputs such as record-keeping, documentation and consistency of appointments. Increased breastfeeding and child immunization are two key examples of outcomes resulting from process improvements. Adams Lake Indian Band now has the highest rate of child immunizations in British Columbia.

When asked to share wise practices for others going through accreditation, Adams Lake Indian Band spoke about the importance of being clear about not only what accreditation can do for the organization, but what it means for the whole community, and about the need to engage the community and leadership in the accreditation process.

- *It's not only about accrediting your health centre; it's about accrediting your services for the community.*

Appendix A

Key Informant Interview Questions – National

Information gathered before interview:

Service type:

Location:

Organization profile (services offered, size of operations):

Narrative: Thank you for taking the time to speak with us today. Just so you know, everything you share with us is confidential and will be cleaned of any identifying information. This interview is also voluntary, so you can feel free to pass on questions you don't want to answer or end the interview at any time. The purpose of this interview is to help us understand what sort of impact that accreditation has on First Nations health and addictions services and also to learn about any wise or promising practices.

Do you have any questions before we get started?

Key Informant Interview Questions
Context – The first few questions are about your organization and your role in accreditation. These questions will help us contextualize the information that you share with us.
1. What is your role regarding accreditation and quality improvement in your organization? (probe: lead, health director, surveyor) [context for analysis]
2. Can you tell us about your organization's experience with accreditation? (probe: when did you start the process? How far along are you in the process?) [context for analysis]
3. Was your community involved or consulted in any way with helping to determine accreditation priorities or processes? [indicator 1.5]
Impact of Accreditation on Operations – The next few questions are about the impacts of accreditation on your organization.
4. How has the information that you received through accreditation been used? (probe: has it contributed to planning, policy development, or health advocacy?) [indicators 1.1, 1.3, 7.1, 7.3]
5. What changes have been made to your operations or your services because of accreditation? (probe: training or professional development, processes, facilities and equipment, staffing] [indicators 2.1, 2.2, 2.3, 3.1, 3.2, 3.3]
6. When gaps or areas of improvement were identified, did your organization have flexibility in how to address them? [indicator 1.2]
7. Did your organization's involvement with accreditation result in new opportunities? (i.e., access to funding opportunities) [indicator 8.2]
8. Did your organization experience any challenges with the accreditation process? [indicator 8.1]
Accreditation Outcomes – The next few questions are about the impacts that being involved in accreditation has had on your clients and the broader community.
9. How has being involved in accreditation impacted your organization and your community? a. What has been the impact on client safety (including cultural safety)? [indicators 2.3, 2.4] b. What has been the impact on quality of care? [indicators 3.3, 3.4] c. What has been the impact on continuity of care? [indicator 4.1]
10. Would you say that accreditation has contributed to improved health outcomes for your community? (Y/N) Please explain [indicators 5.1, 5.2]
11. Would you say that accreditation has contributed to the self-determination of your Nation? (Y/N) Please explain [indicator 1.4]

Key Informant Interview Questions
12. Have you noticed any unexpected impacts that resulted from your involvement in accreditation? (probe: any changes to your relationship with accreditors) [indicators 6.1, 6.2]
Wise practices – The next few questions are about the impacts that being involved in accreditation has had on your clients and the broader community.
13. Can you share with us a success story or significant change that resulted from being involved in accreditation? [indicators 9.1, 9.2]
14. Do you have any wise practices for other First Nations health or addictions services engaging in accreditation? [indicators 9.1, 9.2]

Narrative: Thank you once again for taking the time to share with us. As part of our ongoing consent process, we would like to share your transcript back with you. You can feel free to add, delete, or modify any of the content. Do you have an email address that we can send this to?

Do you mind if we include anonymous quotes from your transcript in our final report? Y/N

Survey Questions - National

Staff Survey Questions
Page 1
The purpose of this survey is to better understand the impact that accreditation has on First Nations health and addictions services and to learn wise and promising practices from those engaged in accreditation. This information is confidential and participation is voluntary. This research is being conducted by Reciprocal Consulting on behalf of the First Nations Health Authority and the First Nations Inuit Health Branch. To learn more about who we, please visit our website [hyperlink].
Page 2
Context – The first few questions are about your organization. These questions will help us contextualize the information that you share with us.
1. What type of service does your organization offer? MULTIPLE CHOICE [context for analysis] a. Health services b. Addiction services
2. What province is your service located in? MULTIPLE CHOICE (select one) [context for analysis] a. British Columbia b. Alberta c. Saskatchewan d. Manitoba e. Ontario f. Quebec g. Newfoundland and Labrador h. Nova Scotia i. New Brunswick j. Prince Edward Island
3. Is your organization currently accredited? (Y/N) (If yes, go to Q4, if no, go to Q5) [context for analysis]
4. How long has your organization been accredited for? MULTIPLE CHOICE (select one) [context for analysis] a. Less than a year b. 1-3 years c. 4-6 years d. 7-9 years

Staff Survey Questions
e. 10+ years
Accreditation Outcomes – The next few questions are about the impacts that being involved in accreditation has had on your organization, your clients, and the broader community.
5. What changes has your organization made to its operations or services because of accreditation? (i.e., changes to policies, procedures, training, equipment, staffing, types of services, systems for client feedback) OPEN ENDED [indicators 2.1, 2.2, 2.3, 3.1, 32, 3.3]
6. Please rate on a scale of 1 to 5, where 1 is not at all and 5 is significantly, the extent to which **accreditation has helped to increase client safety** in your organization: SCALE [indicator 2.4] a. 1 – not at all b. 2 c. 3 d. 4 e. 5 - significantly
7. Please rate on a scale of 1 to 5, where 1 is not at all and 5 is significantly, the extent to which **accreditation has helped to increase the quality of care** in your organization: SCALE [indicator 3.4] a. 1 – not at all b. 2 c. 3 d. 4 e. 5 - significantly
8. Please rate on a scale of 1 to 5, where 1 is not at all and 5 is significantly, the extent to which **accreditation has helped to increase client continuity of care**: SCALE [indicator 4.1] a. 1 – not at all b. 2 c. 3 d. 4 e. 5 – significantly
9. From your perspective, has accreditation resulted in any other impacts? OPEN ENDED [indicator 6.1]
Wise practices – The next question is about any wise practices or success stories that you would like to share.
10. Can you share with us a success story or a wise practice that other services going through accreditation can learn from? [indicators 9.1, 9.2]
COVID 19 response – The last couple of questions are about your experience and response to the COVID 19 pandemic.
11. Please rate your level of agreement with the following statement: My organizations has been better able to respond to the COVID 19 pandemic due to our participation in health services accreditation and/or being accredited? SCALE (strongly agree/agree/disagree/strongly disagree) a. If you agree, please provide an example of how [COVID 19 response]
12. My organization has utilized our accreditation experiences and processes (i.e., standards, policies, plans, partnerships etc.) during the COVID 19 pandemic to help provide and support the following responses: (please select all that apply) MULTIPLE CHOICE a. Accessing traditional medicine and healing (i.e., Elders, knowledge keepers, cultural supports, and ceremonies) b. Accessing Tele-Remote Health (i.e., telehealth services and virtual care options) c. Implementing infection prevention and control measures (i.e., engaging in hand hygiene and using recommended personal protective equipment) d. Utilizing a pandemic and/or emergency plan (i.e., implementing emergency response and established protocols) e. Providing medication management (i.e., safe distribution of medication and communication with other health care providers) f. Accessing health services sites (i.e., cleaning and sanitizing protocols, and safety measures when accessing shared spaces, staff and services)

Staff Survey Questions
g. Providing communication (i.e., ensuring consistent and clear updates with leadership, staff and community on local updates, response and recommendations) h. Providing services (i.e., modification and adaption of existing programs and services) i. Ensuring transition of care (i.e., seamless support and services between providers) j. Implementing strategic and operation plans (i.e., business continuity, service resumption and new risk management planning/practices) k. Implementing decisions (i.e., human and financial resource allocations and leaning on ethical decision-making processes) l. Other (please describe): OPEN RESPONSE [COVID 19 response]
Page 3
Thank you for taking the time to share with us. If you have any questions or concerns about the survey or this research, please email us [hyperlink].
13. Do you consent to us including anonymous quotes from your survey? [Y/N]

Key Informant Interview Questions – BC Specific

[Use website to gather information before interview.] **During Interview confirm:**

Interviewee Name & Title:

Service Type:

Organization profile (services offered, size of operations, size of population served):

Location and Context (region, city/town, urban/rural):

Narrative: Thank you for taking the time to speak with us today. Everything you share with us is confidential and will be cleaned of any identifying information. This interview is also voluntary, so you can feel free to pass on questions you don't want to answer or end the interview at any time. The purpose of this interview is to help us understand the impacts that accreditation and continuous quality improvement (CQI) have for First Nations health and addiction recovery services in BC. It is not about evaluating your program or the work itself.

Do you have any questions before we get started?

Key Informant Interview Questions
Context – The first few questions are about your organization and your role in accreditation and CQI. These questions will help us contextualize the information that you share with us.
1. What is your role regarding accreditation and quality improvement in your organization? (Probe: a. Accreditation or Quality Improvement Lead b. Health Director, Executive Director or Manager c. Band Administration d. Band Governance, e.g., Chief and Council member or Board of Director e. Consultant f. Other [context for analysis]
2. Can you tell us about your organization's experience with accreditation? (Probe: when did you start the process? How far along are you in the process? What number of surveys or cycles has your organization completed?) [context for analysis]
Impact of Accreditation and CQI on Operations – The next few questions are about the impacts of accreditation on your organization.

Key Informant Interview Questions
3. How has the information that you received through accreditation and CQI been used? (Probe: has it contributed to planning, policy development, or health advocacy?) [1.1, 1.3, 7.1, 7.3]
4. What changes have been made to your operations or your services because of accreditation and CQI? (Probe: training or professional development, processes, facilities and equipment, staffing) [7.1, 7.2, 7.3]
5. When gaps or areas of improvement were identified, did your organization have flexibility in how to address them? [1.2]
6. How has your organization's involvement with accreditation and CQI influenced or impacted your relationship with other health service partners, initiatives or systems? [no indicators]
Accreditation and CQI Outcomes – The next few questions are about the impacts that being involved in accreditation and CQI has had on your clients and the broader community.
7. How has being involved in accreditation and CQI impacted your organization and your community? a. What has been the impact on client safety (including cultural safety)? [2.3, 2.4] b. What has been the impact on quality of care? [3.3, 3.4] c. What has been the impact on continuity of care? [4.1]
8. Would you say that accreditation and CQI has contributed to improved health outcomes for your community? (Y/N) Please explain [5.1, 5.2]
9. Would you say that accreditation and CQI has contributed to the self-determination of your Nation? (Y/N) Please explain [1.4]
10. Have you noticed any unexpected impacts that resulted from your involvement in accreditation and CQI? (Probe: Any changes to your relationship with accreditors? Impacts due to Covid?) [6.1, 6.2, 6.3]
Wise practices – The next few questions are about the impacts that being involved in accreditation and CQI has had on your clients and the broader community. (Probe: Teachings that you lean on? Resources?)
11. Can you share with us a success story or significant change that resulted from being involved in accreditation and CQI? [9.1, 9.2,]
12. Do you have any wise practices for other First Nations health or addictions services engaging in accreditation and CQI? [9.1, 9.2, 9.3]
FNHA – The next few questions are about the support provided by FNHA and areas for improvement.
13. What is your level of satisfaction with FNHA support on a scale of 1 to 5, where 1 is not at all and 5 is significantly satisfied? (Probe: Requests for assistance, provided learning opportunities and resources, support with understanding accreditation standards and process, referrals, working with accrediting body, etc.) [8.4]
14. What value do you receive from the Peer Support Network and any suggestions for improvement? [[8.3]
15. What is one opportunity for making the accreditation process better for First Nations health and wellness services moving forward? (Probe: □ Onboarding – getting ready to engage in the process □ Technical support – accessing online portals and assessment tools □ Personnel support – ensuring a supportive partnership with your accrediting body □ Resources available – manuals and online information provided by the accrediting body □ Training - training made available and ability to participate □ Staff mobilization - mobilizing staff teams to do quality improvement activities □ Standards – content and format □ Surveyors – surveyor approach during onsite survey □ Survey process – completing an on-site survey □ Report – learning from outcomes for continuous quality improvement □ Follow-up – meeting any post survey recommendations □ Award – celebrating and communicating achievements □ Other ideas you shared) [9.3]

Narrative: Thank you once again for taking the time to share with us. As part of our ongoing consent process, we would like to share your transcript back with you. You can feel free to add, delete, or modify any of the content. [Confirm e-mail address]

Can we include quotes from your transcript in our final report? Y/N

Can you share some pictures of our Health/Recovery Centre with us to include in our report? Y/N

Survey Questions – BC Specific

Staff Survey Questions
Page 1
Thank you for taking the time to complete this survey. This research builds on a cross-Canada project that the First Nations Inuit Health Branch and FNHA recently partnered on. This second phase of research is a BC specific evaluation process from a BC First Nations self-determination lens. The survey will take under 15 minutes. Everything you share is confidential and will be cleaned of any identifying information. The survey will remain open until June 18, 2021. This work is not about evaluating your program or work itself, it is about learning from knowledge keepers like yourselves and applying your lived leadership for moving forward in new and potential ways.
Page 2
Context – The first few questions are about your organization. These questions will help us contextualize the information that you share with us.
1. What type of service does your organization offer? MULTIPLE CHOICE [context for analysis] a. Health services b. Addiction Recovery and Healing Services c. Other (please specify)
2. What health region is your service located in? MULTIPLE CHOICE [context for analysis] a. Fraser Salish b. Interior c. Northern d. Vancouver Coastal e. Vancouver Island
3. What is your main position or role in your organization? a. Accreditation and Quality Improvement Services b. Health Director, Executive Director or Manager c. Clinical Services; e.g., Primary Care, Dental, Nursing or Home and Community Care d. Program or Project Manager e. Health Programming Staff; e.g., Lead, Coordinator, or Planner f. Indigenous Cultural Advisor, Traditional Knowledge Keeper and Healer g. Health Administration; e.g., HR, Finance, IT or Policy h. Building Maintenance and Safety i. Band Administration j. Band Governance, e.g., Chief and Council member or Board of Director k. Consultant l. Other
4. Is your organization currently accredited? (Y/N) [context for analysis] a. Yes b. No c. In the process, working towards survey

Staff Survey Questions
Accreditation Outcomes – The next few questions are about the impacts that being involved in accreditation has had on your organization, your clients, and the broader community.
5. What changes has your organization made to its operations or services because of accreditation and CQI? (i.e., changes to policies, procedures, training, equipment, staffing, types of services, systems for client feedback) OPEN ENDED [indicators 2.1, 2.2, 2.3, 3.1, 32, 3.3]
6. Please rate on a scale of 1 to 5 (where 1 is not at all and 5 is significantly) the extent to which **accreditation and CQI has helped to increase client safety** in your organization: SCALE [indicator 2.3, 2.4] a. 1 – not at all b. 2 c. 3 d. 4 e. 5 - significantly
7. Please rate on a scale of 1 to 5 (where 1 is not at all and 5 is significantly) the extent to which **accreditation and CQI has helped to increase the quality of care** in your organization: SCALE [indicator 3.4] a. 1 – not at all b. 2 c. 3 d. 4 e. 5 - significantly
8. Please rate on a scale of 1 to 5 (where 1 is not at all and 5 is significantly) the extent to which **accreditation and CQI has helped to increase client continuity of care**: SCALE [indicator 4.1] a. 1 – not at all b. 2 c. 3 d. 4 e. 5 – significantly
9. Please rate on a scale of 1 to 5 (where 1 is not at all and 5 is significantly) the extent to which **accreditation and CQI has contributed to improve health outcomes for your community**: SCALE [indicator 4.1] a. 1 – not at all b. 2 c. 3 d. 4 e. 5 – significantly
10. Please rate on a scale of 1 to 5 (where 1 is not at all and 5 is significantly) the extent to which **accreditation and CQI has contributed to the self-determination of your Nation**: SCALE [indicator 4.1] a. 1 – not at all b. 2 c. 3 d. 4 e. 5 – significantly
11. Has your organization's involvement with accreditation and CQI influenced or impacted your relationship with other health service partners, initiatives or systems? [indicator 6.3] a. Yes b. No i. Please describe:
12. From your perspective, has accreditation and CQI resulted in any other impacts – positive or negative? Please describe. OPEN ENDED [indicator 6.1]

Staff Survey Questions
Wise practices – The next question is about any wise practices or success stories that you would like to share.
13. Can you share with us a success story or a wise practice that other services going through accreditation and CQI can learn from? [indicators 9.1, 9.2]
COVID 19 response – The last couple of questions are about your experience and response to the COVID 19 pandemic.
14. Please rate your level of agreement with the following statements (where 1 is not at all and 5 is significantly): a. My organizations has been better able to respond to the COVID-19 pandemic due to our participation in accreditation and CQI? SCALE [COVID 19 response] b. My organization has utilized our accreditation and CQI experience and processes during the COVID-19 pandemic? (i.e., standards, policies, plans, and partnerships, etc.)
15. What are the opportunities for making the accreditation process better for First nations health and wellness services moving forward? Please select all that apply. [indicators 9.3] a. Onboarding – getting ready to engage in the process b. Technical support – accessing online portals and assessment tools c. Personnel support – ensuring a supportive partnership with your accrediting body d. Resources available – manuals and online information provided by the accrediting body e. Training - training made available and ability to participate f. Staff mobilization - mobilizing staff teams to do quality improvement activities g. Standards – content and format h. Surveyors – surveyor approach during onsite survey i. Survey process – completing an on-site survey j. Report – learning from outcomes for continuous quality improvement k. Follow-up – meeting any post survey recommendations l. Award – celebrating and communicating achievements m. Other:
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16. Additional comments? OPEN ENDED a. Please share more
17. Do you consent to us including anonymous quotes from your survey? [Y/N] [no indicator]

Case Study

Areas of exploration:

1. Context
    a. Service type
    b. Location
    c. If accredited, how long the organization has been accredited for
    d. If not accredited, where they are in the process
2. What value does the organization see in accreditation?
3. What was the organization's experience with the process of going through accreditation?
4. What are the impacts on the organization's operations and services that resulted from going through an accreditation process?
5. What is a promising model or wise practices that can be shared with others going through accreditation?