Report on the Analysis of Accreditation in First Nations Health Services

First Nations and Inuit Health Branch & First Nations Health Authority

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First Nations Health Authority
Health through wellness

RECIPROCAL
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Indigenous Services
Canada

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Executive Summary[1]

This section provides a high-level summary of the findings from the analysis of the impact of accreditation on health organizations and addictions services funded by the First Nations and Inuit Health Branch (FNIHB) and the First Nations Health Authority (FNHA). The purpose of this evaluation was to determine, ultimately, if the accreditation process was a positive and impactful process for First Nations communities.

Methodologies

Findings are based on a mixed-method approach, using both primary and secondary data sources. Primary data was gathered through interviews, surveys and case study examples. See Appendix A for tools used for primary data collection. Secondary data was provided by the FNIHB and the FNHA.

Findings

The following section summarizes the main impacts of accreditation, broken down by indicators related to the areas of inquiry that were the focus of this work.

Self-Determination
Many participants reported that accreditation contributed to First Nations self-determination in the area of health care, both directly and indirectly. Some of these contributions included the development of new education tools for prevention planning and increased involvement from families in planning their own care. The process of contributing to informed decision-making for First Nations communities was another area supported by accreditation. In the accreditation process, First Nations organizations had the flexibility to address areas for improvement specific to the unique and changing needs of their nations. Furthermore, accreditation was reported to contribute to health advocacy as communities were involved in determining accreditation priorities and were involved in the accreditation process.

Client Safety
The majority of participants noted that accreditation improved client safety in their organization. Training and professional development opportunities increased due to accreditation as organizations developed standards for training programs and provided consistent training opportunities. Accreditation also led to the implementation of standardized systems for collecting client feedback, which positively impacted client safety through ongoing improvement to the services. Policies regarding client safety were strengthened, expanded and implemented because of accreditation.

Quality and Continuity of Care
Participants shared that there was an increase in quality of care as a result of accreditation. Participants noted that there were improvements to equipment and facilities and that there was an increase in their staff's skill set as a result of accreditation and receiving further training. As noted above, participants shared changes to policies, and in the area of quality of care, they noted changes to reporting and documentation. Implementing accountability structures as a result of accreditation, such as performance reviews and health and safety reviews, also improved quality of care by providing ways to provide feedback.

Nearly half of the organizations reported that accreditation improved the quality of care for clients by improving information sharing, retaining staff and increasing staff support. Because accreditation is all-encompassing, it has helped to pull people together and facilitate work across departments, which has positively impacted the continuity of care for clients. Additionally, accreditation also supported the implementation of a salary scale, which made organizations competitive with other service providers, supported recruitment and helped to maintain qualified staff.

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[1] For the most part, when the 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.

Improved Health Outcomes
Over half of the participants interviewed confirmed that accreditation led to improved health outcomes. Additionally, participants noted that accreditation increased access to services and service delivery. Furthermore, accreditation led to hiring staff with more experience and improved the quality of services, which contributed to increased trust in services. Overall, there was agreement that while accreditation positively impacts the work, it is one of many factors that supports improved health outcomes and cannot be directly linked to an improvement in health outcomes in communities.

Unintended Outcomes
Organizations identified a number of additional positive impacts beyond client safety, quality of care and continuity of care as a result of accreditation. Unintended outcomes shared by participants included increased credibility, staff buy-in and sense of pride, validation for quality of services, ability to provide consistent services, increased knowledge and understanding of roles and responsibilities, and relationship building. Several organizations also indicated that accreditation resulted in meaningful relationships between accrediting bodies and First Nation organizations.

Changes to Policy, Processes or Plans
The majority of organizations indicated that accreditation contributed to the development of policies, processes and procedures, whether strengthening or formalizing previous policies and procedures, or creating new ones where gaps were identified. Another identified impact of accreditation was the regular updating of processes and procedures to correspond with updated policies. A significant number of organizations also reported that learnings from the accreditation process have been incorporated into planning, including strategic planning, succession planning and organizational decision-making.

Challenges and Opportunities
When noting challenges and opportunities, participants said they experienced challenges with the accreditation process that included the accreditors' approach, organizational buy-in, time commitment, capacity, context and redundancies. The majority of organizations shared that they had access to new opportunities as a result of accreditation, such as funding opportunities, collaborations, service improvements, employee recruitment, improved employee morale and reputation credibility.

Success Stories and Promising Models
Several organizations shared that the accreditation process resulted in changes to their organizational structure that are supporting service delivery as a result of accreditation. A number of organizations also reported engaging in monitoring and reflection practices as a result of accreditation that led to further improvements. A majority of participants offered success stories from their accreditation journey, ranging from an enhanced reputation and opportunities, to improvements in meeting community needs. Regarding wise and promising practices, participants offered practices on staff engagement and team building, as well as operational structures that support service delivery among others.

Case Studies
Three case studies are presented to show an in-depth look at organizational accreditation processes. Meadow Lake Tribal Council found that accreditation provided a road map to connect community-identified needs with new processes and procedures that resulted in both quality improvement and community-focussed service delivery. Dilico Anishinabek Family Care shared examples of better access to specific expertise, the shift to an electronic medical records system to improve services and improvements to patient safety and security. Sexqeltquin Health and Wellness Centre identified how accreditation helped to formalize policies and procedures, improve training and demonstrate improved health outcomes.

COVID-19
Participants shared important ways in which accreditation contributed to their COVID-19 response with regard to implementing guidelines around safe organizational operations. A number of participants indicated that the accreditation process resulted in a higher level of readiness due to the standards already in place. While COVID-19 also caused interruptions in accreditation progress, as well as communication and logistical challenges, survey respondents from across urban and rural health and addiction centres indicated that overall, accreditation enabled their organization to better respond to COVID-19.

Discussion
Ultimately, most participants found accreditation to be an impactful experience that resulted in positive outcomes across urban and rural areas, as well as across Canada. Accreditation supported the development and strengthening of policies, processes and procedures, which can lead to improved client safety, quality of care, continuity of care, and ultimately, improved health outcomes. Engaging in accreditation is a big, ongoing commitment in terms of time and resources, but in general, First Nations health and addictions services reported that it was worth the investment.

1.0 Accreditation of First Nations Health Services

This section provides background information on the accreditation of First Nations health services, including the First Nations and Inuit Health Branch's (FNIHB) accreditation program, the First Nations Health Authority's (FNHA) accreditation program and more information about some of the main health service accreditation bodies in Canada.

FNIHB Accreditation Program[2]

The FNIHB's Quality Improvement and Accreditation Program (referred to as the FNIHB accreditation program) was established in 1999 to support improved quality of First Nations and Inuit health services, increase First Nations control and management of health services, and increase alignment with provincial health services. The program vision is that *First Nations and Inuit manage accredited health services that meet their needs,* while the program mission is to *promote continuous quality improvement through accreditation in First Nations and Inuit health services.*

The program goals include the following:

1. Improve the quality and safety of services
2. Provide optimum care in a respectful environment through the development of culturally responsive competencies in health services
3. Improve organizational accountability
4. Add value by building on Indigenous health practices and world views
5. Facilitate organizations to strive for excellence and promote organizational growth and self-sufficiency
6. Strengthen and build linkages with other organizations to ensure a continuum of care

The accreditation program is guided by the following principles:

⇒ *Client and community responsive*
⇒ *Culturally appropriate*
⇒ *Community paced*
⇒ *Community based*
⇒ *An honouring process*
⇒ *A sustainable, viable, and enhancing process*
⇒ *Inclusive and empowering*
⇒ *Respectful*
⇒ *A voluntary process*
⇒ *Collaborative*

The accreditation program is also guided by the following quality dimensions:

- **Accessible:** Provide equitable, timely and appropriate health services
- **Client-centred:** Actively involve and respect the needs and preferences of individuals, families and communities
- **Culturally competent:** Integrate knowledge and practice in regard to First Nations and Inuit individuals, families and communities

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[2] Information from this section sourced from the following:
- Anderson, M. (2014). *The FNIHB Accreditation Program: Evidence-Base & Data Gathering in Preparation for Future Evaluation.* FNIHB-Health Canada.
- Health Canada. (2009). *First Nations and Inuit Health Services Accreditation Policy Framework.* Retrieved from https://epub.sub.uni-hamburg.de//epub/volltexte/2013/19023/pdf/H34_222_2010_eng.pdf.
- Health Canada. (n.d.). *Accreditation Framework.* FNIHB-Health Canada.

- **Effective:** Achieve the best possible health outcomes, supported by current evidence
- **Efficient:** Make the best use of resources to optimize benefits and results
- **Safe:** Minimize risk and avoid harm

The expected program outcomes are illustrated in the graphic below:

Figure 1. Expected Accreditation Outcomes

Short-Term Outcomes

Increased awareness of accreditation and its benefits

Overlaps are identified within FNIHB processes

Linkages are made between communities, regional health authorities and provincial health services

Leading practices are shared between communities

Medium-Term Outcomes

Increase in number of organizations engaged in accreditation

Continuous quality improvement is integrated into FNIHB programs

FNIHB requirements are streamlined and complement accreditation

Linkages support continuum of care

Long-Term Outcomes

First Nations and Inuit deliver and access quality health services based on standards of excellence

Funding Formula[3]

The amount of funding that an organization receives is determined by a funding formula and is also subject to availability of funds. The funding formula is intended to reflect the needs of organizations undergoing accreditation. All organizations who are funded through this program may receive both a base amount of funding, as well as funding for the accrediting body invoice. Furthermore, community health centres and nursing stations are eligible to receive variable funds to help offset additional costs incurred as a result of participating in accreditation related to service logistics such as the number of sites, number and type of staff, and population size being served.

Current Context[4]

Currently, 99 community health centres and nine nursing stations have engaged in the accreditation process. Of those, 73 community health centres and four nursing stations are accredited. Additionally, 39 out of 45 treatment centres funded by the National Native Alcohol and Drug Abuse Program are in the accreditation process. Funding for these programs has not been increased since FY2017-18, despite the fact that the program continues to grow. For example, in FY2018-19, $6,555,000 was requested for accreditation but the Treasury Board only approved $4,054,397.

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[3] Information for this section sourced from: Health Canada. (2015). *FNIHB Accreditation Funding Formula*. FNIHB-Health Canada.
[4] Information for this section sourced from: Indigenous Services Canada. (2020, July). *FNIHB Accreditation Dashboard*. FNIHB.

Previous evaluations have shown that First Nations and Inuit organizations participating in the accreditation program are exceeding national averages when it comes to senior leadership support for safety; supervisory leadership for safety; learning culture; judgement-free communication; and job repercussions of error.

FNHA Community Accreditation and Quality Improvement Program[5,6]

The FNHA's Community Accreditation and Quality Improvement (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 Health 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 and includes 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 FNIHB's 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 such as First Nations representation at BCPSQC's annual Quality Forum, 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*

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

Figure 1. First Nations Perspectives on Health and Wellness
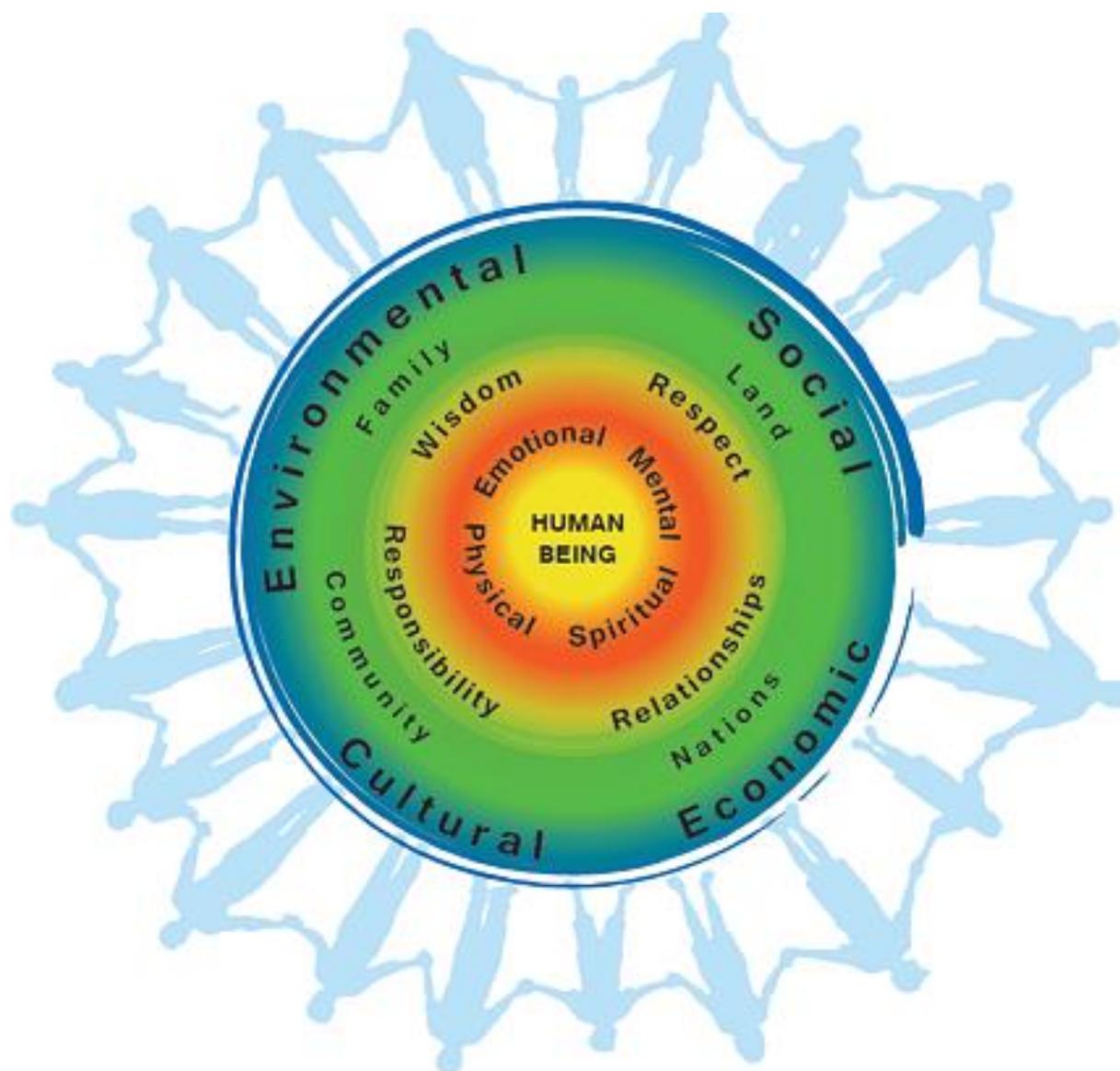
The CAQI program supports communities to pursue and maintain health services accreditation status by providing funding to health organizations and Nations to partner with a recognized Canadian accreditation body. Participation in the program is voluntary. Eligible program participants receive $30,000 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 (CARF). Currently, CAQI is supporting 42 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 (QIS) 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 42 member organizations includes 33 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, including the following three that many First Nations work with: Accreditation Canada, the Canadian Accreditation Council and the Commission on Accreditation of Rehabilitation Facilities.

Accreditation Canada[7]

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.

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[7] Accreditation Canada, *About Accreditation Canada*, 2020. Retrieved from https://accreditation.ca/about/

Pinaymootang Health Centre – Gwen Traverse

Canadian Accreditation Council[8]

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[9]

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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[8] Canadian Accreditation Council. (2020). *About the Canadian Accreditation Council*. Retrieved from http://www.canadianaccreditation.ca/canadian-accreditation-council/.
[9] 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 framed the assessment:

1. **What are the accreditation outcomes and impacts?**
   a. To what extent does accreditation increase the self-determination of First Nations in health care?
   b. To what extent does accreditation increase First Nations client safety?
   c. To what extent does accreditation increase First Nations quality of care?
   d. What impact does accreditation have on continuity of care?
   e. Does accreditation lead to improved health outcomes for First Nations?
   f. What are the unintended outcomes and impacts of accreditation 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?

2. **What are wise practices and lessons learned?**
   a. What are challenges and opportunities related to accreditation?
   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*.[10] 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*   ⇒ *Culturally relevant and responsive*
⇒ *Strengths-based*   ⇒ *Developmental*
⇒ *Participatory methods*   ⇒ *Social justice*

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[10] 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"[11] (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/FNIHB	✓ 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 ✓ Challenges and opportunities ✓ 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
Health services and addictions recovery services / healing houses	✓ Information about organization (i.e., service type, location, number of years in accreditation program) ✓ Improved health outcomes as a result of accreditation ✓ Unintended outcomes and impacts of accreditation ✓ Wise practices (i.e., promising models and success stories)	Case studies
Secondary sources	✓ Impact of accreditation	Literature and document review

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[11] 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 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 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 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 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 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 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
7. What changes to policy, processes and/or plans have been made as a result of accreditation?	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 are the challenges and opportunities associated with accreditation?	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
9. What are some success stories and promising models?	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

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

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 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, the team used descriptive statistics 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.
Once the initial analysis was completed, Reciprocal Consulting reviewed the findings using various comparative lenses. For example, comparisons were made between health services and addiction recovery

services, service provided in rural and remote communities and services provided in urban areas, as well as the number of years that an organization has been involved in accreditation. Comparative analyses are described in the findings section of the final report.

<div style="background-color:#e0e0e0; text-align:center;">**About the Participants**</div>

In-depth qualitative interviews were conducted with 37 participants from 22 accredited organizations across Canada. Surveys were completed by 53 participants from across Canada, with 50 respondents identifying that they were from an accredited organization. Of the three participants who did not respond "yes" when asked if their organization was currently accredited, two indicated that they were in the process of going through accreditation and that they had already experienced impacts as a result of their involvement with accreditation. The third 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 53 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 health directors, executive directors, accreditation leads, program consultants, quality assurance directors and program management staff. Figure 2 describes the proportion of participants speaking from the perspectives of these unique roles within each organization.[12]

Figure 2. Interview Participant Roles (Percentage)

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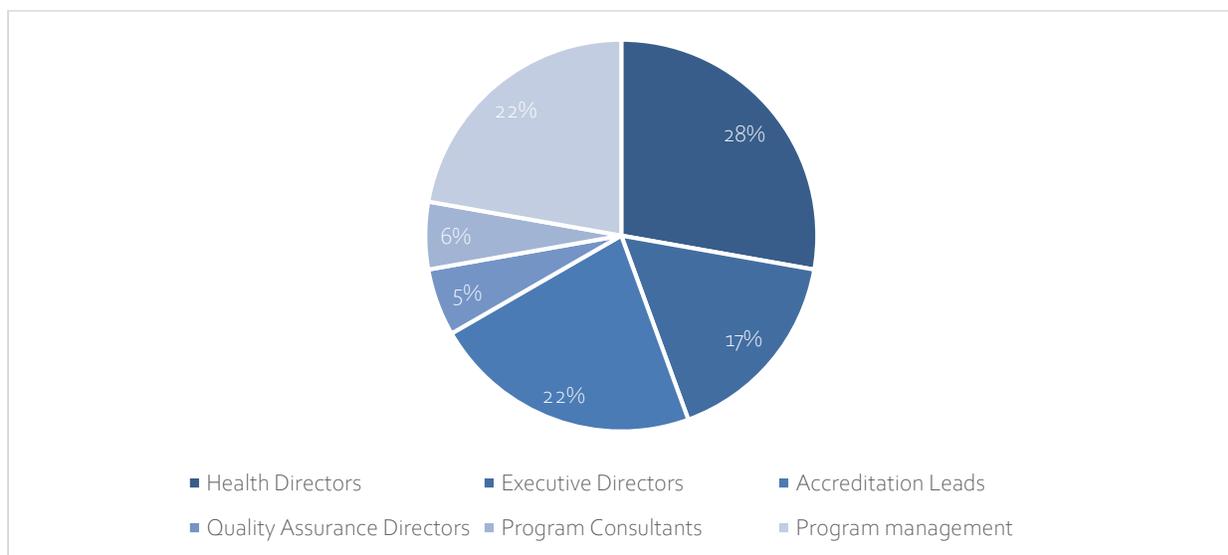
[12] Please note roles were not gathered for survey participants.

Provincial Distribution

Most participants interviewed worked for organizations located in rural communities (n = 19, 86%) across six provinces, with only a few located in urban centres (n = 3, 14%).[13] Survey participants were not asked whether their organizations were located in urban or rural areas.

A large portion of survey and interview participants were located in British Columbia (n = 18 survey participants, 34%; n = 11 organizations interviewed, 50%). The next largest proportion of participants were located in Saskatchewan (n = 12 survey participants, 23%; n = 6 organization interviews, 27%). Participants were also located in Alberta, Manitoba, Ontario, Québec, Nova Scotia and New Brunswick. figures 4 and 5 below provide a visual breakdown of the location for survey participants and organizations interviewed.

Figure 3. Distribution of Interview Participants across Canada (Percentage)
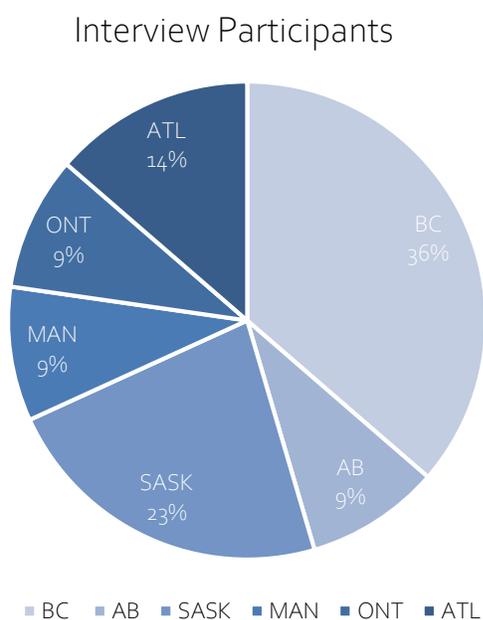
Figure 4. Distribution of Survey Participants across Canada (Percentage)
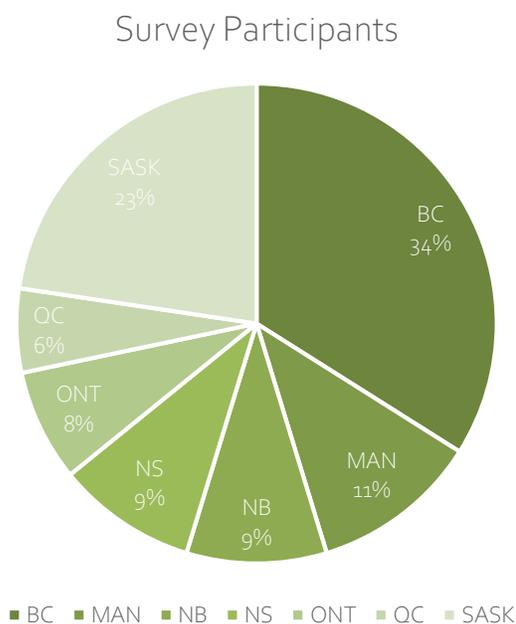
Years Accredited

The amount of time organizations have been accredited was gathered from interview participants and survey participants. Interview participants reported that their organizations had been accredited between a range of two to 22 years. Most frequently, organizations reported being accredited for 10+ years (n = 12, 55%). Survey participants reported that their organizations had been accredited between a range of less than one year to 23 years. As with the interview participants, survey participants most frequently reported that their organization had been accredited for 10+ years (n = 18, 34%). Two of the survey participants indicated that their organization was currently in the process of becoming accredited. Figure 5 below illustrates how many years organizations reported they have been accredited.

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

Figure 5. Number of Years Accredited
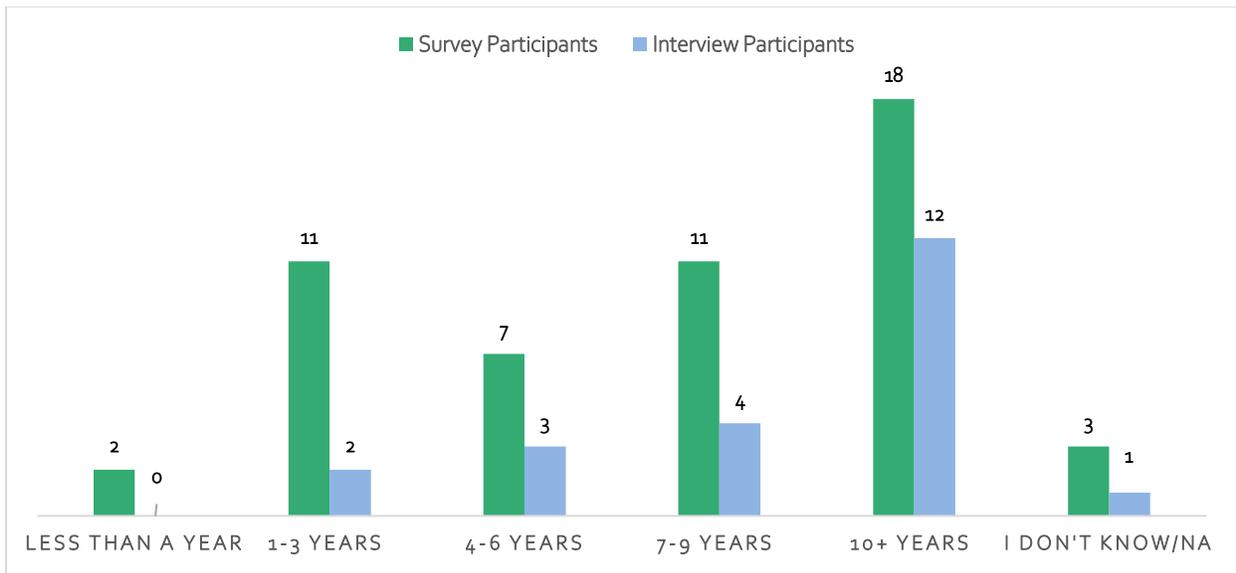
Services Offered

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 = 9, 41%) or addictions services (n = 9, 41%), with some organizations offering both (n = 4, 18%). Survey participants most frequently reported that their organizations offered both health and addictions services (n = 21, 40%), followed by health services only (n = 18, 34%) and addictions services only (n = 13, 25%). Figure 6 below illustrates the breakdown by service type.

Figure 6. Service Type (Number)
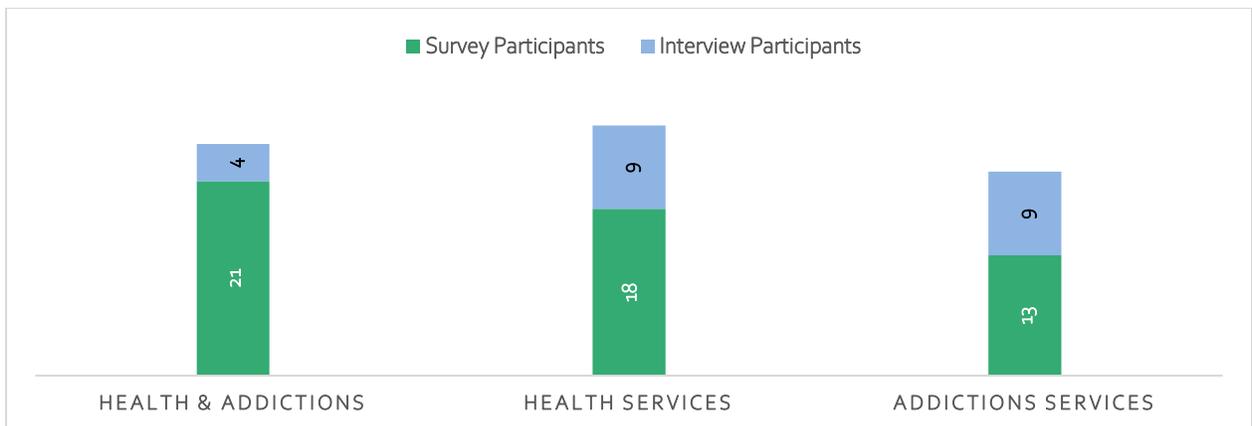
3.0 Findings

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 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.

When asked whether accreditation has contributed to self-determination, organizations most frequently said yes (n = 8, 36%), while an additional four organizations (18%) indicated that accreditation somewhat supported self-determination. In total, over half of the organizations interviewed (n = 12, 55%) reported that accreditation supports First Nations self-determination in some capacity.

- 55% (n = 12) of organizations interviewed indicated increased self-determination because of accreditation
- 59% (n = 13) of organizations interviewed indicated that accreditation supports First Nations to make informed decisions
- 77% (n = 17) of organizations interviewed indicated that First Nations have flexibility in determining how to address gaps in services
- 41% (n = 9) of organizations interviewed indicated that accreditation provides First Nations with knowledge to support health advocacy
- 86% (n = 19) of organizations interviewed indicated that the community is involved in determining accreditation priorities and/or processes

Participating organizations most frequently cited improvements to client safety (n = 15, 68%) when asked how operations have changed as a result of accreditation.

- 50% (n = 11) of organizations interviewed indicated training and professional development opportunities related to client safety
- 59% (n = 13) of organizations interviewed indicated policies and procedures related to client safety are put in place as a result of accreditation
- 23% (n = 5) of organizations interviewed indicated increased cultural safety as a result of accreditation
- 81% (n = 43) of survey participants highly rated the extent to which accreditation has increased client safety

Nearly half of the organizations interviewed (n = 9, 41%) reported an increase in quality of care as a result of accreditation, while 85% (n = 45) of survey participants highly rated the extent to which accreditation has increased quality of care.

Nearly half of the organizations who participated in interviews (n = 10, 45%) mentioned that accreditation has improved the continuity of care for their clients, while 83% (n = 44) of survey participants highly rated the extent to which accreditation has increased client safety.
- When asked to share more about continuity of care, participants most frequently mentioned improved information sharing and retention (n = 9, 41%)

Many organizations interviewed stated that accreditation does lead to improved health outcomes (n = 12, 55%).
- 41% (n = 9) of organizations interviewed indicated increased access to health and wellness services for First Nations

Most organizations who participated in an interview (n = 14, 64%) reported that accreditation contributed to the development of policies, processes and procedures.
- 64% (n = 14) of organization interviewed reported that accreditation informed planning
- 81% (n = 43) of survey participants reported making changes to policies as a result of being involved with accreditation
- 62% (n = 33) of survey participants reported making changes to processes, protocols and procedures as a result of accreditation

Self-Determination

Figure 7. Outcomes and Indicators Related to Self Determination

Area of Inquiry 1.0: To what extent does accreditation increase the self-determination of First Nations in health care?

55% (n = 12) of organizations interviewed indicated increased self-determination as a result of accreditation

59% (n = 13) of organizations interviewed indicated that accreditation supports First Nations to make informed decisions

77% (n = 17) of organizations interviewed indicated that First Nations have flexibility in determining how to address gaps in services

41% (n = 9) of organizations interviewed indicated that accreditation provides First Nations with knowledge to support health advocacy

86% (n = 19) of organizations interviewed indicated that the community is involved in dertermining accreditation priorities and/or processes

Accreditation Supporting Self-Determination

When interview participants were asked whether accreditation has contributed to self-determination, organizations most frequently said **yes** (n = 8, 36%), while an additional four organizations (18%) indicated that accreditation **somewhat** supported self-determination. In total, over half of the organizations interviewed (n = 12, 55%) reported that **accreditation supports First Nations self-determination** in some capacity. Participants shared the ways that accreditation has increased skills, autonomy and leadership. For example, they stated that community members have developed skills to

write policies, procedures, risk assessments and risk control plans, which demonstrates local leadership that extends beyond the program to the wider Nation. Others described how being accredited has allowed for an increased level of responsibility over community service delivery. Another participant shared:

> 🗨 *It's First Nations being in charge of their own programming and being able to align with their other services. This creates more ownership of how health services are delivered and contributes to self-determination.*

A result of the impacts of accreditation on educational tools and prevention planning is the increased involvement from families in their own care planning. This was described as a shift to co-planning, where informational resources are shared rather than care plans being imposed. Planning at the organizational level was also related to self-determination as communities are able to identify their own gaps, goals and priorities rather than taking direction from outside the community.

Participants further described how program involvement in accreditation reached First Nations governments through protocols around engaging local leadership in planning. This enabled collaboration between organizational and Nation-wide goals for service delivery. One participant shared their viewpoint that accreditation can support self-governance by increasing capacity to operate like a provincial ministry by replicating ministry policy and procedure standards, which they related to self-determination.

Others shared that they believe that increased health outcomes at the community level will indirectly enable self-determination as communities are met with fewer health barriers. One participant described how the difficulty in accessing addictions treatment is a significant barrier to self-determination, and therefore that improving addictions treatment in the community can indirectly support self-determination.

Other participating interviewed organizations reported that **accreditation has not enabled self-determination** (n = 4, 18%). The participants who reported that accreditation does not enable self-determination stated that the FNIHB controls the funding, which is a barrier to self-determination. Similarly, it was shared that accreditation standards are mainstreamed to non-Indigenous ways of operating and lack Indigenous world views and standards. One participant explained that accreditation increases colonial government dependency as organizations become reliant on funding from the FNIHB. This participant commented:

> 🗨 *What we do and how we do it is strongly tied to FNIHB.*

Others reflected on their experience of the accreditation process being disjointed from the community and shared that there is not enough education and community involvement in accreditation to enable self-determination. One participant noted that many communities are not aware of or involved in accreditation and are becoming increasingly aware of how it may be of benefit to them as a Nation. There were also comments regarding the lack of meaningful engagement from the band leadership in accreditation processes, resulting in a disconnect between programs and the Chief and Council.

Organizations also commented that **they were not able or not equipped** to speak to whether accreditation supports self-determination (n = 4, 18%). One person commented that as a non-Indigenous person it would not be right to comment. Others reflected that it is difficult to measure progress towards self-determination and the impact of accreditation. One participant commented:

> 🗨 *That is the ultimate goal, we strive towards communities to achieve self-determination. Up to community to decide if we are helping them to get there.*

Accreditation Supporting Informed Decision-Making

The majority of participating interviewed organizations (n = 13, 59%) shared that **accreditation contributes to informed decision-making** with regard to planning and policy development. Participants said that accreditation contributes to strategic planning and helps to identify priority areas. Furthermore, it was reported that information gathered through accreditation has contributed to decision-making by identifying strengths, gaps and opportunities. Similarly, participants described how accreditation improved the robustness of policies by identifying where there were gaps in policies or when policies lacked clarity. One participant reflected on this question, sharing:

> 🗨 *I look at it as an opportunity to grow. It's been really valuable in the sense that it helps us to continue to look at quality improvement initiatives. We are always trying to ensure that we are not getting stuck in the status quo – always looking for opportunities to improve services and provide them in a safe way. For the most part we have bought into it.*

Fort Frances Tribal Area Health Services – Celebration Event for Receiving Accreditation

First Nations Autonomy in Designing and Delivering Services

To assess if accreditation increases self-determination for First Nations, interview participants were asked about the flexibility of their organizations to implement changes when gaps or areas of improvement were identified. The majority of participating interviewed organizations (n = 17, 77%) reported that they **did have flexibility to address identified areas of improvement.**

Organizations shared that they had **flexibility** at the organizational level to adapt to community needs, which enabled continuous change (n = 8, 36%). One participant clarified that their organization was adaptable to community needs and was willing and able to implement change recommendations from accreditation only if they were relevant to and resonated with the community. Others shared that they felt the organization had autonomy to determine how to implement changes and that they had flexibility to address accreditation findings in their own way. Others described how they were able to make changes related to accreditation processes, including changes such as:

⇒ New statistic collection methods and utilization of employee tracking tools to improve staff safety while working in the field in various locations
⇒ Policy and procedure changes for handling pharmacological prescriptions
⇒ Changes to physical environment to make it more client centred
⇒ Implementation of a performance review for the executive director

Participating interviewed organizations shared alternate views as some participants reflected that there were **internal and external barriers that limited flexibility to implement change** (n = 7, 32%). When discussing internal barriers that limit flexibility, participants described that while an organization has flexibility, there can be a lack of consensus within the organization on which changes are needed and prioritized. Others described that implementing change is ultimately left to the teams and their feedback on client and community needs. It was also noted that consensus between the organization and board is needed before significant changes can occur, which is a barrier when the board is understaffed or disjointed from program operations. Participants also described external barriers related to funding that impacted program capacity and the ability to implement change. Participants described how they had organization flexibility, but funding is needed to change operations and that this is a particular issue when changes to infrastructure are needed. Others shared that accreditation standards have increased staff qualification requirements without increased budgets to provider higher wages. As a result, the program has had difficulty recruiting and maintaining staff, which serves as a barrier to implementing changes needed to meet other accreditation standards and recommendations. They shared:

> 🎤 *A lot of questions look at client impact and process impact, but impact on staff is an important lens, because staff turnover and difficulty hiring and retaining staff is a theme. This one says that accreditation set the bar way higher but didn't increase pay and so employees burn out and/or quit for higher-paying jobs.*

When reflecting on flexibility to adapt or implement change based on accreditation findings, participating interviewed organizations commented on how **accreditation bodies had demonstrated flexibility** (n = 5, 23%). Participants spoke about how accreditation bodies and representatives provided standards, but did not dictate what to do or the path to achieve improvement over time. Similarly, others appreciated that the accreditation representatives considered various sets of needs within communities and created flexibility for organizations to consider the unique needs of clients. One participant stated that while the accreditation process has flexibility, ultimately there is a shared set of standards that needs to be met across programs and that individual programs cannot negotiate.

Accreditation Supporting Health Advocacy

Several of the organizations interviewed (n = 9, 41%) reported that **accreditation contributes to health advocacy.** Organizations described using accreditation as a negotiation tool to obtain resources and assure safety and quality as methods to contribute to health advocacy (n = 5, 23%). Participants described how accreditation has helped organizations advocate for improved day-to-day operations and COVID-19 safety protocols. For example, one organization was able to develop a five-year plan to expand dental services and develop needed infrastructure for service provision.

Community Involvement in Determining Accreditation Priorities

Finally, participating interviewed organizations were asked whether their community had been engaged and involved in determining accreditation priorities. The majority of participating organizations said **yes** (n = 19, 86%) when reflecting on community involvement in this process. Most frequently, organizations (n = 7, 32%) identified involvement by the **board and the structure of the organization** as methods for engaging the community. For example, participants shared that their board of directors is made up of

community members from the Nations that they serve and if community members were not on the board, they offered their leadership, gave approvals and/or they were physically located in the communities they serve, which are ultimately staffed by community members. For example, one participant shared:

> 🎤 *Because the board is made up of members of the community, the 11 nations we serve are all represented on the board of directors. That is what makes up our board, through major decision in discussion and then a lot of community engagement work that this is where we are going …we wanted the community to understand why we were doing it and what it meant for them.*

In terms of community involvement, some organizations noted that the Chief and Council would attend meetings and meet with accreditors. One participant reflected that the governance component of accreditation calls for the involvement of First Nations leaders, but that they have no engagement with the community beyond their board involvement.

Other organizations (n = 5, 23%) shared that consultation was done at **various parts of the process through various methods**. Multiple methods of engaging the community were identified, including band meetings, quarterly open forums with the community, newsletter announcements and surveys. One participant shared their reflections:

> 🎤 *At very beginning, I think Accreditation Canada worked very hard to make sure that there was front-line involvement from staff and clients in developing standards. As we got into it, they moved further away. But part of accreditation is involving clients in developing programs so we kind of have too.*

Some organizations (n = 4, 18%) stated that the community was engaged in the process through **client surveys and health planning**. Organizations shared that their community engaged with the health plan and gathered participant feedback, but not specifically with the process and requirements of accreditation. This looked like clients and the community providing feedback on quality improvement initiatives that fed into accreditation, rather than direct involvement in the accreditation process itself. For example, one participant stated that client satisfaction was collected at the end of each intake, which would inform feedback on all aspects of programming, and another participant did a comprehensive survey to collect data on client satisfaction.

Two organizations shared that initially there was community engagement through committees and consultations, but that over time there was less involvement. One organization reported that guidance came from an Elders Committee, where an Elder from each Nation provided guidance on cultural aspects of the services they offer.

Those organizations who did not respond "yes" to the question around community involvement in determining accreditation priorities or processes said they were **unsure if consultation took place with the community** (n = 3, 14%). For example, participants shared that they felt like the relationship was a one-way process where communities had to follow processes and standards that were set by accreditation. Another participant shared that they were new to the role and that although there was the flexibility to integrate feedback, they were not sure it was linked to the previous accreditation process.

Client Safety

Figure 8. Outcomes and Indicators Related to Client Safety

Area of Inquiry 2.0: To what extent does accreditation increase First Nations client safety?

50% (n = 11) of organizations interviewed indicated training and professional development opportunities related to client safety

27% (n = 6) of organizations interviewed indicated mechanisms for client feedback

59% (n = 13) of organizations interviewed indicated policies and procedures related to client safety were put in place as a result of accreditation

23% (n = 5) of organizations interviewed indicated increased cultural safety as a result of accreditation

81% (n = 43) of survey participants highly rated the extent to which accreditation has increased client safety

Accreditation Impact on Client Safety

Interview participants were asked to reflect on how operations have changed because of accreditation (Figure 8 above) and how accreditation has impacted client safety (**Error! Reference source not found.** below). Participating organizations most frequently cited **improvements to client safety** (n = 15, 68%) when reflecting on how operations have changed. Two organizations (9%) indicated they were already doing well with regard to client safety before accreditation.

Survey participants were also asked to rate the extent to which accreditation has helped increase client safety in their organization. Survey participants rated their responses highly, indicating that **accreditation had significantly increased client safety** at their respective organizations. On a scale of 1 to 5, where 1 was *not at all* and 5 was *significantly,* survey participants gave an average rating of 4.3.

Figure 9: Survey Ratings: Accreditation Impact on Client Safety (Number)
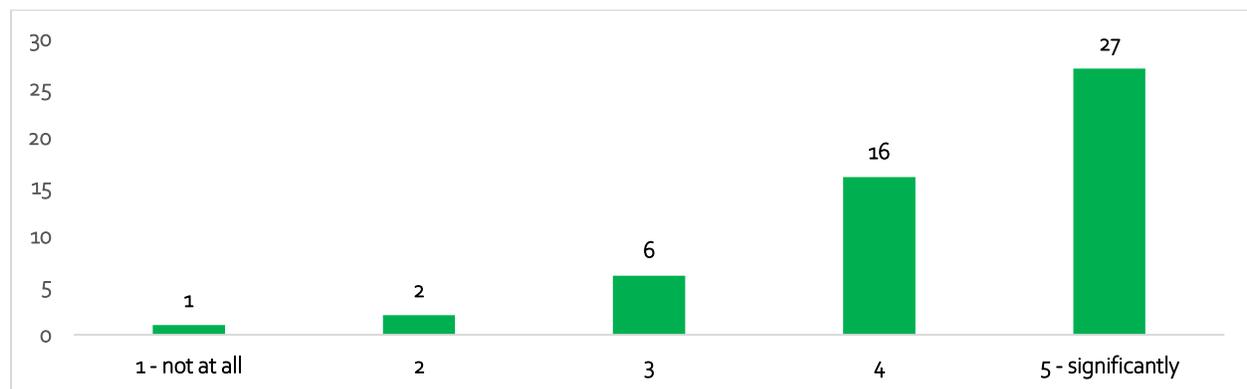
Training and Professional Development Related to Client Safety

Half of the participating interviewed organizations (n = 11, 50%) reported that as a result of their participation in accreditation, there was an **increase in training and professional development**

opportunities related to client safety. The majority of survey participants (n = 29, 55%) also reported increased training and professional development opportunities as a result of accreditation.

Both interview and survey participants provided a number of examples of training and also described how accreditation has identified gaps in training and recertification opportunities. Participants went on to state that as a result of accreditation they now have a standard training program in place with regular training opportunities. Examples of types of training that organizations and survey participants reported that staff have engaged in as a result of accreditation include:

- ⇒ CPR
- ⇒ Suicide prevention
- ⇒ Trauma-informed practice
- ⇒ Cultural safety
- ⇒ Biohazard practices
- ⇒ Crisis response

- ⇒ First Aid
- ⇒ Tree falling (for land-based programming)
- ⇒ Chainsaw safety
- ⇒ Lockout training

Mechanisms for Client Feedback

Both interview and survey participants mentioned **implementing systems for client feedback as a result of accreditation.** When asked to describe changes made to operations and services as a result of accreditation, approximately one-quarter of organizations that were interviewed (n = 6, 27%) and one-quarter of survey participants (n = 12, 23%) reported implementing systems for client feedback. Participants described how prior to accreditation, feedback systems were not formal; following accreditation, standardized practices have been put into place that make it easier for clients to provide feedback. Participants mentioned gathering client feedback via surveys and a drop box location. It was also commented that client feedback informs continuous improvements made to services.

Policies and Procedures Related to Client Safety

When describing changes to client safety as a result of accreditation, organizations that were interviewed described **strengthening, adding and implementing policies related to client safety** (n = 8, 36%). Similarly, when asked about changes as a result of accreditation, several survey participants mentioned implementing policies and procedures specific to client safety (n = 9, 17%). Participants described implementing Occupational Health & Safety policies, Work Safe policies, COVID-19 protocols and incident reporting, as well as implementing an ethical framework. Participants also shared that their policies were client-centred, with one individual stating that an emphasis is put on client rights and services.

Accreditation Impact on Cultural Safety

Organizations that were interviewed described changes in operations regarding **cultural safety and emotional safety** that were introduced as a result of accreditation (n = 6, 27%). Interview participants shared how more conversations on culture, language and racism occurred because of "lunch and learns" with guest educators, leading to staff becoming more aware of resources related to cultural safety. Others described how cultural safety was built into policies and procedures such as culturally relevant content integrated into assessment tools and staff training materials. One program said they improved staff training tools by developing an Elders council that introduced cultural teachings to staff on an ongoing basis. When discussing the creation of a health and safety committee, it was noted that emotional safety and trauma-informed practice would be included in the committee's oversight. One participant reflected on the cultural aspect of this process, sharing:

🗨 *The questions are more culturally relevant, they help to show you the whole person, you can identify areas in their lives that are hurting the most. We do diversity training, Aboriginal wellness training. That allows the staff to be mindful of surrounding, different cultural teachings. When they're learning and sharing they can bring it back into the treatment room where they're helping clients.*

Participants also shared examples of how **accreditation had a negative impact on cultural safety** (n = 2, 9%). For example, one participant shared how accreditation has emphasized professional development and achievement of Western credentials in counselling-related roles, which has influenced hiring processes. Cultural and community knowledge is crucial for cultural safety and competency, yet Western education is prioritized by hiring criteria. This has impacted the involvement of Elders and knowledge holders as they are valued less by accreditation bodies and Western-trained professionals. Additionally, one participant shared that cultural safety is undervalued in accreditation and is therefore pursued independently by community members and leaders.

Quality of Care

Figure 10. Outcomes and Indicators Related to Quality of Care

Area of Inquiry 3.0: To what extent does accreditation increase First Nations quality of care?

36% (n = 8) of organizations interviewed and indicated improved facilities and equipment

23% (n = 5) of organizations interviewed indicated training and professional development opportunities related to quality of care

27% (n = 6) of organizations interviewed indicated policies and procedures related to quality of care of put into place as a result of accreditation

41% (n = 9) of organizations interviewed indicated increased quality of care as a result of accreditation

85% (n = 45) of survey participants highly rated the extent to which accreditation has increased 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. Many of the participating organizations (n = 9, 41%) reported an **increase in quality of care** as a result of accreditation. Interview participants said that accreditation provided a blueprint for quality improvement and helped to create and sustain a cycle of continuous improvement. Participants described a general increase in the standard of care.

Some participating organization (n = 2, 9%) reported that there were no changes to quality of services as a result of accreditation. Participants shared that their organization already produced quality services and invested in training prior to accreditation. One participant commented:

🗨 *Unfortunately, it's usually said that we have to do this because of accreditation, instead of we have to do this to improve our practices. It's a stick versus a carrot approach. However, there have been changes.*

Survey participants were also asked to rate the extent to which accreditation helped increase quality of care in their organization. Survey participants rated their responses highly, indicating that **accreditation**

had significantly increased quality of care at their respective organizations. On a scale of 1 to 5, where 1 was *not at all* and 5 was *significantly,* survey participants gave an average rating of 4.3.

Figure 11. Survey Ratings: Accreditation Impact on Quality of Care (Number)
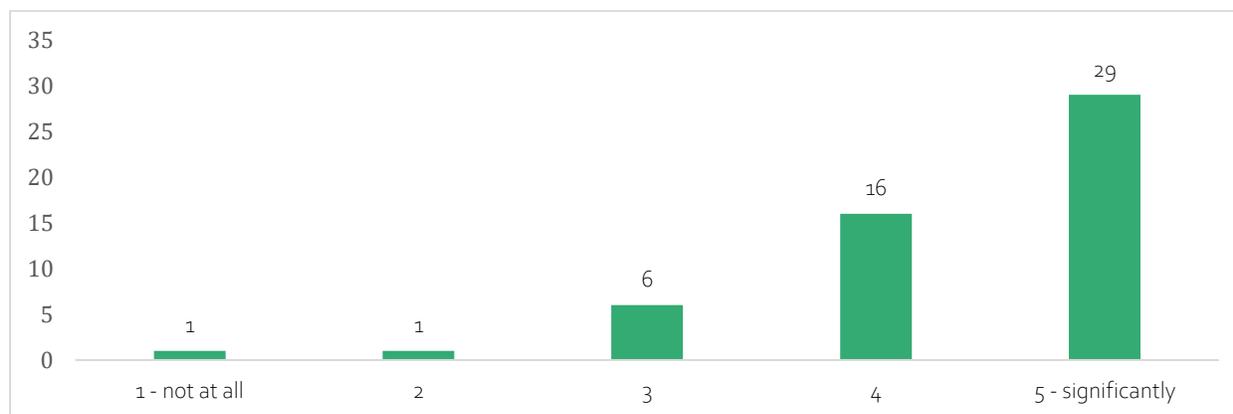
Improved Facilities and Equipment

Both interview participants (n = 9, 41%) and survey participants (n = 12, 23%) said there have been **improvements to equipment** as a result of being involved in accreditation process. Participants reported that their organizations upgraded and bought new equipment, including medical equipment (i.e., monitoring equipment, foot care devices), technical equipment (i.e., computers, laptops, electronic charting system), software (i.e., telehealth), clerical equipment (i.e., photocopy machines, shredders), maintenance equipment and transportation. Some participating organizations mentioned equipment related to physical safety such as security cameras and fob entry security systems. Participants also identified equipment specific to the COVID-19 pandemic.

Training and Professional Development Related to Quality of Care

When asked to describe changes as a result of accreditation, many of the organizations that were interviewed described **increased quality in their staff's skill set** (n = 15, 68%). Participants explained how accreditation has increased professional development and training opportunities, which improved their organization's credibility and attracted more qualified applicants. Similarly, participants noted how standards for hiring criteria changed with accreditation to prioritize applicants with educational credentials and ensured uninterrupted and consistent services. Participants described how accreditation resulted in a tremendous amount of training and development opportunities, including training in the required health and safety certification, accreditation and quality improvement processes, and changes to policies and procedures.

Policies and Procedures Related to Quality of Care

When asked what changes have been made to their organization as a result of accreditation, interview participants described changes to policies and procedures related to quality and care. Most frequently, participating organizations (n = 12, 55%) described changes to **reporting and documentation** to ensure that files are maintained and kept up to date, and that reporting is completed on time, ultimately improving medical management. Participants mentioned reporting in the way of creating systems for filing and keeping documentation and records for incidents and occurrences. One participant stated that this

operational change of having up-to-date information will better serve the public, but will also increase administrative duties. One participant shared a comment around client feedback:

🗨 *To be honest with you, we collect experience feedback on an ongoing basis: client satisfaction surveys, at the time of appointments, during forums, during evaluations. It's all inter-related. When you ask if we make changes, yes, we do that regularly, our data helps us to make decisions going forward.*

Several participating interviewed organizations (n = 11, 50%) also mentioned **implementing accountability structures,** including regular performance reviews and health and safety reviews, as well as creating a committee to oversee and provide feedback on operations and services.

Both interview participants (n = 4, 18%) and survey participants (n = 2, 4%) mentioned implementing **PDSA (Plan Do Study Act)** to improve quality services.

Seabird Island Health Centre

Figure 12. 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?

45% (n = 10)

of organizations interviewed indicated increased continuity of care as a result of accreditation

83% (n = 44)

of survey participants highly rated the extent to which accreditation has increased client safety
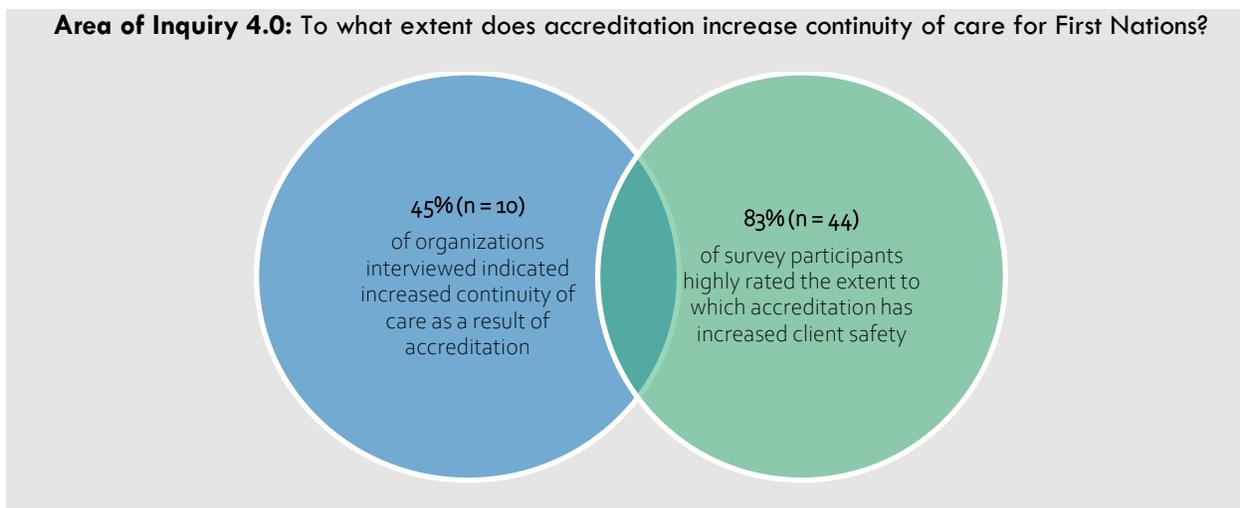
Accreditation Impact on Continuity of Care

Nearly half of the organizations who participated in interviews (n = 10, 45%) mentioned that accreditation has **improved the continuity of care** for their clients. When asked to elaborate on this, participants most frequently mentioned **improved information sharing and retention** (n = 9, 41%). Participants stated that files are better organized, easier to share and easier to access and that referral systems are in place to streamline the process. Participants identified that the documentation, data collection and software systems were more consistent and connected through the health care system, which led to the ability to share information electronically when clients moved to different treatment centres. Additionally, improved information sharing made it easier to identify incidents and come up with improvements. In the same regard, a participant noted that while this has increased the number of meetings, reporting and training requirements, it has also created stronger teams and better communication. One participant shared:

> 🗨 *When we talk about continuity of care, that's what accreditation does for us. It helps us to establish stronger teams and better communication.*

In the area of referrals, interview participants stated that the internal multidisciplinary referral system allowed transferences without disruption and that when clients move on from a centre that their files are handled according to specific standards. This is also true for clients moving across programs. Additionally, this allows for multi-skilled and diverse teams to identify gaps in confidentiality and ensure that clients who are accessing multiple programs and services receive confidential, collaborative and accurate care.

Additionally, some participating interviewed organizations (n = 3, 14%) noted that accreditation has impacted their organization in the area of continuity of care by **increasing staff support** by strengthening the team, reducing staff turnover and hiring more qualified staff. Participants shared that this process has "upped the game" in regard to enabling staff to use their knowledge to help others. One participant commented that because accreditation is all-encompassing, it has helped to pull people together and enables work across departments, which has positively impacted continuity of care for their clients. Additionally, one participant reflected that the implementation of a salary scale, which made the

organization competitive with other service providers, supports recruitment and helps to maintain qualified staff.

Survey participants were also asked to rate the extent to which accreditation has helped increase continuity of care in their organization. Survey participants rated their responses highly, indicating that **accreditation had significantly increased continuity of care** at their respective organizations. On a scale of 1 to 5, where 1 was *not at all* and 5 was *significantly,* survey participants gave an average rating of 4.2.

Figure 13. Survey Ratings: Accreditation Impact on Continuity of Care (Number)
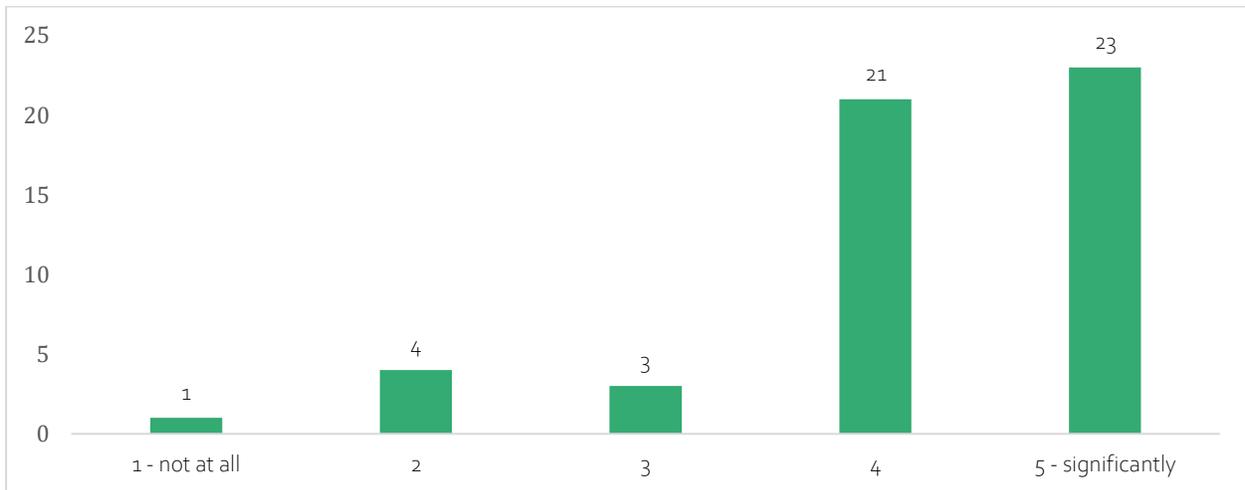
Figure 14. Outcomes and Indicators Related to Improved Health Outcomes

Area of Inquiry 5.0: Does accreditation lead to improved health outcomes for First Nations?

55% (n = 12)
of organizations interviewed indicated improved health outcomes as a result of accreditation

41% (n = 9)
1.of organizations interviewed indicated increased access to health and wellness services for First Nations
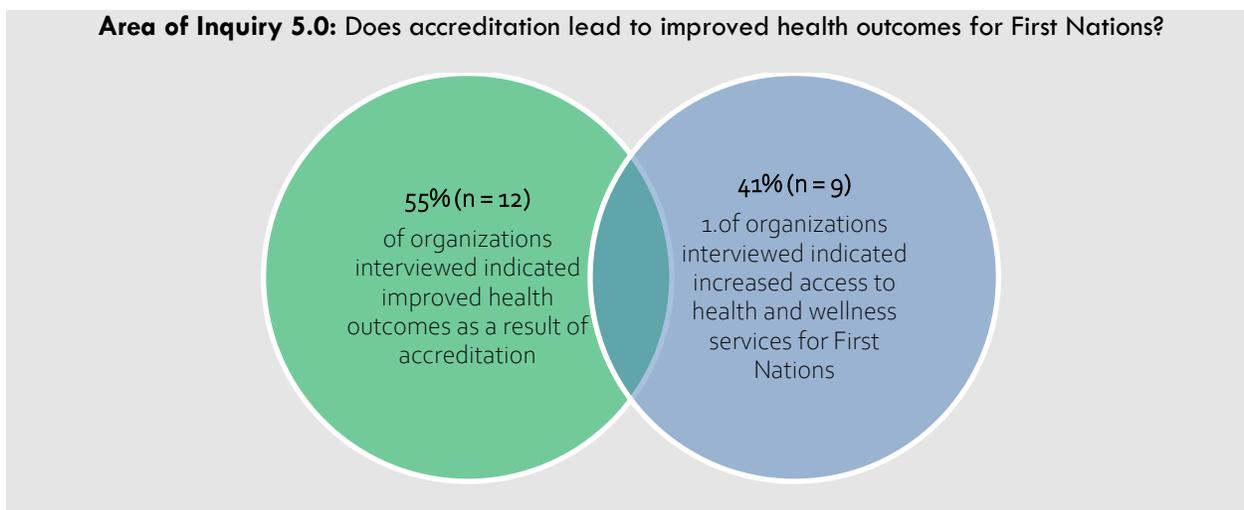
Accreditation Impact on Health Outcomes

When interview participants were asked whether **accreditation leads to improved health outcomes**, 12 participating organizations stated that accreditation does lead to improved health outcomes (55%), while an additional six organizations (27%) provided examples of improved health outcomes as a result of the program, but did not specifically correlate them to accreditation.

When asked whether accreditation leads to improved health outcomes, participants identified improvements they have seen as a result of accreditation and improvements that accreditation has contributed to. Additionally, while not all responses listed specific health outcomes, many inferred that improvements in outputs indicated improved health outcomes.

Participants described improvements such as enhanced standards of care, improved structures, improved record keeping, increased number of cultural programs and increased collaboration among health care providers. Participants cited a number of positive changes as indicators of improved community health including:

⇒ Increased consistency of appointments
⇒ Increased immunizations
⇒ Improved maternal-child health
⇒ Increased performance measurement on wound care
⇒ Increase in occupancy completion rates
⇒ Increase in after-care accomplishments
⇒ Clients going on to complete school or start families after completing additions programs

Interview participants also reported that there is increased staff experience and quality of services, which contributes to greater trust in services. The increased trust in services is expected to support improved health outcomes as clients continue to access health services.

Some participating interviewed organizations reported **difficulty in measuring improved health outcomes** (n = 3, 14%). Interview participants noted that it was difficult to quantify the impact of prevention and that health outcomes stem from many complex factors. In general, while there was agreement that accreditation positively impacts the work, they were unable to correlate accreditation with improved health outcomes. One participant commented that although "clients are not falling through the cracks," at a national level, First Nations continue to experience poorer health outcomes compared to non-Indigenous Canadians.

💬 *I'm not sure that we can measure the difference and whether it can be directly linked to accreditation. I believe it does make a difference, but it's a long-term journey.*

Rising Sun Treatment Centre

Accreditation Impact on Access to Health & Wellness Services

When asked about the impacts of accreditation on health outcomes, several organizations that participated in an interview (n = 9, 41%) reported that **access to services increased** as a result of changes and impacts generated through accreditation.

Both interview and survey participants also identified **increased service delivery** as a result of being involved in accreditation. Participating interviewed organizations (n = 4, 18%) described expanding services to surrounding communities, while others hired more staff, which increases the number of services their organization is able to offer. Survey participants (n = 7, 13%) also described expanded services and programming.

Unintended Outcomes

Figure 15. Outcomes and Indicators Related to Unintended Outcomes

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

55% (n = 12)
of organizations interviewed shared unintended outcomes

18% (n = 4)
of organizations interviewed indicated meaningful relationships have been built between accreditors and First Nations organization/ community members

64% (n = 34)
of survey participants reported additional positive impacts aside from client safety, quality of care and continuity of care as a result of accreditation

Unintended Outcomes

The majority of organizations who participated in interviews (n = 12, 55%) and survey participants (n = 34, 64%) reported **unexpected outcomes** as a result of being involved in accreditation.

Several participating interviewed organizations (n = 5, 23%) reported **increased credibility** as an unexpected outcome of being involved in accreditation. Interview participants described an increased reputation and greater credibility as a result of their organization's involvement with accreditation, citing being asked to present at conferences as an indicator of increased credibility. Interview participants also described the feeling of breaking stereotypes and knowing that their organization is as good as or better than non-Indigenous health services in terms of quality. One participant reported that being accredited was helpful when formalizing memorandums of understanding with the provincial and federal government.

Other unexpected outcomes mentioned by interview participants include:

⇒ The unexpected amount of time needed to invest in accreditation (particularly for health directors)
⇒ Increased custodial services and improved cleanliness of the facility
⇒ Having a pandemic plan in place when the COVID-19 pandemic hit
⇒ Improved quality and nutrition of food being served
⇒ Staff buy-in and sense of pride in being accredited

🗨 *I was pleasantly surprised at how we were able to operationalize the standards, in operationalizing best practices. I was trying to figure out how to do that when we were going through the standards, and then it came how to build the pieces in. How to integrate those into our operations so that they become good, improved standards of service. It worked out well that way. I was surprised with that.*

When survey participants were asked whether accreditation had resulted in any other impacts, participants shared positive impacts related to **increased credibility and validation for quality of services** (n = 9, 17%). Participants noted that accreditation increased the confidence of external

organizations such as funders, clients and the community, partner organizations; and other accredited organizations. Participants shared that as a result of the increased recognition and trust with external partners, they had greater access to funding opportunities and that being accredited strengthened their funding proposals. Participants also noted increased trust from clients and the community in the services being delivered.

Survey participants also commented that having **consistent services that contribute to continuous improvement** (n = 6, 11%) was an unexpected outcome. Participants described services as more consistent as a result of having standardized polices and procedures. Participants also commented that policies and procedures are regularly updated, which contributes to continuous improvement

> 🐦 *I feel that accreditation keeps us from straying off the path. It gives us a baseline to always reflect back on as we implement "new and improved" methods of treatment. It's the "rudder" to our ship as we navigate the waters of the human condition.*

Survey participants also spoke about staff having greater **knowledge and understanding of roles and responsibilities** (n = 5, 9%). This contributed to a clearer reporting structure and helped staff to understand their roles within the larger organization. Related to this, staff learned more about other staff members' roles, which has contributed to strengthening the team.

Several survey participants (n = 5, 9%) also spoke about impacts on **staff well-being.** For example, an unexpected outcome from being involved in accreditation is that staff safety has increased with safety protocols and equipment now in place. Participants also reported that staff now feel empowered and have increased self-confidence in their jobs, and that staff morale has increased. It was also mentioned that staff have bought into accreditation. One participant commented:

Snuneymuxw First Nation – Health Department

> 🐦 *Based on accreditation, staff now feel safe while working with vulnerable groups. Equipment such as outside lights (was almost nil before accreditation) and extra cameras help protect individuals coming and leaving the building, especially at late shift changes. Training for all staff has given a sense of empowerment and self-confidence in their roles. Accreditation has improved the quality of care not only for clients, but for the staff as well.*

Other unexpected outcomes mentioned by survey participants include the following:
⇒ Increased community voice in decision-making
⇒ Leadership team more involved
⇒ Increased calibre of staff
⇒ Increased accountability
⇒ Increased understanding of how the governance structure can support service delivery
⇒ More responsive to community needs

Relationship Building

When describing unanticipated outcomes, some organizations that were interviewed (n = 4, 18%) reported having **positive experiences with** their accreditor. One interview participant stated that the accreditor worked with them to identify the organization's strengths, and that although they initially felt apprehensive about being evaluated, the actual experience of receiving suggestions and feedback was enjoyable. Other participants commented that accreditors were kind and less judgmental than expected.

Some survey participants (n = 2, 4%) described **increased networks and linkages with other organizations** such as other First Nations accredited organizations.

Changes to Policy, Processes or Plans

Figure 16. Outcomes and Indicators Related to Changes in Policy, Process and Plans

Area of Inquiry 7.0: What changes to policy, processes and/or plans have been made as a result of accreditation?

64% (n = 14) of organizations interviewed reported making changes to policies and processes as a result of accreditation involvement

64% (n = 14) of organization interviewed reported that accreditation informed planning

81% (n = 43) of survey participants reported making changes to policies as a result of being involved with accreditation

62% (n = 33) of survey participants reported making changes to processes, protocols and procedures as a result of accreditation

Accreditation-Related Policy and Process Changes

The majority of organizations who participated in an interview (n = 14, 64%) reported that **accreditation contributed to the development of policies, processes and procedures**. Interview participants reported that policies and procedures were strengthened or formalized. Gaps were also identified, and as a result, new policies and procedures were created. See Table 3 below for specific policy and process areas mentioned by interview participants.

The majority of survey participants also reported that accreditation contributed to the development of policies (n = 43, 81%) and processes and procedures (n = 33, 62%). Survey participants described regularly updating policies since being involved with accreditation, and identifying gaps in policies or unclear policies. Similarly, survey participants described regularly updating processes and procedures to correspond with updated policies. Survey participants commented that their processes and procedures were adapted to better centre the needs of clients. Others mentioned that the purpose of process and procedures updates was to improve the quality and safety of services. See Table 3 below for specific policy and process areas mentioned by survey participants.

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

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
Quality of Care	
✓ Evaluation and surveys ✓ Hiring and job descriptions ✓ Staff training ✓ Succession planning	✓ Financial policies ✓ Operational protocols ✓ Staff safety ✓ Work Safe ✓ Required Organizational Practices (ROPs) for each team
Continuity of Care	
✓ Client identification	✓ Client access to services ✓ Data management processes

Accreditation-Related Planning

The majority of organizations who participated in an interview (n = 14, 64%) reported **incorporating accreditation learnings into planning**. Participants reported that accreditation contributed to strategic planning and succession planning, and that it supported decision-making.

Three survey participants (6%) reported that they used **accreditation in their planning** when describing changes their organization has made as a result of

Leading Thunderbird – Youth Treatment Centre

accreditation. Survey participants specifically mentioned accreditation as supporting management planning and the creation of an ethical framework. Two of the survey participants also mentioned engaging in PDSA (Plan Study Do Act).

3.2 Wise Practices and Lessons Learned

The following section provides findings related to wise practices and lessons learned, including challenges and opportunities that resulted from being involved with accreditation, as well as success stories and lessons that others can learn from.

Challenges and Opportunities

Figure 17. Outcomes and Indicators Related to Challenges and Opportunities

Area of Inquiry 8.0: What are the challenges and opportunities associated with accreditation?

77% (n =17)
of organizations interviewed identified challenges that resulted from being involved in accreditation

59% (n = 13)
of organizations interviewed identified opportunities that resulted from being involved in accreditation
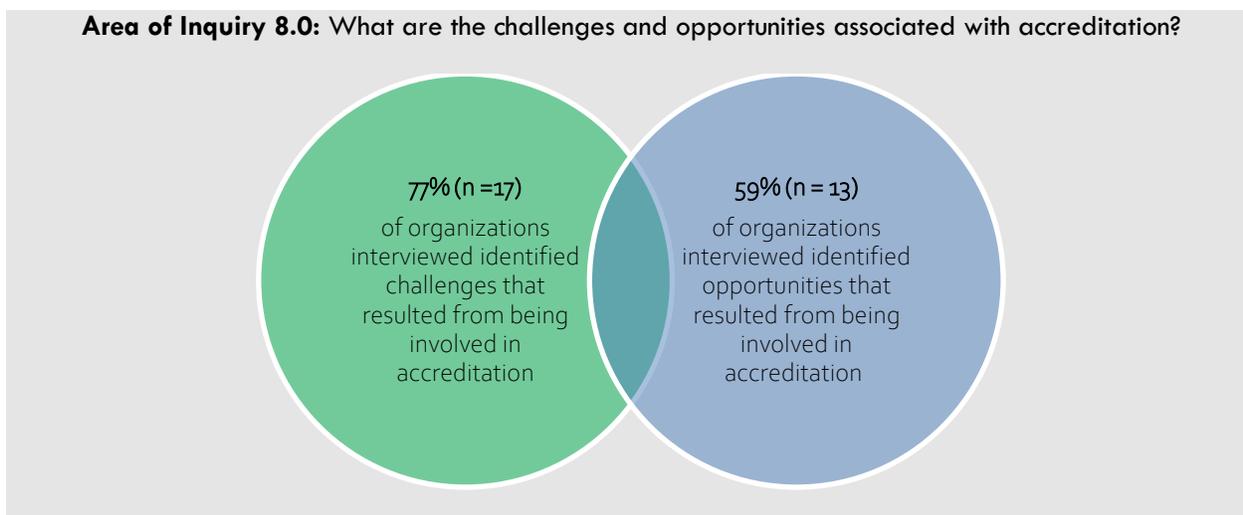
Accreditation Challenges

The large majority of organizations who participated in an interview (n = 17, 77%) reported experiencing challenges as a result of their participation with accreditation. These challenges included the **skill or approach of the accreditor** (n = 9, 41%), with participants reporting a variety of concerns including a punitive tone, inconsistency in the skill level of the surveyors, inequity in the assessment process, lack of guidance or support, poor communication, a lengthy appeal process and a poor resource database. One person spoke specifically about the variable skill level of accreditors in their cultural competence by stating that some accreditation groups were knowledgeable about First Nations community contexts while others were not aware at all.

Participating interviewed organizations reported **organization culture or buy-in** as a challenge (n = 8, 36%) with regard to evaluation. Participants described a lack of enthusiasm or buy-in from external partners such as community leadership, whereby policies were denied by the Chief and Council that were required in order to be accredited, as well as issues with a lack of alignment between the Band and accreditation standards. Participants also described a lack of buy-in at the organizational level resulting in a lack of transparency within the organization, demonstrated by comments about staff hiding problems (also described as a culture of fear) rather than seeking support and improvement through accreditation. Others noted a lack of buy-in at the organization level, with standards not being followed and leadership demonstrating a perception that accreditation is an exercise in checking off boxes, which impacts the organization's culture and the usefulness of accreditation.

Regarding a **one-size-fits-all** approach, participating interviewed organizations reported that it is awkward to scale the accreditation process from large to small organizations and that the feedback they receive is not relevant (n = 7, 32%).

Participating interviewed organizations also described challenges related to **capacity** (n = 13, 59%). Interview participants described staff and governance turnover, a lack of funding, a lack of training and a lack of resources to support client paperwork. Regarding **time commitment**, participating organizations described "*working off the side of their desk*" as well as excessive paperwork and overall work volume as the primary challenges. In the area of capacity, one participant shared:

> 🗨 *Has it impacted what we do, in some aspect yes. It created structure, but with structure comes a cost. We've seen that with level of paperwork that has to be done for addictions and mental health, so much paperwork.*

Participating interviewed organizations who reported that the accreditation process was not culturally relevant described the process as **not being reflective of their organization's culture** and as not fitting a First Nation community context (n = 6, 27%). Participants also reported that the accrediting body did not have an Indigenous lens, that the accreditors did not understand the community and organization context, and that the process conflicted with local cultural protocols. Additionally, some reported a challenge to get First Nations surveyors to participate in the accreditation process, as they needed community engagement and language translation to engage the community

Participating interviewed organizations reported challenges related to **redundancy and inconsistency of accreditation process** (n = 5, 23%). Participants described instances where they were asked to rewrite policy documents that were in use and functional. It was suggested that accreditors analyze how existing tools were serving the organization, rather than requesting that the organization redo documents and processes that were functioning well. One organization described the challenges they experienced when going through two different accreditation organizations to secure more than one accreditation. They found that while core standards overlapped and appeared to align, different surveyors responded differently to the same standards. Similarly, others described tensions as a result of expectations for differing standards from regional health authorities and accreditation organizations. Lastly, with dual accreditation processes, participants noted that the accreditation cycles are accelerated, such as the need to go through an accreditation cycle every two years. One participant shared:

> 🗨 *We didn't learn anything in this second survey. It was awful. It felt like we were being assessed as something that we weren't. They didn't know anything about our community. We dealt with it with Accreditation Canada, and they adjusted our results. The experience has made us a bit hesitant about next time. We were borderline about whether we would do a survey again.*

Remaining interview participants shared that they had **no challenges** (n = 2, 9%).

Accreditation Opportunities

The majority of organizations that participated in an interview (n = 13, 59%) also reported getting access to new opportunities as a result of their participation in accreditation. New opportunities that arose as a result of involvement with accreditation were reported by interview participants and were related to **funding opportunities** (n = 9, 41%). This included both retaining existing funding and accessing new funding opportunities. Participants reported that accreditation status holds value for their funders, increases funder confidence and can be a requirement to retain funding. Participants also reported that while accreditation may not be a requirement for some funding streams, they perceive that having accreditation status strengthens their organization's credibility when submitting funding applications. No financial benefit was also reported, as shared by the participant below:

> 🗨 *I've never seen anything that says you got this because you're accredited. But we always mention that we are accredited because it shows continuous quality improvement and I think that helps us to*

maintain and secure funding opportunities, but I can't think of an example of them saying we got it because we were accredited.

Synergy and collaboration among staff within their organization were noted by participants, as well as having increased capacity due to checks and balances being in place (n = 6, 27%). It was also reported that there was greater understanding and alignment with provincial directives as a result of accreditation, and that new partnership opportunities resulted with the regional health authority and with universities.

S**ervice improvements** reported by participants included reviewing the code of ethics, implementing new software, adding an infection prevention nurse to the team and acquiring dialysis equipment to provide this service close to home (n = 4, 18%).

New opportunities related to **employee recruitment and morale** as a result of involvement in the accreditation process were described by participants (n = 4, 18%), and the high level of engagement of nurses in accreditation was also noted. One participant reported being able to recruit more qualified applicants after becoming accredited.

Participants that reported enhanced **reputation credibility** described stronger client confidence that the program standards on-reserve were meeting Canadian standards (n = 3, 14%).

Success Stories and Promising Models

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

Area of Inquiry 9.0: What are some success stories and promising models?

23% (n = 5) of organizations interviewed stated that their organizational structure supports service delivery

36% (n = 8) of organizations interviewed engaged in monitoring and/or reflection practices that led to change
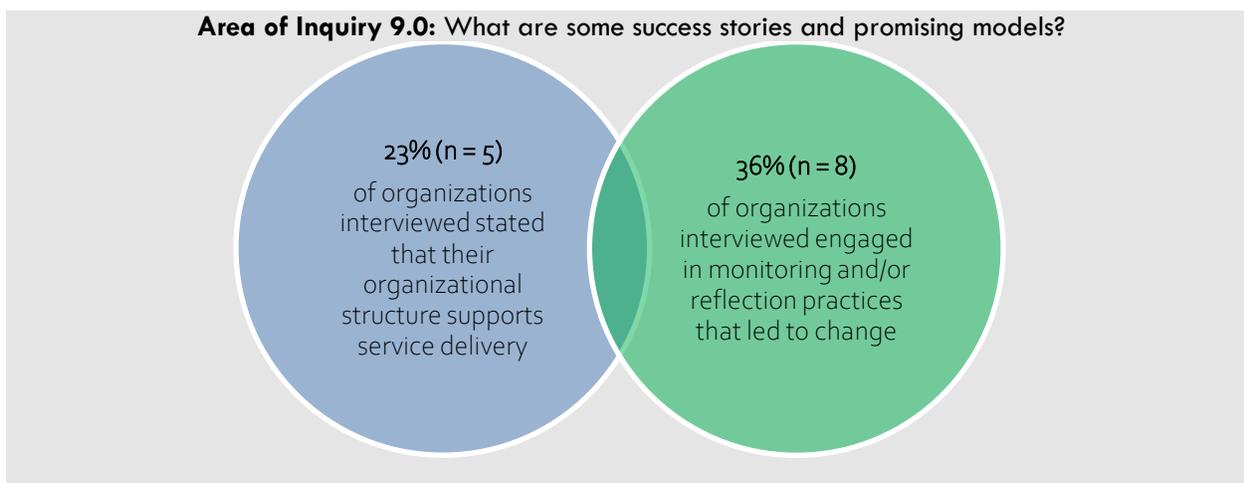
Accreditation Impact on Organizational Structure

Some organizations that were interviewed (n = 5, 23%) reported that their **organizational structure supports service delivery.** Related to this, some organizations (n = 6, 27%) reported **organizational changes** as a result of their involvement with accreditation. Specifically, interview participants mentioned accountability structures put into place – such as changes to supervision, monitoring of Human Resource files and performance reviews – to help support consistent quality service delivery. Other organizational structural changes mentioned by interview participants included streamlining reporting structures, streamlining roles and responsibilities, and changing hiring criteria.

Related to organizational changes, participating interviewed organizations (n = 3, 14%) described how accreditation resulted in **changes to the organization's work environment.** For example, as a result of

their health services undergoing evaluation, an entire organization made changes to its policy and practices.

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

Accreditation Monitoring and Reflection Practices

Several of the organizations who participated in an interview (n = 8, 36%) reported that they had **implemented monitoring and reflection practices** as a result of accreditation. Interview participants described evaluation and monitoring practices such as gathering ongoing feedback and making changes to policies and procedures based on findings. Participants also reported conducting a regular performance review of staff positions, as well as the organization's governance.

Nak'azdli Whut'en Centre

Similarly, some survey participants (n =7, 13%) also talked about **implementing monitoring and performance measurement processes** when asked about changes made as a result of their involvement in accreditation. Survey participants described more comprehensive and structured processes for measuring and monitoring and stated that they incorporate performance measurement into regular practice. Some specific measures mentioned by survey participants as being monitored include medical management measures, safety measures and infection prevention control measures. One participant mentioned that human resource files are tracked for consistency.

Success Stories

Organizations that participated in interviews shared a number of **success stories** that came out of their journey with accreditation (n = 15, 68%). This included recognition of being trained as a surveyor, being invited to share the Jordan's Principle model with the region, and being invited to sit on a Health Canada committee. Success stories also included the organization being the first accredited organization in their

community which led other agencies to become accredited, as well as enhancing their own reputation within the community.

> 🗨 *Did a program on breastfeeding and found that because of accreditation we were able to give info so they can make their own decisions. We found an increase in breastfeeding moms and duration of breastfeeding. There was an increase in the amount in information that was sought out, same with tobacco reduction program brought in tradition and culture around respecting tobacco, grows and distributed tobacco for medicinal and ceremonial purposes. Changed the way people look at tobacco.*

A number of survey participants (n = 15, 28%) also shared **success stories.** These stories included one organization that was able to secure multimillion-dollar funding for an expansion of their child development resource centre as a result of being engaged in accreditation. Another participant said that during the pandemic they were able to switch to an online platform and quickly implement a safety plan with cleaning protocols because the organization already had the infrastructure and a pandemic safety plan as a result of their accreditation work. Participants also described that their organization developed medication management practices from the ground up and are "now leaders in [the] area."

Organizational structure supports reported as successes by interview participants were related to implementing electronic case management and other technology solutions, staff training programs and systems that assist with identifying client needs.

Survey participants also described success stories related to the operations and structure of their organizations, including having accountability structures. Other survey participants mentioned the team building that comes from going through the accreditation process, and the benefits from getting everyone on the same page with a shared vision and understanding of the work. The ongoing learning and awareness building with staff was seen as a success.

> 🗨 *Going through the accreditation process three times in the last 10 years has been a challenge but when you end up accomplishing to meet the standards at the end of the process it gives you a sense of pride and satisfaction knowing that your organization is taking those extra steps to ensure that an organization is doing everything in its ability to provide the best quality of care to the people it serves.*

Success stories shared by organizations who participated in interviews related to **client needs** included clients reporting positive impacts of culture regarding holistic healing, a breastfeeding program that resulted in an increase in breastfeeding incidence and duration, as well as a tobacco reduction program that brought in tradition and culture. Additional examples included an infection prevention control program and the creation of a patient family advisory council.

> 🗨 *As a result of an accreditation recommendation, the organization started a patient family advisory council with eight volunteers from the community that brings the client and patient voice into services and new programs. It has a good cross-section of people, and has been a really good thing for the organization.*

Survey participants also shared success stories related to client needs. Survey participants mentioned being more responsive to client needs and have more awareness of what those needs are as a result of accreditation. One participant stated that their organization now provides 24-hour support. Another participant reported that they are now offering a parenting program and a nutrition program, and that both programs have received significant positive feedback from the community.

Additional significant changes reported by interview participants as a result of being involved in accreditation included an increase in confidence to hold to the standards, increased consistency, an enhanced reputation with referral agents and a vision for the future.

Other significant benefits and successes mentioned by survey participants included increased trusting relationships and collaboration with other health care providers to collectively support clients, staff engaging in self-care practices and maintaining their own health and wellness, and the community having a voice in how health care is provided in the community and the operations of the organization.

Wise and Promising Practices

Wise and promising practices reported by organizations who were interviewed included mentions of **staff engagement and team building** (n = 16, 73%). Participants emphasized the need for constant staff engagement and involving staff at all levels in the organization. Participants described that front-line staff understand the challenges and can help to find innovative solutions to problems. Those that reported this approach also noted that it develops a culture of co-operation and builds knowledge in the leaders of the future. An example of a staff engagement process provided by a participant involved engaging all staff in mapping ethics and aligning them with Accreditation Canada's Required Organizational Practices (ROPs).

Survey participants also mentioned lessons learned related to staff engagement and team building. They described the importance of getting buy-in for accreditation from all staff and management, with one person sharing, "*The faster [accreditation] is embraced and the more people work on it the better the experience will be for the organization.*" One survey participant suggested that buy-in is easier to achieve when staff know why it is important or a priority to achieve accredited status. Related to this, it was mentioned that it is extremely important to have a good accreditation lead who can support staff to understand the importance of accreditation.

Operational structures that support service delivery were also described as a wise practice by participants. These include communicating information about the accreditation process with staff, using social media, providing staff with an accreditation package, using electronic document management and case management systems, having a financial plan related to accreditation and integrating operating standards into day-to-day operations (n = 16, 73%).

When discussing organizational structures, survey participants most frequently spoke about **policies and procedures** (n = 6, 11%). Survey participants stated that it is important to articulate policies and procedures based on what staff are actually doing and to then make changes to policies and procedures based on what will improve quality. One participant stated, "*Remember that it is a blueprint. If it makes sense on paper and it flows well it will be a success in reality.*" Survey participants also stated that it is important to follow the plan, policies and guidelines and to document everything. It was suggested to have regular meetings to keep staff up to date on policies and guidelines and ensure that all staff are included in the review of Accreditation Canada's ROPs. Finally, it was suggested that it is important to have someone who can write up policies and procedures and that experienced staff should provide input into them.

Organizations (n = 13, 59%) also noted the importance of **networking and collaboration**, emphasizing the importance of reaching out to other First Nations involved in accreditation, building a relationship with the accreditor, and building connections with surveyors, mentors, and regional networks (n = 13, 59%).

Some survey participants also mentioned wise practices related to networking and collaboration, including the importance of keeping the lines of communication open with accreditors. It was also mentioned that organizations can learn from the good work done by, and seek support from, other accredited First Nations organizations, and that organizations do not need to "reinvent the wheel."

Regarding **tools and training**, participants identified several areas that can support the accreditation process, such as understanding the continuous improvement process, understanding the change management

process, having financial awareness or competency, and being able to prepare and apply tools such as a self-audit template and a communication and engagement strategy (n = 13, 59%).

One survey participant also noted the importance of development tools to gather data that can contribute to accreditation, and recommended ensuring that the work continues to centre clients and families.

Participants shared their experience regarding **community education and engagement**, offering that sharing the accreditation journey with the community is helpful (n = 10, 45%), stating "*The community has to support the process even if they don't understand it one-hundred percent.*" The importance of including the Chief and Council and other service providers was also described. One participant reported that they were the first organization in the community to successfully pursue accreditation, and other service providers then followed.

Regarding **incorporating a First Nations lens**, participants advocated for increasing awareness of how First Nations programs are run and making culture a priority (n = 8, 36%). An Indigenous accreditation process was suggested, as was the need to balance the "best of the Western model with the best of First Nations culture." Related to this, a number of organizations (n = 7, 32%) reported that accreditation needs to make more room for cultural practices and advocated for an Indigenous accreditation process and greater First Nation representation. The importance of balancing two world views was also described.

Additionally, some survey participants (n = 3, 6%) and organizations that were interviewed (n = 2, 9%) described the importance of **keeping up on the work** and recognizing that it is ongoing. It was stated that it is important to get started early and to keep the momentum going. Participants went on to comment that accreditation is a daily activity and highly recommended not waiting until the last minute to begin. One participant shared that staying engaged in accreditation can help to ensure that it is a smooth process. One participant commented that policies and proposals need to be in place and updated every three to four years.

Other wise practices mentioned by organizations that participated in interviews and survey participants included the following:

- ⇒ Be aware of the resources that are available
- ⇒ Ask for help when you need it
- ⇒ Break down the task into small manageable pieces
- ⇒ Adapt the framework to reflect your organization's ethics
- ⇒ Plan the resources and capacity that you will need to do the work
- ⇒ Have staff focus on an area or department that they are not familiar with to learn more about the organization and strengthen team building by understanding and appreciating what others are doing
- ⇒ Look honestly at gaps and areas for improvement to get the most benefit out of accreditation – use accreditation as a learning opportunity

🎙 *Keep making accreditation part of their daily work, keeping it on their radar, doing the communiques, making sure their accreditation teams are an ongoing team experience and not just around the accreditation survey year of the cycle.*

3.3 Case Studies

The following section highlights the accreditation experiences of three different organizations: Meadow Lake Tribal Council, Dilico Anishnabek Family Care and Adams Lake Indian Band – Sexqeltqin Health & Wellness Centre.

Meadow Lake Tribal Council

Meadow Lake Tribal Council (MLTC) has a humble health team with a powerful story. Located around Meadow Lake, Saskatchewan, MLTC serves nine Nations over a large geographic area. The MLTC Health Team operates a Health Centre and the Mistahay Treatment Centre (MSC), serving about 9,000 band members, including people who are on- and off-reserve.

The motivation to become accredited was to let membership know that the MLTC Health Department, Flying Dust Health Centre, Waterhen Peyakoskan Health Centre and Mistahay Musqua Treatment Centre were meeting or exceeding standards. The MLTC health team received accreditation in 2019, in which they were also the recipients of an accreditation commendation, which is a rare award to receive. The treatment centre is accredited through the Canadian Accreditation Council and the Health Centre is accredited through Accreditation Canada.

To prepare for accreditation, MLTC led a collaborative process to bring everyone along. Every person who works in MLTC health is assigned to an integrated team in order to create diverse perspectives that add value and improve communication. MLTC has nine safety, quality, improvement and risk-management teams, and each team takes responsibility for leading a process area (i.e., client safety or infection prevention control).

Accreditation provided MLTC with a roadmap that connected how the Nations identify their needs, what processes to focus on and how to formalize those processes. The result is both improvement in quality and a way of delivering services that is Nation specific. Accreditation has also helped MLTC strengthen their case in advocating for capital funds for a dental therapy room with Indigenous Services Canada, as well as providing health information to members in Cree and Dene to enhance understanding of health matters.

Following MLTC's lead, two member Nations of MLTC have also engaged in accreditation. As the umbrella organization, MLTC developed policies that each Nation can adopt or adapt so that they do not have to start from the beginning. When Waterhen Lake First Nation received their accreditation, the community came together to celebrate.

Wise practices shared by the MLTC health team included finding ways to make the work practical and part of the day-to-day tasks, recognizing that the work cannot be done in one day, and engaging people in the journey. A number of champions at MLTC helped to maintain energy and focus for this work, and in this same spirit, are ensuring that the capacity to continue this work remains strong.

Meadow Lake Tribal Council

Dilico Anishnabek Family Care

Dilico Anishinabek Family Care (DAFC) is a large organization with over 600 employees that serves 13 First Nations communities in the Robinson Superior treaty area and First Nations people throughout the district of Thunder Bay, Ontario. DAFC provides health services, mental health and addictions services and child welfare, and it also operates an adult residential treatment centre. Both the health program and the residential treatment centre are accredited through Accreditation Canada.

DAFC has said that accreditation is about quality improvement and ensuring safety for clients and staff.

> 🗨 *We are always improving our services by meeting those standards. It's about co-ordination of care and working together as a team. Wrapping our services around a client to ensure they have the best health outcomes. When we talk about continuity of care, that's what accreditation does for us. It helps us to establish stronger teams and better communication.*

DAFC has gone through many cycles of accreditation, and with accreditation, DAFC has seen successful improvements within their organization. One accreditation experience was attended by a surveyor who had expertise in the area of infection prevention and control, and although DAFC was meeting accreditation standards in that area, having access to this expert enabled them to continue to make improvements within the standard. Another success that resulted from accreditation was the use of an electronic medical record system that was a continuous quality improvement initiative. An electronic medical record system automates reminders and alerts, provides one central record that staff have access to and protects the security of clients' personal health information.

> 🗨 *Protecting personal health information helps our clients know that we have respect and compassion for them.*

Now, accreditation is part of staff's everyday work; it is part of their workflow. It is what they do to get the best health outcomes for clients. Following the standards for accreditation ensures that proper safety is in place; for example, having risk management for falls, processes for medication reconciliation, and transfers between services so that people are given information that they need to make decisions and support their own care.

> 🗨 *It's in everything we do, when I talk to staff and teams about accreditation, and I'm asking about a continuous quality improvement initiative, they don't see it as a CQI, it's just a normal part of their everyday work.*

DAFC offered the following wise practices for others going through accreditation:

- Build a relationship with the accreditation co-ordinator and with mentors who you can contact for tips, suggestions and resources.
- Engage your teams and keep it ongoing. *"The survey visit is done, but the survey cycle is never done; its cyclical, it's part of everything that we do."*
- Keep making accreditation part of the daily work and keep it on staff's radar. For example, doing regular communiques.
- Educate clients and partners about accreditation as well. Keep them in the loop even if you don't always refer to it accreditation.

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 the 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.

Adams Lake Indian Band

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.*

Through the accreditation process, SHWC made significant strides in client safety and security, improving 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, the 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.*

3.4 COVID-19 Response

An additional area of interest was hearing how the experience of being accredited impacted organizations' COVID-19 response. 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 their operations were significantly impacted by **COVID-19** because programs had difficulty adapting and continuing service delivery (n = 4, 18%); some also spoke about the difficulty that they experienced trying to **remain open to serve clients** as a result of COVID-19 (n = 7, 32%).

Despite the challenges faced by COVID-19, others described how accreditation supported their organization's response to COVID-19. Specifically, the accreditation process supported:

⇒ Access to safety training
⇒ Safety planning
⇒ Awareness of polices
⇒ Guidelines to safely continue services
⇒ Ease of implementing guidelines around safe operations, infection and prevention control
⇒ Ease of implementing safety procedures like personal protective equipment (i.e., masks, hand sanitizing, plexi-glass protective barriers), social distancing, cleaning protocols and single-use sleeping quarters
⇒ Self-screening systems
⇒ Security systems to gauge numbers of people entering the building

The majority of survey participants **strongly agreed** (n = 20, 39%) and **agreed** (n = 21, 41%) that their organization was better able to respond to the COVID-19 pandemic as a result of participating in accreditation and/or being accredited. Some participants identified that they had a **pandemic plan in place** as a result of accreditation that included emergency shut down policies and infection control policies, and that this improved their response during the pandemic (n = 3, 14%). As a result of predeveloped safety plans, participants reported their response to COVID-19 safety plan development was faster and staff were quick to adapt. It was also noted that previous experience in policy development, working collaboratively with other organizations and adapting practices based on new training and policy development provided the experience needed to adapt during COVID-19. Additional comments were made around the usefulness of safety committees in ensuring COVID-19 standards were met. **Error! R eference source not found.** below illustrates the survey ratings related to COVID-19 preparedness as a result of accreditation.

Figure 19. Survey Ratings: COVID-19 Response Improved as a Result of Accreditation (Number)
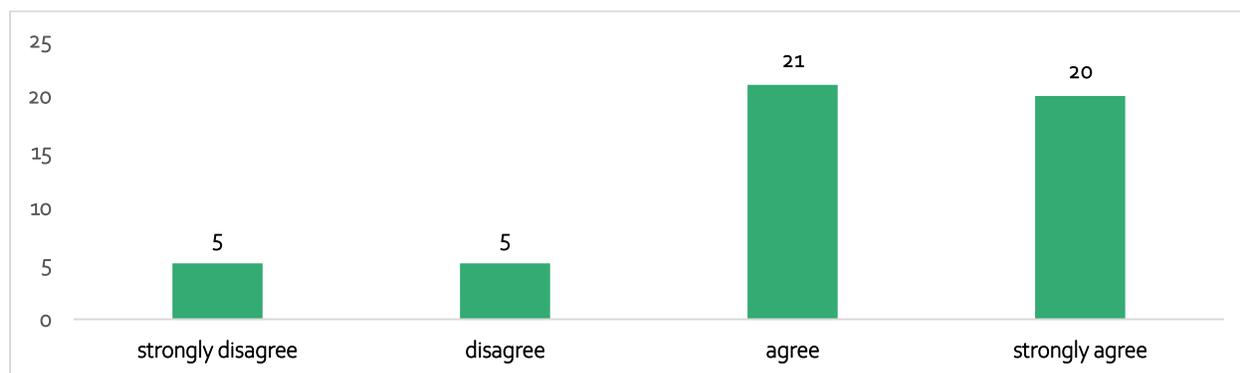
Survey participants were also asked if their organization has used accreditation experiences and processes during the COVID-19 pandemic (i.e., standards, policies, plans, partnerships, etc.) to help provide and support the continuation of services and actions. Areas supported by accreditation during the pandemic are listed in Table 4 below.

Table 4: Services Enabled by Accreditation during COVID-19

Services Enabled by Accreditation	Per cent
Implementing infection prevention and control measures	94%
Accessing health services sites	90%
Providing communication	87%
Utilizing a pandemic and/or emergency plan	83%
Providing services	83%
Accessing traditional medicine and healing	75%
Accessing Tele-Health	72%
Implementing decisions	72%
Ensuring transition of care	66%
Implementing strategic and operation plans	66%
Providing medication management	34%
Other	6%

One participant reported that responding to the pandemic was like "turning a switch on" for staff because of their accreditation, while another spoke about having solid policies in place to respond to COVID-19. Participants shared:

- 🗩 *The part on health and safety for staff and clients – I was surprised at how well we came prepared to address COVID-19 by having gone through a rigorous process of developing a pandemic plan. We had binders and set up how we would handle that kind of a crisis, and then when COVID-19 hit, guess what, it's here. That work was a benefit.*
- 🗩 *Having solid policies in place has allowed us to deal with the COVID-19 pandemic in a more efficient and safer way.*

While many participants reported being able to respond to the pandemic because of accreditation, one participant reported a negative impact from **not being able to work from home** because they were not allowed to bring their laptop off site.

Nelson House Medicine Lodge

4.0 Discussion

The following section discusses the report findings and provides a summary of themes that emerged. It also identifies differences through 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), the province they were located in, or the number of years they have been accredited for.

General Themes that Emerged

A number of themes and similarities emerged across all lenses and from both the interview and survey participants with regard to the impacts that accreditation has either had or contributed to. A brief discussion related to the shared impacts of accreditation described by organizations is provided below.

Organizations shared that accreditation ultimately did support First Nations with self-determination in some capacity, noting increased skills and planning amongst the community, and increased health outcomes for community members. The accreditation process also contributed to informed decision-making, whereby participants noted that accreditation contributed to an increase in planning and policy development and helped to identify community priorities. In the area of autonomy in designing and delivering services, most participants indicated flexibility in addressing areas for improvement to meet community needs as opposed to needing to prescriptively design and deliver services. Participants also shared that accreditation contributed to health advocacy in that it provides organizations with information that was used in negotiation to obtain resources and to assure safety and quality.

In general, participants reported that accreditation supported increased client safety and quality of care. A number of policies and procedures that were created or strengthened as a result of being involved in accreditation helped to increase client safety and quality of care. Training and professional development, as well as the implementation of client feedback systems, were key tools in increasing client safety and quality of care. Fewer organizations reported that accreditation supported increased cultural safety and some noted that cultural safety is not prioritized in the same way as Western knowledge in the accreditation process. Accreditation was also found to support continuity of care, predominantly through improved information sharing and better information management systems.

The majority of organizations found that accreditation did contribute to improved health outcomes in the community, in both tangible and less tangible ways. For example, some participants pointed to specific statistics such as increased number of appointments, immunizations and performance measurement rates. Others stated that although accreditation 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.

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. Because organizations were accredited, participants reported that clients and other service providers trusted them more. For some organizations, this resulted in an increased number of clients accessing services and an increased number of funding and collaboration opportunities. Another unexpected outcome was related to team building and a deeper understanding of roles and responsibilities within organizations. As a result of going through the accreditation process, staff and managers were on the same page in terms of goals, methods and how the work is done. Through increased knowledge and understanding of roles, responsibilities and operations, staff felt more supported and empowered in their own roles.

Analysis Using Different Lenses

In general, few differences in experiences were identified. The lack of difference could in part be explained by the fact that the majority of the organizations we spoke to were located in rural regions and had been accredited for a number of years. Furthermore, although we received a rich amount of

information through the key informant interviews, it may be that we did not have a high enough number of respondents to be able to see differences between provinces. The differences that were identified are described below.

Rural and remote regions more frequently reported that they were required to undergo accreditation in order to continue receiving funding and to demonstrate the value and credibility of their work. Rural and remote regions reported that the accreditation process identified their centres as credible and quality organizations that match national standards. This was reported by both health centres and treatment centres within British Columbia, Saskatchewan and the Atlantic region. Meanwhile, urban centres reported that they gained increased autonomy of innovation with the accreditation 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 safety record keeping. Rural health centres in the Atlantic region and Saskatchewan reported that the accreditation process was at odds with cultural protocols and processes, and did not equitably value cultural knowledge; this was particularly salient in the Western criteria for hiring, which does not hold up the roles of Elders and cultural knowledge holders in cultivating safe space, cultural knowledge and ways of health and healing.

Among urban health centres, challenges with respect to the intention of accreditation were identified. For instance, it was reported that one urban health centre viewed the accreditation process as checking off boxes without meaning, rather than being a process for continual improvement, while another urban health centre reported that there was a culture of fearing weakness, which was a barrier to the accreditation process (i.e., hiding weaknesses rather than embracing weaknesses for improvement).

Treatment centres reported less flexibility during the pandemic, which has impacted access to the program among community members. For instance, some reported that they were unable to work from home during the pandemic, as the accreditation standards did not allow them to bring their laptops off site, while others reported that they were unable to serve clients during the pandemic due to conflicting policies between the Band office and accreditation safety standards. Health centres reported that file systems were more organized and easier to share across the health system because of the accreditation process; more specifically, health centres reported that there is increased consistency among documentation, data that is collected, and software systems used across the health care system, and sharing electronic information between health centres and treatment centres is easier (with client consent).

Rural health centres across Canada reported improved maternal child health, increased rates of child immunizations, and greater awareness of personal health matters (i.e., not procrastinating with health concerns or brushing off health concerns). Additionally, both rural and urban health centres reported increased community pride for the health centre, as well as increased trust with the health system.

Rural health centres in the Prairie and Western provinces frequently reported the process of accreditation was time consuming for the organization and staff who have limited time for additional tasks. Despite the time-consuming nature of accreditation, some health treatment centres reported that the accreditation process led to the development of relationships with their provincial government, and with their accreditors. Finally, rural health and treatment centres explained that the accreditation process led to improvements within their centre, including the improved cleanliness of their centre, better food quality and nutrition, and the establishment of a new department focused solely on quality improvement.

As health and addiction centres dealt with the realities of COVID-19, participants indicated a level of readiness due to the standards in place because of the accreditation process; however, participants from urban and rural areas indicated interruptions in accreditation progress and lack of communication due to the pandemic. Frustrations related to COVID-19 included challenges in staying open to serve clients during this time, as well as frustration with policies that were implemented to adhere to accreditation standards but impeded staff's ability to work from home. Ultimately, survey respondents from across urban and rural

health and addiction centres indicated overall that accreditation allowed their organization to better respond to COVID-19.

Summary

Ultimately, most participants found accreditation to be an impactful experience that resulted in positive outcomes across urban and rural areas, as well as across Canada. Accreditation supported the development and strengthening of policies, processes and procedures, which led to improved client safety, quality of care, continuity of care, and ultimately, improved health outcomes. Engaging in accreditation is a big, ongoing commitment in terms of time and resources, but in general, First Nations health and addictions services reported that it was worth the investment.

Areas of Future Study

Future studies related to the accreditation of First Nations health centres and treatment centres may consider exploring in more depth the challenges and opportunities for improving the accreditation experience. Additional challenges that were identified that could warrant further exploration include:

⇒ The accrediting body's approach when working with an organization
⇒ Redundancies in the process
⇒ Organizational buy-in
⇒ Time commitment and organizational capacity
⇒ Regional differences in terms of support for engaging in and achieving accreditation status and how that impacts the accreditation experience

Appendix A

Key Informant Interview Questions

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

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].
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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]

Case Study

Case study conducted with three organizations in different stages of accreditation.

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?