

# Innovations in accreditation of Aboriginal Community Controlled Health Services

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## Introduction

In this paper we present the Indigenous Accreditation Framework—a piece of work commissioned by the federal government to assist Aboriginal services participate in accreditation. The Framework was intended to streamline instances where services underwent several accreditations.

The paper sets the scene with a background sketch of Aboriginal and Islander Community Controlled Health Services (ACCHS), and a brief scan of accreditation in Australia. It then proceeds to describe the Framework and its recommendations. It concludes with an early reading of the project's impact, although it hesitates to draw firm conclusions pending the rollout of accreditation in ACCHS.

## ACCHS

The comprehensive Aboriginal and Islander Community Controlled Health Service is the central service model for Aboriginal health care. The model first appeared in Australia in the early 1970s and there are now some 151 ACCHS in rural, remote and city locations. Although there are variations in management structures and service mixes, the underlying model is favoured because it:

- gives Aboriginal and Islander people control of their own service
- provides a range of integrated services rather than a single medical service or a fragmented set of specialist services
- deals with population health as well as treatment
- caters to the cultural needs of the service users
- advocates for better conditions, services and rights.

Aboriginal and Islander people have a strong ownership of the service model, notwithstanding serious threats to its survival in the form of funding shortfalls, backlog in capital investment, workforce crises, reporting burdens, and a very low national media profile.

On 20 March 2008, the National Indigenous Health Equality Summit concluded with a formal ceremony at which a *Statement of Intent* was signed by the Prime Minister, the Ministers for Health and Indigenous Affairs, the Opposition leader, and every major Indigenous and non-Indigenous health peak body across Australia.

Among other things, the signatories agreed as a matter of priority:

- To supporting and developing Aboriginal and Torres Strait Islander community-controlled health services in urban, rural and remote areas in order to achieve lasting improvements in Aboriginal and Torres Strait Islander health and wellbeing.

- To respect and promote the rights of Aboriginal and Torres Strait Islander peoples, including by ensuring that health services are available, appropriate, accessible, affordable, and of good quality. (HREOC 2008)

Most ACCHS are funded by the Office of Aboriginal and Torres Strait Islander Health (OATSIH) in the federal Department of Health and Ageing, although many also receive state and territory funding to provide services. ACCHS are represented in the policy arena by the national Aboriginal Community Controlled Health Organisation (NACCHO) and the jurisdictional Affiliates, who also assist with research, training and resource development.

For at least ten years Aboriginal health services themselves, NACCHO, the Affiliates and government considered ways to build capacity in safety and quality among ACCHS. There have been many government and field generated quality initiatives. In 2006, at a Round Table of stakeholders, parties called on government to encourage accreditation in ACCHS, and in particular to choose mainstream accreditation rather than a new and special scheme for the sector. The view was that an Aboriginal community controlled health service-specific accreditation scheme would marginalise Aboriginal services, whereas mainstream accreditation would assure consumers they were getting a standard of service equal to what other Australians were getting.

In 2007, a \$37.5m budget initiative was approved by the then government to support the rollout of accreditation in ACCHS. The initiative covered:

- preliminary research and baseline mapping
- grants to NACCHO and Affiliates to employ accreditation education and development staff
- a panel of consultants (Facilitators) to assist ACCHS to prepare for accreditation
- some resource development
- an Accreditation Support Fund from which ACCHS could apply for accreditation costs including minor works.
- other activities to assist the uptake of accreditation.

## Accreditation

Accreditation of health care services began in the United States in the 1920s initially as a process for university medical faculties to screen training hospitals. In the post Second World War years, the potential for accreditation to improve quality was realised as Deming's Total Quality Management and similar ideas came in to popular use in the manufacturing sector. Accreditation programs emerged which had:

- sets of standards authorised by key stakeholders
- assessment based on the collection and analysis of evidence
- use of self assessment as a way of identifying, targeting and building commitment to improvements.

Contemporary accreditation programs have both compliance and quality improvement elements that work in a complementary way to promote service safety and quality. Compliance enables the service and its stakeholders to plan, measure, and be publicly accountable for performance—confirming achievements and identifying gaps for improvement. The quality improvement elements promote organisational integration, sustainable systems, and a reflective culture that uses data to drive continual improvement.

Although a powerful method, accreditation is but one of many safety and quality processes acting upon service providers including: professional registration, occupational health and safety administration, health regulations, corporations legislation, 'Collaboratives' and other benchmarking programs, performance indicators, program reviews, and government quality initiatives.

In Australia development began on a system of accreditation for hospitals in 1959, leading to the formation of the Australian Council on Healthcare Standards which conducted its first accreditation surveys in 1974. In 1984 the community health movement developed a set of standards resulting in the Community Health Accreditation and Standards Program (CHASP), which in 1997 came under the auspice of the Quality Improvement Council (QIC). At the time of writing, the QIC program was providing accreditation services to some 500 organisations across 30 community based service types in Australia and New Zealand. Australian General Practice Accreditation Limited (AGPAL) was established in 1997 to accredit medical practices using the Royal Australian College of General Practitioners standards—followed by Quality Practice Accreditation (QPA) in 1999<sup>1</sup>.

Other systems such as ISO and the Australian Business Excellence Framework are also used to accredit health services in this country.

## ACCHS accreditation

Accreditation arrangements in Australia tend to be organised around the main service platforms of health care: hospitals, general practitioners, non-bed based health and community services, pathology laboratories, diagnostic imaging etc. These boundaries were anathema to ACCHS which typically include a GP clinic as well as nurses, allied health, aboriginal health workers and general staff. So where ACCHS were comprehensive and integrated in the services they provided, accreditation was more narrowly focused. The medical practice was subject to AGPAL or QPA accreditation while the other services and infrastructure required a more comprehensive and overarching framework such as QIC. Each accrediting body and program of course has its own unique history, auspicing arrangements, conceptual underpinnings, and assessment methodology.

Research conducted by State and Territory Affiliates in 2008, showed that between a third and a half of ACCHS participate in a GP accreditation program for their medical practice, but only a small handful were engaged in accreditation for their non-medical services (OATSIH 2008). Services gave priority to GP accreditation because in a medical service, clinical risk was seen as more serious, and because GP accreditation attracted a substantial Practice Incentive Payment (PIP) grant from the federal government. Accreditation for non-medical services does not attract such a grant.

OATSIH commissioned the Aboriginal Health Cooperative Research Centre (AHCRC) to research the key difficulties facing organisations participating in accreditation. The CRC found:

Preparation time and paperwork particularly affected those undertaking it for the first time but was still reported as a major issue for services undertaking reaccreditation. Services reported being unaware of the workload and how time consuming it is. (CRAH 2008 p12.)

This was compounded when more than one accreditation system was involved:

Duplication of accreditation is confusing for staff. Standards are repetitive, they overlap, are disjointed and miss vital aspects of PHC services. (CRAH 2008 p13.)

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<sup>1</sup> A comparison between accreditation programs may be found in ISQua/WHO 2003 and Skok 2000.

The CRC also found a perception among ACCHS that accreditation bodies do not understand the distinctive nature of ACCHS—especially their adherence to an interdisciplinary primary care model, with strong community engagement, employment of Indigenous health workers, and service models that reflect Indigenous health practice. The CRCAH paper reported that standards commonly lacked reference:

...to community control, team work approach, recognition and inclusion of local initiatives... Specific to the Boards are issues around their role as being from and nominated by the community as well as being consumers.

(CRCAH 2008 p14.)

There is also a frequently expressed view that accreditation bodies design their products and processes for mainstream professional white usage. This is experienced by Indigenous services as unresponsive and insensitive to cultural values.

The CRCAH paper concluded:

A third of services thought the Accreditor's understanding of ACCHO is an issue. There is a lack of accreditation surveyors who have the necessary experience working in a CPHC environment within an ACCHO and of the Aboriginal cultural context. (CRCAH 2008 p13.)

Cultural appropriateness can include an understanding of the needs, history, language, beliefs, practices and relationships in Indigenous communities.

## Indigenous Accreditation Framework

In 2007, OATSIH commissioned an Indigenous Accreditation Framework to suggest some ways of streamlining multiple accreditation. The Framework project, undertaken by the Quality Improvement Council (QIC) produced a set of goals, a plan for recognising standards overlap, a set of procedures for harmonising assessment between accreditation programs, and an evaluation scheme.

The goals addressed the three main accreditation problem areas revealed by the research:

Goal 1 Technically streamline standards and accreditation procedures (Workload and duplication)

Goal 2 Make accreditation more responsive to the needs including the cultural needs of participating organisations and practices (Responsiveness of accreditation bodies)

Goal 3 Support integration of quality improvement (Fragmentation of quality improvement between the medical clinic and other parts of the ACCHS).

QIC mapped QIC standards and those of the Royal Australian College of General Practitioners against a set of ACCHS 'domains'<sup>2</sup> or functions and was able to show substantial overlap between standards concerned with human resource management, health information, and physical resources (both premises and equipment). Subject to ongoing negotiations between the College and QIC, this finding opens the way to some possible exemptions in the assessment process.

Where there was low to moderate overlap between the two sets of standards, the mapping exercise provides a guide to more efficient evidence collection, which should reduce the assessment workload.

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<sup>2</sup> The domains were devised by the CRCAH and reported in CRCAH 2008.

QIC also reached agreement with the GP accreditation providers regarding procedures by which the GP and QIC assessment bodies could collaborate for efficiency and integration of quality improvement. Points of collaboration were found in relation to:

1. Provision of information to the ACCHO by the accreditors about the accreditation program/s
2. Internal management of accreditation requirements
3. Planning of the assessment
4. Surveyor/reviewer training
5. Timing and scheduling of surveys/reviews
6. Feedback session
7. Report preparation.

This suite of collaboration points has since been used to streamline concurrent accreditation survey by AGPAL and QIC in a Queensland ACCHS (see later in this paper).

In addition to the standards mapping, and rationalisation of assessment procedures, the QIC Indigenous Accreditation Framework included recommendations for building a clearer, more sustainable accreditation system for ACCHS which included:

- a user-friendly on-line manual for ACCHS concerning accreditation
- encouragement to government to ensure clarity of roles and responsibilities between support bodies
- development of a cohort of quality improvement leaders and champions in the ACCHS sector
- training of reviewers and surveyors in cultural sensitivity
- an evaluation of the roll-out of accreditation among ACCHS so that stakeholders could continually improve the roll-out strategies.

The Framework was submitted to the Office of Aboriginal and Torres Strait Islander Health (OATSIH) in mid October 2008, with the support of a Steering Committee established to oversee this and other associated reports and known as the Indigenous Services Accreditation Advisory Committee (IHSAAC) which represented the key stakeholders.

## **Implementing the Framework**

Following receipt of the Framework, OATSIH moved to implement a range of actions including both those recommended by the CRCAH and also those made QIC.

OATSIH took up QIC's suggestion of an accreditation manual for ACCHS, and commissioned the Royal Australian College of General Practitioners (RACGP) and QIC to develop interpretive guides to their standards designed especially for ACCHS. This work will be completed in 2009.

OATSIH also convened a national workshop of support bodies to clarify roles. The workshop, held in mid November 2008, brought together: accreditation bodies, assessment bodies, standards owners, ACCHS

state and national peak bodies and Facilitators (consultants hired by OATSIH to help ACCHS prepare for accreditation). The workshop promoted effective working relationships and greater role clarity.

Evaluators were appointed by OATSIH to monitor and analyse the accreditation rollout. They have commenced observing the process, and their findings will contribute to the 'fine tuning' of the rollout.

In late November 2008, Goondir Aboriginal Health Service in Dalby, south east Queensland became the first ACCHS to be assessed under both the RACGP and QIC standards concurrently, using the Accreditation Framework guidelines. The two assessment bodies: Institute for Healthy Communities Australia (IHCA—QIC's licensed provider) and AGPAL planned and scheduled the assessment cooperatively, shared information and met on-site at the conclusion of their assessments to compare findings (which were consistent). It should be noted that at the time of the combined review, consideration by the RACGP the Framework's proposals for mutual recognition of standards had not progressed far. It was therefore not possible to test the impact of these proposals in the Goondir review.

The findings of the independent evaluator were yet to be finalised at the time of writing however they showed that Goondir management and staff thought coordinated procedures had eased the burden of dual accreditation, while providing some important suggestions for improvements. The evaluator also observed that communication between the assessment bodies from the planning stage through to the assessment week itself had improved clarity, consistency and efficiency for all parties. Due to difficulties in coordinating assessment timing, concurrent assessment might be the 'gold standard' to be achieved over time. It is likely that in the short to medium term, RACGP and QIC assessments will occur 6-9 months apart with assessment bodies working together to promote consistent communication and efficient assessment procedures using the Framework developed in this project.

## Conclusions

As the burden of reporting and accreditation assessment grows for government funded health and community services, innovative solutions are emerging. Some health services face two separate accreditation systems because they have both GP and allied health programs. Aboriginal Community Controlled Health Services will routinely have to deal with this problem, as government encourages the services to engage with accreditation. This paper describes some attempts to make accreditation (especially where there are multiple systems) more efficient, more culturally responsive and more likely to lead to sustainable and integrated quality improvement.

The process of research and development of the Indigenous Accreditation Framework has enabled accreditation and assessment bodies, peak organisations and government to work closely to support these reforms. As accreditation rollout moves into its more active phase, it is essential that adjustments continue to be made in order to build and maintain integrity in the system, and where possible those reforms be based on rigorous evaluation and monitoring.

## Abbreviations

ACCHO	Aboriginal Community Controlled Health Organisation
ACCHS	Aboriginal Community Controlled Health Service (term used interchangeably with ACCHO)
AGPAL	Australian General Practice Accreditation Limited (GP practice accreditation body)
CHASP	Community Health Accreditation and Standards Program (predecessor to QIC)
CPHC	Community Primary Health Centre (term used interchangeably with ACCHO and ACCHS)

CRCAH	Cooperative Research Centre for Aboriginal Health
IHCA	Institute for Healthy Communities Australia Limited (licensed provider of the QIC accreditation program for Queensland and Northern Territory)
ISQua	International Society for Quality in Healthcare
NACCHO	National Aboriginal Community Controlled Health Organisation (national peak body for ACCHS)
OATSIH	Office of Aboriginal and Torres Strait Islander Health, federal Department of Health and Ageing
PIP	Practice Incentive Payment
QIC	Quality Improvement Council
QPA	Quality Practice Accreditation (GP practice accreditation body)
RACGP	Royal Australian College of General Practitioners
WHO	World Health Organisation

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## Presenter

**Steve Einfeld** has been the Executive Director of the Quality Improvement Council (QIC) since 2001. Prior to that, he managed a community health centre, was the founding Director of the Victorian Social and Community Services Industry Training Board, and CEO of an employment services agency. QIC has accredited community-based health services for over twenty years, some 150 in rural and remote areas in Australia and New Zealand. Its processes are accredited by the International Society for Quality in Health Care. 500 organisations are in the program across thirty service types. Steve has undertaken a range of consultancies associated with QIC's work, designing and evaluating quality improvement systems. In 2004 he was commissioned to write a standard on community engagement for the World Health Organization. He has recently completed an Indigenous Health Accreditation Framework for the federal government.