Models for a Voluntary Accreditation System for Companion Animal Shelters

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Summary:

Companion animal shelters operate with little or no state or federal oversight. They are not included in the protections offered by the Animal Welfare Act, leaving state anti-cruelty laws to act as a crude measure of minimum standards of care. Voluntary accreditation systems are established and successful in a variety of fields, but a similar model has not yet been implemented for companion animal shelters. A movement has developed within the veterinary community towards standardizing care and practices in companion animal shelters and the Association of Shelter Veterinarians (ASV) released a comprehensive list of guidelines for shelters in 2011. Since their release, a number of shelters have utilized them in an effort to examine the quality of their operations. The establishment of a high-quality accreditation program for companion animal shelters could serve to evaluate, standardize and improve the care of animals in shelters across the country. Accreditation would also assist the public in identifying shelters of high quality from which to adopt animals, make donations of goods and dollars and volunteer their time. Additionally, such a system could serve as a useful tool for funding sources seeking to direct their grants to programs of high quality. Ultimately, under-performing shelters that proved to be pervasively resistant to the implementation of improvements to meet basic standards would receive less support and funding while shelters that were committed to improving their practices would be the focus of support and funds.

Introduction:

Animal shelters were originally developed for the purpose of short term housing of stray livestock, which was often reclaimed because of its inherent economic value (Zowistowski & Morris, 2004). Years later, pounds became a housing facility for stray dogs and

cats. "However, the shelter's primary role was not to provide humane care and treatment of the animals but to provide public safety and to protect private property rights" (Miller, 2007). Shelters were initially developed for short term housing, making quality of care and shelter standards less important. As progress is being made nationwide to reduce dog and cat overpopulation, more and more animals are spending longer periods of time in shelters (Nolan, 2011). These longer stays increase health risks while housing, enrichment and staff training become more relevant (Loveless, 2011; Steneroden, Hill, Salman, 2010; Edinboro, Janowitz & Guptill-Yoran, 1999). Animals held as evidence for court cases can face lengthy holding periods while animals in a sanctuary environment will likely remain there for life. The sum of these factors greatly increases the significance of quality of care and the need for shelter regulation and standardization.

Companion animal shelters initially emerged in response to the needs of individual communities, resulting in a disjointed and unorganized network (ASPCA, 2010). Fewer than half of the states have regulations addressing animal shelters and these are limited to eighteen states which require licensure of shelters and 6 requiring advisory boards to be in place (Newbury et al, 2010). Thus, in many states, state anti-cruelty statutes, which are only relevant in cases of egregious welfare, are the only legal safeguards. Furthermore, companion animal shelters are exempt from protections under the Animal Welfare Act (ASPCA, 2006; Newbury et al, 2010). The impact of this lack of oversight is exacerbated by the diversity of providers and organizations. Today's sheltering community ranges from independent rescuers, foster home networks, sanctuaries, open-admission shelters, limited admission shelters and more. Some are firmly established, well organized and well funded, while others are more loosely organized and operate with fewer guidelines (Newbury et al, 2010; Miller, 2007). Staff and volunteer training

and education, resources, husbandry, veterinary care and standards may be significantly different among these different systems and organizations. With estimates ranging between 6 to 8 million companion animals in US shelters every year, the impact of this lack of quality control and oversight can be quite significant (HSUS, 2013).

Clearly, the purpose of animal shelters has shifted significantly since they were first established. Today, communities are increasingly seeing shelters as community resources for outreach and partnership activities – as well as a resource for family pets. Shelter improvements have been and continue to be an integral tool in the movement to change the face and reputation of the nation's animal shelters (Zawistowski & Morris, 2004). "The way society views homeless animals and the care they should receive in shelters has . . . shifted" (Miller, 2007). This shift is evidenced in the "extensive guidelines and/or codes of ethics issued by trade organizations, regulatory bodies, advisory boards and policy-making agencies for animals in almost every conceivable setting except animal shelters" (Newbury et al, 2010). Care and concern for the welfare of homeless animals in the community is further evidenced by movements in communities such as Hillsborough County, Florida, where a grassroots coalition led the charge for change in their community's animal control organization in response to high euthanasia rates for shelter pets and feral cats (Hamilton, 2010).

Many industries similarly lack formal regulation but have established voluntary participation in a rigorous accreditation program. A movement has developed within the veterinary community towards standardizing care and practices in companion animal shelters and the Association of Shelter Veterinarians (ASV) released a comprehensive list of guidelines for shelters in 2011. However, an accreditation scheme for companion animal shelters has not followed.

Evidence exists that the achievement of accreditation by an organization has a positive impact on the organization's outcomes. Quality external audit or accreditation can augment an organizations ability to improve (Woodhouse, 2003) and has been shown to result in staff perceptions of improved service provision once accreditation is awarded (El-Jardali et al, 2008). In an education setting, implementing curriculum requirements in anticipation of an accreditation process seems to influence positive changes in faculty culture and curricula – with likely positive impacts on student learning (Prados, Peterson & Lattuca, 2005). Statistically significant differences were noted on several dimensions related to quality of work life for staff, job commitment, innovativeness and goal consensus between early childhood centers that were accredited versus those that were not, which has clear implications for quality of services rendered (Bloom, 2010). Furthermore, accreditation – rather than internal inspections or assessments – allows for improvement and accountability because institutions must respond to criticism or suggestions given, suggesting that accreditation is a more dynamic and impactful approach to assessment than simple inspection (Lubinescu, Ratcliff & Gaffney, 2001). The impacts of the accreditation process and the awarding of accreditation on an organization and its staff can produce improved environments and processes, and may be useful when applied to companion animal shelters.

The establishment of a high-quality accreditation program for companion animal shelters could serve to evaluate, standardize and improve the care of animals in shelters across the country. Accreditation would also assist the public in identifying shelters of high quality from which to adopt animals, make donations of goods and dollars and volunteer their time. Additionally, such a system could serve as a useful tool for funding sources seeking to direct their grants to programs of high quality.

In order to better understand the potential for a voluntary accreditation scheme for companion animal shelters, an examination of the etiology, implementation, maintenance funding, governance, organization, benefits and shortcomings of existing accreditation systems from a variety of fields was completed. The following successful voluntary accreditation programs were examined via a comprehensive literature review: the American Animal Hospital Association (AAHA), the National Association for the Education of Young Children (NAEYC), The Joint Commission (TJC), the International Organization for Standardization (ISO) and the Association for Assessment and Accreditation of Laboratory Animal Care (AAALAC). Each scheme was evaluated as described above with the intent of understanding the reasons that accreditation for companion animal shelters does not exist at present as well as identifying possible avenues for policy implementation.

Methods:

A comprehensive literature search of accreditation schemes in general was completed in order to compile an inclusive list of the qualities of successful existing accreditation schemes. Criteria were then selected if they were verifiable and recommended by at least one published source. Sources reviewed included: scholarly journals, industry websites, organizational materials, interviews with representatives from the accrediting body and recipients of accreditation as well as media publications. The criteria were then used to examine each scheme.

Analysis Criteria

Analysis criteria were selected in order to garner an understanding of the cultural, political or economic zeitgeist that allowed or encouraged the genesis of the accreditation scheme as well as the context under which the program was able to persist and flourish. Additional criteria were selected as a result of being outlined in the literature as key factors of successful accreditation programs.

Important features of a successful accreditation scheme include a clear mission statement, involving a wide range of stakeholders in the design, implementation and governance of the program and establishing accreditation standards that exceed those required for licensure while simultaneously encouraging development and improving quality of operations (The International Society for Quality in Health Care, 2004; World Bank Group Multilateral Investment Guarantee Agency, 2004). Additional important factors include, basing accreditation criteria on written and published standards, securing sustainable funding sources, and administering the accreditation process by an independent body with reviews conducted by professional peers. Finally, also significant is the presence of periodic re-evaluations – typically every 2-3 years with interim reporting and monitoring, regular review and revision of standard and that accreditation be voluntary and supplemental to any existing governmental licensure (Health Systems Resource Centre, 2003; Forum of Australian Health Professions Council, 2011; Baker et al, 2007). After consolidating the recommended criteria, the following criteria were used to evaluate each of the schemes.

- Who founded the program and why.
- How the program evolved into a full accreditation scheme.
- What were the original sources of funding? What are they today?
- How or why has the scheme persisted?

- How does the accrediting organization maintain status as a relevant industry leader?
- What are the costs for an organization to participate in the accreditation review process?
- Who from the organization under review is involved in the accreditation process?
- According to stakeholders and/or the organization being accredited – what are the benefits or purpose of accreditation?
- How visible is accreditation to the public or target audience?

Results:

Accreditation Schemes

See Table 1

American Animal Hospital Association

The American Animal Hospital Association (AAHA) was founded in 1933 by seven leaders in the veterinary profession that were interested in helping develop and promote high quality practices and standards (American Animal Hospital Association, 2013). People were returning from WWII and animals were moving from the farm to the bedroom; companion animal veterinary medicine was an emerging sector and the founders recognized that there was a need for better methods and facilities, ultimately culminating in the development of AAHA. Veterinarians began to recognize the emerging importance of companion animals and that clients were willing to pay a fee for their services, but demanded well-rounded patient care (K. Spencer, personal communication, July 22, 2013). Today, AAHA's mission is "to enhance the ability of veterinarians to provide quality care to companion animals, enable veterinarians to successfully conduct their practices and have high quality care facilities and to meet the public's needs as they

relate to the delivery of small animal veterinary medicine." More than 3,200 veterinary hospitals are AAHA accredited today (American Animal Hospital Association, 2013; American Animal Hospital Association, 2011).

AAHA saw a rapid increase in membership and member services in the 1960's and early 1970's and became more relevant during this time by adding features above and beyond accreditation (Foreman, 2013). Educational programs and publications for veterinarians and vet technician position statements, research and collaborations with other leading organizations helped cement AAHA's reputation as a leader in best practices and thought leadership for the international veterinary community (American Animal Hospital Association, 2013; K. Spencer, personal communication, July 22, 2013; Foreman, 2013) .

In the beginning of AAHA's existence, the accreditation process was run by volunteer veterinarians that traveled upwards of 25,000 miles per year to visit and evaluate practices. Membership fees were $60 per year and then reduced to $30 per year as a result of a poor economy. AAHA did not have any paid staff until 1960 and today generates revenue and supports itself through fees and services. (K. Spencer, personal communication, July 22, 2013). Today, AAHA dues are $920 per year and re-accreditation is conducted every 3 years.

AAHA has persisted in part because their heavy focus on the veterinarian – client relationship made AAHA's practices and accreditation very useful. In addition, AAHA's accreditation process, by design, involves all employees of the animal hospital and incorporates team-building into the process. This contributes to a more cohesive veterinary practice and staff buy-in to high standards. (K. Spencer, personal communication, July 22, 2013). Today, AAHA is internationally respected as a leader in professional development, accreditation of hospitals and

high quality educational programs for vets and veterinary staff (American Animal Hospital Association, 2013).

AAHA's standards are reviewed and revised as needed by a board of directors and various committees and advisory groups to ensure that they are in line with developments in veterinary medicine and AAHA's team philosophy. The standards have been revised numerous times since 1933. (American Animal Hospital Association, 2013; K. Spencer, personal communication, July 22, 2013).

The accreditation process is purposely designed to be a team process and involves all employees of the veterinary practice. Every aspect of each person's job is examined, self-evaluations are completed and any changes to the team's approach are recommended by the evaluator. The accreditation process requires a significant amount of time and dedication from the staff, and this is a significant hurdle to overcome. There are over 900 standards that are examined in the course of accreditation and the full process spans one to three months, culminating in a day's visit from the accreditor (Foreman, 2007). The process can reportedly feel invasive and time consuming (K. Spencer, personal communication, July 22, 2013). Staff report benefits some of the benefits of accreditation to be access to educational events, medical journals and products to help improve the practice and care. A significant focus of AAHA's accreditation is geared towards helping hospital managers become more efficient and the practice more successful while the veterinarians and veterinary technicians are exposed to improved medical practices and policies. The entire practice is revitalized and motivated as they learn how to best communicate, interact and collaborate with clients (Foreman, 2007). The ultimate goal of accreditation is for the practice to improve as a whole, making the practice a more client-focused place, a better and more attractive place for current and prospective staff members and a better

provider of care to animals as the practice commits to the best standards of practice in veterinary medical care and business. (Foreman 2007, American Animal Hospital Association, 2013; K. Spencer, personal communication, July 22, 2013).

Despite all of the benefits of accreditation, only about 12% of US and Canadian veterinary hospitals are accredited (American Animal Hospital Association, 2013). The low rate of accreditation is due in part to the fact that AAHA accreditation is not well recognized by the public (K. Spencer, personal communication, July 22, 2013). Once accredited, hospitals have access to the AAHA logo and promotional materials and a plaque is often placed on the building and the logo on the website and stationery. Additionally, the organization is listed in AAHA's database of accredited facilities. It is likely that animal owners benefit from the practices, policies and standards that are part of AAHA accreditation – even if they are not aware of them or of AAHA. AAHA accreditation may be most relevant and recognizable within the industry, resulting in recognition by peers and staff (Foreman, 2007).

Parts of Canada as well as the state of Louisiana accept AAHA accreditation in lieu of state inspections. Inspection standards differ from state to state, but AAHA has recently been recognized as a useful tool for state inspectors as AAHA provides standardization across the board and across state lines. (K. Spencer, personal communication, July 22, 2013).

The National Association for the Education of Young Children

The National Association for Nursery Education (NANE) was incorporated in 1931, later becoming the National Association for the Education of Young Children (NAEYC) in 1964. NAEYC's mission today is "to serve and act on behalf of the needs, rights and well-being of all

young children with primary focus on the provision of educational and developmental services and resources" (The National Association for the Education of Young Children, 2013).

NANE, comprised of professional researchers and educators, began licensing nurseries at the state and local level in the early 1930's, but there was little consistency or enforcement. In 1933 the federal government established a national preschool program via the Works Progress Administration and by 1935 there were more than 2,000 WPA nursery schools serving more than 72,000 children. This provided NANE with an opportunity to push for preschool programming to be extended across the US and began discussions about best practices and techniques while concurrently a group of 25 multidisciplinary leaders reorganized NANE as NAEYC. The US was involved in WWII in 1941, resulting in a rapid development in early childhood programming nationwide. The government became even more involved in funding daycare when congress appropriated funds to keep WPA nurseries open for women involved in the war effort. In 1962, federal child care assistance became available for working mothers receiving welfare benefits and interest in research on the use of child care by working mothers developed in the 50's and 60's (Copple & Thompson, 2001).

In the 1960's NAEYC was able to become much more active in policy issues as a result of federal involvement in early education and the advent of Head Start Programming for young children. The 60's, 70's and 80's saw increasing governmental involvement in daycare and preschool services. Executive staff at NAEYC took advantage of this opportunity and regularly met with the director of the Office of Child Development to provide guidance and advice while also collaborating with the National Council for Accreditation of Teacher Educators. NAEYC firmly established itself as the leader in early childhood education. In 1981, the NAEYC accreditation system was born of concerns from its Governing Board about the quality of the

now large number of early childhood programs that had no regulation and that research funded by the federal government supported the significance of quality early childhood education (Copple & Thompson, 2001). By 1985, NAEYC fully launched its national voluntary accreditation project in response to the large number of families seeking child care and preschool programs as well as the concern about the quality of those services. (The National Association for the Education of Young Children, 2013) Significant public and governmental interest in quality early childhood education and care persisted in the 1980's and 90's and in 1997 President Clinton announced 21.7 billion in spending on child care initiatives over the next 5 years (Copple & Thompson, 2001).

NAEYC remains relevant and influential today by publishing journals and books, holding conferences for practitioners, policy makers, teachers and educators, and publishing policy positions and contributing to policy discussions. Since its founding and even more so today, NAEYC is seen as a leading voice in Congress and in state capitols regarding the needs of early childhood programs and young children (Copple & Thompson, 2001; The National Association for the Education of Young Children, 2013). NAEYC's collaboration leads the ever-evolving shape of early childhood education in the United States, an example being a 2003 summit that invited all stakeholders to participate in a discussion about the future of NAEYC's role and accreditation system with the intent of maintaining NAEYC's position as the standard bearer for program excellence and developing new early childhood program standards and accreditation criteria (Goffin, 2003; Goffin, 2003; Goffin, 2003). In 1995 NAEYC hosted a think tank to review their accreditation system and plan for the future (Copple & Thompson, 2001). In 1999 the Governing Board created a National Commission on Accreditation Reinvention and came up with 10 recommendations to strengthen the reliability and accountability of NAEYC

accreditation and in 2003, NAEYC implemented the fruits of a project initiated in 2001 to reinvent its accreditation system (The National Association for the Education of Young Children, 2013).

Today, NAEYC's membership exceeds 80,000, but the bulk of the organization's funding comes not from fee revenue but from major grantors such as the Carnegie Corporation of New York, the Robert R. McCormick Tribune Foundation, the Annie E Casey Foundation and The Joyce Foundation (National Association for the Education of Young Children, 2013). Initial funding sources were much more modest and NAEYC was initially funded by $4,000 from the Edith Lauer Fund in 1959. In the 1960's, The Grant Foundation and contributions from the family and friends of Rose Alschuler, one of the founding members, funded the development work for the first set of NAEYC guidelines for accreditation (National Association for the Education of Young Children, 2013).

One of NAEYC's current revenue sources is the candidacy fee, which allows a center to access the materials necessary to begin the accreditation process. For an average size organization serving about 100 children would be approximately $600 (K. Pesek, personal communication, July 13, 2013). Many secondary additional expenses present as a result of accreditation: teachers must have certain qualifications making them more expensive hires (K. Pesek, personal communication, July 13, 2013). NAEYC accreditation can come with some significant unexpected expenses as NAEYC requires that insurance benefits be offered to all teachers and stipulates specific facility and environmental requirements that many facilities need to add (K. Pesek, personal communication, July 13, 2013). The accreditation process can take months to complete and requires significant involvement from each of the teachers in the form of documentation and defensible curriculums. (K. Pesek, personal communication, July 13, 2013).

The accreditation process often involves discussions with parents of the children being served and provides a unique opportunity to involve and educate them. Indeed, the program administrator, staff, parents and other involved parties are parties in the accreditation process (Flis, 2002). One of the benefits of accreditation is that staff skills are improved and often become more child and family focused, while less motivated and less committed teachers may resign rather than complete the numerous tasks required for accreditation (K. Pesek, personal communication, July 13, 2013). One administrator noted that completing the accreditation process and being awarded accreditation "boosted staff morale . . . (and) brought us a new level of professionalism. Teachers learned a lot and were able to put it forth in the classroom" (Flis, 2002). Most significantly, some funders look for NAEYC accreditation and feel that it is a mark of quality that not every early childhood program can achieve and are more likely to grant funds to an accredited program. (K. Pesek, personal communication, July 13, 2013).

Some parents demand NAEYC accreditation in an early childhood program for their children and some funders will not consider granting money to a program that is not accredited. NAEYC accreditation is seen as a mark of excellence in early childhood programming, and facilities that win accreditation are given the NAEYC logo for use on correspondence and banners to announce their accreditation. The physical indication of accreditation via banners and signage featuring the NAEYC logo can be quite obvious but may not be understood by all parents and community members, but is often very influential when it comes to funding sources. NAEYC accreditation may also increase reimbursement levels. For example, Chicago Public Schools' base reimbursement rate is $2,000 per eligible student per year, but if an organization is NAEYC accredited that is boosted to $6,000 per year. (K. Pesek, personal communication, July 13, 2013). Additionally, accreditation also results in valuable institutional recognition of the

program's value, which has implications for the pool of job candidates and program status. (Hyson et al, 2009).

The accreditation process can help facilitate valuable links and relationships build on resource sharing between programs. It also helps individual programs develop technical expertise and model professional conduct. New insights are developed, new challenges explored and the program quality is improved for children and families (Flis, 2002). Today, more than 10,000 NAEYC accredited programs serve more than 1 million children (National Association for the Education of Young Children, 2013). Organizations awarded accredited statuses provide annual reports to NAEYC and undergo reaccreditation every 3 years. (K. Pesek, personal communication, July 13, 2013).

The Joint Commission

In 1910, the Council on Medical Education of the American Medical Association published a study commissioned by the Carnegie Foundation for the Advancement of Teaching (Jurkiewicz, 1988). This study exposed what became known as "diploma mills" within the medical education field, which in turn lead to a vast reformation of undergraduate medical education. At the same time, standardization of surgeons was being discussed and the idea of an American College of Surgeons was simultaneously born in 1913. These two events lead to the study of hospitals in North America (Jurkiewicz, 1988). Dr. Allen Kanavel, one of the College's initial members, suggested "some system of standardization of hospital equipment and hospital work be developed to the end that those institutions having the highest standards may have proper recognition before the profession, and those of inferior equipment and standards should

be stimulated to raise the quality of their work. In this way, patients will receive the best type of treatment and the public will have some means of recognizing those institutions devoted to the highest ideals of medicine" (Jurkiewicz, 1988). Ultimately, ACS would undertake development of the hospital accreditation system in order to document treatment outcomes at different institutions so that comparisons could be made and interested parties could begin to examine management and efficiency (Jurkiewicz, 1988).

This study gave birth to the development of "Minimum Standards for Hospitals" in 1917, with support from The Carnegie Foundation with on-site inspections beginning in 1918. In that first year, 671 hospitals were evaluated and only 89 met requirements. ACS released these statistics anonymously, which raised awareness of the need for standardization and accreditation within the American medical community. In turn, the medical community supported ACS accreditation as a way to maintain and improve quality of care. By 1951, more than 3,000 facilities were successfully accredited. (The Joint Commission, 2012; Duffy. 1988). The benefits of the program were quickly recognized and hospitals struggled to upgrade conditions and improve service quality thus increasing the number of facilities seeking and achieving accreditation each year, which in turn attracted additional funding support. (Jurkiewicz, 1988)

Eventually, the accreditation process became too large and too popular for ACS to operate on their own. So, in 1951, ACS collaborated with other national professional organizations and formed The Joint Commission on Accreditation of Hospitals, which later became known as The Joint Commission (TJC) (Duffy,1988). The current mission is "To continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective

care of the highest quality and value" and their vision is "All people always experience the safest, highest quality, best-value health care across all settings." In 2012, TJC reached 20,000 members. (The Joint Commission, 2012; The Joint Commission, 2012).

As the fields of healthcare grew, so did TJC. As a result of widespread acceptance of TJC's accreditation practices for hospitals, TJC began in 1965 to accredit a wide variety of areas of care other than hospitals including areas such as ambulatory care programs, drug abuse and rehabilitation facilities, hospices, long-term care and psychiatric facilities (Hyson et al, 2009; Curran-Ostrow, 1983). Today, TJC also provides educational materials, national and international seminars and conferences, publishes standards and manuals for accreditation, as well as guides geared towards patients, hospitals and health care providers. They publish position statements on practices (e.g. solutions for improving hands-off communications) and tools for providers (e.g. online application for accredited organizations that help simplify the process for solving persistent issues like improving hand hygiene) and consumers (e.g. "Speak Up" video series – designed to encourage active participation in health care). TJC has also developed a consultative arm in 1986 called Quality Healthcare Resources, which serves to expand their reach acts as an additional revenue stream. (The Joint Commission, 2012; Duffy, 1988; Copple & Thompson, 2001).

Initial funding for ACS in 1915 was a mere $500, which was earmarked for the development of their first list of standards. In 1917, ACS received a grant from The Carnegie Foundation and published a one page list of requirements for accreditation (Duffy, 1988; Jurkiewicz, 1988). By 1951, The American College of Physicians, The American Hospital Association, The American Medical Association and the Canadian Medical Association joined with ACS as members, providing the capital and political support needed to create The Joint

Commission on Accreditation of Hospitals. The American Dental Association followed in 1979. The Commission began charging for surveys in 1964 (The Joint Commission, 2012).

Through training, evaluations, publications and campaigns, TJC consistently involves multiple stakeholders (government, health care providers and staff, hospital administrators, consumers and leaders from member organizations) in its efforts, thereby ensuring that they remain relevant and integral to all stakeholders (The Joint Commission, 2012). Furthermore, TJC's standards are agreed upon nationally by health professionals, and are constantly being revised and updated to ensure that they remain current and cutting-edge (Duffy. 1988; The Joint Commission, 2012).

The cost of accreditation varies widely and depends on a multitude of factors, including the size of the organization, number of employees and number of locations. Accreditation and fees for the 3 year accreditation period for a small organization would total approximately $8,000 and the process leading up to and including the accreditation site visit typically takes 4-6 months and requires a significant amount of work from all employees of the organization (The Joint Commission, 2013).

While cost and time are drawbacks to TJC accreditation, there are many benefits that make it an attractive and worthwhile initiative for health care organizations. Accredited facilities have access to TJC information and resources, on-site education and consultation and the accreditation process helps identify strengths and weaknesses of the facility – as well as ways to improve (Duffy, 1988; Jurkiewicz, 1988; Patterson, 1995. Finally, accreditation creates a "contract of responsibility" for effective performance in delivering care and possible (and frequent) third party reimbursements. A substantial majority of state regulatory agencies look to

TJC accreditation as a major deciding factor in granting certification or licensure. In addition, some insurance companies use TJC accreditation as a factor in reimbursement rates and determinations. Most significantly, the federal government often views accreditation as equal to meeting Medicare conditions of participation "deeming status" – thereby relieving the facility of the burden of also undergoing review by Medicare in order to be able to bill for services (Duffy, 1988; Jurkiewicz, 1988; Patterson, 1995). While TJC is not a governmentally regulated agency and does not have the authority to fine or cite organizations that fail to meet their standards, the weight of TJC accreditation is not insignificant. Loss of status may result in loss of millions of dollars in funding from Medicare and Medicaid alone (Franko, 2002).

TJC generates annual reports on performance, quality and safety of the facilities it accredits. Hospitals and health care providers that lead the way in positive patient outcomes are highlighted while the number and nature of confirmed, substantive complaints against accredited facilities is also made public. All of this is done in an effort to make TJC accreditation relevant, useful and accessible to the public. In an effort to augment public awareness of facility status, TJC created a Gold Seal of Approval that is displayed in facilities and on their certificates (The Joint Commission, 2012) TJC continually reviews and revises its standards for accreditation as medical care advances and evolves (The Joint Commission, 2013).

The International Organization for Standardization (ISO)

The International Organization for Standardization, commonly known as ISO (derived from the Greek word meaning "equal") began in 1946 as a union between the International Federation of the National Standardizing Associations (ISA) and the United Nations Standards

Coordinating Committee (UNSCC) as a postwar standardization organization (ISO Central Secretariat, 1997). ISA preceded UNSCC in 1926 but never lived up to expectations of producing the necessary in-depth bulletins to help guide international manufacturing and commerce. When war broke out in 1939 and ISA's international communications were significantly hampered, the organization was shelved. However, ISA's legacy provided an ideal prototype for ISO (ISO Central Secretariat, 1997).

While ISO does not have an explicit mission statement, the organization's stated purpose was to create voluntary international standards developed through global consensus that provided clear, identifiable internationally recognized references so as to promote fair competition in free market economies (The International Organization for Standardization, 2013). Enhanced product quality and reliability, greater interoperability and compatibility, greater ease of maintenance and reduced costs – all results of the standards – helped facilitate trade (Martincic, 1997). ISO's goal was to do standardization work in a democratic way, enabling each member nation representation and equal voting rights. ISO's purpose was to make international standards from those that were already established nationally, thereby making international trade easier and more reliable. In order to accomplish this, ISO established Technical Committees that set standards in specific technical or manufacturing fields. They also established a range of committees to address broader issues in standardization and to provide expert guidance in fields related to standardization (consumer questions, assistance to developing countries, conformity assessment, and information systems and services) (ISO Central Secretariat, 1997). Today's Technical Committees and subcommittees total more than 2,600 (Martincic, 1997). In addition, ISO has members in 163 countries and has published more than 19,500 international standards

covering most aspects of technology, manufacturing and business. (ISO Central Secretariat, 1997).

Initially, ISO simply published recommendations. An explosive growth in international trade as a result of a revolution in transportation methods pushed ISO to take their practices a step further and develop standards from which organizations could seek certification. Multinational companies, institutions in developing countries and governmental regulatory authorities demanded international standards, which ISO developed in response. ISO began as a weakly funded organization with a very small staff. Revenue streams from individual and country memberships provided the income needed for the organization to flourish and grow (ISO Central Secretariat, 1997).

ISO became known as an international specialized agency when they began publishing their recommendations as International Standards and developed deep and significant contacts within international governmental agencies that were interested in the field of standardization (ISO Central Secretariat, 1997). Over the years ISO has achieved Category 1 Consultative Status with the UN Economic and Social Council by the United Nations. In the 1980's the General Agreement on Tariffs and Trade (GATT), a multilateral agreement regulating international trade, required all signatory governments to rely on international standards as the basis for technical regulations – further solidifying ISO's relevance and importance. The World Trade Organization also supported ISO's objectives and approach. ISO grew and gained significance by increasing circulation of their standards and increasing subscriptions – which were directly resultant of political connections that had been established over the years. Furthermore, ISO joined forces with the International Electrochemical Commission in 1947 in an effort to present a united front. This collaboration allowed ISO to gain a stronger foothold and to become more

relevant, and the tactic persists today as technical committees and subcommittees, involving constituents from all signatory countries, work continuously to ensure that the standards are relevant (ISO Central Secretariat, 1997).

Today, ISO is an established presence in manufacturing and service industries that certification is often needed simply in order to be able to conduct business. Customers require it and there is no comparable substitute for it in manufacturing. Being ISO certified assures customers that a third party has thoroughly evaluated the manufacturing and business practices of the company that they are doing business with, and the products can be trusted. (T. Pietrzyk, personal communication, July 6, 2013).

Cost for certification varies based on the size and complexity of the business and re-certification takes place every 3 years with an annual surveillance audit. The process of certification, from start to finish, takes about 3-4 days and can cost a small company from $5,000 - $10,000 with costs being much higher for large companies. Surveillance visits take about a day and cost between $500 - $1,000 while the recertification process takes about 2 days and costs approximately $1,500. A great deal of documentation is required of the business before the audit takes place and much of the staff is often involved in this process. (T. Pietrzyk, personal communication, July 6, 2013).

One of the most significant drawbacks to ISO certification is the time and cost involved. Initial fees are substantial, especially for small businesses (T. Pietrzyk, personal communication, July 6, 2013). However, certification is often required in order for many manufacturers to fully participate in the market. ISO certification benefits consumers and governments worldwide by assuring standardization and quality of products, thereby allowing for free international trade.

(ISO Central Secretariat, 1997). ISO certification is immediately recognized within the business and manufacturing industries and certified companies proudly label their products and facilities as certified.

The Association for Assessment and Accreditation of Laboratory Animal Care

The Association for Assessment and Accreditation of Laboratory Animal Care (AAALAC) is a "private, non-profit organization that promotes the humane treatment of animals in science through voluntary accreditation and assessment programs" and works with researchers and institutions to serve as a bridge between scientific progress and animal welfare (Association for the Assessment and Accreditation of Laboratory Animal Care, 2013). AALAC's mission is to "enhance life sciences by promoting the responsible treatment of animals used in research teaching and testing through voluntary accreditation and assessment programs" (Association for the Assessment and Accreditation of Laboratory Animal Care, 2013). AAALAC was organized during the post WWII science boom as animal research expanded and a new specialty in laboratory animal medicine evolved. In Chicago, much public concern was expressed regarding the use of animals in research, especially research facilities utilizing pound seizures and there was a strong anti-vivisection movement. (Association for the Assessment and Accreditation of Laboratory Animal Care, 2013). As a result, veterinarians from Chicago's major institutions gathered to informally discuss information and best practices regarding the care and use of laboratory animals and by 1950, this group – known as the Animal Care Panel (ACP) held their first meeting (Association for the Assessment and Accreditation of Laboratory Animal Care, 2013). The ACP Committee on Regulations for the Care of the Dog produced their first publication in 1952 entitled "Standards for the Care of the Dog Used in Medical Research" while the National Institutes of Health (NIH) produced a similar guide, written by the Surgery Study

Section of the Division of Research Grants (Association for the Assessment and Accreditation of Laboratory Animal Care, 2013).

Concerns continued to mount as awareness developed regarding the high disease rates among many commercially produced research animals and as a result of cruelty accusations that were leveraged by the Humane Society of the United States against several research laboratories (Association for the Assessment and Accreditation of Laboratory Animal Care, 2013; Clark, undated). The ACP appointed a Committee on Ethical Considerations in the Care of Laboratory Animals to evaluate such allegations and evaluate an institution, upon request. The Committee's focus became generating standards of care, and by 1960 a certification program for standards of laboratory animal care and use as well as an associated accreditation program, were well underway. Funding was supplied by NIH's Division of Research Grants as well as via grants from the Federation of American Societies for Experimental Biology, the Association of American Medical Colleges, the American Heart Association, The New York State Society for Medical Research and the Medical Research Association of California (Association for the Assessment and Accreditation of Laboratory Animal Care, 2013; Clark, undated). With input from the Institute of Laboratory Animal Resources, the National Academy of Sciences and the National Research Council, the *Guide for Laboratory Animal Facilities and Care* (also commonly known as *The Guide*), now in its seventh edition, was published in 1963 by the US Public Health Service. Additionally, a voluntary accreditation program, conducted by peers and designed to help facilities achieve the highest standards in animal care was rolled out and the final culmination was the incorporation of AAALAC on April 8, 1965. (Association for the Assessment and Accreditation of Laboratory Animal Care, 2013; Clark, undated).

ACP's Board of Directors understood that the endorsement, cooperation, participation and financial support of the scientific community would be required if AAALAC were to succeed (Association for the Assessment and Accreditation of Laboratory Animal Care, 2013; Clark, undated). Some of AAALAC's fourteen charter member organizations included the American College of Physicians, American Heart Association, American Medical Association, American Veterinary Medical Association and the National Society of Medical Research (Association for the Assessment and Accreditation of Laboratory Animal Care, 2013). AAALAC's current location in Washington DC allows it to be actively involved in educational, government and scientific organizations and the organization is now known as AAALAC International as the organization's reach expands globally. AALAC's current Board of Trustees is comprised of individuals from more than 60 prestigious scientific and educational institutions, representing perspectives from a wide range of industry stakeholders and represents a variety of countries (University of Texas at Dallas, 2013; Association for the Assessment and Accreditation of Laboratory Animal Care, 2013).

AAALAC garnered considerable interest in the first year after incorporation and approximately 100 institutions applied for site visits. However, subsequent years yielded fewer applications (Clark, undated). AAALAC responded with a comprehensive promotional campaign geared at the scientific community including publishing a letter in the journal *Science* that lauded the benefits and improvements in facilities that were AAALAC affiliated, a flurry of promotional editorials or articles in scientific journals, direct invitations to apply for accreditation from the Board of Directors to directors of laboratory animal facilities and a large direct mail campaign targeted at directors of facilities, hospital administrators and deans of

medical and veterinary schools (Clark, undated). These activities were integral in helping AAALAC get off its feet and achieve widespread acceptance and use.

Today, more than 880 programs are AAALAC International accredited (Association for the Assessment and Accreditation of Laboratory Animal Care, 2013; Association for the Assessment and Accreditation of Laboratory Animal Care, 2013). Facilities may identify their status via "We Are Accredited" rack cards and posters. More importantly, they are listed in the directory of accredited programs. It is widely accepted that AAALAC accreditation signifies that an institution's standards of animal care and use exceed the minimum standards required by local, state and federal laws and indicate sound ethical practices (Association for the Assessment and Accreditation of Laboratory Animal Care, 2013; University of Texas at Dallas, 2013). Accreditation promotes scientific validity by assuring superior animal care, which provides assurance and standardization in a global marketplace. Furthermore, AALAAC accreditation can be used as a recruiting tool to attract talented researchers, professors and employees. Finally, AAALAC accreditation can help ensure funding sources for institutions (University of Texas at Dallas, 2013).

AAALAC produces Podcasts and webinars that discuss topics related to AAALAC accreditation, animal care and use; continuously revises *The Guide* – with an 8th edition in process; offers on-site presentations to help facilities understand what is involved in accreditation as well as provide information to proactively manage animal care and use (Association for the Assessment and Accreditation of Laboratory Animal Care, 2013). Informational sheets and brochures about AAALAC are available in English, Chinese, French, German, Japanese, Korean, Spanish and Thai, and periodically produced specialty publications are made available online (Association for the Assessment and Accreditation of Laboratory Animal Care, 2013).

AAALAC's newsletter "The Report" was published from 1972 – 1987 and was used as a tool to help improve industry communication and understanding of the organizations ongoing activities. "The Report" defined and conveyed important industry definitions such as what constituted a laboratory animal care facility or multiple surgical procedures (Clark, undated). Clearly, "The Report" was key in solidifying AAALAC's role as an industry leader. A reformatted newsletter entitled "AAALAC Communiqué" emerged in 1990 and is still used to increase awareness about the importance and role of the accreditation process and high standards of care and use of animals (Clark, undated). AAALAC maintains its status as the industry leader in part by publishing position statements that can be referenced by professionals seeking further guidance with certain issues (Association for the Assessment and Accreditation of Laboratory Animal Care, 2013; Newcomer, 2012). Today, AAALAC has a full time public relations professional to help coordinate public and professional relations (Clark, undated).

Organizations seeking accreditation are assessed a one-time application fee and subsequent annual fee. Both costs are dependent on the size of the institution's animal facility. Smaller facilities of 1,000 square feet or less are charged an application fee of $3,765 and an annual fee of $2,590 while large facilities of 200,000 to just under 500,000 square feet are charged $13,540 and $9,075 respectively. Very large facilities in excess of 500,000 square feet are charged negotiated rates (Association for the Assessment and Accreditation of Laboratory Animal Care, 2013). Sites are visited every three years for re-accreditation and an annual report is required (Association for the Assessment and Accreditation of Laboratory Animal Care, 2013).

Discussion:

Common Themes and Elements of Strong Accreditation Programs:

AAHA, NAEYC, TJC, ISO and AAALAC are each distinctly different from each other, but there are common themes among the history, funding, design and persistence of these schemes that suggest significance as factors of successful and lasting schemes and are useful to consider when contemplating the plausibility of an accreditation scheme for companion animal shelters.

Each of these was born of powerful, large or highly influential groups that were established as leaders in the field. While funding may have been meager in the early stages, significant revenue streams – often in the form of foundation support – were ultimately secured. Furthermore, the accrediting organizations regularly produce thought policy, respected research, useful tools, national and international conferences and literature geared at professionals, the general public and/or governmental entities. The regular production of relevant information and policy positions appears to help sustain each organization's position as a "go-to" leader on matters of policy, practice and standards.

Successful accreditation program characteristics have a clear definition of purpose and scope of the accreditation process as well as a defined structure and proper governance of the accrediting body, and status as a competent and professional leader in the area of accreditation (Forum of Australian Health Professions Council, 2011). The accrediting authority must also be independent and autonomous with clear, rigorous and fair processes established for carrying out its accrediting functions while simultaneously representing a spectrum of industry stakeholders (Forum of Australian Health Professions Council, 2011). A consistent theme among the

accreditation schemes reviewed was that they were leaders in their industries. Some had humble beginnings, but each evolved into a large, powerful and well respected organization.

The animal welfare field already has several large, well-respected and well-funded organizations who could potentially step into the role of offering accreditation for animal shelters: The Humane Society of the United States (HSUS), the American Society for the Prevention of Cruelty to Animals (ASPCA) and Best Friends Animal Society (BFAS) being the most prominent examples. Additionally, HSUS, ASPCA and BFAS already produce research, literature, policy positions, tools and national conferences – making them relevant and prepared platforms from which to promote a new accreditation scheme for companion animal shelters.

Costs for accreditation vary greatly between the schemes, but the benefits of accreditation for each of the successful programs reviewed are strong and can justify the significant amount of time and resources needed to undergo accreditation, maintain it and the cost involved. Indeed, accreditation or certification can bring financial benefits in higher reimbursement rates, the ability to conduct business internationally; the ability to comply with governing bodies and therefore omitting other laborious and costly certifications processes. Accreditation can also potentially improve regular business practices and client relationships. Animal shelters often struggle with small budgets and adding an additional significant expense in the form of a fee for accreditation could make participation impossible for many. Therefore, it may be necessary during the initial years of the accreditation scheme – as it gains relevance in the industry – for participation costs to be minimal or waived entirely.

As discussed, the accreditation process is almost always a lengthy and involved process. It is typical for the process, from beginning to end, to take several months and to involve most or

all of the facility's staff. This level of commitment may be another significant hurdle for companion animal shelters as it is not uncommon for such facilities to operate with limited or insufficient staff, leaving little or no time for participation in a voluntary accreditation program. For this reason, marketing the commonly cited benefits of team building, producing a more cohesive (and possibly efficient) practice, improving staff skills, ensuring superior animal care, assuring the community of high standards of care and potentially more readily attracting funding should all be highlighted to potential participating organizations. One of the consistent ultimate results of the accreditation schemes reviewed in this paper was an improvement in operations, which would be a valuable asset to many overburdened companion animal shelters.

Launching an accreditation program for shelters would require a large scale public relations campaign – similar to the large-scale outreach campaigns of AAALAC, NAEYC, ISO and TJC. A successful campaign might invite leading shelters to be at the forefront of this movement and be the first to participate in the new accreditation process including national recognition of these trailblazing organizations with testimonials and evidence of the benefits realized by accreditation. Also integral to success would be a campaign inviting major granting foundations to become familiar with the scheme and its value to the industry. Ultimately, grantors should be urged to inquire about the accreditation status of grant applicants and lend priority to organizations that demonstrate achievement of accreditation.

The successful accreditation programs are intimately involved in producing research for major scholarly journals, professional journals, books and industry newsletters. They also generate training and educational resources for accredited organizations or those in process. Finally, they also regularly update their accreditation guidelines and standards to ensure that they

are current and relevant. These practices support the organization's status as the leading voice in the industry.

A regular schedule for re-assessment with accreditation awards valid only for a fixed period of time, such as three years, is also essential as it provides a level of assurance that accreditation standards continue to be met satisfactorily after the initial accreditation award. Annual reporting or surveillance audits should also be conducted. Assessment team members should have clear roles, requirements and responsibilities and should be well qualified peers. Site visits and accreditation visits should have clear procedures established as well as a solid process for arriving at an accreditation decision. The accredited program should be continually monitored in order to ensure that it remains in compliance with the standards of accreditation and procedures should be in place for programs that fail to maintain standards of accreditation between evaluation cycles. Processes should be in place to allow for response to complaints or appeals while stakeholder feedback should be continually sought in an effort to regularly update and improve the accreditation process and standards (Forum of Australian Health Professions Council, 2011; The International Society for Quality in Health Care, 2004).

Published performance standards should be continually reviewed and kept current. In this way, the organization would maintain legitimacy as the disseminating voice on best practices and standards. Again, significant funding would be required, as significant amounts of time from expert veterinarians, welfarists and stakeholders would be required. Clearly, the accreditation program should be sustainable and securely funded and time should be allowed for the accreditation program to gain significance and membership (The International Society for Quality in Health Care, 2004; World Bank Group Multilateral Investment Guarantee Agency, 2004). Perhaps ASV guidelines could continue to be utilized by shelters as a self-evaluative tool

and documented as best practice for animal shelter operations, animal well-being, adoption rates, shelter animal health and more –paving the path for them to be used as a platform for a full-fledged voluntary accreditation scheme for companion animal shelters. Finally, accreditation should be voluntary and built from enforceable governing standards that are written with the goal of improving the shelter's development (Health Systems Resource Centre, 2003).

A strong voluntary accreditation program should meet the bulk of these criteria and serve to measure a program or facility against ideal but achievable standards such as the ASV's while still encouraging continuous improvement efforts as opposed to a licensure program wherein an organization or facility meets minimum standards for operation (Health Systems Resource Centre, 2003). The potential exists for skill sets to therefore be enhanced, teams made more cohesive and animal care improved. With time and program recognition, it is feasible that granting sources would recognize the accreditation program as indicative of a gold standard and favor accredited animal shelters when making funding decisions.

A strong, leading organization such as the Humane Society of the United States, Best Friends Animal Society or the Association for the Prevention of Cruelty to Animals would be the potential organizations to develop and administer a certification or accreditation scheme. These organizations have strong reputations, established funding sources, deep and significant relationships with stakeholders and expertise in the field of animal welfare and animal sheltering which would be necessary to establish an accreditation scheme.. The standards have already been written by the ASV and the conversation regarding next steps and what is achievable needs to begin.

References:

About ISO. (2013). *The International Organization for Standardization.* Retrieved from http://www.iso.org/iso/home/about.htm

A Brief History of ISO (1997). *Martincic, C. J.* Retrieved from http://www.sis.pitt.edu/~mbsclass/standards/martincic/isohistr.htm

Accreditation and Other External Quality Assessment Systems for Healthcare: Review of Experience and Lessons Learned. (2003). *Health Systems Resource Centre.* Retrieved from http://hdrc.dfid.gov.uk/wp-content/uploads/2012/10/Accreditation-and-other-external-quality-assessments.pdf

Accreditation of Health Profession Education Programs. (2011). *Forum of Australian Health Professions Councils.* Retrieved from http://www.healthprofessionscouncils.org.au/Accreditation_of_Programs_-_Good_Practice_and_Essential_Elements_Endorsed_3_March_2011.pdf

American Animal Hospital Association (2011). *AAHA Was Born – November 9, 1933.* [Power Point Slides]. Retrieved from https://www.aahanet.org/Membership/History.aspx

American Society for the Prevention of Cruelty to Animals (ASPCA). (2010). *Keys to a Great Shelter Supplement: Animal Sheltering in the United States: From Impound to Humane*

Community. Retrieved from http://www.petfinder.com/images/help-pets/keys-to-a-great-shelter.pdf

American Society for the Prevention of Cruelty to Animals (ASPCA). (2006) . *Shelter Regulations.* Retrieved from: http://www.aspcapro.org/search.php?cx=006662374600932631778%3An63yw0tcxlg&cof=FORID%3A10&ie=UTF-8&q=shelter+regulations&sa=&siteurl=www.aspcapro.org%2F&ref=&ss=5272j1299912j31

Association for Assessment and Accreditation of Laboratory Animal Care International. (2013). *AAALAC International: History, Programs and Process.* [Power Point Slides]. Retrieved from www.aaalac.org/resources/aaalac_background.pp

Available from AAALAC: Specialty Publications and Newsletters. (2013). *Association for Assessment and Accreditation of Laboratory Animal Care.* Retrieved from http://www.aaalac.org/publications/

Baker, S; Beitsch, L; Landrum, L & Head, R. (2007). The Role of Performance Management and Quality Improvement in a National Voluntary Public Health Accreditation System. *Journal of Public Health Management Practice,* 13 (4): 427-429.

Benefits of AAALAC International Accreditation. (2013). *University of Texas at Dallas*.

[Power Point Slides]. Retrieved from www.utdallas.edu/research/docs/aaalac_benefits

Bloom, P. (2010). The Quality of Work Life in NAEYC Accredited and Nonaccredited Early Childhood Programs. *Early Education & Development.* 7 (4): 301-317.

Clark, D. (undated). AAALAC History Through 1990. *Animal Resources.*

Copple, C. & Thompson, L. (Eds) (2001). *NAEYC at 75: Reflections on the Past, Challenges for the Future.* Washington, DC. The National Association for the Education of Young Children.

Curran-Ostrow, C. (1983). The Historical Precedents for Quality Assurance in Health Care. *The American Journal of Occupational Therapy,* 37(1): 23-26.

Duffy, M. (Ed). (1988). *An Introduction to the Joint Commission: Its Survey and Accreditation Processes, Standards and Services.* Chicago, IL: The Joint Commission on Accreditation of Healthcare Organizations.

Edinboro, CH; Janowitz, LK; Guptill-Yoran, L. (1999). A Clinical Trial of Intranasal and Subcutaneous Vaccines to Prevent Upper Respiratory Infection in Cats at an Animal Shelter. *Feline Practice*, 127 (13):7 – 11.

Education and Outreach Program. (2013). *Association for Assessment and Accreditation of*

Laboratory Animal Care. Retrieved from http://www.aaalac.org/education/index.cfm?printPage=1

El-Jardali, F.; Jamal, D.; Dimassi, H.; Ammar, W. & Tchaghchaghian, V. (2008). The Impact of hospital accreditation on quality of care: perception of Lebanese nurses. *International Journal for Quality in Health Care.* 20 (5): 363-371

Flis, D. (2002). A Relationship with a Purpose: Accreditation Facilitation Projects and Early Childhood Programs. *Young Children,* July: 36-38.

Foreman, J. (2007). Proceedings from the NAVC Conference: *The Value of AAHA Accreditation.* Orlando, FL.

Franko, F. (2002). The Important Role of The Joint Commission. *AORN Journal,* 75(6): 1179-1182.

Frequently Asked Questions. (2013). *The Association for Assessment and Accreditation of Laboratory Animal Care.* Retrieved from http://www.aaalac.org/accreditation/faq_landing.cfm

Friendship Among Equals (1997). *ISO Central Secretariat.* Retrieved from http://www.iso.org/iso/2012_friendship_among_equals.pdf

Goffin, S. (2003). Learning More About the Commission on NAEYC Early Childhood Program

Standards and Accreditation Criteria. *Young Children,* March: 82-83.

Goffin, S. (2003). Making NAEYC Accreditation the Standard-Bearer for Program Excellence. *Young Children,* November: 66-67.

Goffin, S. (2003). Toward New Early Childhood Program Standards and NAEYC Accrediatation as Standard-Bearer. *Young Children,* July: 74-75.

Hamilton, F. (2010). Leading and Organizing Social Change for Companion Animals. *Anthrozoos.* 23 (3); 277-292.

History (Long Version). (2013). *Association for Assessment and Accreditation of Laboratory Animal Care.* Retrieved from http://www.aaalac.org/about/history_long.cfm

History/Mission (2013). *American Animal Hospital Association.* Retrieved from https://www.aahanet.org/Membership/History.aspx

History of NAEYC Accreditation. (2013). *National Association for the Education of Young Children.* Retrieved from http://oldweb.naeyc.org/academy/HistoryNAEYCAccreditation.asp

The History of NAEYC. (2013). *National Association for the Education of Young Children.* Retrieved from http://oldweb.naeyc.org/about/history.asp

History of The Joint Commission (2012). *The Joint Commission.* Retrieved from *http*://www.jointcommission.org/about_us/history.aspx

Humane Society of the United States (HSUS). (2013). *Common Questions About Animal Shelters.* Retrieved from: http://www.humanesociety.org/animal_community/resources/qa/common_questions_on_shelters.html

Hyson, M; Biggar-Tomlinson, H; Morris, C. (2009). Quality Improvement in Early Childhood Teacher Education: Faculty Perspective and Recommendations for the Future. *Early Childhood Researach & Practice,* 11(1).

Joint Commission FAQ Page. (2013). *The Joint Commission.* Retrieved from http://www.jointcommission.org/about/jointcommissionfaqs.aspx

Jurkiewicz, M. (1988). The Joint Commission and the Agenda for Change. *American College of Surgeons Bulletin,* 73 (11): 20-25.

Loveless, S. (2011). Welfare & Ethics in Veterinary Shelter Medicine. *Today's Veterinary Practice*. 1 (1); 50 – 55.

Lubinescu, E; Ratcliff, J & Gaffney, M. (2001). Two Continuums Collide: Accreditation and Assessment. *New Directions for Higher Education*. 113: 5-21.

McClennahan Means, K & Pepper, A. (2010). Best Practices of Accreditation Facilitation Projects: A Framework for Program Quality Improvement Using NAEYC Early Childhood Program Standards and Accreditation Criteria. *The National Association for the Education of Young Children*. 1-68.

Miller, L. (2007). Animal Sheltering in the United States: Yesterday, Today and Tomorrow. *Veterinary Medicine*, 656-663.

Newbury, S; Blinn, M; Bushby, P; Barker Cox, C; Dinnage, J; Griffin, B . . . Spindel, M. (2010). Guidelines for Standards of Care in Animal Shelters. Retrieved from http://www.sheltervet.org/about/shelter-standards/

Newcomer, C. (2012). The Evolution and Adoption of Standards Used by AAALAC. *Journal of American Association of Lab Animal Science,* 51(3): 293-297.

Nolan, R. (2011). Shelter Vets Aim to Raise Level of Care For Millions of Animals. *JAVMA News*.

Our Mission. (2013). *The National Association for Education of Young Children.* Retrieved from http://www.naeyc.org/about/mission

Patterson, C. (1995). Joint Commission on Accreditation of Healthcare Organizations. *Infection Control and Hospital Epidemiology,* 16: 36-42.

Prados, J.; Peterson, G. & Lattuca, L. (2005). Quality Assurance of Engineering Education through Accreditation: The Impact of Engineering Criteria 2000 and Its Global Influence. *Journal of Engineering Education.* 165-184.

Private Health Policy Toolkit. (2004). *World Bank Group Multilateral Investment Guarantee Agency.* Retrieved from https://www.wbginvestmentclimate.org/toolkits/public-policy-toolkit/mod1step3sub1a.cfm

Steneroden K, Hill A, Salman M. (2011). A needs-assessment and demographic survey of infection-control and disease awareness in western US animal shelters**.** *Preventative Veterinary Medicine.* 98: 52–57.

The Joint Commission History (2012). *The Joint Commission.* Retrieved from http://www.jointcommission.org/assets/1/6/Joint_Commission_History.pdf

Toolkit for Accreditation Programs. (2004) *The International Society for Quality in Health Care.* Retrieved from https://www.wbginvestmentclimate.org/toolkits/public-policy-toolkit/mod1step3sub1a.cfm

What is AAALAC? (2013). *Association for Assessment and Accreditation of Laboratory Animal Care.* Retrieved from http://www.aaalac.org/about/

Woodhouse, D. (2003). Quality Improvement through Quality Audit. *Quality in Higher Education.* 9 (2): 133-139.

Zawistowski, S & Morris, J. (2004). The Evolving Animal Shelter. In: Miller, L & Zawistowski, S. (Eds.), Shelter Medicine for Veterinarians and Staff. Blackwell Publishing, Oxford, UK.

TABLE 1	AAHA	NAEYC	TJC	ISO	AAALAC
Organization's mission statement.	To enhance the ability of vets to provide quality care to companion animals, enable vets to successfully conduct their practices and have high quality care facilities and meet the public's needs as they relate to delivery of small animal veterinary medicine.	To serve and act on behalf of the needs, rights and well-being of all young children with primary focus on provision of educational and developmental services and resources.	To continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value.	No mission statement. Stated purpose is: to create voluntary international standards developed through global consensus that provide clear identifiable internationally recognized references so as to promote fair competition in free market economies.	To enhance life sciences by promoting the responsible treatment of animals used in research, teaching and testing through voluntary accreditation and assessment programs.
Year started.	1933	1931 (NANE), 1964 (NAEYC)	ACS (1913), TJC (1951)	1964	1950 (ACP), 1965 (AAALAC)
Wide range of stakeholders represented in design/implementation/governance?	Yes – AAHA has historically collaborated with other leading organizations when developing standards and policies.	Yes – NAEYC's BOD involve multidisciplinary think tanks when seeking input in program changes, development and policy.	Yes – originally designed by members of the American College of Surgeons. Members now include representatives from orgs such as the American Medical Association,	Yes originally born of the International Federation of the National Standardizing Associations and the United Nations Standards Coordinatin	Yes – fourteen charter member orgs, representing prestigious, national orgs. Present BOT include individuals from more than 60 institutions and representing a

			the American Hospital Association and other national health professionals.	g Committee. Today, every member nation has equal voting rights.	variety of countries.
Do accreditation standards exceed licensure standards?	Yes.	Yes.	Yes.	N/A (there are often no other consistent, internationa l standards or licensure to exceed).	Yes.
Accreditation standards based on written, published standards?	Yes.	Yes.	Yes.	Yes.	Yes.
Original and current funding sources	Original: little initial funding – veterinarians volunteered to conduct evaluations. Today: membership dues are primary income source.	Original: modest funding from the Edith Lauer Fund, The Grant Foundation and Rose Alschuer (a founding member). Today: large grantors such as The Carnegie Corp & the Annie E Casey Foundation.	Original: The Carnegie Foundation. Today: Financial stability comes from wide range of member organizations as well as accreditation related fees and services; revenue from consulting arm.	Original: Little funding and a very small staff. Today: revenue streams from individual and country membershi ps.	Original: Grants from NIH and various orgs involved in medical research. Present: Similar charter members, revenue generated by accreditation.
Administered by independent body and professional	Yes.	Yes.	Yes.	Yes.	Yes.

peer reviewers?					
Timeframe for re-accreditation	3 years.	3 years.	3 years.	3 years.	3 years.
Interim monitoring timeframe	None.	Annual report required.	Annual report required.	Annual surveillance audit.	Annual report required.
Are standards continually reviewed and updated?	Yes.	Yes.	Yes.	Yes.	Yes.
Is accreditation voluntary and supplemental to governmental licensure?	Yes.	Yes.	Yes.	Yes.	Yes.
Who founded the program?	Seven leaders in the veterinary profession.	A multi-disciplinary group of 25 leaders, many from education and research.	The American College of Surgeons.	Union between the International Federation of the National Standardizing Association & the United Nations Standards Coordinating Committee.	Veterinarians from major Chicago institutions.
Impetus for program founding	Pet owner demand for improved services, willingness to pay for it.	Federal WPA funding for preschool increased number of preschool programming, but there was little consistency or enforcement.	Poor performance of hospitals raised awareness of need for standardization and improve quality of care.	Explosive growth in international trade, resulting from a revolution in transportation methods.	Cruelty allegations, concerns about quality/source of research animals.

Factors influencing emergence as a full fledged accreditation scheme	The increasingly significant role of companion animals.	*Rapid expansion of preschool programming nationwide as a result of WWII. *Increased federal funding and programs for early childhood education.	*ACS's release of statistics showing that only 89 of 671 hospitals met minimum standards. *Medical community recognized need to improve, embraced accreditation as the vehicle. *More facilities became accredited. *More funding was attracted.	Demand from multi-national companies, institutions in developing countries and governmental regulatory authorities demanded international standards.	*Widespread promotional campaign aimed at the scientific community. *Heavy presence in professional journals.
How is the organization made relevant?	*Produces educational programs and publications. *Publication of position statements. *Heavy focus on vet/client relationship and maintaining a successful practice. *Parts of Canada and the state of Louisiana accept AAHA accreditation	*Publication of journals, books, policy position statements. *Participation in governmental policy discussions. *Hosting national conferences.	*Publication of educational materials, standards and manuals, position statements. *Hosting national and international conferences. *Quality Healthcare Resources – a consultative arm of TJC (est. 1986). *Deemed status	*Deep and significant contact within international governmental agencies. *Maintains Category 1 Consultative Status within the UN Economic and Social Council. *GATT requires all signatory government	*Publication of position statements. *Publication of The Guide. *Regular newsletter (AAALAC Communiqué) *Production of training/informational podcasts, webinars and on-site presentations.

	in lieu of state inspections.		circumvents duplicative Medicare & Medicaid review.	s to rely on ISO standards. *Partnership with the International Electrochemical Commission.	
Costs for accreditation review (including any initial application or registration - type fees)	Approximately $920/year.	Average cost is $600 (programs with 100 children).	Varies significantly. A small organization at one location would be approx $8,000. Large hospitals are negotiated.	Varies significantly. A small company's certification may cost between $5-10,000, surveillance visits range between $500 – 1,000 and recertification approximately $1,500.	Ranges from $6,355 to in excess of $22,615, depending on facility size.
Who is involved in the accreditation review process?	Every member of the veterinary practice.	Parents, teachers, administrators, staff.	All employees, administrators and staff.	Most of the staff is involved.	Most of the veterinary and animal care staff. The institution's IACUC committee can be involved as well.
Benefits to accreditation	*Team building produces a more cohesive vet practice. *Access to AAHA educational events,	*Improves staff skills. *Opportunity to communicate and educate parents. *May significantly	*Access to TJC information and resources. *Assures patients and employees of the facility's	*ISO certification is often needed simply in order to conduct business.	*Promotes scientific validity; standardization in global marketplace. *Recruiting tool.

	journals, resources. *Improvements in hospital management, client relationships and veterinary care. *Indicator of an org using best practices in veterinary medical care.	impact funding sources and reimbursement rates.	high standards / positive outcomes in healthcare. *May increase reimbursement rates. *Medicare and Medicaid "deemed" status.	*ISO certification assures consumers / business partners that products can be trusted. *Assures international standardization and allows free trade.	*Helps ensure funding sources. *Ensures superior animal care.
How is it made visible to public or target audience?	*AAHA logo on stationary, website. *AAHA promotional materials. *Logo plaque on the building. *Listed in AAHA's database.	*NAEYC logo on stationary. *NAEYC banner on building. *Listed in NAEYC's directory of accredited programs.	*TJC Gold Seal of Approval displayed in/on the building. *Annual performance report published by TJC indicates which facilities are accredited and how they have performed.	ISO certification is readily recognized within business and manufacturing industries. Companies label their buildings and products as ISO certified.	*Listed in AAALAC's directory of accredited programs. *Posters and rack cards identifying status may be displayed on site.
How many organizations are accredited today?	3,200 (approximately 12% of US and CA veterinary hospitals).	More than 10,000 programs serving more than 1M children.	More than 20,000.	Members in 163 countries.	More than 880