

Mobile Spay-Neuter Clinic Operations

Emerging Standards in Patient Care and Business Method

VERSION 02-06-02

Prepared for PETSMART Charities

by

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12/05/01

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I. Introduction

Over the past twenty years, high-volume sterilization has become the requisite component of a proactive community response to pet overpopulation. Indeed, over the last decade, composite euthanasia and impoundment statistics have decreased in the U.S. as spay-neuter services have become more accessible and affordable to the general public.

It is beyond the scope of this paper to debate the efficacy of mass sterilization with regard to its effects on pet overpopulation. This research assumes that such debate has long since been settled, viz. opening statements. The scope of this research is concerned, generally, with the efficient organization and deployment of mass sterilization resources, and specifically, with the feasibility of the mobile clinic facility as one means for successful delivery of these resources. There are important legal and political factors that will be considered in this research, but the chief investigative concern is the viability of the Mobile Clinic enterprise as an efficient contributor to mass sterilization efforts.

It is prudent to digress briefly here and clarify key concepts and assumptions regarding pet overpopulation and mass sterilization that form the analytical context of this investigation:

The three key factors for a successful sterilization campaign are volume, accessibility and sustainability. In a simple, static population system, the rate of attrition must exceed the rate of reproduction to affect decreases in overall population. Because we humans are members of our own population, this concept is perhaps intuitive and elementary, but with respect to pets, their compounding, prolific reproductive abilities complicate matters exponentially.

In such a progressively prolific system as the overall U.S. cat and dog population- where even with institutionalized volume euthanasia, attrition is statistically insignificant- stability in the population can only be achieved when the aggregate reproductive capacity (per cycle) is sufficiently limited so as to affect the proportions of the static state system.

Mass sterilization is intended, therefore, to supplement these disproportions and facilitate stabilization and subsequent reductions in the target population*. Since national animal population statistics are more or less best guesses, for the purpose of this research, the “target population” will be defined as the annual surplus population as per combined national euthanasia and adoption statistics.

It is commonly held that a significant proportion of the annual surplus population has origin in the lower-income, remote or rural areas of U.S. communities. For purposes of this research, the assumption is made that the “majority of the target population” has such demographic origins.

The first non-profit mobile spay-neuter clinic in the U.S. was organized specifically to serve that demographic challenge. In 1993, the Houston Animal Rights team, later to become SNAP, Inc, pioneered the use of a mobile surgical facility to provide volume spay-neuter services exclusively to the pets of lower-income families in the Houston area. The original mobile clinic is still in full-time operation today, providing free sterilizations to pets of qualifying pet owners.

Another pioneering achievement of the first SNAP mobile clinic was the arrangement with the City of Houston to subsidize a significant portion of the Clinic annual operating cost. This was a seminal development in the procurement of volume spay-neuter services as a supplement to the municipal animal control mechanism.

SNAP's pioneering efforts in 1993 marked the beginning of a proliferation of non-profit-owned, mobile spay-neuter clinics across the country at a rate of about three new mobile clinics per year. The ownership models varied depending on individual state Veterinary Practice Act guidelines, but primarily non-veterinarian, animal welfare agencies assumed ownership and management of the very specialized and expensive practice of volume veterinary surgery.

State Veterinary Practice Act Guidelines typically provide rules and regulations governing ownership and operation of traditional small and large animal medicine, but there were little or no standards of specialization for mobile volume surgical medicine. Under much scrutiny, new mobile clinic managers and veterinarians helped forge new standards of patient care for this specialized, burgeoning new industry.

Again, SNAP led the new industry with the first publication of a "Guidelines for Patient Care" manual for mobile volume surgery practice. Developed by SNAP's staff and Veterinary Advisory Board, the manual has been continually updated to keep pace with the latest trends in anesthesia and other associated medical technologies, and it has been largely adopted as the de facto industry standard.

These first clinics not only had to pioneer a new medical frontier, they had to also meet the difficult financial challenges of delivering an expensive service to a very poor client demographic. Like the medical component, there were no proven standards from which to build business and revenue models. But unlike the medical end, where by default, veterinarians controlled the process of standardization; there were no professionals with specific experience to inform the business end of the new industry.

Various business approaches have been tried and well tested with respect to the key factors of accessibility and sustainability. Some struggled to meet and sustain performance objectives while others have made leading innovations and set new performance standards. These new standards and innovations will be the subject of the following sections of this report.

II. Emerging Standards

In this section, key parameters of Mobile Clinic operations will be examined. The following is an outline of these parameters as organized for this report:

Ownership Models

- (1) Non-veterinarian-owned, non-profit
 - a. Organization-based
 - b. Coalition-based
- (2) Veterinarian-owned non-profit
 - a. Organization-based
 - b. Coalition-based

Financial Models

- (1) Fees-based Expense Recovery
 - a. Retail Sales
 - b. Contract Services
- (2) Subsidized Expense Recovery
 - a. Grant-based Revenues
 - b. Patronage

OWNERSHIP MODELS

In examining Ownership Models, it is prudent to first distinguish between the terms Practitioner and Proprietor. For this discourse, ownership refers to the overall proprietorship of the operation. Ownership, then, is not meant to refer solely to the title-holder of the physical facility nor to the Practitioner or assignee of patient liability- although in one ownership scenario, Practitioner and Proprietor may be one and the same.

Every state has a Veterinary Medical Board that governs the practice of veterinary medicine through state legislation called Veterinary Practice Act Guidelines. The distinction of ownership by Practitioner and Proprietor will be helpful in summarizing the rules and regulations bestowed on Practitioners and Proprietors by State Veterinary Medical Boards.

In most states, it is not mandatory for the Proprietor of the physical veterinary facility to be a licensed veterinarian, but the facility Practitioner can only be a state-registered veterinarian. Even if the veterinarian is only an employee of the operation, according to typical Practice Act Guidelines, that veterinarian must accept ownership of all medical liabilities. Although legislation may differ slightly from state to state, the owner of all medical liability is always the attending veterinarian. Therefore by law, the attending veterinarian must maintain sufficient control over all functions that affect medical performance. As such, most states do not allow a veterinarian to be employed by a non-veterinary entity, except in special cases when provisioned by law.

Ownership / Non-veterinarian-owned, non-profit agency:

Many state boards have enacted special legislation that extends limited privileges of Practice ownership to non-profit agencies that are organized for humane purposes. In such cases, the Proprietor may own the facility, hire veterinary employees, and control clinic finances. As above, the attending veterinarian owns all medical liability, but in this scenario, the financial liability of the practice is the responsibility of the non-profit agency.

There are two primary categories of Non-veterinarian-owned, non-profit ownership: Organization-based and Coalition-based.

Organization-based, Non-veterinarian ownership is the most common non-profit model. The non-profit Organization/owner conducts the financial activity of the Practice much the same as it would a shelter or other such enterprise. Veterinarian and support staff are hired as employees of the Organization, and equipment and supplies are likewise maintained. The primary benefits of ownership by a sole organization are ease of administrative maneuverability and improved position in the local industry.

The disadvantage of sole ownership is that the Organization assumes the full financial risk and administrative burden of the enterprise. Similarly, the sustainability of the resource is fully subjected to any instabilities of the sole organization. Unfortunately, those clinics that were found in the research to have the most difficulties are those who have the least cooperative affiliation with other groups of similar mission.

Coalition-based Non-veterinarian ownership takes advantage of shared resources, minimizing financial risk and administrative burdens for the organizations involved. In most communities, there is typically more than one organization in need of spay-neuter resources, and as of this writing there are no communities supporting more than one mobile clinic operation. Conversely, some organizations did not have sufficient management and/or operating capital to sustain a clinic on their own, and a coalition-based arrangement was the only means of acquisition.

Coalition-ownership does not necessarily involve more than one organization sharing in title-ownership of the physical facility. Rather, the coalition is formed through some means of agreement to share in the operational burdens of the project with respect to sales, marketing and daily production activities. As reported in the next section on model programs, the top performers in either category of lower unit-cost or highest sustained throughput are those engaged in cooperative endeavors with other agencies.

Ownership / Veterinarian-owned, non-profit agency:

One of the more promising, emerging trends in mobile spay-neuter clinic operations is the proliferation of non-profit clinic ownership by independent veterinarians.

Organization-based, Veterinarian ownership

In this scenario, Practitioner and Proprietor are one and the same.

Instead of an existing non-profit animal welfare agency organizing the purchase of the facility and administering the operation, an independent veterinarian organizes a new non-profit corporation for the purpose of clinic ownership and operation. The veterinarian may be the board president as well as be the attending Practitioner.

What is most promising about this scenario is that all three instances of the Veterinarian-owned, non-profit agencies discovered in this research were seeking cooperative arrangements with non-profit agencies in need of low-cost services. This trend signals a further refinement in convergence of the veterinary profession with animal welfare industry.

Coalition-based, Veterinarian ownership

Another promising, albeit relatively untested model in non-profit mobile spay-neuter clinic operations is Proprietorship by a coalition agency of majority veterinarians. There is one instance underway in the state of Louisiana, where a regional veterinary association has assumed ownership of a coalition-based mobile clinic operation.

Coalition veterinarians make up the executive branch of management and some provide surgical support. The administrative and support functions are shared by hired staff and coalition partners.

Like a for-profit veterinary corporation, this non-profit scenario could take advantage of industry-level economies and further reduce costs in resource delivery, while still preserving the boundaries of veterinary ownership. Because all the coalition veterinarians are also in private practice, at the very least, this approach could improve relations across the non-profit and profit sectors.

FINANCIAL MODELS

Most clinics are organized with the mission of extending services to those in greatest need. The challenge, of course, is in creating a fee structure that is sufficiently affordable to the target demographic as to encourage purchase, and at the same time contribute optimally to the recovery of clinic expenses.

In extreme cases where target clientele are simply too impoverished to contribute any fee of significance, innovative clinics have improvised fee subsidies accomplished through various arrangements.

Fees-based Expense Recovery through Retail Sales

The most general approach to expense recovery is to price out services at-cost. However, clinic operators discover all too quickly that in order to sustain operating costs at lowest levels, support mechanisms typically end up sacrificed to some degree. Those clinics whose staff must perform multiple duties in order to subsidize unbalanced pricing of services admit propensity toward staff burnout and high employee turnover.

One means of subsidizing the revenue stream is to offer sales of retail products in conjunction with the sterilization service. Products such as parasite control and routine vaccines are relatively inexpensive to deliver and offer opportunity for considerable margin. Although this approach has been met with some scrutiny by private veterinarians- whose profits are gained chiefly from sales of same- it has become commonplace, particularly with non-veterinarian-owned mobile clinic practices.

Fees-based Expense Recovery through Contract Services

A growing trend in fee structuring for mobile clinics is the formation of long-term contractual arrangements with other agencies such as humane groups and municipalities. In this scenario, the clinic Proprietor becomes a service contractor, effectively selling units of production to the purchaser. The service agreements may arrange purchase over the span of the contract for set surgery units or whole days of operation. Non-profit agencies or municipalities, who cannot justify the expense or distraction of a full-time spay-neuter operation, especially benefit from such an arrangement.

Contract service arrangements are a variation on the coalition model and achieve similar benefits in balancing financial risk for the Proprietor. Further, long-term sales arrangements minimize sales and marketing pressures, freeing management to focus on core clinic objectives such as improved throughput and patient care standards.

Subsidized Expense Recovery through Grant-based Revenues

Every clinic reviewed for this research has received some form of grant-based revenue. Annual corporate sponsorships are included in this category. Most clinics project grant revenues in their annual operating budgets. The noted trend in the research, however, was a tendency for clinic managers to minimize reliance on annual grant revenues for subsidizing operating costs. Such revenues are typically unsecured and represent more a fundraising goal than a reliable, predictable revenue stream.

As earlier noted, the primary financial challenge for clinic management is to balance service pricing at a level amenable to the target clientele, and at the same time, significant enough to recover reasonable production expense. In every clinic instance, the public price was always below the cost of production thus creating revenue shortfall. In the previous recovery scenarios, it was demonstrated how revenues from retail sales or contract fees subsidized shortfalls and reduced financial risk.

In special cases, where Proprietors have entered into multi-year funding arrangements with Grantmakers, annual grant revenues may be secured by contractual agreement. Without such binding, multi-year agreements, reliance on unsecured grant revenues increases risk and threatens project sustainability. Indeed, grantmakers that were polled on this issue were unanimous in discouraging over-reliance on annual grant revenues for subsidizing operating costs. Grant revenue opportunities, then, are best reserved to fund capital purchase, start-up costs and special needs projects such as equipment enhancement and repair.

Subsidized Expense Recovery through Patronage Revenues

Two of the clinics reviewed in this research were purchased outright by a sole Patron and donated to the Clinic Agency. Even so, as in the previous example, an over-reliance on patronage to subsidize annual operating costs can increase financial risk and threaten project sustainability.

III. Model Programs

In the previous section, key concepts in clinic ownership and finance were identified and summarized. The remainder of this research will expand on these concepts through a summary examination of four Model Mobile Spay-Neuter Clinic Programs in current operation.

For this research, 22 clinics were surveyed and/or interviewed regarding the parameters of ownership, finance and operations. Clinic managers were asked to detail specific aspects of their clinic facility and operations, share financial information and offer any advice or suggestions that might be helpful to other managers.

The model programs presented here were chosen among the overall survey respondents based on unique abilities or innovations in Clinic organization and performance. All of the respondents added value to the effort, and their input and participation is sincerely appreciated.

Overview of Model Programs:

EmanciPet is a non-profit agency founded and managed by Ellen Jefferson, DVM. A local philanthropist donated the clinic facility. This practice is an excellent working example of veterinarian-owned, non-profit agency. EmanciPet combines revenues from Retail Sales and Contract Fees to recover majority-operating costs. Operating goals are 25-40 surgeries/day, 10hrs/day, 4 days/week, 52 weeks/yr, and approximately 6000 surgeries/year.

SNAP-NC was founded by Medical Director, Mary Ann McBride and is another good example of the veterinarian-owned, non-profit agency. Variations are that the clinic is on lease and the clinic pricing strategy is straight pass-through pricing and cash-only.

NMHP-U is an organization-based operation with an aggressive performance agenda and impressive return on investment. The program averages 35 surgeries per day at an average unit cost of \$55.81 per surgery. Operating goals are 35 surgeries/day, 183 days per year, and approximately 6,400 surgeries per year.

Special Mention:

MaxFund (please see Appendix II) is a unique variation on the organization-based operation and deserves special mention because of its lean operating efficiency. MaxFund operates a trailer configuration, and it is the only operation reviewed whose parent company also operates a shelter facility.

Model Program:
EMANCIPET SPAY-NEUTER CLINIC, Continued.

Facility and Start-up Costs:

Our facility cost \$125,000. Our start up costs were \$37,000 for equipment, advertising, special fees, insurance, etc...

Revenue Model: 100% Client Fees (Retail and Contract)

Annual Operating Budget: \$285,000

Staffing Summary:

2 Veterinarians- 1 full-time, 1 contract/part-time
1 Head Surgery Tech/Personnel Manager- Full time
3 Support Technicians- 1 Full time, 2 contract/part-time (60 hours a week)
2 Support Staff- part-time admin
1 Contract Accountant- part-time
Limited Volunteer support

Special compensation programs for staff related to volume or performance:

We have "good job" cards that are given out when someone goes above their job description to do a little more than is expected. Whoever has the most at the end of the month gets a \$30 gift certificate to TJMAXX (we get them free monthly for charging our expenses to Visa). We also give a 1% Christmas bonus (1% of their yearly salary).

*Please see Appendix III regarding Incentive Programs

Target Client Demographic:

We target lower income citizens by parking in locations that are most accessible by them. We do not screen except on our day that we are sponsored by the city (the city only pays for surgeries of animals owned by people who live in certain neighborhoods).

Advertising:

Local newspapers, through animal shelters, sometimes radio (when someone does a story on us).

Client Scheduling:

We schedule appointments for every day, except our Free day with the City of Austin (described above), which is on a first come first serve basis. Client intake is 8-9am and discharge is 5-5:30pm.

Surgery-specific Pricing Schedule

Only require surgery and Rabies (\$6)

Dog spay \$30	Cat spay \$20
Dog neuter \$25	Cat neuter \$15

(There are no weight restrictions on female dogs; we do not charge more for fear of alienating owners. I believe that these animals are at the most risk to reproduce or be euthanized in shelters)

Other surgery pricing:

In heat/pregnant/cryptorchid \$10

Pre op bloodwork \$20

Post op pain medications \$10

Retail Pricing Schedule.

Dhlpp/fvrpc/felv/bordetella vaccine \$10	IV fluids intra op \$10, sq fluids \$5
Frontline dog \$10 per application, Cat \$7 per application	ACT clotting test \$5
Strongid dewormer \$5 for 2 tx	E collar \$10 (\$5 refund on return)
Droncit dewormer \$5 per pill	Heartworm treatment for shelter or foster animals (unowned) \$50-\$150
Ear mite treatment \$5	Mange Treatment \$20-30
Heartworm test \$15	Preventick Collars \$10 ea
Felv/FIV test \$20	Heartgard prevention \$15-30 for 6 mo
	Rabies (\$6)

Cooperative Endeavors:

We have 2 (cooperative) programs: the city of Austin sponsors us one day each week to perform free surgeries and rabies vaccines for East Austin residents. They pay us our daily minimum of \$900 and we do surgeries first come first serve. If we do not have enough clients they still pay us our minimum since we have to pay staff to be there. If we have more than 28 animals, they will pay the extra cost per animal to do as many as we can. They assist us with advertising in Austin.

We have another program with an animal shelter in Lago Vista. We make appointments for our day of surgery there, but they pay half of all the surgery costs so the residents of Lago Vista only have to pay 50%. They also assist us with advertising in that area.

Anesthesia and Surgical Protocols

Preanesthesia:

No preanesthetics given.

Anesthesia:

DOGS: mix of 10cc Ketamine 100mg/ml and 1cc Acepromazine 10mg/ml= give 1cc of mix per 25 lbs body weight; isoflourane gas.

CATS: give 0.5cc/10lbs of Ketamine (100mg/ml) and Diazepam (mg/ml) mixed equally

Surgical Protocol:

I use synthetic absorbable monofilament (such as PDS) for internal ligation and internal abdominal layer closure and sub cutaneous closure. I use Synthetic absorbable monofilament such as Vicryl for intradermal stitching. I occasionally use CatGut for ligation and Braunimid nonabsorbable for skin stitches.

Pain Management:

We offer post op pain medication in 2 injections- Torbugesic 10mg/ml (0.1cc/10lbs) and Ketofen 100mg/ml (0.1cc/10lbs) for \$10 extra – lasts 24 hours

Summary of Provisions for Post-Operative Emergencies (Dr. Jefferson):

I carry a cell phone and either myself or my head tech carries a pager at all times. If there is an emergency, our clients are instructed to call the pager and if no response to call the phone. We discuss it on the phone with the owner to determine the severity. We like to see all of our own emergencies if at all possible. If it cannot wait until the following day we offer to see the animal at either a day practice or an emergency practice here in town that allows me to come and see my own patients and care for them. This decreases our costs. Owners are advised (and they have to sign for) that if the animal has a preexisting problem or mutilates its surgical site, the owner is responsible for the bill but we will help them as much as possible (by seeing them ourselves). If it is a surgical complication like a hernia or bleeding then we will pay their bill to correct the problem.

Facility Maintenance Procedures:

We have a check-off list for the 1st and 15th of each month. Each person has a job on those days and we rotate duties. On those days we will do whatever is needed (check oil, change air filters, wash van, empty isoflourane, clean autoclave, etc...)

**Model Program:
SNAP-NC SPAY-NEUTER CLINIC, Continued.**

Facility and Start-up Costs:

Lease agreement for Facility and equipment at \$2500/month

Revenue Model: “99% Client Fees (surgery only)”

Operating Cost: AVG \$1050 per day of operation.

Staffing Summary:

- 1 Veterinarians- full-time
- 1 Head Surgery Tech- Full time
- 1 Support Technicians- Full time
- 2 Support Staff- part-time

Target Client Demographic:

We do not target clients based on income – everyone is eligible. However our client surveys reveal that about 80% of clients served have never been to a vet before, and of the remainder, 10% have only been once.

Advertising:

Yellow Pages, Flyers and PR opportunities inconjunction with other humane organizations.

Client Scheduling:

We pre-schedule appointments, and walk-ins are accepted according to availability. Patient intake is accomplished between 8:00 and 8:30AM. Intake forms are pre-printed and handed out to pre-scheduled clients as they arrive. This minimizes intake time. Every animal gets a full physical and surgery begins by 9:30AM.

Surgery-specific Pricing Schedule

Surgery pricing includes surgery and rabies, distemper and parvo vaccines.

Dog spay or neuter \$75	Cat spay or neuter \$45
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Other surgery pricing: Post op pain medications \$10

Retail Pricing Schedule.

Microchip \$20	Heartworm Test \$15
Feline Leukemia/FIV Test \$20	Frontline - 1 Appl \$5 cats/\$10 dogs
DeWormer 2dose \$10	Kennel Cough Vaccine \$10

**Model Program:
SNAP-NC SPAY-NEUTER CLINIC, Continued.**

Cooperative Endeavors:

We do work with shelters and humane societies, animal control facilities, and schools to advertise our program and surgery dates. Note re cooperation with community veterinarians: every surgery client is asked to get a second-round booster vaccine (vaccines are included in surgery cost) at a local veterinary clinic. Information on local veterinarians is provided.

Anesthesia and Surgical Protocols

Preanesthesia:

Dogs get a pre-op cocktail of Ace/Atropine

Anesthesia:

Dogs and cats get KET/VAL Injection; dogs get ISO Gas.

Surgical Protocol:

On female dogs, I use all Gut with a three-layer closure (single interrupted on the linea, followed by a two layer closure). On very large dogs, I use Monocryl. For male dogs and female cats, I make a two-layer closure. – no skin sutures.

Pain Management:

We offer Torbugesic for post op pain medication and also, either a Torb elixir or Etogesic Tablets for take-home pain management.

Summary of Provisions for Post-Operative Emergencies (Dr. McBride):

We are accessible by pager 24-7. Staff manages postoperative care if possible. Other arrangements are made as needed.

Facility Maintenance Procedures:

Our routine facility and generator maintenance is donated by local businesses.

Model Program:

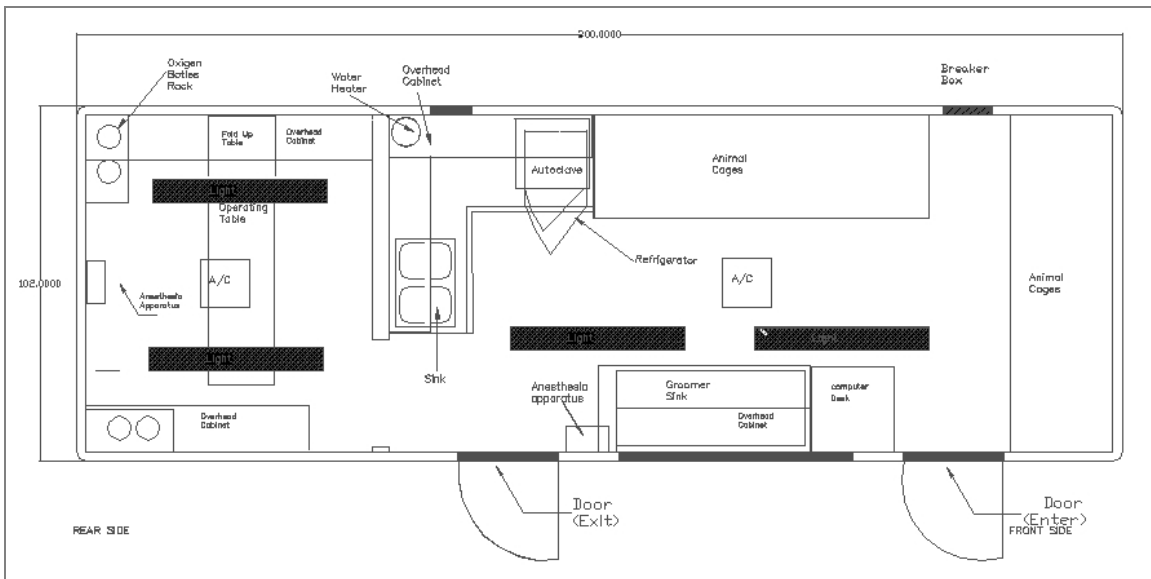
NMHP-U SPAY-NEUTER CLINIC

No More Homeless Pets in Utah
Spay/Neuter Program Director, Nikki Sharp
324 S. 400 W. St. C
SLC, UT 84101
web: <http://www.utahpets.org/>
Email: nikki@utahpets.org
801-364-0370 ext. 415

Facility and Equipment Summary:

2000 Isuzu Truck FTR 51 Custom conversion/General Truck and Body
Onan 10.0 KVA Diesel Generator
34 cages (4 cages have separators)
Tuttnauer 2540M Autoclave
Gaymar Pump
Apnea Monitor
Pulse occimeters
(we found the apnea monitor works a lot better and was a lot more durable)
2 isoflourane anesthesia units

“We did not have use for the grooming tub and wanted to improve cage capacity, so we removed the tub and added a bank of Eight Shorline Cages”



**Model Program:
NMHP-U SPAY-NEUTER CLINIC**

Facility and Start-up Costs:

The facility was purchased by Maddie's Fund for \$153,728.
NMHPU purchased \$10,533.45 in start-up supplies and equipment.

Revenue Model: Client Fees – 66%; Grants and Sponsorship – 34%

Annual Operating Budget:

Operating Budget based on 6400 surgeries: \$309,543

Advertising: \$15,000

Non-Clinic Staff Expense: \$32,701

Total Expenses: \$357,244

This translates into an estimated **\$55.81 per surgery.**

Staffing Summary:

1 Veterinarians- full-time
3 Tech/Managers- Full time
2 Support Staff- part-time admin
1 Contract Accountant- part-time
Significant Volunteer support

Additional management support functions include:

*Spay/Neuter Program Director-Oversees the mobile clinic program along with 3 additional spay/neuter initiative programs with the objective of 7,500 surgeries statewide in addition to the Big Fix's 5,000, involving approx. 70 veterinarians. Position would exist without the Big Fix. Estimated Gross Expense: (50% Time for Big Fix)

*Marketing Director-Coordinates marketing mix for the clinic as well as the entire No More Homeless Pets in Utah Program. Position would exist without the Big Fix. Estimated Gross Expense: (25% Time for Big Fix)

*CFO-Handles financials, budgets and inventory control for clinic. Position would exist without Big Fix. Estimated Gross Expense: (15% of time for Big Fix)

**All annual gross expenses are liberal estimates and are included in the Big Fix budget estimates.

**Model Program:
NMHP-U SPAY-NEUTER CLINIC**

Special compensation programs for staff related to volume or performance:

We have created 2 incentive programs that management and staff attribute to a 25% DECLINE in medical complications:

- Annual Bonus-10% of Salary if year end goal is met (5,000 surgeries).
- Daily Bonus-\$20 for reaching 30 animals and \$3/animal after that.

*Please see Appendix III regarding Incentive Programs.

Target Client Demographic:

We do not screen clients based on income. However, we do target our service to two primary geographic areas: Rural Areas with no local veterinarian and Low Income Urban Areas.

Advertising:

We do extensive advertising and use one or all of the following depending upon the community and the community coordinator: Newspaper Press Releases, Direct Mail Post Cards, Radio PSA's, Flyers, Utility Bills, Community Newsletters, Pre-banner at site location , or an Ad in the local paper.

Client Scheduling:

Appointments are pre-scheduled, but walk-ups are permitted as space allows. In communities where there is no community coordinator, then we only do first come first serve. Client intake is accomplished between 8:00-8:30AM.

Surgery-specific Pricing Schedule

Only require surgery

Dog spay \$40	Cat spay \$25
Dog neuter \$30	Cat neuter \$15
Family Plan (Whole litter with mother) \$85	

Other surgery pricing:

- \$10 extra for pregnancy and dogs over 80 lbs.
- \$10 extra for optional pain meds/5 day supply (Etodolac/Dogs, Torb/Cats)

Retail Pricing Schedule.

All Optional

Rabies, combo, Fel Luk Vacc \$10	Antibiotic \$10
E-collar \$10	

**Model Program:
NMHP-U SPAY-NEUTER CLINIC**

Cooperative Endeavors:

The NMHP-U coalition is an informal alliance of traditional shelters and animal control agencies, rescue organizations, foster groups, and veterinarians. The program is directed by a steering committee drawn from the principal agencies.

Pharmaceutical and Suture Inventory

Pharmaceuticals	Suture
ACE Promazine 10g/ml - 50ml Bottle	Chromic Gut Cassette 50m #1
Amoxicillin Susp. 250mg/5ml 100ml	0 Generic PDS
Atropine S.A. Inj 100ml	2/0 Generic PDS
Baytril Inj 20ml	3/0 Generic PDS
Cephalexin Tabs 250mg 100ct	2/0 Generic Vicryl
Clavamox Drops 15ml	3/0 Generic Vicryl
Clavamox Tabs 210's 125 mg Ea.	
Clavamox Tabs 210's 250mg Ea.	
Diazepam 5g/ml - 10ml vials	
Dolorex (generic Torbugesic) 10g/ml - 50ml bottle	
Domitor 10ml	
Epinephrine HCL Inj 10ml	
Etodolac 200mg Caps (Generic Etogesic)	
Etodolac 300mg Caps (Generic Etogesic)	
Etodolac 400mg Tabs (Generic Etogesic)	
Heparin - 30 ml vials	
Isoflurane Halocarbon Vet Label 250ml	
Ketamine Inj 10cc Ea.	
Ketoprofen Inj. 10% 100ml	
Lidocaine 2% Inj. 50ml vial	
Panallog Ointment - 15ml tube	
Puralube Veterinary Opth. Oint.	
Telazol inj 100mg/ml 5ml Ea.	

Summary of Provisions for Post-Operative Emergencies:

Quality Control Manager carries 24 hr. cell phone. All emergencies go through the Quality Control Manger. When necessary, clients are advised to see an emergency vet and NMHPU covers the cost if it is determined by the emergency veterinarian that the patient's complication was due to the surgery from the Big Fix. A log is kept of emergency calls.

Facility Maintenance Procedures:

The Facilities Manager maintains the service schedules for the truck and generator.

V. Closing Remarks

The presentation of the model programs was intended to demonstrate the core attributes and strengths of the mobile clinic resource. For organization-based ownership, the financial information provided by the NMHP-U and MaxFund Clinics reveals the prospect of this resource as a cost-effective means for the procurement of repeatable spay-neuter resources. Likewise, Emancipet and SNAP-NC demonstrate comparable efficiencies for veterinarian-owned non-profit efforts.

In the course of this research, some inefficient clinic operations were also observed. It was reasoned unproductive to exploit these poor performers due to the fact that these struggling efforts were more generally the result of insufficient revenue modeling or unstable management schemes, rather than any property specifically inherent to mobile clinic operations. Appendix IV offers a conceptual operating model based on the best attributes of revenue modeling and operations management found in the course of this research.

The composite results of the research revealed that on average, non-profit clinics are able to produce a quality service at an affordable price for the target consumer, and with reasonable return for the investor. Perhaps the most intriguing investment quality of this resource is its repeatability. The rated survivability of the average facility is 12 to 15 years. Even with conservative estimates of depreciation and maintenance costs, the model programs demonstrate that mobile clinic ownership is a superior, cost-effective investment over outsourcing equable service volumes through private veterinarians.

Another, more obvious strength of the mobile facility is that by design, it can bring the service to the target client- both urban and rural. This attribute was not emphasized in the report, but all the model programs take full advantage of this capability. NMHP-U covers practically the entire state of Utah, MaxFund targets both inner city and Rural areas and SNAP-NC covers more than 20 counties. Many such extreme areas do not have reasonable access to private veterinarians. Even with the consistent travel expense of a 90-mile radius or greater, the NMHP-U and SNAP-NC clinics maintain a lower unit cost that is substantially improved over private retail (20% to 40% less cost).

Ultimately, the strength and viability of the mobile clinic investment is measured in both unit-cost and sustainability. The model programs prove that it can be less expensive to own the resource and produce the units than to buy the units at even 40% off retail. Regarding pet overpopulation, of course, sustainability is the key. Sustainability is the test of effort over time. So, time and effort will tell.

At least in the near term, the future looks promising for the mobile clinic enterprise to make a significant, cost-effective impact in our industry.

V. Appendices

Appendix I: Contact Information

EMANCIPET SPAY-NEUTER CLINIC

Executive Director, Ellen Jefferson, DVM
2729 Exposition Blvd #124, Austin, TX 78703
Email: epjdog@aol.com
(512) 497-5166

SNAP-NC SPAY-NEUTER CLINIC

Medical Director, Mary Ann McBride, DVM
PO Box 17043, Raleigh, NC 27619
web: <http://www.snap-nc.org/>
Email: <mailto:mcbride3@bellsouth.net>
(919)783-SNAP

NMHP-U SPAY-NEUTER CLINIC

No More Homeless Pets in Utah
Spay/Neuter Program Director, Nikki Sharp
324 S. 400 W. St. C
SLC, UT 84101
web: <http://www.utahpets.org/>
Email: nikki@utahpets.org
801-364-0370 ext. 415

MAXFUND

Executive Director, Nancy Suro
1025 Galapago St. - Denver. CO 80204
Email: nburneysur@aol.com
Web: <http://www.Maxfund.org/>
303-595-9481
Fax 303-595-0665

SNAP, Inc.

Executive Director, Sean Hawkins
Po Box 70286
Houston, TX 77007

Best Friends Animal Sanctuary

Communications Director, Bonney Brown
5001 Angel Canyon Road
Kanab, UT 84741-5001 U.S.A.
web: <http://www.bestfriends.org/>
Email: bonney@bestfriends.org
Phone: 435-644-2001 X108
Fax: 435-644-2078

Best Friends Community Programs

National Director, Paul Berry
P.O. BOX 9205 - New Orleans, LA 70094
web: <http://www.bestfriends.org/>
Email: paulb@bestfriends.org
Phone: (504)342-1022
Fax: (504)342-0919

Matthews Specialty Vehicles

Sales Coordinator , Deanne Way
Web: <http://www.msvehicles.com/>
Email: dway@msvehicles.com
(877) 905-4MSV Ext. 209

La Boit Inc.

National Sales Representative, Koni Wade
Web: <http://www.laboit.com/>
Email: mailto:laboitAZ@aol.com
800-776-9984
623-581-9162
623-581-2922 (fax)

General Truck Body

Engineer, Arcadio Morgado
Email: arcadio.morgado@generalbody.com
(713) 228-2516

Appendix II: MaxFund Configuration

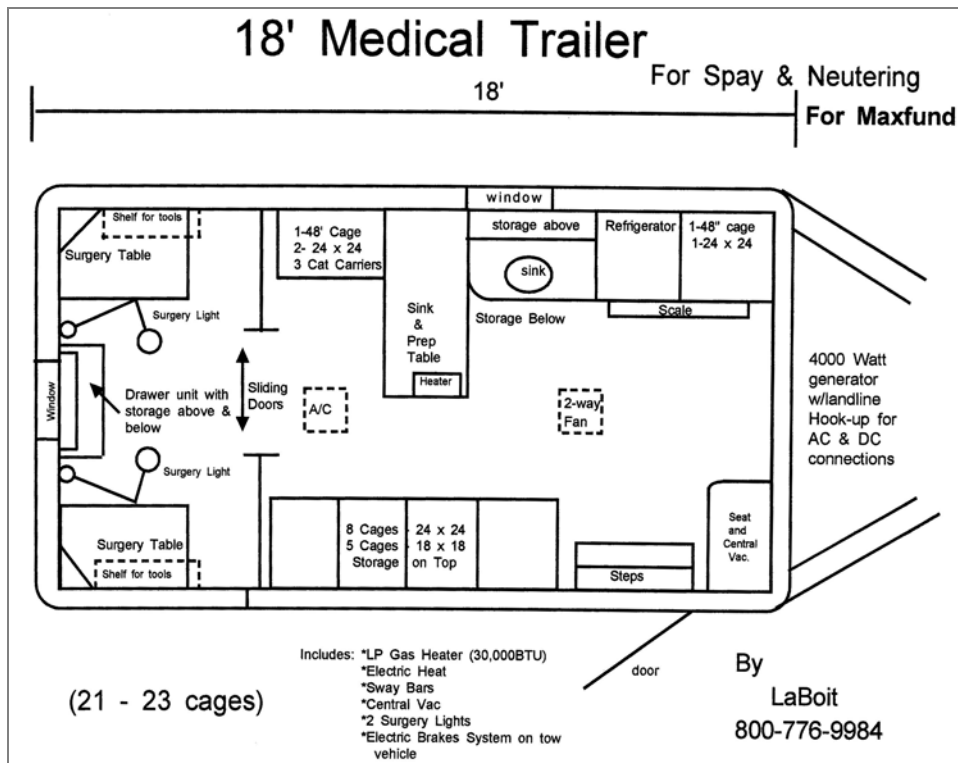
For consistency in financial analysis, the only clinics considered in this report for Model Programs were those in full-time operation. While MaxFund does not maintain Full-time operation, the Clinic does deserve special mention because of its very efficient economies and cooperative organizational approach.

The clinic operates only one week each month, but manages to accomplish 40 – 45 surgeries per day at an approximate cost of \$1200/day or a very impressive average unit cost of \$28 per surgery. MaxFund works in cooperation with other agencies in both rural and inner city areas. Agency Partners split the cost of the service with MaxFund and provide local advertising, lodging and volunteer support. MaxFund is an excellent working example of the ideal organizational approach for clinic operations outlined in Appendix IV.

MAXFUND

Executive Director, Nancy Suro
 1025 Galapago St. - Denver. CO 80204
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 303-595-9481
 Fax 303-595-0665

“Our facility is a LaBoit 18’ Clinic Trailer, pulled by a Dodge 2500 diesel. “



Appendix III:

A Word or Two About Incentive Programs by Dave Sweeny, DVM

December 15, 2001

In July, 2001 our mobile spay/neuter program began a daily incentive plan for the staff working on the mobile unit. This plan was implemented on top of a previously adopted yearly performance bonus. While viewed by some as innovative, some might view these bonuses as potentially damaging to the mobile program. As I worked on the mobile van both before and after the daily bonus implementation, I feel that I can offer some valuable insight concerning bonus programs.

I have worked as a veterinarian for over 11 years, working in over 10 veterinary clinics in capacities as varied as specialty practice, equine practice, small animal general practice, special event equine and food animal practice, relief practice, stationary spay neuter practice and mobile spay neuter practice. I have served in practice management positions in several practices and was very active in my family's large veterinary practices.

During my experiences I have seen a variety of compensation programs for veterinary and support staff. The two basic types of compensation are salary and commission, with a myriad of possibilities of how they are implemented. I have seen instances where both basic types of compensation have fundamentally changed the care given veterinary patients. I have seen commission compensation result in improved care, but have also witnessed it result in worsening pet care. By the same token, I have seen the same results with salaried compensation. Certainly these observations are subjective. Many veterinarians and managers have had their own experiences and can draw their own conclusions. I would, however, like to discuss what I feel are the positives and negatives of each compensation type.

Veterinarians working on salary may tend to be more thorough with their patient's care. The veterinarian feels no direct pressure "to produce" and may be less inclined to hurry to the next patient to raise daily transaction totals. A salaried veterinarian, on the other hand, may be less inclined to provide appropriately aggressive patient care, especially when it could be viewed as inconvenient to the veterinarian, i.e. a patient that arrives in the office just before lunch or closing. Salaried veterinarians may also be more inclined to give away services, as it will not impact their own compensation. However I know some commissioned veterinarians that feel less guilty (towards their employer) about giving away their services, as they feel that they are not just giving away hospital revenue, but their own revenue too. On the other hand many commissioned veterinarians may tend to give away fewer services, as it results in a negative financial impact on them. Commissioned veterinarians might be more inclined to work harder, as they will see a direct financial benefit result from their efforts. There does however exist the possibility that excessive services may be offered patients to increase revenue, or that thoroughness may be sacrificed for speed to enable more client transactions and revenue. In group

practices there also exists the possibility that commissioned veterinarians may negatively affect the practice by competing with one another to provide patient care.

I have had far fewer experiences with technician bonus, or incentive programs, compared to those of veterinarians. Most of those experiences have been negative. One plan offered technicians monthly bonuses when their aggregate pay was less than 8% of the total practice gross revenue. The lower the salary below 8%, the higher the bonus. The technician supervisor was given full authority to determine technician salaries and hours. That clinic was perpetually understaffed by technicians and had high turnover due to technician burnout. In my opinion patient care in that practice suffered because of the bonus. Another example was a clinic that offered technicians 10% of the increase in monthly revenue based on the previous year. While this seemed to have less negative impact on the patient care, it did not appear to be a strong motivator, and did in the end prove quite destructive when other coworkers in the (large 24 hour) practice did not receive bonuses.

Two commonly heard comments about veterinary practice is that our support staffs are underpaid and that it is difficult to keep veterinary technicians from leaving the profession after only a few years. Certainly the veterinary profession must at least try to address these issues as they result in having a significant effect on the quality of nursing care our patients receive. I feel that it is probably difficult in many veterinary circumstances to develop a lay staff bonus program that will improve patient care in addition to enhancing economic performance. I propose, however, that in certain veterinary practices a bonus system can actually improve patient care, make the practice much more productive, greatly improve moral, and lastly, quite possibly improve the pay and staying power of veterinary technicians.

First, why do technician incentive programs rarely work, especially when many veterinarian incentive programs are generally perceived as at least somewhat effective? First let me say that veterinary technicians can be as essential to the success of a practice as the veterinarians themselves. Great technicians can make things run more efficiently and more successfully, thus benefiting the practice. However I believe that in most circumstances bonus pay proves to be a poor motivator for technicians. It is my opinion that in most cases technicians do not perceive a direct relationship between their own efforts and monthly practice revenue. For an incentive to work, there should be a fairly clear relationship between effort and production. For example, when a veterinarian provides a service and charges a fee, the practice computer notes exactly what that vet has done. It could not be clearer. A vet that works twice as hard as his/her colleagues will be compensated for the extra effort. However a technician in a similar circumstance certainly sees a less clear benefit. In larger practices the effect of one technician on clinic revenue is probably pretty small. The very hard working technician's efforts are pooled with those of the other technicians. That hard working technician might be less inclined to go the extra mile when it is perceived that his/her colleagues are not as industrious, but are still sharing in a bonus program. Certainly, I must add that there are of course other incentives for technicians to work hard: love of animals, helping an animal or an owner, self pride, supervisor recognition, future promotion, pay raises etc. Yet, I believe that most veterinarians, myself included, make poor personnel managers, and are fairly poor at recognizing and rewarding good work in a timely fashion. In addition, most vets I

know wish that the economics of veterinary practice would allow them to pay their technicians more.

When I began this paper I stated that would offer my insight on my experience with a mobile spay/neuter van incentive program. Yet before I do that I need to share my beliefs on whether or not veterinarians should be paid commissions. The answer is simple, but not very clear: Some veterinarians should work on commission, some should not. Some veterinary clinics should offer to pay commission, some should not. Some vets are simply just not comfortable working on commission. They may feel too much pressure to generate income. They might feel they are becoming overzealous in recommending treatments for animals. I know of one practice where the veterinarians were on a salary with bonus. Many of the technicians and receptionists freely and angrily expressed the opinion that one of the staff veterinarians was routinely overcharging clients. Regardless of whether that vet was overcharging clients, the practice was very negatively affected by the impression. I have heard of and seen horrible competitiveness in large practices where many, or all of the vets are on commission. In such practices with such extreme competition I do not see how patient care cannot but suffer. Some practices are just not busy enough to pay a commission. So, why pay veterinarians commission if it can be so destructive? Because people who are rewarded for their efforts work better and tend to be happier. Let me use myself as an example. While working in emergency practice I was scheduled (but often times worked more than) 98 hours every other week. Some nights I would not get a break for 14-16 hours, or basically, until the shift was over. The stress level of the job was very high. I frequently found myself in quite involved, prolonged surgeries and was often dealing with very stressed clients. While, in spite of all the drawbacks, I enjoy emergency medicine and surgery, it would certainly lose some of its appeal if I did not feel that I was being rewarded for the stress and for the time away from my family. That is why most ER vets that I know are paid some form of commission/bonus.

One thing I mentioned briefly above, but need to address now, is quality of care. In most circumstances, it is my feeling that veterinarians with high standards of care will maintain them, regardless of the form compensation received. While there certainly are exceptions, veterinarians who strive to maintain high quality do so out of commitment to the belief in the value of those standards and are unlikely to compromise those standards for financial reasons.

Above I mentioned that technician bonus programs may be ideally suited for mobile veterinary clinics. This is mainly because of the incredible amount of teamwork involved in mobile spay/neuter practice. Because of space limitations you have a small number of typically well cross trained individuals that thrive as a team and die as individuals. In high volume/small space mobile spay neuter practice one failing team member can easily bring the whole team down. On our van each person knows their exact responsibilities and understands that the success of the team depends on each one of them. If only one person fails to perform their job, our performance lags greatly. Each team member knows that they are directly responsible for the success of the program and they know that by working hard they will be rewarded.

Before implementing the daily incentive plan on our mobile van our technician staff would rarely take any initiative to work harder to enhance our performance. Animals that arrived after the designated intake times would usually be refused regardless of our surgical numbers for the day. The staff seemed pleased with lower turnouts and only rarely took more than the target number. The work tempo was generally quite slow. Frequently I would wait between surgeries while the next patient was being prepped. The staff would take little “mini breaks” between inductions. If we had low patient numbers on a certain day, the staff tended to be euphoric. All of this changed when the technician bonus was implemented. Suddenly the technicians were suggesting and implementing ways to be more efficient. Animals were frequently taken long after designated intake times were over. Our morning exams were suddenly being done more efficiently. I began waiting less frequently and for shorter periods for animals to be prepped for surgery. Intake and discharge became much more organized and efficient. The end effect was that we were able to surgically treat more animals in a shorter period of time, with what I believe is better quality. Most importantly, the staff seemed happy at the end of the day.

Each of our staff members believes in the spay/neuter cause. Yet each of them has his/her financial concerns. By working harder and more effectively, they are able to more effectively help the animal cause, in addition to helping themselves financially.

Our surgical/anesthetic complication rate is extremely low. We have not had a single surgical/anesthetic death since our bonus program began on July 1. That’s over 2600 animals. Since July 1 we have had to pay one private veterinarian \$151 for a minor surgical complication. We have not been asked to pay any others. Our infection rate is virtually nonexistent, despite the fact that we do not routinely use antibiotics.

As I mentioned above, I believe that veterinarians with high practice standards maintain them, regardless of the form of compensation received. I do not, however, feel this is true of most technicians. While some technicians might have difficulties with too high, or too low of standards of care mandated by the supervising veterinarian, in most instances, I feel the technicians will simply try to comply with the standards of care mandated by the supervising veterinarian. It is essential that the veterinarian sets and enforces the standards with some degree of vigilance. It is not uncommon for veterinarians with high standards to be questioned about those standards. I don’t know how many times I have been asked why I examine my patients before surgery, or why I wear cap, mask and gown during surgery. Those same technicians that may have previously worked under more relaxed circumstances are of course inclined to revert to their old ways. This is why the veterinarian must vigilantly monitor and maintain practice quality. While our technicians might grumble about the time it takes to do exams, or complain about having to intubate every cat spay, they nevertheless take great pride in the results of our high quality.

One last item I wish to mention briefly is our yearly bonus. This bonus is not nearly as effective a motivator as a daily bonus. Yet it is effective in decreasing staff turnover. Staff members are unlikely to leave until the end of the program year when the yearly bonuses are distributed. Of course this greatly aids our standards and continuity of care.

David J. Sweeney, DVM
Chief of Staff, Big Fix Mobile Spay Neuter Van
Veterinarian/Liaison, No More Homeless Pets in Utah

Appendix IV: Conceptual Clinic Operating Model

The following is a conceptual operating model based on the best attributes of revenue modeling and operations management found in the course of this research. This Conceptual Model is provided to complement the research findings, and is not intended to suggest any deficiencies in actual operating models having dissimilar attributes.

Ownership Recommendations

For new investments, *Coalition-based ownership* is the recommended ownership model, but with a few important caveats:

1. The hub of the Coalition should be a *single lead agency* that has title ownership of the facility and complete autonomy over Medical and Business Protocols. This Lead Agency may be a veterinarian-owned or non-veterinarian owned non-profit; however, if non-veterinarian-owned, the Lead Agency should incorporate a Medical Advisory Committee to oversee Medical and Operations Standards.
2. Coalition Partners should be apportioned Enterprise Ownership by contractual agreement, whereby each coalition partner would negotiate a specific, *term-limited liability*, sharing in the administrative and financial burdens of the enterprise. According to terms specified in the Agreement, Coalition members would thereby be granted specific usage, fundraising and public relations privileges.

The Coalition-based approach to ownership is recommended for two primary reasons leading to improved sustainability:

1. **Shared Administrative Burden:** Because, by design, these clinics typically have narrow revenue margins; consistent, capacity client turnout is critical to sustainable fiscal health. Those clinics that pre-schedule their daily client capacity demonstrate superior sustained cost efficiencies over those clinics that do not regularly pre-schedule to capacity. However, the administrative burden on client pre-scheduling is substantial. The target client demographic is typically remote and lower-income, and, because mobile clinics typically operate in a different area day-to-day, the marketing, advertising and customer service functions become increasingly complex and burdensome. Coalition partners would share these administrative burdens by providing the client marketing and scheduling functions in their constituent areas thereby reducing administrative overhead and improving production volume.
2. **Shared Financial Burden:** By design, client fees for reduced-cost spay-neuter services are typically priced below production costs. Hence, as

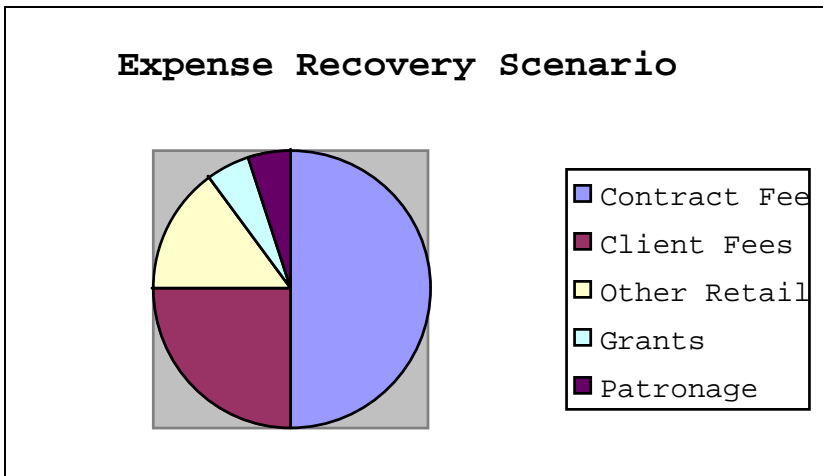
described in the section on Revenue Modeling, production costs must be subsidized. In the Coalition-based approach to ownership, Coalition partners subsidize the cost of the project in proportion to the quantity and scope of services provided by the clinic in the coalition member's constituent area. Subsidy fees and terms would be pre-negotiated by contractual agreement.

Finance Recommendations

Fees-based Expense Recovery through Contract Services is the recommended primary* approach to financing the operations costs. Client Fees on surgery and fees on Other Retail sales (of non-surgical products/services) should be reserved for secondary subsidy.

As noted in the Finance section of this report, over-reliance on both projected grant revenues and patronage weakens revenue predictability and introduces potential short-term instabilities beyond the control of the clinic operator. As with Client Fees and Other Retail sales, then, revenues from Grants and Patronage should be reserved for secondary subsidy.

*For the purposes of this report, the terms Primary Revenue and Secondary Subsidy are meant to designate expense recovery proportions as follows: the Primary Revenue would contribute at least 50% of the recovery and the secondary subsidies combine to recover the remainder as illustrated in the following chart:



The Coalition-based ownership is best suited this approach of recovering operating costs primarily through contract fee arrangements. These fee arrangements are accomplished with coalition partners as well as correlated municipal agencies such as public health or animal control.

The remaining recommendations in this section are based on the following (hypothetical) assumptions:

- The clinic operates from a central hub with population of at least 500,000 people within a 90-mile radius.
- The climate in which the clinic operates will necessitate the facility to have heating provisions in winter and cooling provisions in summer.
- The climate will also present moderate seasonal parasite issues for animals including fleas and heartworms.
- At least 30% of the host population is within +10% or below the HUD guidelines for low-income wage earners.

Recommended Service Offerings

Just as every state has Veterinary Practice Guidelines, every local veterinary community has what is referred to in industry as Local Quality Care Standards. These unwritten local standards are derived from state practice guidelines as well as local veterinary-preferred minimum practice standards that typically exceed the state requirements. For example, some “veterinary communities” may “agree” that all surgical patients should be required a full blood workup, while others might only require that such decisions be left to the discretion of the attending veterinarian. Blood work requires sensitive lab equipment that is not so well suited for mobile clinic facilities (but certainly not impossible). In cases where blood work or some other procedure or treatment is determined necessary by the attending veterinarian, the patient is simply refused surgery and recommended to a local veterinary practice for follow-up.

The following sample service schedule is based on the above assumptions:

Dog spay \$30	Cat spay \$20
Dog neuter \$25	Cat neuter \$15

Other surgery pricing (no weight restrictions):

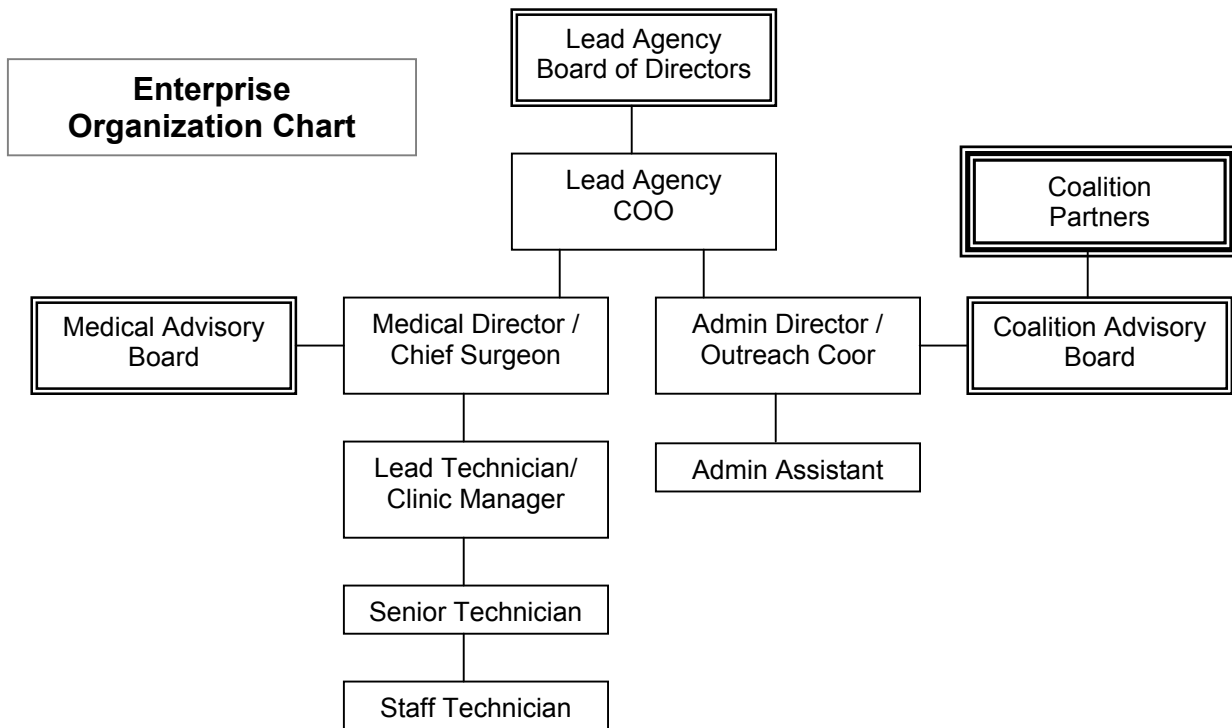
- In heat/pregnant/cryptorchid, add \$10
- Optional pre-operative blood work, add \$15
- Post-operative pain medication, add \$10

FVRCP/Rabies/ FeLV \$20	Rabies/DA2LPP-CV/Bordetella \$20
Felv/FIV test \$20	Heartworm test \$10
Frontline Appl \$7/cat, \$10/dog	Dewormer \$5 per treatment
Ear mite treatment \$5	Heartgard prevention \$15-30 for 6 mo

Recommended Management Methods

As mentioned in the Ownership Recommendations, the lead agency of the coalition provides direct management oversight of administrative and medical operations. The Lead Agency would construct a Medical Advisory Board made up of staff and/or select local veterinarians. Also an Operations Advisory Board made of coalition partners would be formed to inform day-to-day operations issues.

Direct Management Oversight responsibilities of administrative and medical operations are sufficiently specialized and burdensome to require a separate manager/director over each function. Following is a recommended enterprise-wide Organizational Chart followed by a summary of brief job descriptions:



Brief Summary of Job Descriptions:

Lead Agency Board of Directors is responsible for financial oversight of clinic operations. Board members are organized into committees, which have specific planning and monitoring functions relative to the Business Plan and overall Strategic Plan of the Enterprise.

Medical Advisory Board is composed of staff and/or local private veterinarians, who maintain and monitor medical quality assurance standards.

Coalition Advisory Board is composed of Coalition Partner appointees who advise the Lead Agency on Coalition issues.

Chief Operating Officer is a board member appointed as Coordinator of Board Committees as well as board liaison to Medical Director and Admin Director. Maintains Performance Reporting activities.

Medical Director/Chief Surgeon oversees all issues and responsibilities related to medical protocol, quality assurance and technical staffing. Responsible for coordinating medical and sales performance reporting.

Lead Technician coordinates surgery and post-op support, and serves as facility manager in charge of inventory and coordination of facility maintenance.

Senior Technician supports Lead Tech in patient care and is responsible for coordinating client intake, discharge and clinic records.

Staff Technician supports Lead Tech in patient care and is responsible for instrument and kennel maintenance.

Administrative Director manages relationships with coalition partners, and oversees all issues and responsibilities related to routine financial transactions, site and client scheduling, public relations and marketing. Responsible for coordinating marketing and Partner performance reporting.

Coalition Partners are responsible for local advertising, site scheduling and preparation, client screening and appointments.

Administrative Assistant supports Administrative Director and handles office reception.

Please see sample budget at end of this Appendix for estimated labor costs.

Performance Modeling

The foundation of this management methodology is the Enterprise Strategic Plan. The Strategic Plan will focus the vision and mission priorities of the Enterprise in incremental, annual stages over a three-year period. These strategic priorities are further defined in terms of structured finance and production goals in the Annual Business and Operations Plans.

The Annual Business Plan provides the detailed blueprint for accomplishing specific actions in a time-phased manner. The Operations Plan outlines in detail specifically who is responsible for carrying out the time-phased activities of the Business Plan. Organizing the Management Methodology around such planning activities cultivates an operating momentum based on consistent performance priorities, rather than ad lib and reactionary tactics.

Performance benchmarking and contingency planning are hallmarks of this management approach. Timely reporting and open communications at all levels of the organization are essential. In a well defined set of plans, every board member, advisor, manager and staff member know exactly what s/he must do each day to ensure the ongoing success of the enterprise.

Such diligent performance modeling and reporting is especially useful, too, for those investors who require certain performance objectives of their investments. Indeed, more and more, investors are taking a more informed, hands-on approach to ensuring the accuracy of their investment decisions. The relatively large investment required for a mobile clinic facility purchase would oblige the conscientious investor to seek and encourage such organizational sophistication that is achieved through comprehensive planning.

Business Planning is essentially the process of reverse-engineering the vision of the Strategic Plan. So as not to over-simplify, or worse, over-complicate the process, planners should design concise and measurable goals that are meaningful to all stakeholders in the enterprise, including the investor(s) as well as the staff. A brief example of this planning logic can be illustrated in consideration of the present conceptual model, where: first,

The Strategic Plan sets the specific goal of providing spay-neuter services to under-served, low-income family pets in the community at an annual volume sufficient to decrease Community euthanasia by 10% per year; The Strategic Plan calls for a Community Needs Assessment (CNA).

The Needs Assessment determines the prime target communities and necessary target annual volume (TAV) to accomplish the 10% annual reduction goal. The TAV drives the Production Schedule of the Operations Plan.

The Operations Plan designs an appropriate structure to support the demands of the Production schedule including performance requirements and benchmarking for Client Scheduling, Clinic Workflow, Labor Requirements, Quality Assurance, and Inventory Management.

The Financial Plan reduces the performance objectives of the Operations Plan into quantifiable financial goals and benchmarks. And finally, the Financial Plan derives the Cash Flow Plan.

The Cash Flow Plan involves timing the revenues and expenditures such that there is always sufficient cash available to meet obligations without having to incur interest expense from borrowing or having to request short-term bailouts from investors.

The Operations, Finance and Cash Flow plans combine to form what is traditionally called the Business Plan. As indicated, all the planning is predicated on Benchmarking, which is the chief organizing activity for staff and management. Benchmarks link planning with daily operations and provide reference points to help the clinic stay the course of optimal productivity.

The most effective system for maintaining benchmarking is to build this activity into a staff Performance Incentive Program. Though there is some debate on Incentive Programs in clinic operations, such programs are very effective in encouraging timely performance reporting by key staff. Please see Appendix III for more information on Performance Incentive Programs.

Facility Recommendations

All the clinic operators interviewed for this report shared important insights into design considerations for mobile clinic layout and appointments. It is beyond the scope of this report to make specific recommendations on manufacturers, and each have their certain strengths. In this section, then, recommendations on clinic appointments will be described in generic terms that could be customized into any of the manufacturer offerings.

Cab versus Trailer: The trailer models appear to be the more economical approach, but owners of cabin models claim the conveniences of a single, self-contained unit are worth the extra cost. One advantage of the trailer model is that it can be “dropped off” from one location to another and the pull-vehicle can be used for staff transport between operations. This attribute does present further cost savings on the trailer approach, especially for remote, extended-stay operations. Further, if the driving cab has mechanical malfunction, the entire operation must cease until the cab is repaired. The trailer affords the added contingency that if the pull-vehicle has malfunction, another can be leased to avoid any cancellations.

Body Construction: Aluminum Frame and flooring is preferred over wood frame because of added strength and durability, and significant reductions in weight.

Flooring and Paneling: Foam or similar substrate flooring is recommended for comfort; flooring and wall paneling covered with an impermeable, washable surface rated for veterinary use.

Cabinets: Aluminum cabinets recommended; countertops covered with an impermeable, washable surface rated for veterinary use.

Other Storage: Some models allow for skirting that can provide significantly more storage space underneath the facility. Exterior storage is important since the interior is optimized for cage space.

Generator: Minimum 10KVA generator recommended (13.5KVA preferred for units with two A.C.s); vented, radiator cooled with shore power auto-override, and noise and vibration mufflers. If the Cab or Pull Vehicle is Diesel, then a diesel generator is recommended. But gasoline units are reportedly more convenient for remote operation where diesel may be difficult to locate. Winterizing recommended for cold weather climates.

Prep Room: Separate from Surgery area by lockable sliding door with window; in proximity of cages/recovery; Combination Prep Table/Shallow Tub recommended (Storage or cages underneath); Countertop Autoclave at double sink; anesthesia/vaporizer and O₂ connector at prep table.

Operating Room: If space permits, Dual V-top surgical tables with hydraulic lift are recommended to minimize transition time between surgeries; rolling gurney for anesthesia/vaporizer; in-wall O₂ connector between surgery tables; Ceiling mounted surgery lights with rotation capability; Rolling adjustable-height gurney table for surgical instruments.

Oxygen storage, delivery: In-wall oxygen lines and wall receptacles recommended with speed connectors; Oxygen bottle storage rack, 4 – 6 bottles.

Computer: On-board computers run Practice software which tracks patient information, prints client forms, and tracks controlled drugs and inventory. Laptop computers with under-counter printers are the most popular configuration.

Cages: Stainless steel cages recommended. Most clinic manufacturers offer a standard layout of 22 to 25 cages. As surgery proficiencies improve, the experienced surgeon can produce closer to 30 or more surgeries per day with no compromise on quality. Cage space, then, is critical and the interior should be optimized for maximum cage capacity. Clinic operators have removed toilets,

closets and tubs to maximize cage capacity. Large cages should be purchased with dividers.

Plumbing System: Electric hot water heater; minimum 100-gallon aluminum fresh water tank; minimum 100-gallon brownwater tank recommended.

Cabinets: Overhead and base storage cabinets with self-locking spring doors and single throw latches for easy access recommended. Lockable cabinets in Operating Room for storage of controlled substance are typically required by law.

Air Conditioning System: Separate units recommended for surgery and prep areas with separate exhaust.

Toilet: Those who have them installed like the privacy, efficiency and convenience; those who don't, claim extra cage space is worth the inconvenience.

Also recommended:

Pull out, floor slide Digital scale

Pulse Oximeters and/or other vital monitors/Attending Vet

Active vaporizer venting (rather than passive)

Centrifuge and other Bloodwork equipment/Attending Vet

Sample Budget Scenarios

The following Budget scenarios accompany the foregoing conceptual model. Operating Budgets are typically derived from the Financial Planning Process. The full Financial Plan being composed of the three primary components:

1. **The Prospective Income Statement** quantifies the Enterprise Operating Plan. This statement would include the forecast estimates of the Production and Administration Departments.
2. **The Prospective Balance Sheet** forecasts the Enterprise assets (Accounts Receivable, etc.) and liabilities (Accounts Payable, etc) over the business planning period.
3. **The Cash Flow Plan** provides a detailed estimate of cash position throughout the planning period and projects the timing of cash inflow and cash outflow.

Sample Budget 1 represents a conservative estimation that assumes full start-up organization (no shared expense) and full employee benefits. Sample Budget 2 represents probable savings achieved if clinic is merged with an existing operation, with contract employment, etc. For comparisons, see Budget Notes.

SAMPLE CLINIC BUDGET 1

NOTES:

PROJECTED REVENUES:

Coalition Partner and Contract Fees	134,400
AVG Client Co-pay (\$33)	164,736
Donations*	0
Grants*	0
Sponsorships*	<u>0</u>
Total Revenues	299,136

\$700/day of Op, 16 days/mo, 12 mo/yr
 AVG 26 Surgeries/day, 16 Surgery days/mo, 12 mo/yr

PROJECTED EXPENSES:

Accounting & Auditing	1,200
Advertising and Promotion	6,000
Misc fees	1,200
Contract Services	
Management Consulting	8,000
Technical / Assistants	1,200
Veterinarian	3,780
Insurance Expense:	
Auto, Board liability	6,000
Fuel for Mobile Clinic	3,500
Maintenance & Repairs	4,499
Medical Supplies and Equipment	48,000
Communications	1,500
Clinic Supplies	3,000
Miscellaneous	2,500
Office Expense	3,510
Salary Plus Benefits and Cost of Labor:	
Admin management	33,121
Admin Support	21,292
Technical / Assistants	58,308
Veterinarians	76,889
Performance Incentives	16,000
Uniform Allowances	600
Continuing Education	3,000
Veterinary care - emergency	<u>1,000</u>
Total Expenses	308,599

Strategic and Business Planning Co-management
 Relief support AVG 1 day/mo @ \$100/day
 Relief Vet Support AVG 1 day/mo @ \$45/ 7hrday

4 days per week* 90 mile radius

AVG Four full Surgery Days/week

Beeper, Cell Phone, LD charges

800#, Internet Access, Supplies

Full Health Benefits, Employee Taxes

One Full-time Mgr

One Full-time Ex Asst

One Lead Tech, One Asst Tech

One Full-time Vet

Net Deficit Before *Philanthropy **-\$9,463**

Recoverable through Philanthropy

SAMPLE CLINIC BUDGET 2

PROJECTED REVENUES:

Coalition Partner and Contract Fees	76,800
AVG Client Co-pay (\$33)	164,736
Donations*	0
Grants*	0
Sponsorships*	<u>0</u>
Total Revenues	241,536

PROJECTED EXPENSES:

Accounting & Auditing	600
Advertising and Promotion	3,000
Misc fees	1,200
Contract Services	
Management Consulting	8,000
Technical / Assistants	1,200
Veterinarian	3,780
Insurance Expense:	
Auto, Board liability	4,800
Fuel for Mobile Clinic	3,500
Maintenance & Repairs	4,499
Medical Supplies and Equipment	48,000
Communications	1,500
Clinic Supplies	3,000
Miscellaneous	2,500
Office Expense	1,755
Contract Employees (No Benefits):	
Admin management*	14,000
Admin Support*	9,000
Technical / Assistants*	48,800
Veterinarians*	65,000
Performance Incentives	16,000
Uniform Allowances	600
Continuing Education	3,000
Veterinary care - emergency	<u>1,000</u>
Total Expenses	244,734

Net Deficit Before *Philanthropy **-\$3,198**

NOTES:

(*)Reductions from Clinic Budget 1

*Reduced to \$400/day of Op, 16 days/mo, 12 mo/yr
 AVG 26 Surgeries/day, 16 Surgery days/mo, 12 mo/yr

*Assume 50% Shared/Existing Organization

*Assume 50% Shared/Existing Organization

Strategic and Business Planning, Co-management

Relief support AVG 1 day/mo @ \$100/day

Relief Vet Support AVG 1 day/mo @ \$45/ 7hrday

Assume 20% Shared/Existing Organization

4 days per week* 90 mile radius

AVG Four full Surgery Days/week

Beeper, Cell Phone, LD charges

*Assume 50% Shared/Existing Organization

Assume Contract Employment, Taxes (No Benefits)

*Assume 50% Shared/Existing Organization

*Assume 50% Shared/Existing Organization

*One Lead Tech, One Asst Tech/Contract EMPL

*Contract Vets=1Full-time Vet less benefits

Recoverable through Philanthropy