Treating the Treatables - Saving Lives Through Medical Protocols, Foster Care and Proactive Thinking

Webcast Transcript

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[Beginning of Audio]

Lynne Fridley: Good evening, everyone. I'm Lynne Fridley, Program Manager for Maddie's Institute[SM]. We're very happy you were able to join us tonight. Welcome to tonight's webcast, "Treating the Treatables: Saving Lives through Medical Protocols, Foster Care and Proactive Thinking." Our presenter, Dr. Elizabeth Berliner, will talk about how to develop medical protocols, how these protocols save lives, and the issues faced in fostering treatable pets.

I'm honored to introduce you to Dr. Berliner, the Janet L. Swanson Director of Shelter Medicine of the Maddie's® Shelter Medicine program at Cornell University's College of Veterinary Medicine. She serves as the Association of Shelter Veterinarian's board of directors and the organizing committee for the new shelter medicine specialty. At Cornell she directs the internship and the residency in shelter medicine, trains veterinary students in both classroom and shelter settings, and consults with national shelters regarding best practices.

We'll be starting the presentation in just a few moments, but before we do we have some housekeeping items to go over. First, please look at the left-hand side of your screen where you'll see a Q&A window. That's where you can ask questions during the presentation. Dr. Berliner will answer questions at the end of the presentation, but please don't hold your questions until then. We probably won't be able to process questions that come in during the last few minutes.

If you need help with your connection during the webcast you can click on the "help" icon which is at the bottom of your screen. Along with the "help" button you'll also see other little images. These are widgets that will take you to additional resources that Dr. Berliner and Maddie's Institute want to share with you. Please be sure to check them out.

Before I turn things over to Dr. Berliner I want to say a few words about Maddie's Fund. We are the nation's leading funder of shelter medicine education, and it is our goal to help save the lives of all of our nation's healthy and treatable shelter dogs and cats. Our founders, Dave and Cheryl Duffield, were going through a difficult time in their life, but they were sustained by the unconditional dog of their little dog, Maddie. They promised her that if they ever made it big they would pay back her devotion by helping make this country a safe and loving place for all of her kind. When their dreams did come true, they made good on their promise by creating Maddie's Fund, honoring their cherished companion and the special bond that they shared with her. Please use what you learn here tonight to carry on the dream Maddie inspired.

Dr. Berliner, thank you for being here with us tonight.

Dr. Berliner: Hi, Lynne. Thank you very much for that introduction and for the chance to present this evening. I want to say a few words about who's out there in the audience because we did a pre-webcast survey and I do have the results from that. And rather than pull questions tonight, I will be presenting some of the information that I collected in that survey.

One of those is who I'm actually talking to, and so just so you know how I've kind of designed this webcast, we have – about 40 percent of our audience is shelter staff and administrators, 24 percent are vets and vet techs, 28 percent of you are volunteers – and at least 1 of you is out there lime-dipping a kitten while you listen to this this evening – as I was told earlier today, and 9 nine percent of you are pet owners. So I'm really excited to have such a diverse audience and I hope that each of you can find something tonight that you can take back to your own organizations, because I really tried to shoot wide in order to be able to address all those different areas of interest.

I have a very ambitious plan, and those of you who have heard me speak before know that I tend to run long, so I am attempting not to do that this evening but to try and cover a lot of material. So on my list for this evening – certainly I want to start by discussing medical decision making and kind of quality of life assessments and how we can apply those to our companion animals, especially our shelter animals. I want to talk a little bit about what treatable means, especially with foster care in mind, because one of the challenges with treating treatable animals in foster care is case selection of animals. And I think that's a big area where we really need to kind of look at how that process happens, and so I'll talk about that quite in depth.

I am going to review some elements of state veterinary practice acts, and that may seem like an odd thing to drop into this presentation. But

certainly foster care occurs often in collaboration with a brick and mortar shelter or a home-based rescue group, and while veterinarians are often involved they don't tend to always be present at the time treatment decisions are made and those sorts of things. And there actually are laws out there that kind of govern who can practice veterinary medicine, who can prescribe medications and treatments, and it's important that we go over some of those details because it does impact our foster treatment and protocols.

I'm also going to talk about how using medical protocols can be used to expand treatment, make it more uniform, and make it more effective in foster homes. And I'm going to give you some key examples of some foster protocols and some cases where they can work fairly well, and I will talk about specific case examples.

So can't do a presentation without some pictures and stories, so because I get to present tonight I get to tell you some of my stories. So we'll have some cute pictures at the end and some good stories to back that up. Each one of those I'll be using as an example of one of the principles that I present earlier in the presentation.

And then we'll try to get to some questions, maybe some answers, maybe not. It's important that you understand that these protocols I'm giving you or these examples I'm giving you are not handed down in stone. We are all – this is a work in progress. Our own foster program is a work in progress. And so understand that I don't hold myself out there as the expert, and each of you out there has been working in a program that I'm sure has good ideas to contribute and things that work for you. And so with any luck we'll be able to have some of that exchange. I don't have all the secrets. I make mistakes every day, so I'm just trying to offer some ideas and maybe a little background in creating these protocols.

And I will also state the caveat that writing protocols is usually not fun for the average person, and I'm not the first person to struggle to make myself sit down and do it. But if you have a template, if you have something to start with, it seems a lot less daunting. And so that is my goal, is to at least leave you with something to start with so that this project doesn't feel quite as daunting and overwhelming.

So who's out there? Well, I am preaching to the choir. One of my questions was, "Does your organization employ the use of foster homes to house animals?" and 95 percent of the 137 people that replied indeed are using foster homes to house animals. So I'm preaching to the people who are doing the work, and in recognizing that I've really tried to make this useful for you. In fact, in the process of pulling this together I had one person contact me through e-mail who could have given the webinar, and I

may have tried to encourage her to give it instead of me. I was unsuccessful at that.

I should also tell you I have an audience in the room with me, so if there's any background – including a dog – so if there's any background rustling of guacamole and chips, that's where it's coming from, is my audience. They have been instructed to laugh at my jokes, *[laughter]* and so that may actually help us get through this hour. So I hope that doesn't distract you too much; personally I find it helpful.

All right, so let's get to our first section, which is – treating the treatables; the title of this talk. What does that really mean? So I wanted to give a little bit of background information based on some of the feedback I got from the survey, and so not everyone is using Asilomar Accords, and I'm not saying that everyone needs to the Asilomar Accords. But I wanted to make sure that I presented this so that we all kind of start on the same page. And so the Asilomar Accords was a document that was assembled in 2004 by a group in Asilomar, California. And so this group of animal welfare advocates got together and among other things created these classifications by which we can look at animals' conditions, be they medical or behavioral, and classify them based on what we think a reasonable owner in the community would provide for that animal.

And so there are four classifications, and this is where the word "treatable" comes into play. So the first classification is healthy, and that is defined by the Asilomar Accords as an animal that has absolutely nothing medically wrong with it essentially. A treatable animal, an animal with treatable conditions, may break into two categories. So you can be treatable-rehabilitatable, which means you're an animal that has a condition that could be treated and cured with the help of a reasonable owner in your community, and then there's treatable-manageable, which represents chronic conditions that, again, you assume a reasonable owner in the community could manage in their home. And then there's the classification of unhealthy-untreatable, and those are conditions that are more severe, more debilitating, or have an impact on welfare that may not be treatable in the community by a reasonable owner. That is not to say that somebody wouldn't endeavor to treat them or that an owner wouldn't go above and beyond, but for the average owner in the community that would be something that would seem outside the realm of being treatable.

And so these classifications, again, are meant to represent particular communities and the owners in those communities. They are not meant to deem or designate an outcome for an animal; instead it is just to try and help engage a wider realm of thinking when looking at that animal as it enters the shelter.

So – okay. And so I did a little bit of a survey and asked whether people were suing the Asilomar Accords in their shelter, and indeed 22 percent of the people responding to the survey are using the Asilomar Accords, 39 percent are not using the Asilomar Accords, and 39 percent weren't sure whether their organization used it or not. And so that is why I wanted to make sure I kind of started with those definitions, so that people understood what treatable means in this context. And so treatable means a condition that would be treated by a reasonable owner in your community, and therefore then trying to apply that to an animal in your shelter.

I think that using the terminology for me also really helps in conversations around medication decision making, because if you have those terms you can begin to use them amongst yourselves in the shelter to try and really talk about what the challenges are for each animal, and then how you can meet those challenges. And again, even an unhealthy-untreatable animal will often find treatment in a shelter when people go above and beyond what the community is even doing. So it is not an outcome-based terminology; it is simply a way of thinking about conditions.

So the stated intention of the Asilomar Accords at that time was to enable uniform and accurate data collection across animal sheltering organizations. And so the intention, at least as it was defined at that time and still on the website with the organization, is a data aspect, to help shelters kind of compare how they're doing, or to at least get a sense of how shelters are doing in various communities.

I think other outcomes have come out of using that system, and that is essentially this idea of trying to put the shelter animal, that homeless animal that comes into the system, at the same level of owned animals in the community. And our communities are very different, so what may be treatable in an urban setting may not be treatable in a really rural setting based on resources and those sorts of things, but it is the goal of putting that shelter animal at the level of owned animal care. And that's not a stated intention necessarily, but I do think it's an outcome that has come to be in the last decade as we've worked with this terminology, worked with the system, and tried to see how to best apply it.
The other outcome and the thing that I really like in at least using some sort of terminology like this, whether you use Asilomar or you design your own, is that I think it does help promote organization decision making. I think it's useful for organizations to kind of at least think through what is reasonable treated in their population and have that idea long before each animal kind of walks in the door, because that's what enables you to create protocols and systems that allow you to do that treatment in an efficient way, in a timely way, and in a humane way. And so I think what's been nice about using the Accords, at least in the organizations I've used it in, is

that it helps with some of that medical decision making in a way that makes it stepwise and logical for people.

So in looking at your own organization, it can be helpful to really kind of sit down with a group of people – your veterinarian, your administration, your kennel staff, your board members, your volunteers, whoever it is – and really think about what is treatable for your organization. What are the things that we can manage and treat well? What are the conditions that we can adopt out in this community? What have we been successful at? What are the ones that are harder for us to place? And really kind of strategize so that you can define – and I'm going to use the term exit plan – for an animal from the time it comes through the door. And my idea of an exit plan is that when an animal walks through I really want to already be thinking about how to help it get placed in a home or transferred to a place where it can do better. And so for me, I'm very keyed into every animal that walks through the door having an exit plan, and foster can be a huge part of that exit plan. But I tend to even in the process of applying foster care in an exit plan have a real set goal in that and a real set timeline.

So if you're looking at what's treatable for your organization and you're considering what does a reasonable owner in your community – what are they able to do, there are several elements to that, because on one level it seems like it's really just about your owners in the community. And certainly there are people factors – what can your staff do? What can they provide? What can your foster parents do? What level of investment can you make of your staff and even your administration in a particular case? There are disease factors or animal factors, and those, too, seem fairly easy to define. The animal has X condition. This condition X can be treated in our shelter or can be treated in foster. We have a fair – you know, we have good results in treating it and curing it, or treating and managing it in this environment. And so animal, people, and disease all play a role in figuring out what is treatable for your organization.

The other aspect that we can't forget is obviously the animal's welfare, and I don't think anybody ever really forgets about that. But I do want to spend a little bit of time talking about how we assess companion animal quality of life, because certainly it is critical that if we are going to treat an animal for a medical condition, that that animal is amenable to treatment, that it will accept treatment in whatever way, shape, or form we are offering it, and that essentially we can foresee that treating it will improve its quality of life, and that we can provide a good quality of life in the process of providing treatment.

When I worked in private practice I worked in a clinic that had 24-hour care. I worked in a clinic that had some pretty high-level emergency care.

I often had conversations with owner about the fact that, you know, when animals come in in pain or suffering, trauma, severe disease, that we try to make them as comfortable as possible, but there's always that element that they are uncomfortable and we are prolonging or providing increasing discomfort in the process of trying to treat them, and they don't have the ability to tell us what they want. And so we always have to make that judgment of whether this short-term discomfort is acceptable for the long-term goal of giving them health or relief or a new home, and I still kind of keep that in the back of my mind always. Is what I have out there for this animal long-term enough that I can feel okay about what its short-term situation is? And I have found that it's helped me a lot in the animal shelters in even thinking about the choices that I make for those animals that come into my care.

These webcasts are always difficult because this is exactly when I would love to know, you know, some feedback from all of you, and it doesn't really set us up for that. In a classroom scenario I'm always kind of able to get that feedback, because I'm sure some of you are nodding and some of you are probably a little confused. But I hope that that makes sense for a lot of you who find yourself in this position of being the decision-maker and trying to figure out what's the best route for these animals as they enter the shelters.

If you're working with the actual Asilomar Accords, there is also a part of it where your shelter designs something called a pet evaluation matrix, and essentially that's a fancy word for a table where you try to proactively think through what are the conditions, the medical conditions and the behavioral conditions, that come into our shelter, and then how would we classify them between healthy, treatable-rehabilitatable, treatable-manageable, or unhealthy-untreatable. And then, you know, some kind of thoughts on why that classification may be or what the exceptions may be, because certainly some of these animals come in and you may not know whether they're going to be rehabilitatable or manageable at the moment, so some of them can end up a little fuzzy. But it can help to create these, and again I have talked to shelters about creating this kind of table even if they're not using Asilomar necessarily, because I do think it's a way of kind of sitting as a group and proactively brainstorming what your exit plans are or what your thoughts are for these animals in terms of what you can manage, and then getting that on paper separate from each animal coming through the door and kind of starting from scratch each time they walk in.

And it's also a good opportunity for conversation among some of your key decision makers and players to kind of really discuss this. And because sometimes the decisions that people would make for their own pets don't necessarily apply to an animal in the shelter who may not be amenable to

treatment or may have a combination of diseases, and so it can really help just as even a point of conversation to sit the team down and talk about this.

These matrices do – there are several examples that exist on the Asilomar Accords website. You can actually look at the one that have been published by several organizations using the Asilomar Accords. They vary; they're very different. And again I remind you that just because a particular condition is classified as U-U, that is not a euthanasia decision. It simply means that the organization has identified that this is not typically a treatable or — it's not a healthy or treatable condition in their community, but often the goal is to actually move to provide treatment for animals that may have U-U conditions, with the caveat that, again, case selection probably plays an important role there, and that certainly that animal is amenable to treatment. Because if it gets a U-U classification, it has something that's probably causing a significant level of suffering or distress to that animal and would certainly cause a certain level of distress to an owner. And so then it comes down to case selection, and really, kind of, figuring out and problem solving: how do we relieve that distress? Or that level of stress? And can we and should we?

So once again I emphasize, not the last word in decision making, and this does incorporate both medical and behavioral health. I'm not going to talk tonight about using foster for behavioral conditions. I think that's a whole other presentation and a good one, but it's not where I'm going to go this evening, because then I really would go for three hours, and you would all be sleeping, and I would still be up at 2:00 a.m. talking.

So I throw this up just as a schematic to remind you that decisions to treat any animal, any one animal, really impacts all three elements of an organization. So it's about organizational health and commitment and finances. It's about that animal, its personality, its level of disease, its – every element about that animal and its space now that it has entered your space of the shelter or the foster system. And then there's the people equation, and we all know that well. I don't have to tell you that sheltering is a people business in the sense that there lots of people that are very committed, not only to the animals but to the organizations and to whatever set of decision making tools they use in their life. And so really this is always something that is both business decisions and emotional decisions and medical decisions all wrapped up together. But you do have to keep in mind the health of your organization and the health of your people as well as the health of that animal when you're making a decision. You need to encompass all three, or else the decision will not be one that can be well-balanced or well-supported in your organization.

And of course no talk would be complete without reminding us all of the five freedoms, which I always come back to. But ultimately when we are looking at that animal with disease in our shelter setting or our foster setting we need to remember those five basic freedoms that we promise them. So freedom from hunger and thirst – that we can typically provide with water and a diet as long as they're actually eating and managing to take in the basic needs that they have.

Freedom from discomfort I find harder. We certainly want to provide it, but it means providing an appropriate environment including shelter. Comfortable resting areas should be something we can do, but overall discomfort becomes a little bit more challenging, especially as we try to evaluate the animals in our care. And again I'm going to go through some specifics and things we can use to do that.

Freedom from pain, injury, or disease by prevention or rapid diagnosis and treatment – that's a big one for me because I always talk to the veterinary students about how that's really prevention or rapid diagnosis and treatment. Diagnosis and treatment is the realm of a veterinarian, and so that is where vets come into play and need to be available and need to be accessible and need to be accessed in order to really try to provide for freedom from pain, injury, and disease. It also means about managing those chronic conditions and managing on the bottom fear and distress in order to keep that animal really as comfortable and healthy and happy as we can in what is often a less-than-perfect setting for them. Because really the perfect setting would be a loving owner who was providing them with that more direct care instead of us trying to provide it for so many animals simultaneously.

And then the fourth one certainly, freedom to express normal behavior – this is where I usually make a joke about the fact that my animal's normal behavior I don't necessarily want them expressing on a daily basis, and so I probably impact their fourth freedom on a daily basis. But the truth is we do want them to have the ability to express some normal behaviors that don't completely negatively impact our lives, and we do that providing sufficient space and facilities, and sometimes the company of an animal's own kind. Sometimes they don't necessarily want that. But I do remind everybody that this is what it comes down to when we really try to look at the animals that we become responsible for.

All right, so I'm going to take a little sideline into quality of life measures, and I hope some of this is new for some of you. It's a particular passion of mine to try and use these tools to really assess how animals are feeling or doing when they're in my care.

So we have a couple of different ways of talking about quality of life, so I'm going to digress to human healthcare for just a moment, because this is where we have more tools to work with. So in human healthcare there are several areas of assessment that we use in deciding whether a person has a good quality of life. So physical and mental health are important. Health risks and conditions are important, your actual health status. Are you functional? So, functional status. Socioeconomic status we know plays a role in quality of life, not only self-reported but in indirect reporting, and it also impacts physical health. And social support is a big area of assessment in human healthcare.

And we've got a couple of examples out there that if you're interested in this I would encourage you to look at. They're available online. We have the World Health Organization's quality of life tool, and that is a self-reporting tool. So you can go on there and fill out – I can't remember exactly how many questions; I want to say it's about 100 – questions, and then it'll kick back to you what your quality of life is. So if you're interested in that sort of thing and you like those BuzzFeed quizzes, you can do one on your own quality of life and see how you're doing. *[Laughter]* The vet students tend to not do so well when they do those, but it is out there.

The CDC also has one that's specifically related to health quality of life, and that is also a self-reporting tool. So you can sign on there and talk about whether you're having good days or bad days, whether you are functional, and it can kind of kick back to you what your health – in terms of your health what your quality of life is. And what's key in this is that human healthcare is really focused on self-reporting. And according to the CDC the most accurate predictor of mortality or morbidity for a person who is ill is their self-report. So more so than anything else – the doctor may think that their quality of life is terrible and that their prognosis is terrible, their family may think their prognosis is terrible, but if a person feels good about themselves, their quality of life, and their prognosis, that actually is a better indicator of how ill they will be and when they may actually fail physically. And so we know that in humans that self-report is impossible, and obviously our dogs and cats cannot fill out the tools or report to us how they're feeling. And so that leaves us trying to figure it out for them.

So philosophy has looked at this question as well, and this is from some work – a review by a veterinarian that was published in JAVMA, and who has tried to sum up some of the philosophical frameworks that we can use in looking at assessing animals' quality of life. And so one of the philosophical frameworks applied in people and also applied in animals is kind of this objective list theory. And so you have this idea that there are things that are objectively good for an individual, they may not know

what's good for them, and you can kind of objectively measure physical or physiological parameters and decide what's good and how good they're doing. And this is – for those of you who are veterinarians and vet techs or anybody involved in medical, this is the kind of thing that we do in medicine. So we objectively know what's good for someone and then we kind of measure how they're doing against that. We take a heart rate, a temperature, and we decide whether that represents something that's good or bad. And so this objective list theory really allows that third person to kind of look at the individual and try to assess how they're doing and their quality of life.

Preference satisfaction is another one that's been applied, certainly in research, and so this is one where you actually kind of look and see whether the individual has choices, can make choices, and what they choose, and then do they get access to what they choose. And so if they are preferencing something and they then can kind of satisfy that preference or desire, then they have a better quality of life. And so that is another one that there's been attempts to kind of apply that to our companion animals and research animals indeed.

And then there's kind of this hedonism, and I always kind of laugh at that term, but this sense that your quality of life is excellent when you are in a positive state and have absolutely no negative feelings. And certainly all of us may have rare moments in our lives when we are in a positive state with no negative feelings, but in general I think if we held up that that was the best quality of life, for one we probably wouldn't accomplish much, and then for two it would probably be a very rare state. So that one I find a little less useful in trying to talk about animal populations, but I think the top two are really helpful in trying to think through how to evaluate that animal's perspective.

So what do we have for our companion animals? When we try to really assess their quality of life, we do it by proxy. We have people that report for them. So their owners, their veterinarians, the kennel staff, the volunteers, the adopters – they observe and interpret. We interpret physiological parameters like heart rate. We may interpret behaviors. We don't have direct reporting or self-assessment, and that's the best thing you can use for people, so instead we're left with kind of this interpretive quality of life status.

I throw up this picture because you look at these dogs and you think, "Dang, they have a pretty nice quality of life." I will tell you, each of those three dogs came into our local shelter on different occasions. In all cases they came in rather destitute. I think there's two teeth left between the three of them. *[Laughter]* You may notice the tongues hanging. And they're all seniors, geriatric dogs with various osteoarthritis and maladies.

But I will tell you that by my proxy evaluation and interpretation these dogs are living the dream. And so although their quality of life may have been compromised upon presentation, these are dogs that their exit plan really has consisted of blankets and pillows and amazing, amazing times. And so I hold these guys up as ones that may have come in initially not looking so grand and perhaps a little questionable in terms of what their quality of life was, but we have vastly improved that for them. And the one in the middle is mine so I can say that for sure. I can tell you right now he's spoiled rotten.

And so when we look at animals we're really talking about some general concepts: comfort and discomfort, medical health, emotional health. Are their fundamental needs met? That goes back to the five freedoms. Do they have some control over their environment? I think that's huge for animals in the shelter, and one thing that foster care really provides is a bit more control over the environment, a bit more freedom to move around. And then social relationship – we know that's important in people. We think it's important in animals, but they can't self-report necessarily.

And for Frank McMillan, who's an internist, a veterinarian at Best Friends, for him he talks about quality of life in animals as a balance between pleasant and unpleasant feelings, that they really at every moment are either feeling good about things or bad about things. And our goal is to optimize the good. He also emphasizes along with Bernie Rollin that animals don't really have a sense of the future, and so they may not realize that they need to essentially suffer and, you know, really work through something in this moment for a big, long-term payout. Certainly most of us know that and have done that, but again I always throw out to the vet students that that's our way of life, but animals don't know that, and so they don't know that payout is coming. And so really for them at any moment it's about are they feeling good or bad, and we need to remember that, that as we're looking at that animal are they feeling good or bad, and what can we do to maximize the good for them, because that's really about providing adequate welfare.

We do have some examples in veterinary medicine of kind of tested and proven proxy assessments for animals, and I'll kind of go through these really fast because they don't necessarily apply clearly. But I wanted you to know there are some tools out there. So Hartmann and Kuffer have put together a quality of life assessment for FIV cats particularly, and that's one where owners answer questions and vets answer questions – again, these are proxy assessments because the cats can't answer the questions. And then it kind of has a scale, and you do some computation, and you get a kickback on how the animal's doing. So that does exist.

There's one called FETCH, which is cardiac health in dogs, so dogs with cardiac conditions. The cardiologist fills out some questions and the owner does, and then again computation kind of kicks back a score for how that animal is doing. And then there's one by Wiseman and Orr that looks at chronic pain.

There's no gold standard, because the gold standard for quality of life assessment is a self-report, is what does the individual say themselves. So we do not have a gold standard; all we have is the ability to kind of build these tools and test them repeatedly to decide whether they are valid or reliable.

The one that's used most commonly, and I'm sure some of you out there have seen this in practice, is this one by Dr. Villalobos, which is a quality of life scale that she designed for owners with pets with chronic conditions. And this one really again goes back to those basic needs. And so she asks her owners to score their pet in regards to hurt, hunger, hydration, hygiene, happiness, mobility, and more good days than bad, and each of those is a zero to ten scale. And then you essentially add up those points. So there's a series of questions – and, again, proxy assessment; the owner fills it out – and it tries to help them decide how their animal is doing in terms of quality of life. So that's kind of the most common one that's out there that is used in practice, and I often do encourage people to kind of take a look at it and think about it for that shelter animal, particularly a foster animal, because the beauty of foster care is it in an initial home to assess how they would do in a home. And so it gives us a lot more information, I think, in terms of daily function, mobility, and comfort, than a shelter setting may. And so this tool I think can be really helpful, especially with some of our older animals where mobility is compromised or there may be pain, and I encourage people to take a look at it if you haven't seen it. It's also in the useful links from this webinar.

And then the last – and again, I said I wasn't going to talk a lot about behavior, but I did want to include this, that the other way I think we use proxy assessment in shelters is a behavioral measure. What is the animal demonstrating in the shelter? Are they demonstrating normal, species-typical behavior? So they're grooming themselves, they're demonstrating play, they're demonstrating social interactions with people, or are we seeing abnormal behaviors? And we all know that *[inaudible]*, when they start circling in the cages, when they're jumping off the wall, that that is a bad sign in terms of welfare in the shelter. And for me that is usually a key sign that we need something else for that animal, and foster care is sometimes a good choice.

Lynne Fridley: Dr. Berliner?

Dr. Berliner: Yes?

Lynne Fridley: Dr. Berliner, it looks like we may run over if we're going to take some questions, so I just wanted to warn the audience that this may run a little over one hour. And we're going to take as many questions as we possibly can at the end. Sorry to interrupt.

Dr. Berliner: Oh, that's okay. I think some of this will go a little bit faster as I move along, too.

Lynne Fridley: Okay, great.

Dr. Berliner: This philosophical part is always a little bit more challenging I think to lay out, but the protocols will be pretty quick. So response to environmental manipulations in in terms of enrichment – are the animals responsive when we interact with them? Are they showing avoidance or aversion behaviors and trying to get away from things we're providing? And, again, preference studies – if we give them options for things, what do they choose, and then are we able to give them more of that? So this sort of element, too, I think plays a big role in looking at how an animal's doing in the shelter, and then whether foster care might be a better option for them.

All right, so let's see. Let's actually talk about protocol-based foster care, since that's why we are here. And so what does this all have to do with foster care? I think I've probably said it a few times already now. I think assessing quality of life of the animal is key in deciding whether it's treatable, and then assessing how they're doing in the shelter in terms of their quality of life in-shelter helps to assess whether they'd be better in foster care and whether we can serve them in foster care. And all of this comes back to proper case selection for foster animals. I think it's key to the animal's welfare, in terms of deciding who's best-treated, how do we treat them most efficiently, and are we really going to provide appropriately for them when we do that.

So a little sideline – this was from your survey. I asked, "How does your organization provide medical care for fostered animals?" and what came back is that about two-thirds of the organizations that answered this survey were working with a private vet in the community. And this was not exclusive answer so it could be a combination of things. One-third of the people replying, their organizations paid a staff vet. Almost half of them had a paid technician in providing medical services, and 20 percent – one-fifth had a volunteer vet. So kudos out there to the volunteer vets helping shelters provide medical care, because certainly this is critical in treating

treatable animals, and sometimes it takes a lot of creativity and figuring out how to do it for your organization.

So the role of protocols in the shelter, why we need them, is because we really need standard practices, and that enables the staff to actually enact care for our animals. And what I'm going to say is that I think we actually need to go a step further, and once you have protocols for your shelter-based medical care, really looking at trying to do protocols specific to foster care. That provides training for foster parents on basic aspects of disease, supportive care, housing and decontamination, and what the adoption implications are.

Specific to foster care there has to be some plan in place for 24/7 emergency care. Foster parents need to be able to access someone from the shelter or a veterinarian in the community or the technician — it can be somebody at the shelter with medical training to provide them with advice and/or referral for animals, and overnight or weekends. And then those protocols also help to give clear expectations for what treatment entails. What is actually involved in treating that animal so that it can best be done in foster care?

Recognizing that – and I was just at a conference last week, a day-long symposium put on by HSUS called "Rethinking of the Cat," and one of the first things the first speaker said when she got up there is, "You need to know your local laws." And everybody kind of laughed, but it's really true. There are laws that dictate what sort of treatment can be administered by a non-veterinarian in every state, and these things fall under the Veterinary Practice Act. It's not sexy or exciting to read, but you need to know that they are out there.

So at the state level there is a Veterinary Practice Act that defines the scope of veterinary practice, and usually it is limited to a licensed veterinarian in every state. The realm of the veterinarian is diagnosis and treatment of disease, and this is fairly consistent across the states. This is in practice acts in many states if not all of them, so diagnosis and treatment of disease. Prescribing medication is the realm of a licensed veterinarian by law. And performing procedures like surgery, alternative medicine, and in many places dental – not all – is considered veterinary practice and kept to a licensed veterinarian.

In some states providing recommendations is the realm of a licensed veterinarian, and this is coming out of telemedicine or online consultation or phone. And so it's important that you know whether providing a medical treatment recommendation is legally restricted to veterinarians in your state and be really careful about whether you're following that restriction or not. So I wanted to bring it up because I want you to know if

you're not a veterinarian that this does exist out there, and it does impact how veterinarians can work with your shelter.

It's also important to know that in some states there's actually recognition of a role for the shelter, and I'll talk about that a little bit further down this slide. So the AVMA, which is the professional organization of veterinarians, wrote a Model Practice Act in 2013. This is not a piece of legislation per se; it is a document that is meant to act as a model for the states that write the practice acts. Like I said on the last slide, that is a state-level legislative piece, and this is a model that the larger national organization has written.

What they say is that – they define very specifically direct supervision of veterinary practice means that there is a licensed vet on the premises who assumes responsibility for the procedure. Indirect supervision means that the vet does not need to be on the premises but has given written or oral instructions, is available by phone, and assumes responsibility. And it does include a specific statement for shelters saying, "Trained employees may provide treatment for shelter-owned animals in compliance with written standard protocols developed in consultations with a veterinarian."

So why is this important? It's not national law and it's not federal law, but it is the Model Practice Act for states to create their practice acts. Some states are more shelter-friendly than others. This is a very shelter-friendly statement, actually, because it really says that as long as a veterinarian is assuming responsibility for the treatment of shelter-owned animals, then it can be offered. And this really empowers shelters and shelter vets to create protocols that then can be followed in the event that illness arises, which it does.

And so the key here is I think the AVMA has actually been really progressive in writing this, and I'm hoping that more states kind of fall in line to be a bit more inclusive in some of their own practice act writing. And it would be impossible for me to talk about each state; they all differ greatly. But I do want you to know it's out there and you should look at it. They are published online in each of the states, and it will impact your organization.

So most shelters, we encourage them to have medical protocols with added specifics for foster parents. And so a shelter protocol – and I have a template in your resources section – has a title of disease, should have a shelter policy, should have how to recognize and diagnose disease, who should be notified when there are cases of disease, how to treat it, what the outcome decisions may be – what is possible – and are there any special considerations for adopting this animal out. Is there education that needs to occur or special notification or memos?

So I asked you guys, how are you doing in terms of foster handbooks and protocols? And in asking whether your organization had them, 37 percent of you said your organization does not have a foster handbook or medical protocols, and I found this a little bit surprising because that's pretty low. And so the first step I would argue is that you need to have a foster handbook, and so what I did is I put together some examples in the resources, and it's not that hard. There are lots of examples out there and templates out there to put together a foster care manual. It should include organizational information, some training information – start really simple and steal. Go out there and steal what you like from online, and I've got some really nice models that you can steal from. When I Googled "foster care manual for shelters or animals" I got almost a million hits within 40 seconds. That can be overwhelming, so I tried to narrow it down for you. But a handbook comes first for sure.

When I asked about is your organization offering formal training for foster care, 50 percent said no, and that also kind of surprised me. That was lower than I expected. And so obviously – and I got quite a few comments that people really felt like they needed more support for fostering, and that came across the board. And so I'm hoping – I also pulled together a bunch of training resources for you. There's lots of stuff available online now, but there's also some really important elements in getting your foster people together and working together.

The biggest thing that – when I asked about your experience, most of you felt supported by your organizations, but many of you felt that there was – that you could benefit from more support. 86 percent of you said that fostering was rewarding, but certainly there was an element of looking for more support from the organizations that you're working with. And I did a quick survey just to see what kinds of animals were being fostered in your organizations so that I knew which cases to pull together, and obviously underage kittens seemed to be the ones that all of us are fostering. Beyond that, then I looked at ringworm and parvo and trauma, and those are the ones I kind of focused on. So I'm going to talk briefly about each of those, and I have given you some sample protocols for both – let's see, I did parvo and I did diarrhea, particularly in kittens as your examples that are attached to this webinar at the end.
When I asked what you guys needed it was across the board. These were, boom, the three things: we need more training, we need more support and mentoring, and we need more communication. And so I wanted to make sure I kicked that back to you that, indeed, people want in-person sessions. They want training specific to certain types of fostering and I'm going to talk about that. I think foster training really should be specialized. People should kind of pick areas and then kind of become specialists in those areas. I want to make sure I point out in terms of kittens that nobody

misses the Maddie's Institute training videos on orphaned kittens; there's a link at the end of this. If you did not see the orphaned kitten webinar, if you did not see those videos on how to feed a kitten, how to stimulate a kitten to [urinate/defecate], you need to watch those. Those are amazing training materials for your shelter. And then my favorite at this point foster care manual is, indeed, the SPA of San Francisco. I included that link as well. That's a really nice one to start with and really inclusive.

In terms of support and mentoring, pairing a more experienced foster parent with a less experience foster parent – really helpful. And you guys all said you wanted adequate supplies, and that was a big one, making sure that you had the things you needed. And that's a basic, and I support you in that for sure.

And then communication – people use listservs, Google Documents, an emergency contact phone. And I included an animal sheltering article as well about an on-deck system for scheduling fosters, which I know Sandra Newberry also talked about in her webcast. That article's available online and really helpful, so lots of things out there to change what you're doing even tomorrow and to start small with some new changes so that you can feel more supported.

Here's my exit plan spiel. Foster care needs to be planned, not a default. So the shelter's role is really defining. What makes good foster animals? What does well in foster? And having a timeline – people should not put animals in foster because they don't know where else to house them or they're not sure what else to do. The foster needs to be a planned system. You know how long they're going out for, what the goal is, what the prognosis is, what their exit plan is for adoption or transfer or whatever it is, and making sure that you match your foster parents to the correct cases.

The foster's role is to know your limits and to be sure you ask for help, because we really need you not to burn out. We really need you to be able to stick with it. And so that case selection and the matchmaking I think is lot more important than maybe we've given attention in the past when we've just simply said, "Who can take this animal because we need it?"

The veterinary support piece is another huge piece and obviously my area of interest. Everybody said, "I need after-hours support, I need an on-call somebody who can help me or refer me," and I think every shelter needs to have some emergency care plan. I know resources are tight, but if you're going to treat treatable conditions, if you're going to take on the parvo cases, the neonatal kittens, the orthopedic cases that may be tricky, you have to have veterinary support for that and you have to have emergency veterinary support for that for people and animals to be successful. Remember, a foster parent is meant to take the role of an

owner, not a veterinarian. So we can provide them with special training, foster parents with special training, just like we can provide owners with special training, but we cannot expect them to act as a veterinarian. That is not their role. They're expected to act as a really invested, super supportive owner who doesn't need a lot of sleep. But that is what we need them to be: owners, not vets.

The protocol specific to foster care – I've given you a template at the end of this talk, and that's kind of a schematic of it there. So it's similar to an overall protocol for the shelter. There's a policy, recognition and diagnosis, notification, treatment in foster care, and this is written for foster parents essentially. It may be a little bit more detailed than what you want, but it's kind of designed to take that in-shelter medical protocol and apply it to a foster home and give foster parent's something to work with and really outline what are the outcome decisions, what does this mean for the animal long term in terms of adoption. And I have popped that up there so that you guys can just take it and populate it for your own shelter in collaboration with your veterinarian.

So now we get to stories, and yeah, I might run a little bit long so I'll try to cut some of the stories short, but really I wasn't going to talk about these in great detail. They're more to illustrate the idea of these protocols.

So orthopedic cases as foster cases: I think a lot of these can make some really good foster matches and be highly successful. If it's an orthopedic case where you already have a healing, stable fracture, you have a postoperative animal; you have minimally-displaced fractures or young animals that will heal relatively easily. Cats with pelvic fractures – these can all be good foster scenarios. You see here Shamrock who was a pitty that came to us with a chronic luxated hip, FHO – that was a great foster: a two-week plan for postoperative care, starting physical therapy, managing pain, and then that dog was actually adopted by a friend of the foster parent. So even better: her exit plan avoided the shelter.

These animals need to be able to function, urinate and defecate on their own. You need to be able to manage their pain in foster, and they should be behaviorally sound obviously. But you can have some real success, and again exit plans: How long are we going into foster? What are the expectations of the foster parent? What medications do they need to provide? Do they need to start physical therapy? But all of that is outlined in your protocol for orthopedic cases specifically, and then each animal may have their own physical therapy plan or something specific to them.

The role of the foster home is to provide that supportive care, and they have a clear diagnosis and prognosis. So it's not to take an animal that's

limping and kind of put them in foster and see what happens. You need to do the work upfront so that foster parent knows what they're dealing with. Cage rest is usually what's involved, and managing pain and physical therapy.

This was a dog that had come in as a cruelty case. Limb amputation, also a starvation case, and her plan was a four-week foster plan. Again I'm a little spoiled. She went in with a veterinary student who babied her to no end, and this was a year later when I saw her back with her owners at a local clinic, which was pretty exciting.

Parvovirus – you may be surprised – in fact I'm surprised that I might bring up parvovirus as an outpatient or a foster protocol. But Colorado State has done a lot of work looking at outpatient protocols for parvo for owners. And so they did a study comparing in-hospital care of parvo with outpatient care of parvo, and they've had grand success with an injectable outpatient protocol that's much cheaper and manageable. What is key here is that if you are going to treat parvovirus in a foster home – because you can't manage the infectious disease biohazards in your shelter – that means that is a specially trained foster home with a special facility essentially. They are going to commit to that; that is their project. They're going to have a cleanable, disinfectable, contained space for that. They may need special training in how to give subcutaneous fluids – not intravenous, not ongoing ICU-level care, but maintaining some fluids. But I do think that now that we know that we can be successful with an outpatient protocol between a hospital and an owner that there's some new room for looking at how we can treat parvo in a foster home that is specially trained for that.

And so I actually did provide an example foster protocol for that. Now I am not encouraging you all to open up your bathrooms and put parvo puppies in them. That is not what I'm saying. What I'm saying is that if your shelter has found itself unable to treat parvo in your shelter because of restrictions in the building or isolation, this may be an option for you if you have the right foster person in your community who can take that on as their thing and that's what they do. And you might be surprised that you can find those people. So this is something that you can look at the protocol I provided and kind of assess it, talk to your veterinarians, and see whether there's potential. I also made a link to the actual Colorado State page to help if your vet wants to look at that or help you design something for your particular organization.

Kittens are the big one, right? We all send kittens into foster. We've been doing some work lately tracking our kittens in foster to try and figure out how to be more successful in terms of supporting more of them and not worrying so much about losing some of them in foster care, which many

of you wrote to me in the survey about the pain that is involved – your own personal pain in losing foster kittens. The thing that we've found this summer with the study that we've done – and I included a copy of our template. We've asked all of our foster parents to monitor weight daily, to monitor ins and outs, to monitor disease scale. We give them all a gram scale. We give them all a fecal scoring chart so they can kind of score the poop. And we can talk to them on a regular basis about these various components of kitten health, and then recognize earlier if something's going wrong.

No one has the big secret about kitten diarrhea. I know you all want me to have some magic bullet for kitten diarrhea; I do not. I wish I did, but I do think that enhancing your kitten fostering by really close monitoring, monitoring weight and then kind of adjusting food, adjusting some support, nutraceuticals, et cetera. I included a kitten diarrhea protocol for foster parents also in the resources which I encourage you to take a look at.

And then there's lots of resources – I already talked about the Maddie's Institute videos, critical, critical, critical for your people that have kittens at home, neonatal kittens or kittens that they're fostering. There's also a really good tube-feeding video that I found. It was my favorite; I've looked at a lot of them. I think teaching tube-feeding to some of your more advanced fosters can be a lifesaving piece of education, those that are taking on the really young. Tube-feeding can be really scary, so it's advanced fostering, but specialized training is possible for those guys, to teach them.

And this just gets to the fact that fostering really is about levels. There are people who will want to be basic foster parents. They should get your healthiest, and in this case it's healthy kittens and moms and kittens. And then you can really start to look at advanced levels of fostering and providing the training specific for that, and then I would argue you start to look at even having specific disease fosters like parvo, like ringworm, people who really focus on those areas.

I have a couple of scan issues. This is just a couple of slides – we're actually wrapping up – and I put this picture up because this cat was one of my own personal tortures. And looking at her, you have to love her, right? But do know she's wearing that jacket because she's pulled all her hair out, and she's got that e-collar because she licks herself continuously. Skin issues for me are one of the hardest ones to look at for foster care because I don't have a timeline. It's not something like parvo where you know that if you get them through it in 10 to 14 days you're kind of out of the woods. Skin drags on and on and on, and it's probably going to be a chronic issue for your adoptive owner. And so in committing to these it's

really important that you have your plan in place and organized and you know exactly what you're willing to take on.

So these were more thrown up there for discussion. Allergy cats – this is pretty girl without her coat on, as you see. This case took about two months to get under control in foster, and that was a specialized foster who really took interest in this, was willing to manage an allergy issue which involved a hypoallergenic diet trial, various medications. This was way above and beyond. If you're going to commit to some of these cases, you need to know that they can go on for months, and you need to have a plan in place for that because they really do become chronic manage issues.

Your foster's role here is to really assess whether you think that an owner's going to be able to manage this condition. And that's kind of their job, is to be able to measure how much is involved and is the animal suffering in the process, because some of these conditions are pretty uncomfortable. And what is your timeline or what are your goals? Certainly outcomes – you hope that that outcome is adoption, but you need to recognize that at times the welfare – these animals can be so debilitated that their welfare can be compromised.

You know, is mange a fosterable condition? Again, do you have somebody willing to take it? What's your timeline for treatment? Sarcoptic mange is highly treatable, two to three weeks. It is contagious. It is zoonotic to people, so that means you have a protocol in place that informs the person of exactly what they're taking on, how to treat it, and what the goal is, which is two to three weeks from now the animal gets adopted, doesn't linger because it can move along.

Demodex can be harder, can take longer, but certainly in some puppies it's self-limiting, and so they will just resolve it on their own, so maybe that's completely reasonable. I think most of the time it is.

Ringworm is another one like parvo. I am not telling you all to start fostering ringworm. But if you have particular fosters who want to make this their project – because in reality if they contaminate that particular room or area of their house they probably shouldn't take other types of fosters. They need to become your ringworm foster. It is a four- to six-week commitment a lot of times, maybe shorter, but that's what you should anticipate. They're going to have environmental contamination. They need to strictly isolate that animal from other animals. So this is an advanced, specific fostering setting.

The actual treatment for an animal amenable to treatment is a reasonable treatment: oral medications and some dipping, some baths. But certainly it's going to take somebody with a special drive to do this, and they

shouldn't do other types of foster then in that setting. They need to confine that area. Essentially it creates an isolation with better enrichment, better human interaction than you may be able to have in your shelter.

So I'm wrapping up now. In summary foster patient care selection is key. Really try to choose animals – for foster parents to be successful they need to have cases they can succeed with. And so it's really important that the shelter plays an active role in looking at the quality of life of the animal, looking at the condition and its treatability, and then assigning appropriately with a timeline, a plan, and reasonable biohazard management, clear expectations in terms of what are the outcomes, and then support of the shelter staff and the veterinary staff. And each of these dogs are cases that were fostered with our local organization – again, clear timelines. Even though Daisy on the bottom was my foster – four weeks at Christmastime – but I knew that's exactly what I was getting, and that that ex pen was going to be the centerpiece of my kitchen when my family came to visit.

So in conclusion – I'm trying to skip a slide; that's not going to work. All right, you just have to see them all now. Foster patients are cute. That's that slide, because I'm not going to tell you all the stories of them. But yes, choose them appropriately.

And in conclusion, having protocols does save time and lives. Veterinarians are essential to medical protocols for foster care – absolutely essentially. And foster care is absolutely the pinnacle of community collaboration. Communication is the other thing all of you kicked back to me in the survey. Communication. Communication. We need to know what's happening. We need to be able to communicate with other foster owners, with the shelter, ongoing training, and ongoing conversation about how we can do it better. And so I applaud you all in the efforts that you're doing and I thank you for it and I hope that you have found this helpful and that you find the resources helpful in going back to your shelters and problem solving what you're trying to work on.

I do at the end of this presentation, and you'll see it when it's online, have all of my references that I referred to, along with a repeat of all the URLs and links. But those will be published on the Maddie's site. So, Lynne, I apologize. I did run a little bit long. Do we have time for a couple questions?

Lynne Fridley: Sure, yeah. We'll go with a couple of questions, Dr. Berliner. Let me pull one up here and we'll take the first question. "What are the key issues with ringworm foster care? I'm interested in becoming a provider for ringworm-afflicted cats and kittens."

Dr. Berliner: Great question. So I would say there are a couple issues. The biggest one is contamination of your home environment, because once you get ringworm in your environment it can be very hard to remove from your environment, and then it is a concern for your own pets, for you because it is zoonotic, and for any future foster animals that you bring into your home. And so the people that I know that have successfully done ringworm at home, they essentially have a space that they have made their ringworm treatment area: a bathroom, an extra bathroom that they don't use, you know, maybe a basement bathroom. I had one woman who actually built like a shower kennel in her basement because she decided this is what she wanted to do. Showers actually make really — those big shower cubicles make really nice housing units for kittens with ringworm, because then you just turn the shower on and wash things down.

So decontaminating the environment is key. You cannot have fabrics. You cannot have carpets. You need to manage the biohazards. But if you can do that — I mean, again, no one wants to use knives for ringworm. It's a skin condition that doesn't bother the animal, but it is a public health concern and it is often prolonged treatment, so four weeks minimum. But if you are able to kind of look at your home environment or design a facility and take that on as your project, any shelter would love to you have because you will absolutely save lives. And what you're also doing is preventing the spread of ringworm through the rest of the shelter, and a ringworm outbreak can shut a shelter down, can really be debilitating. So somebody who is willing to take that on and then kind of learn about the disease, learn about how to decontaminate the environment between cats coming in, and how to protect themselves and the rest of their home, that person is absolutely invaluable.

Lynne Fridley: So the next question is, "Can a dog with sarcoptic manage reasonably be managed in a foster home with other pets?"

Dr. Berliner: That's a good question. So sarcoptic mange is transmissible to other pets. That dog would need to be isolated at least for – now it depends on which dermatologist you talk to, but my local dermatologist has given me permission to essentially after the second treatment, which is week two, allow that animal to then be bathed and kind of released into adoption even. So two treatments is generally enough to feel like you've gotten it under control for a basic case of mange. I will tell you that complicated cases of sarcoptic mange that are really severe with skin infections, that level is going to take longer. But if you have applied a dose, whatever dose your veterinarian – there are different meds, but a veterinarian prescribes a dose of medication. There may be some bathing that occurs, and then a second dose of medication. At that point it is probably safe to go ahead and let them be released with your other pets.

The other part of that is making sure that your pet has a flea and tick treatment that helps prevent mange, and there are some. I don't want to promote products right now on this webcast, but there are some flea and tick treatments that also are effective against mange. If I was taking home a sarcoptic mange dog I would just make sure that I was treating my own pets with that flea and tick treatment, and that would provide that extra insurance so that I didn't worry so much.

In cases of sarcoptic mange, it's really an allergic reaction to very few mites, and so there aren't many mites. It's not like a flea infestation where the animal's covered. And so those are actually fairly easy to keep from spreading as long as you are smart about it and you actually start treatment on that dog and then essentially protect the other dogs. I would not mix them immediately but I would isolate for a period of time, usually a week.

Lynne Fridley: Excellent. Let's take another question. "How successful do you think a high-volume shelter could be with only a part-time veterinarian, approximately 15 to 25 hours a week?"

Dr. Berliner: Yeah, that's tough. That is really tough. And I'm not sure what high-volume means in terms of intake numbers there. Every shelter could always use more veterinarians. And I say that as a veterinarian and I really I'm biased, but I really think on some level that's probably a true statement. If you have a veterinarian who's only part-time, I would encourage you to do something that may sound a little crazy initially, but you need to take that veterinarian and not just have them looking at individual ill animals and not just having them do spay/neuter when they walk in that door. If I was a shelter hiring a part-time shelter veterinarian right now, I would give them a fair amount of time if not all of their time initially to sit down, walk through the shelter, look at the protocols in place, and write protocols – medical protocols, treatment protocols, treatment protocols – because that is what's going to essentially take what they know and stretch it out over the rest of the staff.

So your best use of that vet initially is not treating the injured animal that walks through the door. Maybe you have to continue to use a private practice vet or whatever you've done in the past for that. Maybe you need to get in a spay/neuter person to do spay/neuter for that day a week or two days a week, so that that vet could really focus on getting protocols in place and training staff, because that will essentially expand that part-time veterinary role into a team of people who can enact what that vet recommends. And that's going to be the way that you're most successful in that scenario with a high-volume shelter and a vet only 15 to 20 hours a week.

Lynne Fridley: Okay, excellent. Here's another question. "Cost is a major factor for treatable animals. How do you handle this?

Dr. Berliner: Cost is a major factor for treatable animals, and that's where I go back to the idea of what is reasonable for an owner in your community, because cost is a major factor for owned animals, too. Owners struggle to meet the needs of animals that they own, and a lot of them end up at our shelter, right, because now we will see animals that can't treat their animal and so their solution is to surrender it to the shelter.

A couple of ways – I don't have the absolute answer on that. Obviously there's an element that it's going to cost money. Certainly there's the idea that working with a veterinarian that can help you look at options. So it used to be that you walked into a veterinary hospital with a dog with parvo and you – here – received a bill or an estimate for $2,000.00 because inpatient was all that would be offered to you. Now we have research that shows that outpatient can be helpful. So you need a vet that is willing to kind of look at options and try to manage that case in a reasonable fashion – what is reasonable for your shelter.

The other is that medical fundraising does tend to be successful, so really going after donations or money to support medical cases specifically can help with that. Having protocols actually is cost-effective, because if you have outlined how to treat a particular condition, that means you have kind of – you've decided what the standard medications you want to use are. Maybe you order them in bulk. Maybe you do a cost analysis to see which of the three options is most cost-effective.

And then certainly I think the last element is that sometimes it may be cost-prohibitive to treat a condition. If your shelter can't afford to treat a condition humanely and in a timely fashion, then maybe that animal's not capable of being treated in your shelter. And none of us wants to be in that scenario, but I do worry that if we expect owners to treat a condition, then we need to be ready to treat that condition. We need to do it quickly and effectively and relieve that animal's suffering. And if we can't do that, then we need to really look at whether that animal is treatable in our environment.

Lynne Fridley: And possibly they could transfer to a rescue organization that could take it. We'll take one more question and then we'll wrap up for the evening. "Would behavioral issues be included in the Asilomar Accords?"

Dr. Berliner: Yes. The matrix – the Asilomar Accords apply to behavior conditions, and the matrix, that chart that I talked about, organizations are also encouraged to have a behavioral chart that they refer to. And like I said, I think there could be an entire webcast on foster care for behavioral issues

because I think case selection is key there. Having behavior modification protocols are key. There's all sorts of things that are really useful in approaching behavior with that kind of thinking, and so absolutely.

Lynne Fridley: Excellent. Well, that's the end of our event this evening. We want to thank Dr. Berliner and all of you for your time tonight. Please click on the link on your screen to take our survey. If you don't see it, it may have been blocked by your pop-up blocker or it could be on a different screen, but that's okay. We'll e-mail the link to you and we'd really appreciate it if you'd take a few minutes to respond.

Make your plans to join us for our next webcast, "The Best Medicine: Playing with Shelter Dogs," with Dr. Brenda Griffin on October 2nd at 9:00 p.m. Eastern. Get more information and register on our website at www.MaddiesInstitute.org. All of the resources that Dr. Berliner talked about tonight are also available on our website immediately after this presentation. If you didn't get a chance to look at the widgets and the resource widget at the bottom of your screen, just go to our website and they'll be there.

Thanks for tuning in. We've really enjoyed sharing our evening with you tonight. Good night, everybody.

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