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A Qualitative Case Study of Accessible Veterinary Care Programming in Sacramento County, California

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Preamble

This study was conducted to support regional planning for accessible veterinary care efforts in Sacramento County by documenting the services provided by nonprofit and animal sheltering organizations, identifying perceived gaps in care, and provider proposed interventions to increase accessibility. The thesis presented here intentionally provides greater detail than would typically be permitted in a journal article allowing for fuller description of the regional context, study methods, participant perspectives, and analytic interpretation, thereby supporting transparency and preserving the complexity of the findings. Following completion of the thesis, the manuscript will be shortened and reformatted for future publication in the Journal of Shelter Medicine and Community Animal Health while retaining the study's primary findings.

Abstract

This study characterized the accessible veterinary care program landscape in Sacramento County, California, identified provider-perceived gaps in care, and examined strategies to strengthen regional service delivery. A qualitative embedded single case study was conducted with representatives from nine of twelve eligible nonprofit and animal sheltering organization-operated programs during 2025. Semi-structured interview transcripts, field notes, and publicly available program materials were analyzed using inductive thematic analysis. Participants reported that demand for spay/neuter, urgent medical, and dental services exceeded available capacity, while preventive services were perceived as relatively available. Workforce shortages, administrative burden, funding limitations, and infrastructure constraints restricted service

delivery and program growth, while referrals, resource sharing, and complementary program roles supported access across the regional network. The findings suggest that regional accessible veterinary care program planning should address service-specific gaps while investing in clinical capacity, organizational infrastructure, workforce development,
and continued interorganizational coordination.

Introduction

Access to veterinary care is a complex public health challenge involving many barriers that can prevent families from obtaining timely care for their animals. National survey data indicate that barriers to veterinary care have increased, with the proportion of families reporting at least one barrier rising from 25% in 2018[1] to 37% in 2025.[2] While appointment availability and transportation were frequently reported, cost is consistently identified as the most common barrier to care across studies.[1,2] Notably, recent survey data showed that more than half of pet owners have delayed or declined recommended veterinary services with 71% citing financial constraints as the primary reason.[3] While cost-related barriers affect families across the socioeconomic spectrum, lower-income families are disproportionately impacted, putting the estimated 23 million American pets living in poverty at increased risk of forgone or delayed care.[4]

When families lack access to veterinary care, animal health and welfare are jeopardized with consequences extending beyond the individual pet. Delayed or forgone care may lead to family distress and anxiety, straining the human-animal bond,[1] increasing risk of zoonotic disease spread,[5] and contributing to pet relinquishment and euthanasia.[2] Additionally, veterinary professionals and animal welfare workers may also experience moral injury when financial

limitations prevent families from obtaining needed care, contributing to occupational stress and burnout.[6,7]

In efforts to improve accessibility, animal sheltering organizations (ASOs), nonprofit groups, and veterinary colleges have developed accessible veterinary care (AVC) initiatives designed to address barriers to care. These initiatives serve diverse communities through a range of care delivery models, including subsidized preventive care, high-quality high-volume spay/neuter (HQHVSN) services, and mobile and community-based clinics, while also providing supports such as transportation, translation, and collocated human health services.[8,9] AVC programs have expanded substantially in recent years, with approximately 60% of animal sheltering organizations now providing some level of community-facing veterinary care, reflecting the sector's growing role in supporting pet retention and preventing unnecessary shelter intake.[10] Despite this expansion, many programs face persistent challenges that limit their ability to sustain community-facing services. In California, 81% of surveyed ASOs reported being unable to consistently provide community-facing "safety net" veterinary services, with funding and workforce limitations identified as primary barriers.[11]

Sacramento County contains a diverse network of animal welfare organizations, nonprofit clinics, and community-based veterinary programs that provide services to pets and their families. However, there is limited systematic documentation of the services currently available, how organizations interact within the broader care landscape, and where providers perceive persistent gaps in care. A coordinated understanding of the regional service environment is needed to support strategic planning, strengthen collaboration among organizations, and inform allocation of limited workforce and financial resources.

To date, studies have largely focused on national trends in accessibility or individual programs.[12,13] While developing networks of accessible care options and increasing pet family awareness of these options have been proposed as mechanisms to increase access,[14,15] little published research examining how multiple AVC programs function collectively within a defined regional service environment was identified at the time of this study. Landscape assessments are commonly used in human healthcare planning to identify service gaps, understand referral pathways, and guide resource allocation; however, similar assessments of veterinary care systems remain limited.

Accordingly, this study sought to characterize the AVC program landscape in Sacramento County, California, and identify opportunities to strengthen service delivery. The research questions guiding this study were: (1) What veterinary services are currently offered by ASO and nonprofit AVC programs in Sacramento County? (2) Where do program practitioners and managers perceive gaps in AVC? and (3) What interventions or collaborations do participants believe would strengthen AVC in the region?

Methods

Study Design

This study was informed by a pragmatic philosophical orientation, in which methodological choices are guided by their utility in addressing real-world problems.[16] Qualitative case study methodology was used to provide in-depth understanding of local systems, processes, or phenomena within their natural context through the analysis and integration of multiple data types.[16] In human healthcare research, case study designs are

frequently used to investigate care delivery and interprofessional collaboration that cannot be understood apart from their context or without incorporating the experiences of those involved .[17,18] Through emphasizing real-world complexity, case studies can provide practical insights to inform healthcare delivery, policy, and improvement.

This study utilized a qualitative embedded single-case study design where the Sacramento County accessible veterinary care network was conceptualized as an overarching singular case with individual AVC programs serving as embedded subunits of analysis. The overarching case was bounded geographically to Sacramento County, temporally to the 2025 study period, and organizationally to nonprofit and ASO AVC programs providing community-facing veterinary services to family-owned dogs and cats during the study period. Analysis of multiple types of qualitative data including semi-structured interviews, field notes, and program websites allowed for understanding of program-level practices along with shared contextual factors influencing AVC delivery in the county.

Regional context/setting

Sacramento County is in the northern portion of California's central valley with a population of 1.6 million living among 560,000 households. At the time of this study, the county was predominantly urban (97%), with a median household income of $92,175 and 12.5% of residents living below the federal poverty line, defined as an annual income of $31,200 for a household of 4. There were an estimated 6,615 residents experiencing homelessness.[20] Approximately 42% of residents identified as White (non-Hispanic), 25% Hispanic or Latino, 19% Asian, 9% Black or African American, and 5% American Indian, Pacific Islander, or 2 or more racial groups.[19]

Positionality and reflexivity

The research team consisted of three university-affiliated veterinarians involved in AVC program management and care delivery in the region. The research team's positionality facilitated access to participants and pre-existing knowledge of the region, which required attention to potential power imbalances and bias. To mitigate the possibility of undue influence, recruitment materials emphasized voluntary participation and confidentiality, and reflexive memos were maintained throughout data collection and analysis to surface and challenge researcher assumptions.

Sampling and recruitment

This study included nonprofit and ASO-operated AVC programs which provided community-facing veterinary services while addressing one or more barriers to care identified in the literature. Eligible programs were located in Sacramento County and operational or in planning during the study period. Programs were identified through professional knowledge of the region, web-based searches, public veterinary service directories, and referrals from participating organizations.

Purposive total population sampling was used to recruit representatives with operational knowledge from all eligible programs to develop a comprehensive and equitable understanding of the regional service landscape.[21] A representative from each eligible program was contacted by email on two occasions and provided with an invitation to participate, along with an overview of the study's purpose and procedures.

Data collection

Semi-structured interviews were conducted with AVC program representatives by one of the authors (JK). An interview guide was developed with input from veterinarians experienced in shelter medicine and AVC programming. Interview domains included program mission, services offered, communities served, operational strengths and constraints, perceived gaps in accessible veterinary care, and potential approaches to improve access to AVC programs in Sacramento County. The semi-structured interview format ensured that domains of interest were addressed while allowing flexibility to explore emerging issues and participant perspectives.[22] The interview guide was piloted with an AVC program veterinarian in a neighboring county to assess question wording, flow, and interview length.[23] Interviews were conducted between April and December 2025 via Zoom or in person based on participant preference and ranged from 22 to 55 minutes. With participant consent, interviews were audio recorded using a smartphone and digital recorder and transcribed verbatim to support accurate analysis.

Field notes were recorded during and immediately following each interview to document contextual details, nonverbal cues, and analytic reflections.[24] These notes supported interpretation of the data and enhanced rigor by contributing to an audit trail and promoting reflexive awareness. Publicly available organizational documents, including websites, mission statements, and service descriptions, were collected and reviewed to contextualize interview findings and support understanding of each program within the bounded case.

Data analysis

Qualitative data analysis software was used to organize interview transcripts, field notes, and organizational website materials.[25] Qualitative data was analyzed using inductive thematic

analysis to understand each program in its own context while allowing for cross-program and systems-level insights.[26,27] The first author (JK) conducted all coding and theme development. Transcripts, field notes, and organizational website materials were read repeatedly to facilitate familiarization with the data. Meaningful segments of text related to the study's aims and research questions were assigned preliminary descriptive and in-vivo codes, staying close to the participants' language. Similar codes were grouped into categories based on shared meaning and subsequently developed into themes and subthemes representing patterned responses across participants. Themes reflected participants' experiences and perspectives and were compared across programs to identify systems-level factors influencing AVC delivery within Sacramento County.

Rigor and ethics

The study protocol was granted exemption by the University of California, Davis Institutional Review Board (IRB #2279921-1). To enhance credibility and transparency, analytic decisions were documented through memos and an audit trail.[28,29] Reflexive notes recorded during and after interviews were incorporated into analysis to support contextual interpretation and to maintain awareness of the researcher's positionality as a veterinarian within the community.

Participants were informed of the study's purpose and verbal consent was obtained at the time of interviews. Participation was voluntary and participants had the opportunity to stop the interview or omit any questions they did not wish to answer. Because the network of AVC programs in Sacramento County is small and interconnected, there was risk of deductive disclosure for participants through organizational roles and program descriptions. To minimize

this risk, participants were assigned identifiers reflecting their organizational role, but unrelated to their respective program.[30] To support confidentiality within the small and interconnected accessible veterinary care network, programs are described by organizational and service characteristics rather than by name.

Results

Results are presented in relation to the study's three research questions. Participant and program characteristics are first described to characterize program models, services provided, and communities served. Thematic findings are then presented, describing perceived gaps in care and organizational factors influencing program capacity, followed by findings related to interorganizational coordination, complementary program roles, and participant-identified opportunities to strengthen regional access.

Interview participant characteristics

Twelve programs met the study inclusion criteria. Representatives from nine of twelve eligible programs identified participated in this study. Program representatives held a variety of operational and clinical leadership roles including program manager, coordinator, and veterinarian (DVM), providing perspectives on program service delivery and community needs **(Table 1)**. Several participants held dual roles, simultaneously providing direct patient care while also fulfilling program administration and managerial duties including four DVMS who concurrently performed program administrative duties and direct patient care, two operations managers who were also registered veterinary technicians

performing limited clinical duties, and three program coordinators, two of whom also participated in patient care.

Table 1. Characteristics of interview participants representing Sacramento County accessible veterinary care programs (n = 9).

Role	Number of participants (n=9)	Participant quotation identifier
DVM/program administrator	4	D1, D2, D3, D4
Operations manager/RVT	2	R1, R2
Program coordinator	3	C1, C2, C3

Sacramento County AVC program models and services provided

Characteristics of the nine participating AVC programs represented by interview participants are summarized in **Table 2**. Programs were implemented through a variety of care delivery models including stationary, student-run, mobile outreach, and periodic pop-up clinics. One program providing HQHVSN services was in the planning stage at the time of this study. Programs varied in scope of services offered, including wellness/preventive care, HQHVSN services, focused medical and surgical services, and full-service care. Communities served included unhoused and housing-insecure, lower-income, and geographically-defined municipal or county residents.

The three programs with representatives that declined or did not respond to recruitment emails included a mobile ASO-operated vaccine and spay/neuter clinic providing care to lower-income communities, a fixed site ASO-operated vaccine clinic open to all county residents, and a periodic nonprofit mobile spay/neuter clinic open to all regional residents.

Table 2. Characteristics of and services provided by participating Sacramento County accessible veterinary care programs (n = 9).

Organizational type	Program format	Community served	Services Offered				
			Spay/ neuter	Wellness/vaccines	Focused medical services	Focused surgical services	Full service
ASO	Stationary	Regional residents±	✓	✓	✓	✓	
ASO	Stationary	City residents	✓°	✓			
ASO	Stationary	City residents	✓	✓			
ASO	Mobile outreach, stationary	Unhoused/ housing insecure	✓	✓			✓
ASO	Mobile outreach, stationary	Unhoused/ housing insecure	✓	✓	✓	✓	
Nonprofit	Pop-up	Unhoused/ housing insecure	✓°	✓	✓		
Nonprofit	Stationary, Student-run	Unhoused/ housing insecure	✓°	✓	✓	✓°	
Nonprofit	Stationary HQHVSN	Regional residents	✓				
Nonprofit*	Stationary HQHVSN	Regional residents	✓	✓			

ASO – Animal Sheltering Organization
HQHVSN – *High-quality, high-volume spay/neuter*
Focused medical services – *treatment of select conditions conducive to outpatient setting (e.g., dermatologic disease, minor illness or injury, select chronic disease management)*
Focused surgical services – *procedures beyond spay/neuter (e.g., mass removals, amputation, enucleation, dental procedures)*
Full service – *comprehensive care comparable to general practice setting*
✓ - *service provided directly by program*
° - *by subsidized referral to partner organization*
± - *county residency required for select programs*
* - *program in planning at time of interview*

Thematic analysis

Three major themes emerged from inductive thematic analysis relating to perceived gaps in services, factors impacting care delivery, and the partnerships that support AVC program function in Sacramento County. Across programs, participants described a network of distinct

clinic models working collaboratively to provide care and keep pets with their families in the face of staffing and capacity challenges. **Table 3** presents the themes, subthemes, and illustrative participant quotations.

Table 3. Illustrative quotes supporting three themes and subthemes developed through thematic analysis of Sacramento County AVC program representative interviews.

Theme	Subthemes	Illustrative Quotes
Community demand for accessible veterinary care services exceeds available program capacity	• High demand for spay/neuter services • Gaps in minor medical, emergency,	"We schedule about 600 appointments in less than 30 minutes - they're gone. We schedule an entire month in about half an hour." (R2)

	urgent care, dental care • Participants identify cost as primary reason clients seek AVC services	"Dentistry and oral care are a huge unmet need in the pets of the unhoused. We have 16 patients on our dental waitlist, which only has severe cases. I have no idea when my team will be able to get to these patients." (D2) "A lot of people just can't afford services elsewhere." (R1)
Organizational capacity constraints limit care delivery and program growth	• Challenges recruiting paid and volunteer personnel • Role overload and administrative demands • Financial and infrastructure constraints	"I'm trying to think about how to increase our capacity. I think it's a huge personnel issue. I need more help." (D3) "We contemplated a major dental mash-style clinic with partners, but haven't been successful in coordinating the effort. We have the staff and equipment, we just need someone to pull it all together. Unfortunately, I don't have the bandwidth right now." (D2) "A huge challenge is space. We need more physical space." (R2)
Partnerships and interorganizational coordination strengthen the accessible veterinary care program sa fety net	• Partnerships extend capacity beyond the resources of individual organizations • Specialized program models serve complementary roles within the regional AVC network	"We don't have a microscope so I can't look samples, but if I had concerns about something, I could always refer to someone or a partner." (D1) "How do we do the best that we can with the resources that we have? By not trying to be all things to all people." (D2)

Theme 1: Community demand for accessible veterinary care services exceeds available program capacity

Participants described important differences in program capacity across the Sacramento County AVC program network by service provided. While preventive wellness services were described as in high demand across programs and communities served, they were

generally viewed as available with one participant reporting, “there's plenty of microchips and vaccines to go around and people have access to that if they want it” (D2). However, participants consistently reported that demand for spay/neuter, urgent medical, and dental services exceeded available capacity.

All participants expressed concern over the availability of accessible spay/neuter services, describing rapid appointment filling, waitlists of up to 200 animals, and appointment wait times of 4 to 6 months. ASO programs providing spay/neuter services for animals in their care frequently served rescue groups and partner shelter organizations, with one participant expressing concern that limited availability of appointments for owned pets could contribute to ongoing overpopulation, shelter crowding, and perpetual waitlists.

Minor medical, urgent, and dental care services were also consistently identified as major unmet community needs. A participant from an ASO-operated program described increasing demand for financial assistance with medical conditions, stating, “There's more demand for conditions where owners must decide between euthanasia or treating their pet. …we're spending between two hundred and three hundred thousand a year on owned pets. And that represents a very small number of the ones that need treatment” (C3). Dental care was similarly highlighted as a significant gap, with one participant noting, “Really, dental care is what we need a ton of right now” (D1). Participants serving unhoused clients emphasized that timely access to urgent care was particularly important in this community, as delays in treatment often resulted in loss to follow-up when clients relocated or lost access to communication. One participant who had previously worked in another state reported that local shelters there routinely provided urgent care for families unable to afford emergency services and found it surprising that there was “nothing like that here, even for skin and ear infections” (D3).

Participants consistently identified cost as the primary reason families pursued services from AVC programs. Participants reported that clients often sought assistance after receiving estimates beyond their financial means and frequently viewed AVC programs as a last resort when the alternative was foregoing treatment or euthanasia. Cost barriers were also described among unhoused clients with one participant from an ASO-operated program open to all regional residents reporting, "We are seeing an increased number of unhoused individuals visiting our clinics, where even paying half or a third of the estimate that we give them is a challenge," (R1) indicating that financial barriers may persist even when services are substantially subsidized. Several participants also noted that their programs served as most of their patients' sole source of veterinary care because no affordable alternatives were available. One participant summarized participants' perceptions of community need and why families seek care from AVC programs, stating the county "needs lower cost dentals and urgent and emergency care, along with spay neuter. And [people use AVC programs] because of cost. Some people can afford thousands of dollars, but not everyone. We need options" (D4).

Theme 2: Organizational capacity constraints limit care delivery and program growth

Participants described organizational constraints limiting care delivery and program growth. Workforce shortages, competing administrative demands, and limitations in infrastructure and funding were consistently identified as barriers to expanding services and increasing program capacity.

Workforce limitations were described across clinical, support, and volunteer roles. Participants reported challenges recruiting and retaining veterinarians, RVTs, support staff, and volunteers, which affected both current service delivery capacity and opportunities for future

expansion. One participant reflected on ongoing staff shortages stating, “When we first started the program, we were intended to have a full-time coordinator, full-time veterinarian, two full-time vet techs, and two full-time animal control officers. We've never had that” (C1). Challenges hiring RVTs were reported by multiple participants, including one HQHVSN program manager who described hiring a veterinary assistant after an unsuccessful prolonged attempt to recruit an RVT. Although the assistant was described as a valuable addition to the team, they could not induce anesthesia, which reduced clinic efficiency and surgical capacity. Volunteer recruitment was similarly described as difficult, with one participant observing that “volunteering is kind of that luxury. We're asking people to take time out of their already busy schedules to work a sixth or even seventh day” (C2). The same organization described losing a volunteer veterinarian who had previously performed surgeries and dental procedures onsite, resulting in procedures being referred to a partner hospital thus requiring additional coordination. Participants also expressed concerns about staffing future service expansions. One program planning to increase surgical capacity through acquisition of a larger trailer questioned whether sufficient personnel could be recruited to support growth stating, “We're getting a bigger trailer that has two surgery tables. So then the next problem will be, are we going to have enough support staff to be able to safely do more surgeries?” (D2).

In addition to clinical staffing challenges, participants described balancing patient care delivery with administrative responsibilities including volunteer management, program evaluation, grant writing, and partnership coordination. These activities were viewed as essential to sustaining programs but frequently competed with time available for service expansion and organizational development. Volunteer coordination was described as time-intensive, particularly for programs relying heavily on volunteer labor. One participant reported, “I can’t do these

clinics on my own. It's too much organizing since we'd see upwards of 60 people. Because I also have to coordinate the volunteers" (D1). Limited capacity for data collection and program evaluation was also noted, with one participant explaining that "every end of the year we're like oh, we could have tracked that. We should be tracking that," but that "stuff's coming in so fast that I don't think that we always have the bandwidth or capacity to do deep, deep data analysis" (C1). Similarly, one participant explained, "I'm always looking at grants. Whether I have the bandwidth to apply for the grants is the issue right now, and I don't" (D2). Participants also described challenges coordinating collaborative initiatives despite recognizing their benefit in addressing unmet community needs. One participant discussed efforts to organize a multipartner dental clinic stating, "We have the staff and equipment, we just need someone to pull it all together. Unfortunately, I don't have the bandwidth right now" (D2). In larger organizations, staffing shortages in other departments also affected AVC programs, with one participant reporting that AVC personnel were periodically reassigned to shelter operations during periods of severe understaffing.

Infrastructure limitations were also described as barriers to increasing program capacity. Participants reported that physical space constrained the number and type of patients that could be accommodated, particularly in HQHVSN where one participant expressed that "a huge challenge is space. We need more physical space" when describing efforts to accommodate more pets per day in their clinic (R2). Mobile outreach programs similarly noted that van and trailer capacity limited the number of procedures that could be performed in the field. While the representative of one mobile program described intentionally designing the program van for offroad capabilities to reach encampment sites, this resulted in forfeiting vehicle space which presented an unexpected challenge as most patients requiring treatment and transport were

large breed dogs. Notably, two programs described ample clinical space in the face of understaffing, representing underutilized resources available within the network.

Funding constraints were frequently identified, with descriptions of expiring grant funds that supported direct care and support services including transportation, temporary fostering, and emergency care. Participants also noted grants were often available to support direct patient care but less commonly available to fund the personnel needed to increase organizational capacity. Several participants emphasized that sustainable growth would require paid positions rather than continued reliance on volunteer labor. As one participant explained, “we should pay people if we're asking them to come out and work. Especially since our clinics are on Saturdays and that's asking people to work yet another day.” The participant further noted, “if we don't pay, it shows that we don't value the work. Good people want to get paid too” (D1).

Theme 3: **Partnerships and interorganizational coordination strengthen the accessible veterinary care program safety net**

Participants consistently described partnerships and interorganizational coordination as essential aspects of AVC delivery in Sacramento County. Rather than operating as independent organizations attempting to meet all community needs, programs frequently relied on referrals, resource sharing, and collaborative problem solving to extend access. Although collaboration helped organizations maximize use of limited resources, participants emphasized that partnerships functioned as a compensatory strategy for extending capacity rather than a complete solution to unmet community need.

Participants described referral and coordination networks as important strategies for connecting families with services unavailable through their respective programs. Referrals were

commonly made to organizations offering care outside of a program's scope including spay/neuter procedures subsidized through a voucher program when in house capacity was unavailable and specialty procedures when available and medically appropriate. Participants also described intentional efforts to strengthen communication and coordination among AVC providers. One program leader reported establishing regular coalition meetings to discuss community needs, share information regarding available resources, and improve coordination across the county. These meetings were described as opportunities to better understand each organization's capabilities and identify referral pathways for clients requiring services outside a program's scope of care.

Participants serving pets of the unhoused and underhoused particularly emphasized the importance of coordination among outreach programs, shelters, and veterinary providers. One participant noted that "there's a lot of networking that's helped support the unhoused community and the underhoused community in keeping their pets," highlighting the role of coordinated efforts in preserving the human-animal bond as well as improving pet and family welfare.

Beyond referrals, participants described partnerships as a mechanism for extending service capacity beyond what individual organizations could achieve independently. Examples included collaboration between outreach programs and referral hospitals for advanced surgical procedures, allowing mobile programs to focus on preventive care and spay/neuter services while partner organizations provided more specialized interventions. One outreach program described relying on a partner organization to perform mass removals and other specialty surgeries, enabling the mobile team to dedicate additional appointments to spay/neuter services. Participants also described coordinated responses to complex community situations requiring contributions from multiple organizations. One

participant recounted a collaborative effort involving outreach programs, a local shelter, and veterinary students to address canine parvovirus and dog overpopulation at an encampment through medical fostering, rehoming, and spay/neuter services. Another participant described a dog initially identified through a vaccine clinic that subsequently received surgery, temporary housing support, and specialty treatment through multiple partner organizations, illustrating how continuity of care was achieved through collaboration across the network.

Participants described how different program models occupied distinct but complementary roles within the broader AVC landscape. Rather than attempting to provide every type of service, organizations frequently focused on specific populations, geographic areas, or service types and relied on partnerships to address needs outside their expertise or capacity. One participant summarized this approach by asking, “How do we do the best that we can with the resources that we have? By not trying to be all things to all people.” Mobile outreach programs focused on unhoused and geographically isolated populations, HQHVSN programs concentrated on surgical capacity, student-run programs emphasized preventive care and training, and other organizations provided targeted medical, financial assistance, or referral services. Participants described this specialization as a practical response to limited resources that allowed organizations to collectively provide a broader range of services than any single program could offer independently.

Participant suggestions for increasing/strengthening AVC

Participants shared their perspectives on strategies to support the AVC network in Sacramento County (**Table 4).**

Table 4. Participant suggestions for strengthening the Sacramento County AVC network

Recommendation area	**Participant suggestions**
Workforce development	• Increase training of HQHVSN veterinarians • Expand community medicine training • Increase training in spectrum of care approaches • Compensate staff for weekend/community clinic work
Care coordination and navigation	• Develop streamlined referral pathways to surgical services • Create centralized client navigation or call center to connect clients with appropriate resources
Integrated community-based care models	• Expand collocated veterinary and social services • Develop urgent care model serving unhoused and low-income communities

Workforce development was the most frequently discussed strategy with participants emphasizing the need to provide training opportunities for veterinarians in HQHVSN and spectrum of care approaches while increasing the number of paid positions in AVC programs. One participant stated that "the university could help by training more spay/neuter vets," while describing difficulty recruiting veterinarians with HQHVSN experience willing to work outside of traditional companion animal general practice. Participants also suggested introducing students to community medicine and HQHVSN career pathways early in

veterinary school, with one participant noting that exposure “early in a vet students’ career to let them know, this is an option” could increase awareness of these career opportunities (R2).

Additionally, several participants highlighted the value of veterinary student involvement in AVC programs. One participant described positive experiences working alongside veterinary students during outreach events and noted that “it’s a little bit of an eye opening experience for them,” preparing them to meet the needs of all families they may encounter in their careers while also increasing service capacity for the program. Participants also emphasized the need for increased training in spectrum of care approaches. One participant described challenges navigating professional criticism when adapting diagnostic and treatment recommendations to client financial circumstances and suggested that veterinary training should place greater emphasis on providing practical, evidence-based care within resource constraints. Participants noted that increased exposure to spectrum of care decision making could improve veterinarians’ confidence serving resource limited communities who may not have access to specialty care.

Improving care coordination and referral infrastructure was another commonly suggested strategy. Participants described challenges navigating specialty and surgical referrals, particularly for complex cases requiring advanced care. One participant suggested that streamlined referral pathways to specialty services could improve access, explaining that “having one person to call” and review available resources for a case would facilitate referrals and reduce barriers to obtaining care. Participants also proposed developing a centralized client navigation system or call center to connect families with appropriate resources in the region. One participant envisioned “a central receptionist or coordinator” who could help clients navigate available services within the accessible veterinary care network, reducing the burden on families already facing financial and social challenges.

Finally, participants described opportunities to expand integrated community-based models of care. One participant proposed developing a community veterinary teaching and urgent care center that combined spay/neuter services, urgent veterinary care, veterinary student training, and colocated social services for underserved populations. The participant envisioned a model where veterinary care could be delivered alongside housing, mental health, and other supportive services, noting that existing programs often function as "band aids" and that greater infrastructure and reliability could provide centralized services for families in a consistent location. Participants also emphasized the need for affordable urgent care services for unhoused and low income communities, given how lack or deferment of treatment affects welfare and increases risk of relinquishment.

Discussion

The findings of our qualitative case study of the AVC landscape in Sacramento County, California, document that AVC programs function as an important safety net for pet families, but are constrained by workforce shortages, limited organizational bandwidth, and uneven capacity across service types. These results suggest that access to veterinary care in the county is a service specific and networked phenomenon shaped by the interaction of community need, program resources, and interorganizational collaboration.

Demand exceeds capacity with variable access across service types

A central finding of this study is that community demand exceeded participating program capacity, with provider perceptions of access varying substantially by service type. Participants consistently described scarcity of spay/neuter, dental, and urgent/emergency care, while

preventive services such as vaccines and microchipping were perceived as relatively available. National and state survey results of ASOs echo these findings, with organizations reporting consistent limitations in spay/neuter availability, particularly in community-facing programs,[11] suggesting that these challenges are not unique to Sacramento County.

Interestingly, national surveys found that one third of families reported challenges accessing preventive care when desired,[2] while providers in this study perceived these services as relatively available. This discrepancy may reflect regional differences in program availability, as national family survey findings may include communities with fewer AVC programs or fewer low-cost vaccine and wellness options than were described by providers in Sacramento County. It may also reflect differences between program level service availability and family level experienced access where providers may view preventive services as relatively available because vaccines and microchips are offered by multiple programs, while families may still face barriers related to cost, transportation, scheduling, awareness, eligibility, or clinic hours.

Ultimately, these findings suggest that Sacramento County families may have meaningful access to preventive services while still facing major barriers to more complex categories of care. This distinction carries practical weight for local planning, as expanding vaccine access or wellness appointments alone does not address unmet need in urgent care, dental care, or surgical capacity, all of which depend more heavily on anesthesia, clinical space, specialized equipment, and skilled personnel. Future needs assessments and planning efforts should therefore evaluate preventive, surgical, dental, and urgent care capacity separately rather than treating veterinary care access as a single category.

Organizational capacity constraints limit care delivery and program growth

The most constrained services including spay/neuter, dental, and urgent care were those requiring the greatest combination of skilled personnel, equipment, dedicated clinical space, and coordination, which were the resources participants most often identified as limited. One high volume spay/neuter program hired a veterinary assistant after an unsuccessful effort to recruit a registered veterinary technician, but because the assistant could not induce anesthesia, surgical caseload was reduced. Another participant captured the same dynamic directly: "We can have the best veterinarians on the planet, but they can't do their own induction" (R1). A stalled multi-partner dental initiative was described not as lacking clinical resources, but coordination capacity (D2), and physical space was noted as limiting surgical volume by another participant (R2). These examples support the interpretation that the scarcity of surgical, dental, and urgent care reflects the clinical and organizational infrastructure these services demand. These findings confirm and expand existing veterinary workforce literature. Shortages of veterinarians and credentialed technicians are well documented, particularly within the nonprofit and shelter sectors that deliver much accessible care.[10]

A second category of constraint that participants raised that is less frequently examined in the veterinary literature was insufficient administrative and coordinative capacity. Participants frequently described knowing what services were needed and what partnerships could help, yet described lacking the bandwidth to write grants, manage volunteers, evaluate programs, or coordinate partners. This suggests the limiting factor was often not a shortage of ideas and partners to collaborate with, but a shortage of organizational capacity to implement them.

This pattern resonates with longstanding observations in the nonprofit management literature, which holds that coordinators, development staff, and managers serve as essential organizational infrastructure yet are chronically underfunded relative to direct services. This

dynamic is sometimes termed the "nonprofit starvation cycle,"[31] and participants described it precisely, noting that grants more readily funded direct patient care than the personnel needed to expand program capacity, and emphasizing that sustainable growth would require paid positions rather than continued reliance on volunteer labor. These findings suggest that investments in organizational infrastructure including paid coordinators, grant writing support, volunteer management, and data capacity may increase service delivery even without building new clinic spaces or adding veterinarians. This reframes the workforce problem in AVC: the personnel most urgently needed may include not only veterinarians and registered veterinary technicians, but the coordinators and managers who allow clinical capacity to be deployed. Notably, expanded training in HQHVSN and community medicine, which is the most frequently proposed solution to clinical shortages, requires relatively long lead times before it can improve the workforce, underscoring the value of near-term investment in organizational capacity.

The AVC landscape functions as an interdependent network

While presenting challenges, organizational constraints motivated programs to collaborate to increase care to Sacramento County communities, creating a safety net of services for pets and families in need. Participants described a system in which programs occupied complementary, often deliberately specialized roles connected through referrals, coalition meetings, voucher programs, and collaborative case management. One participant articulated this specialization: "How do we do the best that we can with the resources that we have? By not trying to be all things to all people" (D2). Rather than each program attempting to provide comprehensive care, organizations relied on one another to address needs outside their individual scope, extending the reach of collectively limited resources.

This interdependence served multiple functions including connecting families to services unavailable within a given program, extending capacity when one organization could not meet demand, and enabling coordinated, multiorganizational responses to complex situations no single program could manage alone. These patterns mirror concepts from human healthcare, where differentiated providers coordinate through referral pathways and care navigation to serve populations no single provider could serve alone, and where the safety net is characterized as chronically underresourced.[32] Veterinary access to care scholarship has likewise begun to emphasize systems level rather than purely individual barriers,[8] and the 2024 AAHA Community Care Guidelines frame veterinary access as a coordinated, multiple organization endeavor emphasizing collaboration, family centered care, and flexible care options rather than a "gold standard only" approach.[14] By documenting the referral pathways, coalition structures, and deliberate specialization through which Sacramento County programs coordinate, this study offers an empirical account of a regional AVC network as a working system rather than a set of independent providers.

Importantly, participants did not present collaboration as a solution to unmet need so much as a compensatory strategy for managing it. Partnerships extended capacity but did not eliminate the shortfalls described above reflecting that the network was adaptive but resource constrained. Strengthening referral infrastructure, centralized client navigation, and coalition coordination may improve efficiency and continuity of care, but coordination alone cannot manufacture the clinical and organizational capacity the network lacks.

Implications for animal welfare and the human-animal bond

Participants repeatedly noted that clients often sought medical care after estimates exceeded what they could pay, and that some families had no realistic alternatives for dental, urgent, or surgical service. Barriers to veterinary care are known to affect animal welfare, human well-being, and veterinarians' own experiences of moral injury and burnout.[33] Accessible veterinary care program capacity has implications in preserving the human-animal bond and maintaining welfare for animals, families, and program staff alike. The present study shows how these pressures are experienced by local AVC programs where teams respond to urgent community need while operating within limited staffing, funding, and space constraints. This tension helps explain why AVC programs are both essential and vulnerable as they serve families and animals with few alternatives, while also depending on limited staff, funding, and volunteer capacity.

Implications for Sacramento County and similar regions

Taken together, these findings suggest that future investment may be most effective when it addresses service specific gaps, organizational and administrative capacity, and network coordination. Funding should not only target direct patient care, but also support staffing for coordination, scheduling, data tracking, volunteer management, and partnership development. Additionally, regional collaboration may be formalized where feasible so that referral pathways, shared priorities, and joint planning reduce duplication of services and improve client navigation.

These priorities also help frame one participant’s more ambitious proposal that echoed several participants’ desire to expand integrated community-based models of care. The participant proposed developing a community veterinary teaching and urgent care center that

combined spay/neuter services, urgent veterinary care, veterinary student training, and collocated social services for underserved populations. The participant envisioned a model in which veterinary care could be delivered alongside housing, mental health, and other supportive services, noting that existing programs often function as "band aids" and that greater infrastructure and reliability could provide broader and deeper reach for families (D1).

While a new integrated center may appear to conflict with the finding that improvement may depend less on creating new programs than on strengthening existing ones, these approaches can be compatible rather than competing. A model of this kind would not need to duplicate existing services. Instead, it could function as connective infrastructure for the established network by consolidating constrained services such as urgent care, dentistry, and surgical capacity simultaneously providing centralized navigation and building workforce capacity through student training in community-based, spectrum of care practice. Framed this way, the proposed center represents investment in the network's missing infrastructure rather than the addition of another stand alone provider.

Sacramento County appears to have a relatively established collaborative network that already includes many features of a coordinated care system. As such, the most promising opportunities may lie less in establishing entirely new and independent programs than in strengthening the capacity, sustainability, and connectivity of programs already in place. Findings from this study suggest that access to veterinary care is shaped not only by the availability of clinicians and funding, but also by the organizational infrastructure and interorganizational relationships that determine how existing resources are coordinated and deployed.

Limitations

This study has several limitations. The cross sectional design described the Sacramento County AVC landscape at a single point in time and therefore cannot capture ongoing evolution in community need and partnerships as evidenced by one HQHVSN program in the planning stage at the time of this study. Additionally, the study captured the perspectives of AVC program representatives providing understanding of the "supply" side of accessible care, but not those of the families who use these services, nor of private general practitioners and specialists who form part of the broader regional care system. Participants' perceptions of need may not reflect families who do not access AVC programs at all. Interviews also indicated that referral relationships extend across county lines among Sacramento, Yolo, Placer, and El Dorado counties, yet the study was bounded to Sacramento County and nonprofit and ASO-operated programs. The findings therefore describe one important component of the regional system rather than its entirety.

Finally, the first author's position as a veterinarian within the Sacramento County AVC community provided valuable contextual knowledge and access but also introduced the potential for connection bias and for power dynamics to influence participant responses. As described in the methods, reflexive memoing, an audit trail, and emphasis on voluntary, confidential participation were used to mitigate these influences, but the findings nonetheless reflect interpretations shaped by the research team's positionality. Additionally, because the provider network is small and interconnected, confidentiality constraints limited the organizational detail that could be reported. Consistent with the study's qualitative case study design, these findings are intended to provide transferable insight into the functioning of a regional AVC network rather than statistically generalizable conclusions (Lincoln & Guba, 1985).

Future directions

These limitations point to several directions for future work. Client centered studies examining perceived barriers across specific service types would complement the supply side perspective described in this study and clarify whether families experience the same service specific gaps that providers described. Evaluation of referral network effectiveness and client navigation could test whether coordination interventions measurably improve access. Studies focused specifically on administrative and coordinative capacity in AVC organizations would help determine whether such investments increase service delivery, as our findings suggest. Finally, implementation research utilizing evidence-based frameworks such as the Consolidated Framework for Implementation Research[34] evaluating workforce development and coordination interventions, including spectrum of care and HQHVSN training pipelines, could identify which strategies most efficiently expand access over both near and long-term periods.

Conclusion

This study shows that AVC in Sacramento County depends on more than individual clinic capacity. Access varied across service types, with surgical, dental, and urgent care most constrained. Organizational and administrative capacity in addition to clinical staffing limited the ability of programs to expand, and care was delivered through an interdependent network of specialized organizations that managed, but did not eliminate, persistent scarcity. By documenting both unmet need and the collaborative systems already in place, this thesis suggests that targeted, service specific expansion, coupled with strengthening organizational capacity and

network coordination may improve access to veterinary care while supporting animal welfare and preservation of the human-animal bond.

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Appendix

Interview guide

Sacramento County Accessible Veterinary Care Program Interview Guide

- Participant inclusion criteria:
  - Representative of an accessible veterinary care clinic or program defined as a clinic or program that addresses any barrier to care including cost, transportation, communication, culture, available hours, and community awareness of available services located in Sacramento County, California.
  - Respondent $\geq$ 18 years of age

- Session introduction:
  - Review the purpose of the project, that the session will be recorded, and that the results will be used for local planning and may be published in a scientific journal.
  - Get verbal consent from participants prior to starting the interview.
  - Primary questions will be asked of all participants. Follow up questions/probes denoted by letters will be asked pending responses to the preceding question.

- Questions:

1. **How did the program/clinic start?**
    a. *What were some of the factors that inspired its creation?*
    b. *What were the needs the program aimed to address at the time?*

2. **How has the program evolved over time?**
    a. *What are some changes that have shaped its current form?*

3. **What types of services does the program currently provide?**
    a. *Clinical services – wellness, sick pet care, emergency care, spay/neuter, other surgeries, medical record review/counseling*
    b. *Behavior/training - educational content, behavior consults, training classes*
    c. *Transportation*
    d. *Social service*

4. **How frequently are the services offered, and what does that look like in practice? Where are the services offered?**
    a. *Are there any seasonal changes in the frequency of services?*
    b. *(If services are offered outdoors) How do you handle inclement conditions, whether that's rain, heat, or poor air quality?*

5. **How does your program manage medical records for the patients you see?**
    a. *Are records electronic? Paper?*
    b. *What type of documentation do clients receive at the time of their appointment?*

6. **Please describe the clientele seeking care from your program.**
    a. *Where do they live? How far do they travel to seek your services?*
    b. *Is your program the only provider your patients see, or one of many providers they see to get the care they need?*

7. **What, if any, criteria must families meet in order to receive services?**
    a. *How do you ensure the process is transparent and accessible to everyone who needs assistance?*
    b. *How do families find out about the program?*
8. **What is the typical wait time for families seeking services?**
    a. *How do you manage waitlists?*

9. **How does the program address any language or communication barriers that might come up?**
    a. *What languages are translation services most commonly requested?*
    b. *How do folks without computers or cell phones get in contact with your organization*

10. **Why do you think families specifically seek care from your program?**

11. **What additional services or support have families been requesting recently?**
    a. *Can your program provide these services, or refer to someone else in the community?*

12. **Can you describe the staffing structure of your program?**

13. **Does the program hire from within the communities it serves? If so, could you share how the hiring process works?**
    a. *How has hiring locally affected the program?*

14. **How is the program funded, and what contributes to the program's financial sustainability?**
    a. *Do families seeking care through the program pay for services? If so, how are fees structured?*

15. **Are there any specific challenges the program has faced?**
    a. *What steps has the program taken to overcome these challenges?*

16. **Are there any successes that you'd like to share?**

17. **Are there aspects of the program that you feel are especially important for the community? Based on your experience, are there any gaps in accessible veterinary care in Sacramento County that need attention?**

18. How can UC Davis SVM help? Do you want the university's help?