PN-ABZ-430

National Conference on Advances in Hospital Management in the Republic of Albania

Sponsored by:

USAID
United States Agency for International Development

in Cooperation With

OIH/DHHS
Contract Number 282-92-0067

Category II - Health Financing

Tirana, Albania

November 30 - December 1, 1995

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Introduction

USAID sponsored the National Conference on Advances in Hospital Management in the Republic of Albania from November 30 to December 1, 1995. The purpose of the conference was to share the experiences and lessons learned by seven Albanian managers who were trained in the areas of cost finding/financial modeling for decision making, strategic planning, pharmaceutical purchasing and medical records management and used the skills derived to change the management systems in their own institutions.

This conference culminated a series of training and technical assistance intended to assist the Ministry of Health and Environment (MOHE) of the Republic of Albania to develop skilled health care managers. This process sponsored by USAID began in January, 1994 with an eight week Health Services Management Program (HSMP). The purpose of the HSMP was to provide key managers with the basic knowledge and skills to efficiently and effectively manage their health services. Forty-five physician leaders, economists, department heads and deputies of the Ministry of Health and Environment were trained in health care management. Later in 1994, an additional 25 hospital economists were trained in skills specific to the financial operation of institutions.

Beginning in November, 1994 and continuing through 1995, USAID sponsored technical assistance to a small group of select managers from the University Medical Center of Tirana and Durres Hospital to develop the practical application of management skills within their institutions. In April, 1995, the seven Albanian managers participated in a USAID study tour to experience and observe health care management at a hospital in the United States.

Through the study tour and technical assistance process counterpart relationships developed between the US consultants and the Albanian managers. The products of these relationship were practical examples of implementation of modern health care management skills and systems at the two Albanian hospitals. The National Conference on Advances in Hospital Management was an opportunity for the Albanian counterparts to share their experiences with representatives of hospitals from throughout Albania and to disseminate information regarding how other Albanian health care managers also could develop similar systems within their own institutions.

Program Description

The National Conference on Advances in Hospital Management in the Republic of Albania was conducted at the Tirana International Hotel in Tirana during the period November 30 to December 1, 1995 (see conference program attachment A). Over eighty Albanian health care managers representing thirty-nine hospitals and the MOHE participated in the three day conference. Each hospital was represented by the hospital director and chief economist (see participant list attachment B).

The program was introduced by Dr. Maksim Cikuli, Minister of Health; Ms. Deedee Blane, USAID Representative; Dr. Teodor Todhe, Director of Hospitals, MOH; and Dr. Mentor Petrela, Director, University Hospital Center. James F. Janeski served as program facilitator.

Four sessions representative of the subject areas which had been developed by the US consultants and their Albanian counterparts were conducted simultaneously three times during the duration of the conference. This provided the participants an opportunity to experience each of the sessions in small groups of approximately 20 persons each. This arrangement encouraged active participation and discussion.

The Albanian counterparts each presented information regarding the management topics on which they focused during the technical assistance process. The US consultants served as facilitators during the small group discussions. The sessions were divided as follows:

Session 1 - *Application of Analytical Techniques to Financial Decision Making*

Group Leaders: Haki Copani, Economic Director, Durres Hospital
Nevila Karruku, Accountant, University Hospital Center
Enzo Archetti, FNFMA, Consultant

Session 2 - *Strategic Planning for Future and Current Needs and the Best Utilization of Resources*

Group Leaders: Dr. Mikel Nocka, Director, Durres Hospital
Christopher Newman, CHC, CHE, Consultant

Session 3 - *Medical Records for Managerial Decision Making*

Group Leaders: Dr. Mehdi Alimehmeti, Vice Director of Medical Affairs, University Hospital Center
Dr. Natasha Celiku, Chief of Statistics, University Hospital Center
Roland Dale, RRA, Consultant

Session 4 - *Group Purchasing of Pharmaceuticals*

Group Leaders: Gentiana Metuli, Attorney, University Hospital Center
Aferdita Tafaj, Economic Director, University Hospital Center
Todd Ebert, RPh MS, Pharmacist, Consultant

(See attachments C-F for the learning materials which were distributed during each of the sessions.)

The conference concluded with an open discussion during which time the larger group of participants were given the opportunity to describe how they intended to utilize the information collected during the conference.

Participant Evaluation

A brief evaluation form was distributed to the participants at the conclusion of the conference. It included five questions repeated for each of the four management topic sessions and five questions regarding the general organization of the conference. The evaluation required responding to each question based on a scale of excellent, satisfactory or poor. The five questions were intended to evaluate whether the objectives were met, the hospital represented would benefit, the consultant gave a clear and logical presentation, the consultant understood the subject matter and there was sufficient time for discussion. The general conference questions were intended to evaluate the conference rooms, services overall, seminar and audibility.

Although the responses varied, the questions regarding meeting the objectives of each management topic session and the clarity and knowledge of the consultants generally received very high ratings. The responses to the questions regarding whether the hospitals represented would benefit from the information and the sufficiency of time were nearly evenly divided between excellent and satisfactory. The greater majority of the respondents rated the organization of the conference as excellent (see attachment G for Summary of Evaluation).

Recognition

Each of the conference participants received a certificate recognizing his/her participation in the conference. The Albanian group leaders received special recognition for their accomplishments in their respective management areas (see attachment H for Example of Certificate).

December 1, 1995

8:00-10:00 **Session III**
Small Groups 1 - 4

10:00-10:15 **Coffee Break**

10:15-12:15 **Session IV**
Small Groups 1 - 4

12:15-13:15 **Coffee Break**
Organizational Meeting
for Team Leaders

13:15-15:00 **Plenary Session**
(ALL participants)

Presentations by Team Leaders

Conference Evaluation

- James Janeski,
  Program Facilitator

Concluding Remarks

- Dr. Maksim Cikuli,
  Minister of Health
- Ms. Dianne Blane
  Representative of USAID
- Dr. Teodor Todhe,
  Director of Hospitals,
  Ministry of Health

15:00-17:00 **Reception**

Organizer

Healthcare Enterprise International, Inc.

(HEI)

Washington, D.C.

Sponsor

The United States Agency for

International Development

(U.S.A.I.D.)

USAID

THE NATIONAL CONFERENCE ON ADVANCES IN HOSPITAL MANAGEMENT IN THE REPUBLIC OF ALBANIA

November 30 - December 1, 1995

Balsha Room

Tirana International Hotel

Tirana, Albania

NATIONAL CONFERENCE ON ADVANCES IN HOSPITAL MANAGEMENT IN THE REPUBLIC OF ALBANIA

Program

November 30, 1995

8:00-9:00 **Registration**

9:00-10:00 **Plenary Session**
(All Participants)

Introductory Remarks:

° Mr. Joseph Lake,
United States Ambassador

° Dr. Maksim Cikuli,
Minister of Health

° Ms. Dianne Blane,
USAID Representative

° Dr. Teodor Todhe,
Director of Hospitals
Ministry of Health

° Dr. Mentor Petrela,
Director
University Hospital Center

° Mr. James Janeski, FACHE
HEI Program Facilitator

10:00-10:20 **Coffee Break**

10:20 - 12:30 **Session I**

Small Group Sessions
(participants will be divided into four groups that will rotate through all sessions.)

Group 1
Application of Analytical Techniques to Financial Decision Making

Workshop Group Leaders:

Haki Çopani,
Economic Director,
Durres Hospital

Nevila Karruku, Accountant,
University Hospital Center

Enzo Archetti, FNFMA
HEI Consultant

Group 2
Strategic Planning For Future and Current Needs and the Best Utilization of Resources

Workshop Group Leaders:

Dr. Mikel Noçka,
Director, Durres Hospital

Christopher Newman, CHC; CHE
HEI Consultant

Group 3
Medical Records for Managerial Decision Making

Workshop Group Leaders:

Dr. Mehdi Alimehmeti,
Vice Director of Medical Affairs,
University Hospital Center

Dr. Natasha Celiku,
Chief of Statistics,
University Hospital Center

Roland Dale, RRA
HEI Consultant

Group 4
Group Purchasing of Pharmaceuticals

Workshop Group Leaders:

Gentiana Metuli, Attorney,
University Hospital Center

Aferdita Tafaj,
Economic Director,
University Hospital Center

Todd Ebert, R.Ph., M.S.
Pharmacist
HEI Consultant

12:30 - 13:00 **Coffee Break**

13:00 - 15:00 **Session II**

Small Groups 1 - 4
(same as the morning session, all participants will rotate through all sessions during the conference)

15:00 **Luncheon**

National Conference on Hospital Management in the Republic of Albania
Participant List

Name	Position	Hospital
1. Dr. Genc Doçi	Drejtori	Shkoder
2. Berhri Hajdar	Nën drejtori ekonomik	Shkoder
3. Dr. Piro Pine	Drejtori	Korçe
4. Amin Zyfi	Nën drejtori ekonomik	Korçe
5. Dr. Shefqet Deliallisi	Drejtori	Elbasan
6. Z. Korsar Hysaini	Nën drejtori ekonomik	Elbasan
7. Dr. Servet Kojdheli	Drejtori	Vlorë
8. Z. Besniku Sula	Nën drejtori ekonomik	Vlore
9. Dr. Selami Nazifi	Drejtori	Diber
10. Z. Ferdi Fita	Nën drejtori ekonomik	Diber
11. Dr. Mikail Miti	Drejtori	Berat
12. Z. Bujar Lazimi	Nën drejtori ekonomik	Berat
13. Dr. Xhevahir Haxhiu	Drejtori	Kukes
14. Dr. Petrit Lleshi	Drejtori	Kruje
15. Z. Lelezim Guni	Nën drejtori ekonomik	Kruje
16. Dr. Mikel Noçka	Drejtori	Durres
17. Z. Haki Çopani	Nën drejtori ekonomik	Durres
18. Dr. Pavllo Quendro	Drejtori	Gjirokaster
19. Z. Jorgo Pano	Nën drejtori ekonomik	Gjirokaster
20. Dr. Ali Peli	Drejtori	Fier
21. Z. Lulijeta Seiko	Nën drejtori ekonomik	Fier
22. Dr. Agim Berzati	Drejtori	Lushnje
23. Z. Desdemona Mane	Nën drejtori ekonomik	Lushnje
24. Dr. Vasfi Topçiu	Drejtori	Pogradec
25. Z. Lindita Bice	Nën drejtori ekonomik	Pogradec

Name	Position	Hospital
26. Dr. Petrit Stafa	Drejtori	Mat
27. Z. Bujar Rami	Nën drejtori ekonomik	Mat
28. Dr. Dede Jaku	Drejtori	Lezhe
29. Z. Taim Bushi	Nën drejtori ekonomik	Lezhe
30. Dr. Riza Matoshi	Drejtori	Tropoje
31. Z. Bajram Gjongeci	Nën drejtori ekonomik	Tropoje
32. Dr. Sherif Fusha	Drejtori	Puke
33. Z. Rifat Kopani	Nën drejtori ekonomik	Puke
34. Dr. Gjovalin Leka	Drejtori	Miredite
35. Z. Albana Leka	Nën drejtori ekonomik	Miredite
36. Dr. Islam Veliu	Drejtori	Kavaje
37. Z. Bardha Gjoka	Nën drejtori ekonomik	Kavaje
38. Dr. Gjergji Dhano	Drejtori	Librazhd
39. Z. Mirela Mucollari	Nën drejtori ekonomik	Librazhd
40. Dr. Luan Drumushi	Drejtori	Gramsh
41. Z. Fatmir Shtylla	Nën drejtori ekonomik	Gramsh
42. Dr. Niko Bendo	Drejtori	Kolonje
43. Z. Hyzain Lico	Nën drejtori ekonomik	Kolonje
44. Dr. Qazim Metani	Drejtori	Skrapar
45. Z. Gezim Ajazllari	Nën drejtori ekonomik	Skrapar
46. Dr. Mikail Spiro	Drejtori	Permet
47. Z. Genti Ahmataj	Nën drejtori ekonomik	Permet
48. Dr. Skender Bajrami	Drejtori	Sarande
49. Znj. Veronika Bako	Nën drejtori ekonomik	Sarande

Name	Position	Hospital
50. Dr. Eshref Shehu	Drejtori	Tepelene
51. Z. Luman Seferi	Nën drejtori ekonomik	Tepelene
52. Dr. Seit Jaku	Drejtori	Has
53. Z. Jonuz Lala	Nën drejtori ekonomik	Has
54. Dr. Seit Ymeri	Drejtori	Koplik
55. Z. Nazmi Selgjokaj	Nën drejtori ekonomik	Koplik
56. Dr. Nazif Koltraka	Drejtori	Bulqize
57. Dr. Ahmet Ulaj	Drejtori	Laç
58. Z. Robert Mone	Nën drejtori ekonomik	Laç
59. Dr. Robert Sejdini	Drejtori	Peqin
60. Z. Xhevdet Kasa	Nën drejtori ekonomik	Peqin
61. Dr. Dhimo Bullari	Drejtori	Kuçove
62. Z. Bujana Huta	Nën drejtori ekonomik	Kuçove
63. Dr. Fehti Pepa	Drejtori	Mallakaster
64. Z. Lamce Murati	Nën drejtori ekonomik	Mallakaster
65. Dr. Engels Barbuta	Drejtori	Devoll
66. Z. Perlat Xhaci	Nën drejtori ekonomik	Devoll
67. Dr. Sami Beqiri	Drejtori	Delvine
68. Z. Teuta Ruci	Nën drejtori ekonomik	Delvine
69. Dr. Roland Berdufi	Drejtori	Spitali Psikiatrik Elbasan
70. Z. Arben Kurmaku	Nën drejtori ekonomik	Spitali Psikiatrik Elbasan
71. Dr. Vladimir Cela	Drejtori	Spitali Psikiatrik Vlore

Name	Position	Hospital
From Tirana:		
72. Dr. Zhani Treska	Drejtori	Maternity
73. Z. Edmund Verçani	Nën drejtori ekonomik	Maternity
74. Dr. Hasan Hafizi	Drejtori	Pneumo-Phthysiatric
75. Z. Hysni Shabani	Nën drejtori ekonomik	Pneumo-Phthysiatric
76. Dr. Mentor Petrela	Drejtori	Q.S.U.
77. Z. Aferdita Tafaj	Nën drejtori ekonomik	Q.S.U.T.
78. Z. Saimir Kadiu	Drejtori ekonomik	Ministria e Shëndetësisë
79. Z. Kristo Haxhi		Ministria e Shëndetësisë
80. Z. Tatjana Harito		Ministria e Shëndetësisë
81. Z. Vigan Saliasi		Ministria e Shëndetësisë
82. Znj. Fiorentina Gjeçi		Health Insurance Institute
83. Znj. Merita Guçe		Health Insurance Institute
84. Znj. Flora Hobdari		Health Insurance Institute
85. Znj. Gentiana Metuli		Q.S.U.T.
86. Dr. Natasha Celiku		Q.S.U.T.
87. Znj. Nevila Karruku		Q.S.U.T.
88. Dr. Mehdi Alimehmeti		Q.S.U.T.

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FINAL REPORT

November Albanian Conference

DEC 1 8 1995

by:

Enzo G. Archetti, Team Leader

Mission Dates: November 25 - December 3, 1995

This report was prepared for

Healthcare Enterprise International, Inc.
under contract with
U.S. Agency for International Development
Contract # 180-0038
Private Health Care Markets Project:

Submitted December 13, 1995

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December 13, 1995

Executive Summary:

I. BACKGROUND

Since early 1994, Albanian hospital managers have been involved in management and financial training programs at University Hospital in Tirana, and at Durres Hospital. The training has proceeded very well, with an extremely enthusiastic group of hospital managers. In addition to the training received in Albania, a training program was organized in the United States for three weeks, allowing hospital managers from Albania to see first hand how U.S. hospitals operate; how group purchasing affects hospital operations; how planning is an integral part of everyday hospital operations; and, how proper medical record keeping can provide vital data for managing scarce hospital resources.

The Albanian hospital managers are now prepared to share their experiences, lessons learned, successes and possible recommendations with other Albanian hospital managers. In view of this, a conference was planned to take place on November 30 and December 1, 1995, at which to present their experiences at a practical level.

II. PURPOSE

U.S. consultants returned to Albania to assist in the planning and implementing the financial management portion of the two-day conference for managers of all Albanian hospitals. During the conference, American consultants and Albanian counterparts instructed managers of other Albanian hospitals regarding cost finding/financial modeling for decision making; U.S. consultants assisted in the technical preparation for and provided overall guidance in the organization of this conference.

III. TASKS

The tasks performed by U. S. consultants with Albanian counterparts were as follows:

1. Developed and finalized the financial management portion of the program outline for the conference with Albanian counterparts.

2. Finalized the list of topics and presenters (Albanian and U.S. presenters, with the majority of presentations being Albanians).

3. Finalized presentations and performed rehearsals.

4. Conducted the financial management portion of the conference.

5. In-brief and out-brief with OAR Tirana.

IV. TEAM

The team was comprised of:

Financial Management/Cost Finding and Statistical Modeling:
Enzo Archetti, Team Leader.

Develop and Finalize the Financial Management Portion of the Program.

On Monday, November 27, Mr. Archetti met with the presenters of this portion of the conference program, Haki Copani, Economic Director of Durres Hospital and Nevila Karruka, University Hosital Economist. A review of the materials prepared was conducted.

It had been decided to let Haki Copani lead off the session with some history of the project. He would follow with an explanation of the financial management techniques described and demonstrated during our visits to Albania in October 1994 and March 1995. He would then detail their attempts to apply these techniques in their environment. As the final step of his introduction, he would share the experience of visiting an American hospital and seeing, first hand, the potential of these techniques.

Mr. Copani would follow his introduction with a comprehensive discussion of the budget process as a management tool. Several concepts new to the Albanians were to be introduced. They included departmentalization, use of occupancy statistics, involvement of clinical managers in the process, budgeting for internal management, and comparison of budget to actual to enable short term corrections. A Question and Answer period would follow. The assumption was made (correctly) that the Q & A would raise the question of how to implement such a budget which would be the lead-in for Nevila Karruka's description of the Chart of Accounts and Cost-Finding through the Step Down (allocation of indirect costs to revenue producing departments).

Miss Karruka's presentation would begin with the definitions of Current Assets, Non-Current Assets, Liabilities, Capital, Revenue and Expenses. She would then proceed to number each of the categories. Through subclassifications she would departmentalize expenses. Considerable time would be spent on the natural classification of expenses with questions asked and answered as she went along. The objective was to have the audience understand the universal aspect of the natural classification of expenses within the unique aspect of departmentalization. Once that was accomplished she would move on to "closing" the indirect expenses such as depreciation, housekeeping, maintenance and administration into the patient care (revenue producing) departments. With that accomplished she would apply the patient day statistics to each department and develop a cost per patient day by department and for the whole hospital.

Tuesday, November 28, a national holiday in Albania, was spent refining and rehearsing the presentations in private.

On Wednesday, November 29, all of the presenters assembled at the Administration Building at University Hospital for formal rehearsals which included practice at handling the overhead projector and transparencies. The rehearsals were conducted before the entire group with translators for the benefit of the Americans.

Because of a conflict in schedules, Thursday morning did not begin with the plenary session but with the first series of instructional sessions. The session began with my introduction of myself, the Albanian instructors, and the lead-in to their presentation. Haki Copani began, as intended, with an overview and then moved into the budget. Our group was on the quite side which gave Mr. Copani the opportunity to move along at his predetermined pace.

The following is the outline of the presentation:

Mr. Archetti introduces Mr. Copani.

Haki Copani:

1 - Introduction - History of the Project
* The Old Way
* The American Experience
* The New Way

2 - Three Topics to be Covered
* Budgeting
* Chart of Accounts
* Cost Finding

3 - "Let's Make A Budget for a Typical Hospital"
* Quantification of the Hospital's Activity
* Organizing the Quantification Along Lines of Responsibility
* Use of Prior Year's Expenses and Statistics as Benchmarks
* Use of Current Year's Expenses and Statistics, Projected to Year End, to Refine the Benchmarks
* Estimating Next Year's (The Budget Year) Expenses and Statistics
  - Based on Statistics (including Patient Classification to measure load per nurse)
  - Based on Management Input (Reality-based estimates)
  - Anticipated Changes in Prices and Income

* Involving Clinical Management
  - Making the Budget Their Budget

4 - Using the Budget for Cost Control
* Comparing Actual to Budget
* Controlling Costs through Regular Management Meetings and Analysis of Variations from Budget
* Flexibility (When to Change your Expectations)

5 - Closing Remarks
* Administration Builds the Budget
* Administration Manaages the Budget

6 - Questions and Answers

Mr. Archetti: "Miss Karruka will now show you how to organize your data."

Nevila Karruka: 1 - The Chart of Accounts (Codification)
* What is it - A number system - think of it as an address
* What are its components
  1-Assets
  2-Liabilities
  3-Equity
  4-Revenue
    -Patient Revenue
    -Non-Patient Revenue
  5-Expenses
    -Patient Direct Expenses
    -Patient Ancillary Expenses
    -General Expenses
    -Administrative Expenses
* Departmentalization
  -Collecting data along lines of responsibility
* Natural Classification of Expenses
  -Personnel costs
  -Supply costs
  -Other costs (travel, interest, insurance, etc.)
* Closing Remarks
* Questions and Answers

2 - Cost Finding
* Identifying the Cost of Caring for a Patient
  -Direct Costs
  -Indirect Costs
* Allocating Indirect Costs to Patient Care (Revenue Producing) Departments
  -Allocation Criteria (Sq. meters, meals

served, etc.)
-Sequence of Allocation - The Step Down

* Merging Financial and Statistical Data
  -Cost per Patient Day
  -Cost per Procedure
  -Cost per Treatment Protocol (DRG)
*Closing Remarks
*Questions and Answers

The Thursday morning session was followed by the plenary session where complementary and inspiring statements were made by the Albanian hosts and the American sponsors of the conference.

The Thursday afternoon group was more active with spontaneous interchanges. Mr. Copani cut several minutes from his documentation of personnel costs, which seemed well-known to the audience, to give Miss Karruka more time to discuss the Step Down.

Observations: Handout should have contained more on the budget. Haki Copani's animated delivery made up for the lack of audio-visual aids and the "dryness" of the material. Audience members were polite but did not hesitate to talk among themselves. Speakers did not seem to mind.

The Friday morning session had the disadvantage of being in a room too large for the group. There were some hecklers in this group, most noticably a physician who came late, carried on private conversations, and left before the session ended. The group seemed to side with the program.

The Friday afternoon session produced the most exchange between speakers and audience. Seated around a large oval table the group commented, asked questions, disagreed and agreed vocally throughout the session. Haki Copani was at his best, removing his jacket and getting into the fray. The audience was very attentive during Miss Karruka's presentation, truly interested in the mechanics of this new financial reporting technique.

The closing plenary session devoted some time to comments from the audience which were, for the most part, positive and inquiring as to the possibility of future programs of this type.

Appendix A of this report consists of Haki Copani's visual aids which were not included in the handout and Nevila Karruka's visual aids which were in the handout.

APLIKIMI I TEKNIKAVE ANALITIKE NE MARRJEN E VENDIMEVE FINANCIARE

DIRECTORATE OF HOSPITALS
DURRES

OPERATION DATA

NUMBER OF BEDS & THEIR USE

NR	SERVICES	YEAR 1994		YEAR 1995		YEAR 1996	
		NR	USE%	NR	USE %	NR	USE %
1	PATHOLOGY	120	87	120	89	120	90
2	SURGERY	65	81	65	82	65	84
3	MATERNITY	85	89	85	91	85	93
4	PAEDIATRICS	70	84	70	85	70	87
5	SHIJAK	20	87	20	89	20	90
6	ORTHOPAEDICS	60	93	60	93	60	93
	TOTAL	420	87	420	88	420	89

DIRECTORATE OF HOSPITALS
DURRES

OPERATION DATA

STATISTICS OF SOME COMPONENTS

Nr	SERVICES	ADMISSIONS			PATIENT DAYS			AVERAGE LENGTH OF STAY			ADM.	PAT. DAY	A. L. S.
		1993	1994	1995	1993	1994	1995	1993	1994	1995	1996	1996	1996
1	PATHOLOGY	1461	1576	1426	18057	19774	15877	13.5	12.4	11.1	2100	21170	10.1
2	SURGERY	1055	2056	1663	10763	14416	11410	8	7.1	6.8	2250	19220	8.5
3	MATERNITY	5735	5131	3992	15857	14837	12977	2.8	2.8	3.2	5300	17300	3.26
4	SOMATIC PAEDIATRICS	1517	1126	1321	12477	8113	10485	8.9	7.5	8.2	1800	14000	7.8
5	INFECTIOUS PAEDIATRICS	478	441		5195	4965		10.9	11				
6	INFECTIOUS DISEASES	670	711	363	9306	9169	4668	14.7	12.9	12.8	500	6200	12.4
7	SHIJAK	421	512	493	5681	6351	5475	13.5	12.4	11.1	660	6570	9.95
8	ORTHOPAEDICS	108	111	89	18137	15322	12469	146	161	126	118	16600	141
9	TOTAL	11445	11664	9347	95473	92947	73361	8.34	7.97	7.84	12728	101060	7.93

DURRES HOSPITAL ACTIVITIES

1. PATHOLOGY
2. SURGERY
3. MATERNITY
4. PAEDIATRICS
5. PHYSICAL REHABILITATION (ORTHOPAEDICS)
6. SHIJAK HOSPITAL
7. INTENSIVE CARE UNIT
8. OTHER COMMON UNITS
9. SUPPORT SERVICES
10. EMERGENCY & ADMISSION UNIT
11. OUT - PATIENT

DREJTORIA E SPITHLEVE
DURRES

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TE MEMH OTEA

SHERBIMI I PATOLOGJISE.

I. PATOLOGJIA E PERGJITHESHME.

1.. Reparti Kardiollogjisë
2.. Reparti Nefrollogjisë
3.. Reparti Gastroenterollogjisë dhe Hepatollogji
4.. Reparti Reumatollogjisë
5.. Reparti Alergollogjisë
6.. Reparti Pneumonollogjisë
7.. Reparti Endokrinollogjisë
8.. Reparti Hematologjisë
9.. Reparti Neurollogjisë
10.. Reparti Dermatologjisë

II. INEKTIVI I TE RRITURVE

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PATHOLOGY SERVICE

I. GENERAL PATHOLOGY

1. CARDIOLOGY DEPARTMENT
2. NEPHOLOGY DEPARTMENT
3. GASTRO - ENTEROLOGY/ HEPATOLOGY
4. RHEUMATOLOGY DEPARTMENT
5. ALERGOLOGY DEPARTMENT
6. PNEUMOLOGY DEPARTMENT
7. ENDOCRINOLOGY DEPARTMENT
8. HAEMATOLOGY DEPARTMENT
9. NEUROLOGY DEPARTMENT
10. DERMATOLOGY DEPARTMENT
11. ADULT'S INFECTIONS DEPARTMENT

SURGERY SERVICE

1. GENERAL SURGERY
2. ORTHOPAEDICS / THAUMATOLOGY
3. UROLOGY
4. O.R.L.
5. OCULISTICS
6. EMERGENCY ADMISSION

DIRECTORATE OF HOSPITALS
DURRES

OPERATION DATA

MATERNITY SERVICE

1. GYNAECOLOGY DEPARTMENT
2. OBSTETRICS DEPARTMENT
3. NEONATIVES' DEPARTMENT
4. PREMATURES' DEPARTMENT

PAEDIATRICS SERVICE

1. PAEDIATRICS DEPARTMENT
2. INFECTIOUS PAEDIATRICS
3. EMERGENCY ADMISSION

DIRECTORATE OF HOSPITALS
DURRES

OPERATION DATA

PHYSICAL REHABILITATION SERVICE

(INFANTILE ORTHOPAEDICS)

1. ORTHOPAEDICS DEPARTMENT

28

DIRECTORATE OF HOSPITALS
DURRES

OPERATION DATA

SHIJAK HOSPITAL

1. PATHOLOGY
2. PAEDIATRICS
3. MATERNITY
4. OUT - PATIENT

DIRECTORATE OF HOSPITALS
DURRES

OPERATION DATA

INTENSIVE CARE SERVICE

1. PATHOLOGY DEPARTMENT
2. SURGERY DEPARTMENT
3. MATERNITY DEPARTMENT
4. PAEDIATRICS DEPARTMENT

OTHER COMMON SERVICES

1. PHARMACY
2. LAB
3. ANATOMY - PATHOLOGY
4. BLOOD BANK
5. REHABILITATION (PHYSIOTHERAPY)
6. X - RAY
7. STERILIZATION

SUPPORT SERVICES

1. CARPENTRY
2. ELECTRICITY
3. APPLIANCES' MAINTENANCE & REPAIR
4. BRICK LAYING
5. PLUMBING
6. DIETARY
7. LAUNDRY
8. HEATING
9. MECHANICAL REPAIRS
10. OTHER

DIRECTORATE OF HOSPITALS
DURRES

OPERATION DATA

EMERGENCY ADMISSION SERVICE

1. EMERGENCY ADMISSION

DIRECTORATE OF HOSPITALS
DURRES

OPERATION DATA

OUT - PATIENT SERVICE

1. DERMATOLOGY
2. RHEUMATOLOGY
3. SURGERY
4. PSYCHIATRY
5. ENDOCRINOLOGY
6. INFECTIOUS DISEASES
7. HAEMATOLOGY
8. CARDIOLOGY
9. HYPERTONY
10. O.R.L.
11. OCULISTICS
12. ONCOLOGY
13. NEPHOLOGY
14. NEUROLOGY
15. ALERGOLOGY
16. X - RAY
17. PNEUMOPHTISIATRY
18. GASTROHEPATOLOGY
19. PHYSIOTHERAPY
20. MATERNAL CONSULTANCY

Unive .ty Hospital Center at Tirana
1st Six Months 1994 Statistics

Total Hospitals

Services	# of Beds	# of Cases	# of days	Available Days	Percent of Occupancy	Average L.O.S.	Percent of Cases	Percent of Days
Nefrologji (Peds)	15	131	1384	2715	51.0%	10.56	0.79%	0.72%
Endokrinologji (Peds)	10	91	1208	1810	66.7%	13.27	0.55%	0.62%
Gastroeterologji (Peds)	10	32	923	1810	51.0%	28.84	0.19%	0.48%
Hematologji (Peds)	15	136	2030	2715	74.8%	14.93	0.82%	1.05%
Reanimacioni (Peds)	12	125	1377	2172	63.4%	11.02	0.75%	0.71%
Kati 1 (Contageous)	30	406	4056	5430	74.7%	9.99	2.44%	2.10%
Kati 2 (Contageous)	50	501	5498	9050	60.8%	10.97	3.01%	2.84%
Kati 3 (Contageous)	40	470	5451	7240	75.3%	11.60	2.82%	2.82%
Reanimacioni (Contagec	125	1408	15229	22625	67.3%	10.82	8.46%	7.87%
Kati 1 (Psych)	18	70	2341	3258	71.9%	33.44	0.42%	1.21%
Kati 2,3,4 (Psych)	80	330	10009	14480	69.1%	30.33	1.98%	5.17%
Riaftesimi (Psych)	40	137	5231	7240	72.3%	38.18	0.82%	2.70%
Children (Psych)	10	21	778	1810	43.0%	37.05	0.13%	0.40%
	1479	16646	193533	267699	72.3%	11.63	100.00%	100.00%

Univer y Hospital Center at Tirana
1st Six Months 1994 Statistics

Total Hospitals

Services	# of Beds	# of Cases	# of days	Available Days	Percent of Occupancy	Average L.O.S.	Percent of Cases	Percent of Days
Kardiologji	110	1221	16801	19910	84.4%	13.76	7.34%	8.68%
Hematologji	34	344	4646	6154	75.5%	13.51	2.07%	2.40%
Alergologji	25	296	3925	4525	86.7%	13.26	1.78%	2.03%
Hepato – gastro	55	491	7446	9955	74.8%	15.16	2.95%	3.85%
Endokrinologji	38	442	5583	6878	81.2%	12.63	2.66%	2.88%
Nefro – hipertoni	54	432	8380	9774	85.7%	19.40	2.60%	4.33%
Reumatologji	30	286	4768	5430	87.8%	16.67	1.72%	2.46%
O.R.L.	45	864	5964	8145	73.2%	6.90	5.19%	3.08%
Okulistika	50	891	5960	9050	65.9%	6.69	5.35%	3.08%
Stomatologji	17	184	2067	3077	67.2%	11.23	1.11%	1.07%
Dermatologji	40	391	5555	7240	76.7%	14.21	2.35%	2.87%
Sem Profesionale	25	310	3532	4525	78.1%	11.39	1.86%	1.83%
Klinika 1 (Surgery)	30	696	4277	5430	78.8%	6.15	4.18%	2.21%
Kardio–kirurgjia	40	273	4095	7240	56.6%	15.00	1.64%	2.12%
Klinika 2 (Surgery)	55	643	8946	9955	89.9%	13.91	3.86%	4.62%
Klinika 3 (Surgery)	50	813	6696	9050	74.0%	8.24	4.88%	3.46%
Plastika (Surgery)	70	706	11228	12670	88.6%	15.90	4.24%	5.80%
Neuro–kirurgjia	20	101	2291	3620	63.3%	22.68	0.61%	1.18%
Reparsi & persier (Peds)	13	304	2568	2353	109.1%	8.45	1.83%	1.33%
Pavioni 10 (Peds)	30	352	1634	5430	30.1%	4.64	2.11%	0.84%
Pavioni 8 (Peds)	35	138	1072	6335	16.9%	7.77	0.83%	0.55%
Hepatit viral (Peds)	25	212	2845	4525	62.9%	13.42	1.27%	1.47%
Sem aorogene (Peds)	23	432	3521	4163	84.6%	8.15	2.60%	1.82%
Pneumologji (Peds)	30	434	3772	5430	69.5%	8.69	2.61%	1.95%
Alergologji (Peds)	25	305	2693	4525	59.5%	8.83	1.83%	1.39%
Kirurgji (Peds)	23	656	3416	4163	82.1%	5.21	3.94%	1.77%
ORL (Peds)	12	329	1508	2172	69.4%	4.58	1.98%	0.78%
Kardiologji (Peds)	10	81	920	1810	50.8%	11.36	0.49%	0.48%
Neurologji (Peds)	10	161	1909	1810	105.5%	11.86	0.97%	0.99%

ASPEKTI TEORIK

00-----00----0----0000----000

I II III IV V

I.FUSHA E PARE.Percaktuesi i perberesve.

Prefiksi
00----------Organizata prind

01----------Spitali "A"

02----------Spitali "B" etj.

II.FUSHA E DYTE.Percaktuesi i fondeve.

Prefiksi
10----------Fondi i percaktuar nga buxheti

20----------Fondi i percaktuar per qellime specifike nga donatore te perkohshem me tej:

21----------Fondi i percaktuar per qellime specifike nga donatore te perkohshem ne valute

22----------Fondi i percaktuar per qellime specifike nga donatore te perkohshem ne leke

23----------Fondi i percaktuar per qellime specifike nga donatore te perkohshem europiane

24----------Fondi i percaktuar per qellime specifike nga shoqata bamiresie

01-20----------Fondi i percaktuar per qellime specifike nga donatore te perkohshem per spitalin"A"
I. II.

III.FUSHA E TRETE.Elementet financiare.

Prefiksi
1----------Aktivet

2----------Detyrimet

3----------Kapitali i vet

4----------Te atdhura nga pacienti

5----------Te ardhura te tjera

6----------Shpenzime te spitalit

7----------Humbja dhe fitimi i paparashikuar

ASPEKTI PRAKTIK(ZBATIMI)

0———0000———000

I II III

I.FUSHA E PARE.Percaktuesja e perberesve.

Prefiksi
0————Administrata

1————Sherbimi i pathollogjise(ish spitali nr.1)

2————Sherbimi i kirurgjise(ish spitali nr.2)

3————Sherbimi i pediatrise(ish spitali nr.3)

4————Sherbimi i semundjeve ifektive(ish spitali nr.4)

5————Sherbimi i neurologjise-neurokirurgjise(ish spitali nr.5)

6————Sherbimi i semundjeve onkologjike(ish spitali onkologjik)

II.FUSHA E DYTE.Elementet financiare dhe specifikimi i metejshem i tyre.

1.Aktivet

2.Detyrimet

3.Kapitali ivet

4.Te ardhura nga pacienti

5.Te ardhura te tjera

6.Shpenzimet

7.Humbjet dhe fitimet e paparashikuara

Pra 1000———Aktivet.Per specifikime te metejshme dote shohim faqen ne vazhdim.

1000----------AKTIVET

1100----------CASH

1110----------ARKA

1120----------BANKA

1200----------DETYRIME TE TE TJEREVE NDAJ NESH

1210----------KLIENTE

1220----------DEBITORE TE NDRYSHEM(DETYRIME TE PUNOJESVE TE SPITALIT)

1300----------MJETE TE TJERA JORRJEDHESE

1310----------IVENTARI

1320----------PARADHENIE

1400----------INVESTIMET AFATGJATE

1500----------TOKA,NDERTESA,PAISJE

1510----------TOKA

1520----------NDERTESAT

1530----------PAISJE FIKSE

1540----------MATERIALE KONSUMI

1550----------INVENTARI I IMET

1600----------AMORTIZIMI

1601----------AMORTIZIMI I NDERTESAVE

1602----------AMORTIZIMI I MJETEVE FIKSE

1603----------AMORTIZIMI I INVENTARIT TE IMET

1700----------NDERTIME NE PROCES

1800----------MJETE TE TJERA JORRJEDHESE

2000----------DETYRIMET

2100----------DETYRIMET NDAJ TE TRETEVE

2200----------KREDITORE TE TJERE

2210----------TAKSAT E SPITALIT

2220----------REDUKTIMET NE PAGESE

2230----------TAKSAT E PUNETOREVE

2231----------SIGURIMET SHOQERORE

2232----------SIGURIMET SHENDETESORE

5000----------TE ARDHURAT

5100----------TE ARDHURAT NGA DHENIA E GJAKUT

5200----------TE ARDHURA NGA EKO

5300----------TE ARDHURA NGA PARKINGU

5400----------TE ARDHURA NGA HOTELERIA .

ifl

6000----------SHPENZIMET(klasifikimi natyror i tyre)

6100----------PAGAT

6101----------PAGAT E MJEKEVE

6102----------PAGAT E INFERMIEREVE

6103----------PAGA TE TJERA

6200----------SHPENZIME UDHETIMI

6201----------SHPENZ. UDHETIMI BRENDA VENDIT

6202----------SHPENZ. UDHETIMI JASHTE VENDIT

6300----------MATERIALE E FURNITURA

6310----------USHQIME

6320----------BARNA E MATERIALE MJEKIMI

6330----------KANCELERI

6340----------REAGENTE

6350----------TE TJERA

6400----------SHERBIME NGA TE TRETET

6410----------UJE

6420----------ENERGJI ELEKTRIKE

6430----------TELEFON

6440----------POST-TELEGRAF

6450----------KARBURANT

6460----------TE TJERA

SHERBIMI I PATHOLLOGJISE(ish SPITALI Nr.1)

KLINIKAT

001----------KARDIOLOGJI

002----------HEMATOLOGJI

003----------ALERGOLOGJI

004----------GASTROENTEROLOGJI

005----------NEFROHIPERTONI

006----------REOMATOLOGJI

007----------REOMATOLOGJI

008----------O.R.L

009----------OKULISTIKE

010----------STOMATOLOGJI

011----------SEMUNDJE PROFESIONALE

012----------DERMATOLOGJI

013----------LABORATORI KLINIK

014----------LABORATORI BIOKIMIK

SHERBIMI I KIRURGJISE(ish Spitali Nr.2)

KLINIKAT

020----------KLINIKA I.

021----------KARDIOKIRURGJI

022----------KLINIKA II.

023----------KLINIKA III.

024----------PLASTIKA

025----------KLINIKA VIII

013----------LABORATORI KLINIK

SHRBIMI I PEDIATRISE(ish Spitali Nr.3)

KLINIKAT

030——————————REPARTI I PERZIER

031——————————PAVIONI VIII.

032——————————PAVIONI X.

033——————————HEPATITI VIRAL

034——————————SEMUNDJET AEROGENE

035——————————PNEUMONOLOGJIA

003——————————ALERGOLORJIA

036——————————KIRURGJIA

008——————————O.R.L

001——————————KARDIOLOGJIA

037——————————NEUROOGJIA

038——————————NEFROLOGJIA

005——————————ENDOKRINOLOGJIA

004——————————GASTROENTEROLOGJIA

002——————————HEMATOLOGJIA

039——————————REANIMACIONI

013——————————LABORATORI KLINIK

014——————————LABORATORI BIOKIMIK

SHERBIMI I SEMUNDJEVE INFEKTIVE(ish.Spitali Nr.4)

KLINIKAT

040——————————KATI I.

041——————————KATI II.

042——————————KATI III.

039——————————REANIMACIONI

013——————————LABORATORI KLINIK

SHERBIMI I NEUROLOGJI-NEUROKIRURGJI(ish Spitali Nr.5)

KLINIKAT

050——————————KATI III.

051——————————KATI IV.

039——————————REANIMACIONI

037——————————NEUROLOGJI

052——————————RIAFTESIMI

053——————————FEMIJET

054——————————KATI I.

055——————————KATI I.&II.&III.

056——————————PSIQIATRIA

013——————————LABORATORI KLINIK

SHERBIMI I SEMUNDJEVE ONKOLOGJIKE

KLINIKAT

036——————————KIRURGJIA

060——————————GJINEKOLOGJIA

061——————————KYRITERAPIA

062——————————RO...TERAPI

063——————————KIMIOTERAPI

064——————————REPARTI DITOR

013——————————LABORATORI KLINIK

SHpenzimet e pacaktuara	80.000
Departamenti 1	100.000
Departamenti 2	60.000
Departamenti 3	40.000
Departamenti A	200.000
Departamenti B	250.000
Departamenti C	150.000
Total	880.000

	Departamenti 1	Departamenti 2	Departamenti 3
Depart.1	------	10%	-------
Depart.2	25%	------	20%
Depart.3	15%	20%	-------
Depart.A	30%	40%	35%
Depart.B	20%	------	45%
Depart.C	10%	30%	-------
Totalet	**100%**	**100%**	**100%**

Departamentet	Shpenzimet	P.specifike x	Shpenz.pacakt.	Alokimi
1.	100.000	12.50%	80.000	10.000
2.	60.000	7.50%	80.000	6.000
3.	40.000	5.00%	80.000	4.000
A.	200.000	25.00%	80.000	20.000
B.	250.000	31.25%	80.000	25.000
C.	150.000	18.75%	80.000	15.000
Totali	800.000	100.00%		80.000

	Nga bilanci	sh.pacakt.	subtotal	Dep.1	subtotal	Dep.2	subtotal	Dep.3	Kost.totale
shpenz.pacakt.	80,000	80,000							
Shpenz.indirekt.									
Depart.1	10,000	10,000	110,000	110,000					
Depart.2	60,000	6,000	66,000	27,500	93,500	93,500			
Depart.3	40,000	4,000	44,000	16,500	60,500	20,778	81,278	81,278	
shpenz.direkte									
Depart.A	200,000	20,000	220,000	33,000	25,300	41,556	294,556	35,559	330,115
Depart.B	250,000	25,000	275,000	32,000	297,000	-----	297,000	45,719	342,719
Depart.C	150,000	15,000	165,000	11,000	176,000	31,166	207,166	---	207,166
TOTALI	**880,000**	**80,000**	**880,000**	**110,000**	**880,000**	**93,500**	**81,278**	**81,278**	**880,000**

ALLOCATED

25%*110.000=27.500
15%*110.000=16.500
30%*110.000=33.000

	Departamentet qe shperndajne shpenzime					
		DEP.1		DEP.2		DEP.3
Depart.1		---		10%		---
Depart.2		25%		---		20%
Depart.3		15%		20%		---
Depart.A		30%		40%		35%
Depart.B		20%		---		45%
Depart.C		10%		30%		---
TOTALI		**100%**		**100%**		**100%**

PER DEPARTAMENTIN E DYTE

2\9 *93.500=20.778
4\9 *93.500=41.556
—
3\9 *93.500=31.166
9\9

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Trip Report

National Conference on Advances in Hospital Management Tirana, Albania *November 30 & December 1, 1995*

prepared for

USAID under Contract #H-217-95

by

J. Christopher Newman, MBA

December 4, 1995

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II. Measures of Success 1
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III. Observations 2
IV. Evaluation 4
V. Recommendations 5

I. Objectives of the Trip

1. To demonstrate to the Albanian hospital directors and economists (financial managers) from Albania the techniques of strategic planning.

2. To communicate how planning can help hospital managers and economists to more effectively allocate resources.

3. To show how the preparation of a strategic plan will make justification of budget requests more effective.

II. Measures of Success

1. Understanding of the concepts and techniques presented by Dr. Mikel Noçka, Director of Durres Hospital, in the break-out sessions as shown by the Albanian attendees through their questions and comments.

2. Expressions of interest in continuing the project by the participants in this and the other demonstration projects (i.e., financial planning, medical records, and group purchasing of pharmaceuticals).

3. Expressions of intent by attendees to use the planning concepts and techniques at their hospitals.

III. Summary of Activities Undertaken

1. Prepare the strategic planning module for the conference by writing the strategic plan from data obtained in meetings in Durres and in New Jersey with the top managers of the hospital, chiefs of services, and department directors, data supplied on request by the hospital, tours of the facilities (Durres Hospital campus, surgery hospital, and the Children's National Orthopedic Hospital); editing the presentation slides; and, supervising their translation and printing. One hundred copies of the Albanian presentation plus ten copies of the Albanian and English versions of the plans and the English version of the presentation were delivered to the conference site.

2. Assist in the on-site preparations and rehearsals of the presentations, including assembly of the conference note book in Albanian.

3. Introduce Dr. Noçka at the four breakout sessions at the conference and participate in the question and answer portion of each session.

4. Attend the luncheon at the end of the first day and attend the reception at the end of the second day.

IV. Observations

1. Participants responded favorably to the strategic planning presentations and discussions; at every session there were pertinent questions and lively discussions.

2. Major problems were identified in the hospital sector of the health system:

   - Buildings need reconstruction
   - Budgets are inadequate and too restrictive for local management decisions
   - Staff is not well-trained
   - Management skills and performance need to be improved

3. The question of whether hospital directors have to be physicians came up in several of the sessions.

4. Managers from so-called tier-two hospitals (approx. 15 to 25 beds) and tier three hospitals (under 15 beds) felt that their concerns were not specifically addressed at the conference, as expressed by a hospital director at the closing plenary session and by participants in the strategic planning sessions. In fact, Dr. Noçka, speaking now as the director of one of Albania's largest hospitals but also reflecting his experience as director of the 20-bed hospital in Shijac, expressed the hope that these smaller hospitals would be included in subsequent USAID project activities.

5. Poor job performances, the absence of performance standards, and lack of adequate training were major concerns. No recommendations were made, except that nurses, as well as physicians, should be allowed to visit more developed hospitals abroad.

6. Learning and awareness of the significance of elements in the plan occur slowly over time. An example is that even though I had previously explained the content of a job description and how job performance can be assessed, the medical director of Durres hospital cornered me at a coffee break and asked me for the meaning of that objective in the hospital's strategic plan. It took him six months to get around to asking.

7. In one group, a participant asked about family services, referring to the relationship of primary care services and preventive health to the hospital. If I understood this correctly—and we spent a few minutes talking in the group about the problem—it is a good sign that the local managers have identified what I have sensed in previous trips: there is little active coordination between outpatient and inpatient care. This is, of course, complicated by hospital-based physicians doing ambulatory care on the side or, as in Durres, at an especially organized ambulatory clinic with six beds in pediatrics.

8. Dr. Noçka plans to expand on a concept he has put into place at Durres Hospital and which he described at each of his four sessions— a 24-hour bed unit in the hospital. Currently, he has only two beds so designated, but he wants to have six in the new hospital. Its purpose is to observe patients to ensure that they do in fact need to be admitted. His concern seems to be that the specialty medical directors in the hospital have not been strict enough in refusing to admit patients.

9. In U.S. hospitals, these problems in inappropriate admissions or lengths of stay could be quickly uncovered and corrected through computer or hand analysis of the medical records abstract. Even this simple analysis cannot be performed in Albania at any of the hospitals, including Univ. Hospital Center (though this will soon be ameliorated with the new computer system in medical records) because records are kept by hand and the abstracts are not compiled.

10. In regard to choosing qualified staff, Dr. Noçka mentioned in each of his sessions that hospital directors should not hire staff just because they need work. The reason they may be tempted to do so is that few qualified candidates are attracted by the very low salaries. Dr. Noçka said that nurses can make more money as waitresses, which is easier work. Nevertheless, he exhorted the directors to exclude from consideration such candidates as a community ambulanca nurse with twenty years' experience but insufficient skills for hospital work, or a mother with minimal qualifications needing to support five children.

11. Cooperative planning of patient referrals and allocation of resources were major sources of concern at the sessions. Underlying the concern, I suspect, is that the tier two and tier three hospitals stand a good chance of being merged with larger ones. The debate, then, in the sessions was concerning the danger to patients of transport if serious medical or surgery cases cannot be handled. "Even a trip of one half hour on some roads in Albania would kill a very sick patient," one participant asserted. While comments such as this have the purpose of elevating the importance of these small centers, they do raise fundamental issues in regard to the deployment of resources. Dr. Noçka made clear, however, in each of his sessions that he clearly recognizes that Durres Hospital should have only the basic four services of pathology (internal medicine), surgery, obstetrics/gynecology, and pediatrics, and rejected my suggestion in one of the sessions that the hospital could develop more capable and comprehensive programs in one or two specialties.

12. A consideration that I did not have the opportunity to explore in regard to the previous point is the extent to which hospitals conserve their budgets by so-called "turfing" or transferring difficult and costly patients to another facility. I am not sure whether budgets for these cases actually follow patients, as, for instance, they do in the UK's NHS. If they do not, there is a budgetary incentive to refer out.

13. Some managers expressed interest in developing DRGs (Diagnostic Related Groups). For this to occur, the entire nation's hospitals would have to use the ICD-9 medical records codes (International Classification of Diseases, 9th edition, clinical modification) to determine the groups. Another consideration is that this latter step is a prerequisite for Albania to participate in the WHO (World Health Organization) annual compilation of health care statistics. Albania is currently the only European country not to do so.

14. Pooling of (illegal) direct payments made by patients and their families to physicians and nurses came up on more than one occasion. This money represents a significant proportion of the cost of health care and it is not accounted for by the official budget. One hospital director I talked to said that he has demanded of his physicians that they hand over to him the amounts they collect—he then distributes a portion back to the physicians, keeping some for the hospital's budget, and giving some to the nurses. I am pretty sure that I understood him to say that he lacks control over this practice, since there are no records, and that lately the physicians have been claiming that their volume has been going down; however, he suspects they are just keeping more.

15. The practice of ordering clinical laboratory tests and radiology exams more frequently than is medically justified from the test results reported on the chart is a waste of resources, according to Dr. Noçka, and he cites this as an example of a savings opportunity.

16. Foreign donor agencies and grateful foreign patients are sources of funds to improve facilities. Dr. Noçka has had several such good fortunes such as a new ambulance from the Lyons Club and $3,000 from a German tourist for renovation of the intensive care unit.

17. Food expenditures are much too low to be adequate; Lek 70 per patient per day. Patients' families bring in supplementary food. Dr. Noçka mentions food service, as well as laundry, as potential out-sourcing opportunities.

V. Evaluation

The conference demonstrated the power of the management practices presented. The attendees were impressed by the depth of knowledge and commitment of the Albanian demonstration projects' teams. This was expressed in informal remarks during the breaks and reception (and in the formal statements at the concluding plenary session). As such, the conference created constructive role models for the Albanian health managers.

At the same time, the benefits of the project to the participating Albanian managers were made apparent in the presentations in the form of trips to the U.S., computers for the hospital, and donor and soft loan funds for construction and equipment. The unspoken message was that those managers who participate in the reforms will enjoy these same benefits.

A healthy appetite for debate and discussion was apparent in the group sessions, after the formality of the prepared presentation. This demonstrated both a sense of competitiveness and a willingness to take the risk of speaking their minds.

The ability of outside assistance to make significant positive advances in the Albanian health care system has grown appreciably as a direct result of the training and demonstration projects sponsored by USAID. Because the participants in the earlier training sessions have acquired new management skills, they can take on more and accomplish more. It was reported to me informally that other training sessions are more theoretical. The practical, hands-on, approach of these demonstration projects is more attuned to the managers—and the ministry staff—who are interested in achieving practical results as soon as possible.

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VI. Recommendations

It is recommended that the demonstration projects be continued. The conference created momentum and raised expectations in what I perceive as the following areas:

1. Strategic Planning: I would like to suggest the following in strategic planning demonstration projects. They are logical extensions of the Durres Strategic Plan.

   - demonstration strategic planning project at a second tier hospital;
   - cooperative planning exercise organized among all hospitals, polyclinics, health centers, and ambulancas within a district; and,
   - monitor how Dr. Noçka and his staff incorporate the planning objectives into their next year's budget and activities.

Because strategic planning uses information from both finance and medical records, I would like to recommend the following in regard to those areas:

2. Financial Accounting: A master chart of accounts should be developed and implemented nationally. Also, a cost allocation system should be created, much like the Medicare cost report but tailored to the circumstances of Albania.

3. Medical Records: The ICD-9-CM codes, together with CPT-4 codes for procedures and diagnoses, should be implemented nationally, for which training needs to be conducted, with translation of the code books. Unit record systems should be instituted in all health care institutions.

4. Operations Improvement: My exposure to the operations of Durres Hospital and my discussions with the managers lead me to recommend that a national program of operations improvement be developed to raise the standards of performance and productivity. I made a similar suggestion at the Technical Assistance Group in January 1995 at USAID. This project should begin with a consultation with senior managers who have taken part in the USAID training courses to review the opportunities for operations improvement. A determination of likely savings and quality improvements will then be made based upon data furnished by these representatives.

   For instance, a preliminary list of departments and how they would benefit from operations improvement consists of the following:

   - Finance—automation with computers will reduce accounting staff time, improve quality
   - Pharmacy—establish protocols for such drugs as antibiotics, examine relationship between nosocomial infection rates and drug prescriptions
   - Clinical Laboratory—reduce unnecessary testing, improve testing techniques, establish accurate test ordering and results reporting
   - Acute Care—develop clinical pathways, reduce unnecessary lengths of stay, reduce inappropriate testing, establish consult and referral criteria
   - Medical Records—establish criteria for completeness of records
   - Kitchen Services—determine minimum dietary nourishment levels, establish costs parameters, purchasing practices, explore group puchasing opportunities.

Workbook for Hospital Strategic Planning

prepared for

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December 4, 1995

by

J. Christopher Newman, MBA

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Acknowledgment

I would like to express appreciation to the USAID personnel in Tirana, particularly Mrs. Diane Blane and Mr. Cameron Pippit for providing support for this project and to those in Washington who worked hard for its success, Ms. Susan Matthies and Ms. Catherine F. Cleland. Support for this project was also expressed by the Minister of Health. Most important has been the work performed by Dr. Mikel Noçka and Mr. Hoki Copani, Chief Economist.

The USAID team was ably led by Mr. James Janeski and inspired by the energy and commitment of Dr. Michael Counte, who served as organizer and faculty member of the training modules.

I. Introduction

This workbook has been prepared to complement the demonstration project in strategic planning for Durres General Hospital. That planning process was conducted from July 1994 to December 1995. It built upon the two courses in hospital management and financial techniques given in Tirana under this same USAID Project from January to June 1994.

Hospitals in Albania are in transition. While there are many problems, through persistent and dedicated application of effort by the hospital directors and economists and their medical, nursing, administrative, and support staffs, a great deal can be accomplished.

These points were brought out at the national conference which was attended by some 100 hospital directors, economists, and ministry staff on November 30 and December 1, 1995. The strategic plan for Durres Hospital was presented by its director, Dr. Mikel Noçka, as a demonstration of the techniques that will help Albania's health care managers to make the improvements needed to meet the expectations of the country's citizens for high quality, accessible, and cost effective care.

The preparation and continued refinement of a strategic plan will help to identify ways to address these problems and will assist the Ministry of Health in determining the hospitals' roles. Managers who use these planning tools will find that they can create a framework that prioritizes objectives, allocates resources, and prepares the clinical and support staffs for the future.

II. Organizing the Process

The process is managed by the Director of the Hospital. He begins by developing a series of planning steps, such as those suggested in Exhibit A. He will create a planning group consisting of the chief economist, chief medical officer, chief of statistics, and chief of nursing. In certain situations, the District Health Officer should be an *ex officio* member. This is illustrated in Exhibit B.

The medical chiefs of service—pathology (internal medicine), surgery, emergency, pediatrics, obstetrics/gynecology, and specialty medicine—and the managers from Clinical Lab, Security, Radiology, and Pharmacy (including Materiel Management) should be included when the program plans develop actual quantities and specific utilization volumes.

Work Steps

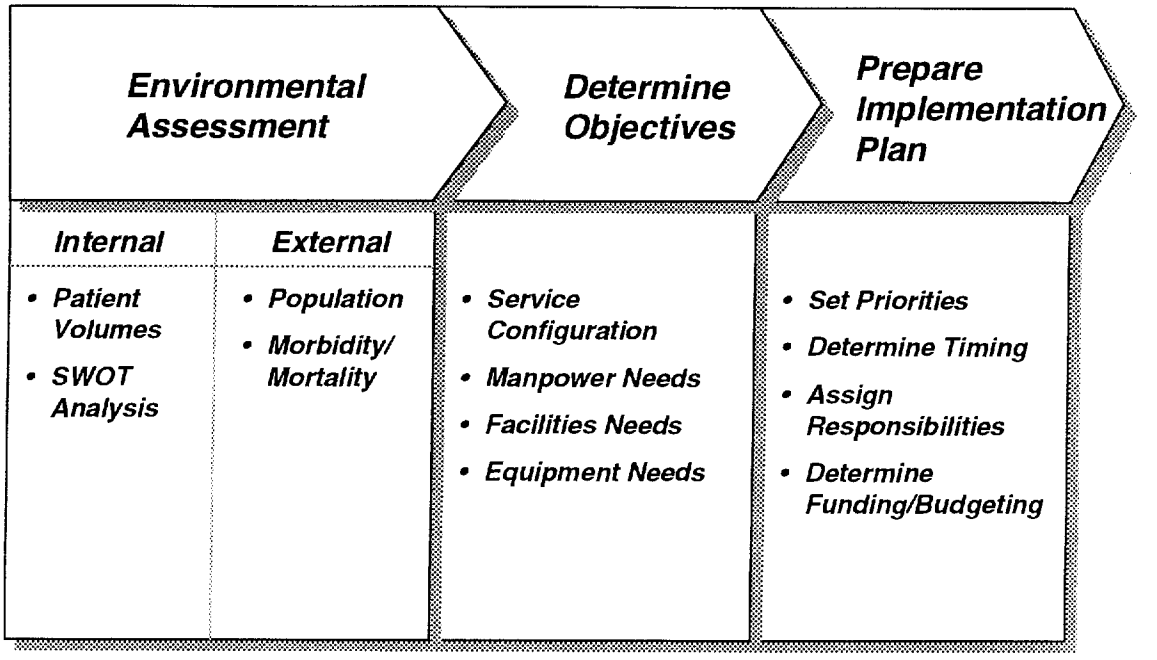

Exhibit A

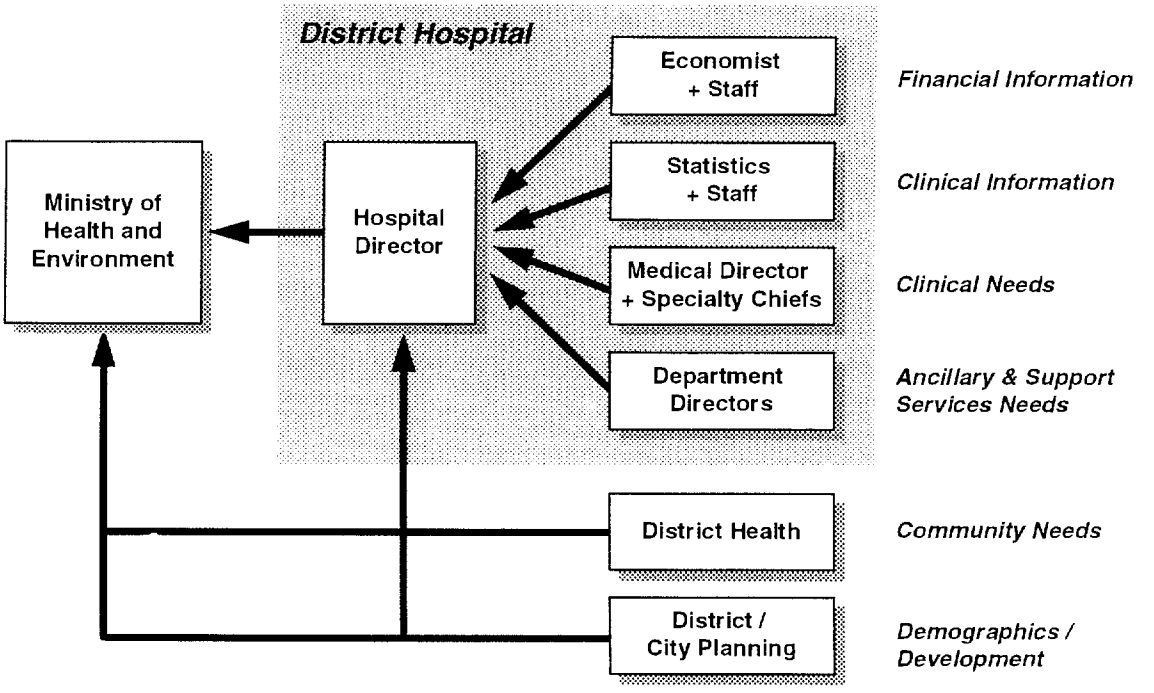

Exhibit B

III. Obtaining the Information

There are both internal and external sources of information and some ingenuity must be used when going outside the hospital and the ministry to obtain it. The following is a rough guide to these sources:

a. Mission statement—planning group

b. Environmental Assessment:

SWOT Analysis—planning group

Population—National and district planning offices

Morbidity—hospital and ministry statistics

Mortality—hospital and ministry statistics

Costs of Care—analysis of data from the hospital's economist and statistics

Regulatory—review of governmental laws

Competition—various, observation

Staffing—hospital's own records, health ministry records

In Exhibit C, the planning process is shown as a series of events beginning with the analysis of the population, including the hospital's utilization, and recognizing the population's morbidity and mortality rates. The SWOT analysis—Strengths, Weaknesses, Opportunities and Threats—assists the planning group in developing an understanding of the institution's position. Finally, this understanding, together with an analysis of the population's characteristics and health needs, leads to the development of institutional objectives and a plan for its financing.

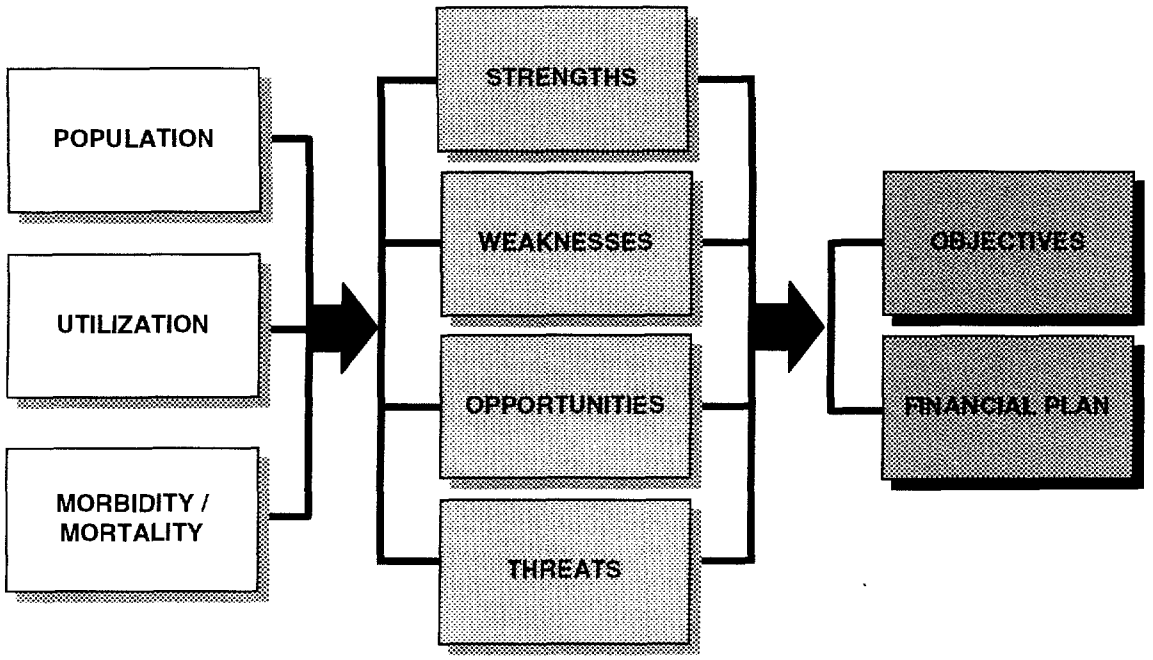
POPULATION
UTILIZATION
MORBIDITY / MORTALITY
STRENGTHS
WEAKNESSES
OPPORTUNITIES
THREATS
OBJECTIVES
FINANCIAL PLAN

Exhibit C

IV. Analysis of the Information

The planning group should conduct the analysis of the data guided by the hospital's director or his designate. Additionally, an outside facilitator is recommended; that is, a moderator knowledgeable enough to be constructive and critical, whose interest in the outcome of the analysis is unbiased and neutral.

The objective of this step is to identify patterns in the clinical and non-clinical data and to determine from them the answers to such questions as:

1. What are the principal clinical activities at the hospital?
2. How well have resources been spent in their support?
3. What clinical needs in the community are currently not met well by the hospital?
4. What areas of the hospital have gained or lost in productivity, measured by units of input versus units of output?

V. Determining the Mission

All management decisions are made from the foundation of the hospital's mission.

The mission statement incorporates the assumptions and policy objectives of the ministry and the district in terms of the population served (both in number and in geography), the services to be offered (in terms of programs, staff skills, and equipment capabilities), and the philosophy of access to these services. It should be no more than four or five sentences and should be as specific as possible.

VI. Framing the Objectives

The following steps should be taken to frame the objectives:

1. Identify where mission, capabilities and performance are not well matched
2. Organize them in groupings under broad headings, such as budget, staffing, facilities, operations effectiveness
3. Determine how to measure success
4. Determine, within the planning group, which of the list are the five highest in priority. These become the strategic plan's objectives.

It should be noted here that one of the tendencies in strategic planning is to "plan to plan." In other words, to set an objective within your plan to address an important issue in the future when, hopefully, there will be sufficient data coupled with the willingness to analyze it. This is not in itself a harmful or negligent tactic, since it provides concrete proof of intention to focus on issues. The first step of a "plan to plan" might be the assignment of a white paper (a report on current conditions) to provide a focused environmental assessment on that single issue.

VII. Preparing the Workplan

The objectives are now prioritized by the planning group. As this step is taken, the group as a whole or one designated member should identify how long the objectives will take to be accomplished to the levels already quantified. It is essential to assign the responsibility of accomplishing each objective to a specific individual.

Finally, costs should be identified to meet the objectives, so that the objectives set in the strategic plan can be incorporated into the annual budget requests and justified based upon the hospital's analysis and the consensus of purpose among the clinical and management staffs.

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VIII. Conducting Periodic Reviews

Each year, some two or three months ahead of preparing the annual budget request, the hospital's planning group should meet to update the environmental assessment, recognize progress made on the objectives, and rededicate themselves to uncompleted objectives. At this time, the group will identify new objectives that may have come to light or gained in importance due to changes in the internal or external environments.

DREJTORIA SPITALIT
DURRES

Durres Hospital
Durres, Albania

Five-Year Strategic Plan
1995 – 2000

August 1995

Prepared with the assistance of:
Metis Associates, Ltd.
Chicago • Dallas
U.S.A.

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I. EXECUTIVE SUMMARY

Strategic planning sets a course for the future. This Five-Year Strategic Plan is intended to summarize the current conditions of service, both clinical and financial, at Durres Hospital and to identify the high priority initiatives for the institution's management to accomplish. The contents and the direction set by the plan are totally the work and determination of the hospital's management team. Outside consulting was used to facilitate the process of planning.

Durres Hospital is at an important point: within the next five years it will undergo a significant physical change with the addition of a new building on its campus to replace the one with 150 beds that was severely damaged and partly demolished as a result of a flood in 1992. This new facility will provide a significant opportunity for improved management practices, particularly because it will bring together the hospital's inpatient beds at one site and it will provide a physical connection between the Maternity service and Pathology, Surgery, and diagnostic services, including Emergency. And it will achieve a better relationship to Pediatrics and Infections Diseases, as well.

Management practices will be improved as a result of the acquisition of contemporary concepts and skills from courses provided both in Albania and during a study tour in the United States. The addition of computers will greatly enhance these improvements, and they will play a large part in easing the preparation of management reports and preparation of budget information.

The Durres District is in a unique position in Albania from the point of view of health care. It is only 39 kilometers from Tirana, where there is concentrated the most sophisticated health care resources in the country, but it is also an important sea port and emerging recreational center due to its large expanse of undeveloped beach property. Thus, even though it is relatively nearer to specialty back-up services, the local demand for services will increase considerably with economic development, so that it will have to improve its health care services accordingly.

In other ways, Durres District is similar to the other larger districts in Albania, such as Elbasan, Korce, Shkodra, Vlora, and Fier, all of which have populations within 40% of Durres', while Tirana's population is double that of any other district. These similarities are: improved management to distribute the limited budgetary resources to the best possible effect, coordination of primary and secondary services so that the latter is not unnecessarily burdened, provision of adequate specialty services to meet the demands of the growing industrialization and middle class, upgrading of facilities and equipment, and improvement of the level of training of health care workers, both nurses and physicians.

Durres Hospital appears to serve principally its own district's population; however, it is unknown to what extent patients leave Durres District to Tirana for care. The kind of care is principally related to pregnancy and childbirth, gastrointestinal illnesses, trauma, pulmonary diseases, and cardiac diseases. In regard to obstetrics and gynecology services, Durres Hospital has developed a good level of service. The same level of care, though, does not appear to be present in the other areas of high service need. This is shown by the allocation of the budget by service, and can be observed first-hand; however, no data from medical records or other sources were examined to determine any specific determinants of the quality of care provided.

Management has determined that its priorities should be in the following areas:

- Clinical Services
- Facilities
- Manpower
- Management

It is believed that resources will be made available to make improvements in all these areas. The resources of the national health care budget to Durres Hospital will be supplemented through various outside agencies and organizations, not the least of which is the loan provided for the new hospital building.

II. MISSION STATEMENT

Durres Hospital management determined the hospital's mission to be comprised of the following elements:

1. Scope

- A district hospital
- Ambulatory care services to chronic and urgent care patients
- Health Educatioin in polyclinic with ambulance transportation as appropriate (Note: Primary care, by default, coming directly to polyclinic and hospital)
- Emergency care, with ambulance vehicles

2. Population Served

- Durres District plus Kavaja for complex surgical and medicine, plus obstetrics

3. Purpose

- Maximize quality of care
- Provide care to all who need it
- Improve quality of life (through provision of high quality of care) at most cost effective

III. ENVIRONMENTAL ASSESSMENT

1. Population Served

Durres Hospital, together with Shijak Hospital, serves the Durres District, which is the second most populated district to Tirane. The district's exact population is not possible to calculate, since there is a considerable number of persons who are living either in Durres or the outlying village who are not registered. It is estimated by the Durres District Council that there are 20,000 persons living in the district in addition to the 186,361 who are registered. The total population would then be over 200,000.

It is known that the registered population consists of 48,033 families, or 3.9 persons per family. For the population that lives in the cities of Durres and Shijak, which comprises the majority of the registered population (i.e, 100,000 in Durres and 11,000 in Shijak, or nearly 60% of the district's total), there are 30,351 families, or 3.7 persons per family. In the villages, on the other hand, there are 17,682 families, or 4.2 persons per family.

The following is the breakdown of the population by Commune:

Commune	Residents	Families
Sukthi	11,313	2,898
Katundj i Ri	10,761	2,712
Rrashbulli	14,344	3,065
Shafzotaj	10,997	2,711
Gjepalaj	5,570	1,245
Ishmi	7,480	1,735
Maminas	5,839	1,355
Manez	8,695	1,561
Grand Total	**74,999**	**17,282**

A. Patient Origin Study

A patient origin study was performed by the medical records department during December 1994 and January 1995. Patients were not selected at random, however; the criterion for selection was being in the most frequently encountered diagnostic group for the hospital section (i.e., pathology, surgery, pediatrics). Seventy patient records were examined. In regard to place of residence, the breakdown was as follows:

Origin		Number	Percent
Durres City			
City Zone	1	3	
	3	1	
	4	3	
	5	4	
	6	3	
	7	2	
	8	5	
	10	3	
	11	2	
	12	5	
	13	2	
	14	2	
	15	1	
	16	4	
	17	3	
	18	3	
Sub-Total		**46**	**66%**
Shijak		6	
Sukth		4	
Manja		1	
Rrashbulli		2	
Sallmone		1	
Other		3	
Total Outside Durres City		**17**	**24%**
Total Durres District		63	90%
Kavaja		7	10%
Total		**70**	**100%**

B. Demographic Profile and Projections

The latest census conducted in Durres District in 1989 showed that the average age is 34 years. The breakdown is as follows:

Up to age 18	32%
Ages 18 through 60	52.5%
Over 60	15.5%

One-fifth of the population is between ages 25 and 35.

The live births registered in 1994 were 3.298 and the infant deaths registered were 1,020. The infant mortality under the age of one in Durres District in 1994 was 112 or 0.6 per 1.000. There were 19 cases of child death from age one to age 4. Of the total. 40 (or 30%) were in the city of Durres and only one was in the city of Shijak.

The hospital management believes that the population of the Durres District will grow to at least 215,000 to 220,000 in five years. This is not unreasonable, though it should be tested with more definitive demographic analysis of the trends in fertility, infant mortality, and death by all other causes. However, if we assume that the current population is approximately 206,000, a net growth of just 2% per year would yield a total population of 227,000 in five years.

2. Healthcare Institutions and Services

A. Hospitals

Durres Hospital has the following services and bed complement:

Building	Service	Level	Beds
Maternity			85
	Obstetrics	1	(8)
	Obstetrics	2	20
	Gynecology	2	10
	Obstetrics	3	20
	Obstetrics	4	25
	Gynecology	3	10
Infectious Disease			40
	Infectious Disease	2	20
	Infectious Disease	3	20
Pediatrics			70
	Short Stay	1	(6)
	Ped. Infectious	1	20
	Pediatrics	2	50
Pathology			73
	Cardiology	3	10
	Pulmonology	3	8
	Neurology	3	8
	Nephrology	3	4
	Hypertension	3	4
	Gastroenterology	3	5
	Hematology	3	5
	Allergy	3	4
	Rheumatology	3	5
	Endocrinology	3	5
	Dermatology	3	2
	Ophthalmology	3	2
	Intensive Care	3	6
	Urgent Care	3	5
Surgery			50
	Oto-Rhino-Laryngology	1	5
	Surgery	1	10
	Surgery	2	35
Total Durres Hospital			**318**
Shijac Hospital			20
National Orthopedic			60
TOTAL			**398**

(Note: Beds in parentheses are not counted in the total.)

The building that was destroyed by the flood in 1992 contained the following:

Building	Service	Level	Beds
Destroyed/Unusable			150
	Pathology	1	65
	Surgery	1	60
	Neurology	2	10
	Ophthalmology	2	15

B. Polyclinic and Health Centers

Durres Hospital manages the Polyclinic that is located in Durres City. Its physical size and layout were not examined as part of this plan; however, its services are integrated with those of the hospital and should be considered in relationship to the programs provided by the hospital.

The neighborhood health centers (*ambulancas*) in Durres City and in the rest of the district are managed by another section of the Durres Health District. They are not a direct part of this plan; however, the scope of their services are important in regard to the demand for services provided by both the Polyclinic and the hospital's emergency services. In addition, the pediatrics section operates a short stay unit (i.e., the patients do not stay overnight), which is the equivalent of a walk-in clinic for patients who cannot or do not want to be cared for in the Polyclinic or *ambulancas*.

C. Other

Other services, such as dentistry, pharmaceutical distribution and sales, and community health, are not the responsibility of the hospitals and are not considered in this plan.

3. National Programs and Policies

Plans for the development of an insurance scheme and for the improvement of primary care have been developed by the Ministry of Health and Environment. In addition, a systematic downsizing of the bed supply and improvement of the physical facilities and equipment has been underway for the past several years.

The new replacement hospital project for Durres Hospital is part of this program of improvement. The plans call for:

Service	Beds
Surgery	50
Trauma	(15)
Ophthalmology Oto-Rhino-Laryngology Maxillo-Facial	15
Pathology. including all the sub-specialties	80
Total	**145**

(Note: Beds in parentheses are not counted in the total.)

The bed complement of Durres Hospital will be 340 at the end of the construction, which will probably be in 1999, if the building's design is complete by mid-1996. The addition of the Shijac and National Orthopedic hospitals will make a total bed count of 420; however, the continued provision of beds in Shijac may be reconsidered, since it is not far from the district hospital and has few patients currently.

Beds by Service	
Maternity	85
Obstetrics	65
Gynecology	20
Pediatrics	70
General Pediatrics	50
Ped. Infectious	20
Pathology	120
General Pathology	80
Infectious Disease	40
Surgery	65
General Surgery	50
Oto-Rhino-Laryngology	15
Pediatric Physical Rehab. Hosp.	60
Shijak Hospital	20
Total	**420**

4. District Programs and Policies

There is close service relationship between the *ambulancas*, which are organized under separate management and report to the Durres Health District, and the Polyclinic and district hospitals, which are managed by the Hospital District. Formal or informal coordination of these services should take place in order to improve the cost effectiveness of the care delivered at each site, whether *ambulancas*, Polyclinic, or Hospital, since there is an apparent breakdown of the process according to the physicians at the hospital.

5. Morbidity and Mortality

The principal diagnoses reported by Durres Hospital to the Ministry of Health and Environment in 1993 were as follows:

Rank	Discharge Diagnosis	Cumulative Percent
1	Normal Deliveries	15.95
2	Gastroenteritis/Colitis	30.89
3	Bronchopneumonia	44.72
4	Enteritis	52.32
5	Voluntary interruption of pregnancy	59.79
6	Tonsillitis	65.94
7	Complicated pregnancies	69.19
8	Spontaneous abortion	72.16
9	Viral hepatitis	74.50
10	Bronchitis (>14 years)	76.76
11	Appendicitis	78.31

Source: Report to Ministry of Health & Environment, 1993.

Absent from these diagnoses are the specialty cases in general and trauma surgery, oncology, and circulatory diseases. There may be some difficulty in accurate diagnosis; for instance, appendicitis may be used for abdominal pain of etiology unknown or to describe an exploratory operation. On the other hand, specialty cases may be self- or physician-referred to Tirana or elsewhere. Data of patient origin from the University Hospital Center would indicate the degree of emigration from Durres District for specialty—and, perhaps—routine care.

Causes of Death:
The hospital reports that the causes of death are the following:

Trauma	34.6 %
Pulmonary	25.6
Heart	15.2
Nervous diseases	11.5
Other	13.1
Total	100.0 %

The admitting diagnoses to the hospital are reported as follows:

Trauma	16 %
General Surgery	15
Parasitic infection	17
Pulmonary	11
Heart	10
Urology	9
Other	22
Total	100.0 %

6. Bed Need

The short-term hospital beds that will be in service in Durres District in the year 2000 will be 340 at Durres Hospital and 20 at Shijac Hospital. Since Shijak Hospital has limited capabilities and treats only very minor cases, its beds should not be considered acute care. Therefore, the district's projected population of 200,000 persons will have 1.7 acute care beds per 1,000 population.

While this ratio is below the national target of 3 beds per 1,000 population, current occupancy levels do not indicate that there is a lack of bed capacity in Durres District. This may in part be due to the large supply of beds in Tirana to the east and also the availability of another hospital in Kavaja immediately to the south. In fact, major cases, such as head trauma and oncolgy, are routinely sent to Tirana from Durres. In the future, however, Durres Hospital's improved facilities may mean that these cases are not transferred. For instance, the new emergency room and surgery facility will probably mean that traffic accident victims will remain at Durres for treatment and the new radiolcgy unit will decrease the hospital's reliance upon Tirana for diagnostic imaging.

The currently projected beds show that the hospital will have sufficient capacity to accommodate a projected increase in utilization from 11,150 admissions to 14,000 admissions and still have capacity for further increase. The capacity of Durres Hospital (and the National Orthopedic Hospital) to accommodate future demand is shown in Appendix A in the calculation of bed occupancy (section k.). In the year 2000, there will be an average occupancy of 62.3% with no service over 72% occupancy. Even if the projected decline in average length of stay (from 7.8 days to 6.5 days) does not occur, the occupancy would not exceed an average of 75%. In comparison, community hospitals in the United States aim at an occupancy level between 80% and 90%, depending upon the mix of services and the proportion of multiple-occupancy patient rooms. Also, at 6.5 days average length of stay, the 340 acute care beds projected for Durres Hospital in the year 2000 could accommodate over 19,000 admissions, which is 5 000 or 36% more than the 14,000 admissions projected.

IV. INSTITUTIONAL ASSESSMENT

1. Patient Volumes by Service

See data in Appendix A.

2. Operational Performance to Budget

Service	Cost	Adjusted Patient Days	Allocated Costs	Cost/Adjusted Patient Day
Surgery	14,580	14,416	17,786	1,234
Maternity	20,900	14,837	24,199	1,631
Pathology	8,080	19,774	12,477	631
Pediatrics	12,870	13,078	15,778	1,206
Infectious Diseases	4,760	9,169	6,799	742
Orthopedics	9,160	15,322	12,567	820
Emergency	3,580	3,007	4,249	1,413
Polyclinic	7,790	6,543	9,245	1,413
Other	21,380			
TOTAL	**103,100**	**96,146**	**103,100**	**1,072**

[Note: For Emergency and Polyclinic adjustment = (expenses for service/total expenses) x (actual patient days)].

The variation of cost per patient day among the services was discussed with hospital management and the chief of maternity, which has the highest cost per patient day. Further study is needed to identify the reason for the discrepancy in costs among services.

3. SWOT Analysis

The results of the SWOT analysis with the hospital managers and medical staff leadership identified the following (see Appendix C for complete SWOT analysis):

Strengths:

- Performance of the hospital to budget
- Training of staff

Weaknesses:

- Poor equipment
- Absence or lack of dependable supply of basic utilities, such as water and electricity
- Poor physical coordination of services due to services located in separate buildings

Opportunities:

- Planned new hospital building will improve facilities in surgery, pathology, emergency, and radiology, and improve the coordination of services by concentrating the acute care beds at one site
- Privatization and liberalization of purchasing practices will improve the hospital's ability to obtain high quality, cost effective goods and services

Threats:

- Loss of job security as a result of the decentralization and privatization reforms
- Poor salaries are driving good nurses and physicians from employment in the hospital
- Budget constraints will continue and the hospital will not be able to keep up with the demand for services

V. STRATEGIC INITIATIVES

1. Clinical Services

Hospital management projects 4,200 annual births and 14,000 total annual admissions in five-to-ten years.

The admissions will break down as follows:

Pathology	1,978
Surgery	2,581
Infectious Diseases	893
Pediatrics	1,968
OB/GYN	6,441
Orthopedics-National Child	139
Total	14,000

The average length of stay is projected to be 6.5 days and the total patient days 91,000, for an average daily census of 249. The resulting occupancy rate will be 68%, a level which leaves some room for growth while allowing for daily fluctuations in census.

1.1. Identify the pieces of equipment that are obsolete and order their replacement after it has been demonstrated that the recommended model is cost effective.

1.2. Improve the level of clinical performance of physicians by:

a. Creating a job description for the hospital's clinical director.
b. Monitoring the performance of physicians through the creation of an audit of medical records and the evaluation of the results by the hospital director, the clinical director. and the service chiefs.
c. Making improvements to the medical education program. Explore enhancing the visitation of outside Clinical faculty to the hospital and the attendance of hospital staff physicians at lectures and presentations at the university in Tirana and abroad.

1.3. Improve the level of clinical performance of nurses by:

a. Appointing a nurse specialist who is available to all nurses to consult on questions of patient management, sterile techniques, and nursing skills.
b. Creating a nurse education ladder that rewards nurses for making improvements in their skills.

2. Facilities

2.1 Prepare a list of desired facilities attributes and work to ensure their inclusion in the new hospital building. On this list might be:

a. Emergency generator for intensive care. operating rooms and emergency
b. Emergency water supply

2.2 Complete the functional and space programs and architectural design for the new hospital building by working with the Project Commission and the design consultant chosen to complete the building's plans.

3. Manpower

3.1. Devise job descriptions for all managerial positions and put into place periodic review appraisals of performance by each person's direct supervisor.

3.2. Prepare a job evaluation process and implement.

1st year: Prepare a management organization chart with a table describing the principal responsibilities and qualifications of each position.

4. Management

4.1. Explore outsourcing of hospital support services in such areas as nutrition and food services, materiel management, housekeeping, hospital maintenance, radiology, etc.

1st year: Prepare an outline of specifications for selected services, such as food service and housekeeping.
Make contact with local prospective vendors.

2nd year: Contract with a vendor.

4.2. Install and develop computer-assisted systems in finance, pharmacy and statistics and, later, in other clinical and support areas.

1st year: Install 3 computers with printers in Finance, Pharmacy, and Statistics.

2nd year: Develop computerized monthly management reports that track actual performance to budget.

4.3. Create and implement a periodic management reporting system that describes the performance of the hospital's operating departments.

4.4. Put into place a budget preparation process that identifies the needs of each department for each category of expenses.

4.5. Improve medical records through the application of JCAHO standards for their preparation and review. In particular:

a. Implement a unit record number for medical charts by January 1, 1996.
b. Obtain and implement a file folder system that permits the storage and retrieval of records conveniently. This should be a set of racks that hold the folders upright to permit easy viewing of record numbers.

4.6. For the pharmacy and clinical laboratory, perform a study to determine the accuracy and reliability, as well as the timeliness, of results reporting from time of physician order.

a. **Expenses (by category)**	**Cost**
Personnel	**63,400**
Surgery	8,960
Maternity	12,250
Pathology	4,660
Pediatrics	10,040
Infectious Disease	2,070
Orthopedics	4,350
Emergency	2,900
Polyclinic	5,750
Total	12,420
Supplies / Equipment	**4,000**
Surgery	500
Maternity	760
Pathology	180
Pediatrics	250
Infectious Disease	120
Orthopedics	310
Emergency	360
Polyclinic	220
Total	1,300
Food	**6,500**
Surgery	810
Maternity	1,450
Pathology	1,080
Pediatrics	730
Infectious Disease	620
Orthopedics	1,510
Emergency	--
Polyclinic	--
Total	300
Medicine	**7,900**
Surgery	1,980
Maternity	2,440
Pathology	860
Pediatrics	950
Infectious Disease	180
Orthopedics	160
Emergency	220
Polyclinic	600
Total	510

DURRES HOSPITAL — OPERATING DATA

a. Expenses (by category)	Cost
Utilities	**12,800**
Surgery	1,980
Maternity	3,850
Pathology	950
Pediatrics	850
Infectious Disease	670
Orthopedics	1,480
Emergency	190
Polyclinic	230
Total	2,600
Equipment Maintenance	**8,500**
Surgery	350
Maternity	150
Pathology	350
Pediatrics	50
Infectious Disease	1,100
Orthopedics	1,350
Emergency	50
Polyclinic	850
Total	4,250
Equipment Purchase	--
Surgery	--
Maternity	--
Pathology	--
Pediatrics	--
Infectious Disease	--
Orthopedics	--
Emergency	--
Polyclinic	--
Total	--
TOTAL	**103,100**
Surgery	**14,580**
Maternity	**20,900**
Pathology	**8,080**
Pediatrics	**12,870**
Infectious Disease	**4,760**
Orthopedics	**9,160**
Emergency	**3,720**
Polyclinic	**7,650**
Total	**21,380**

b. Staff

Doctors	**119**
Surgery	18
Maternity	19
Pathology	12
Pediatrics	15
Infectious Disease	3
Orthopedics	3
Emergency	9
Polyclinic	20
Total	20
Nurses	**365**
Surgery	46
Maternity	80
Pathology	25
Pediatrics	65
Infectious Disease	13
Orthopedics	27
Emergency	15
Polyclinic	35
Total	59
Sanitary Workers	**118**
Surgery	23
Maternity	30
Pathology	11
Pediatrics	21
Infectious Disease	8
Orthopedics	8
Emergency	3
Polyclinic	4
Total	10
Support Staff (Kitchen, laundry, security)	**127**
Surgery	11
Maternity	18
Pathology	16
Pediatrics	15
Infectious Disease	2
Orthopedics	9
Emergency	5
Polyclinic	2
Total	49

	1990	1991	1992	1993	1994	2000
c. Admissions						
Surgery	2,096	1,890	--	1,555	2,056	2,581
Maternity	6,118	6,478	5,293	5,735	5,131	6,441
Pathology	1,378	1,250	780	1,461	1,576	1,978
General Pediatrics	1,683	1,436	794	1,517	1,126	1,414
Infectious Pediatrics	778	449	248	478	441	554
Infectious Disease	1,187	940	564	670	711	893
Orthopedics	167	144	137	108	111	139
Total	**13,407**	**12,587**	**7,816**	**11,524**	**11,152**	**14,000**
d. Patient Days						
Surgery	19,451	15,293	--	10,763	14,416	15,149
Maternity	34,327	32,212	24,248	15,857	14,837	15,592
Pathology	19,842	19,125	7,630	18,057	19,774	20,780
General Pediatrics	17,782	13,272	5,031	12,477	8,113	8,526
Infectious Pediatrics	14,512	7,600	3,178	5,195	4,965	5,218
Infectious Disease	16,282	13,090	8,710	9,306	9,169	9,635
Orthopedics	40,125	23,961	24,160	18,137	15,322	16,101
Total	**162,321**	**124,553**	**72,957**	**89,792**	**86,596**	**91,000**
e. Length of Stay						
Surgery	9.3	16.4	--	8.0	7.1	5.9
Maternity	5.6	4.9	4.5	2.8	2.8	2.4
Pathology	14.4	14.3	16.7	13.5	12.4	10.5
General Pediatrics	10.6	9.3	6.5	8.9	7.5	6.0
Infectious Pediatrics	18.7	15.0	12.8	10.9	11.0	9.4
Infectious Disease	13.7	13.6	15.5	14.7	12.9	10.8
Orthopedics	240.3	180.0	183.0	146.0	161.0	115.5
Average	**12.1**	**9.9**	**9.3**	**7.8**	**7.8**	**6.5**

f. **Patient Visits**

Tests/Procedures	1990	1991	1992	1993	1994
Emergency - Urgent Care					
Pathology	450	415	260	485	525
Surgery	1,200	1,120	--	940	1,180
Laboratory Analysis(Hospital)					
Clinical	--	--	--	--	26,586
Biochemical	--	--	--	--	43,402
Radiology Films (Hopsital)					
Chest X-Ray	--	--	--	3,474	--
Abdominal X-Ray	--	--	--	715	--
Various Radiographic Exam	--	--	--	2,725	--

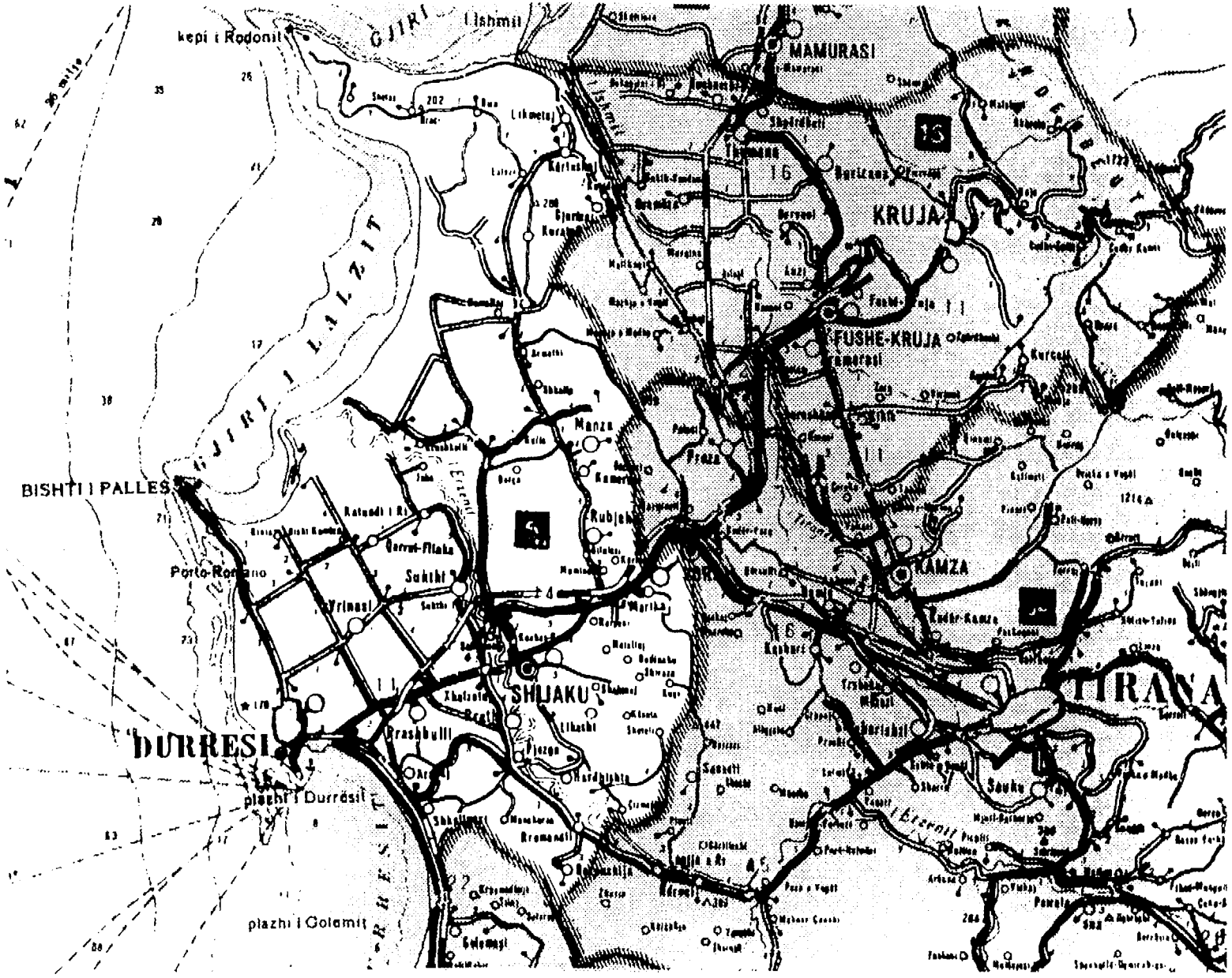
	Fluoroscopy	Radiography	ECHO	Analyze Clinic-Biekinik
g. **First 6 months of 1993**				
Maternity			542(a) 490(b)	
Pathology(Int. Medicine)	1,980	379		--
Surgery	437	1,536	327	3,746
Pediatrics	1,824	517	--	--
First 6 months of 1994				
Pathology(Int. Medicine)	2,680	538	--	--
Surgery	332	1,428	408	3,867
Pediatrics	1,967	432	--	--

(a) 8 months, ambulatory patients
(b) 8 months, inpatients

h. Polyclinic	1990	1991	1992	1993	1994
Rheumatology	--	9,919	9,113	8,764	1,733
Surgery	--	19,180	25,016	22,201	3,819
Psychiatry	--	3,798	4,145	3,146	1,053
Gastroenterology	--	5,398	7,093	3,747	623
Endocrinology	--	4,146	4,790	3,759	1,420
Infectious Disease	--	1,120	604	1,910	1,030
Hematology	--	1,798	3,265	4,954	854
Cardiology	--	17,610	22,789	9,749	1,952
Hypertension	--	6,791	6,015	4,984	812
Otorhinolaryngology	--	20,880	15,948	16,382	3,828
Oncology	--	3,380	3,745	4,652	1,575
Dermatology	--	33,661	31,921	21,986	11,957
Ophthalmology	--	17,519	21,333	18,709	6,078
Nephrology	--	4,044	4,289	3,196	631
Neurology	--	11,882	12,212	9,124	1,603
Allergy	--	2,612	3,034	3,282	1,278
Radiology	--	3,920	3,798	3,880	4,252
Orthopedics	--	6,908	1,680	--	--
		174,566	**180,790**	**144,425**	**44,498**

	1990	1991	1992	1993	1994	2000
***i.* Average Daily Census**						
Surgery	53.3	41.9	-	29.5	39.5	41.5
Maternity	94.0	88.3	66.4	43.4	40.6	42.7
Pathology	54.4	52.4	20.9	49.5	54.2	56.9
General Pediatrics	48.7	36.4	13.8	34.2	22.2	23.4
Infectious Pediatrics	39.8	20.8	8.7	14.2	13.6	14.3
Infectious Disease	44.6	35.9	23.9	25.5	25.1	26.4
Orthopedics	109.9	65.6	66.2	49.7	42.0	44.1
Total	**444.7**	**341.2**	**199.9**	**246.0**	**237.2**	**249.3**
***j.* Beds Available**						
Surgery	75	75	0	50	50	65
Maternity	85	85	85	85	85	85
Pathology	75	75	73	73	73	80
General Pediatrics	50	50	50	50	50	50
Infectious Pediatrics	20	20	20	20	20	20
Infectious Disease	40	40	40	40	40	40
Orthopedics	60	60	60	60	60	60
Total	**405**	**405**	**328**	**378**	**378**	**400**
***k.* Bed Occupancy**						
Surgery	71.1%	55.9%	-	59.0%	79.0%	63.9%
Maternity	110.6%	103.8%	78.2%	51.1%	47.8%	50.3%
Pathology	72.5%	69.9%	28.6%	67.8%	74.2%	71.2%
General Pediatrics	97.4%	72.7%	27.6%	68.4%	44.5%	46.7%
Infectious Pediatrics	198.8%	104.1%	43.5%	71.2%	68.0%	71.5%
Infectious Disease	111.5%	89.7%	59.7%	63.7%	62.8%	66.0%
Orthopedics	183.2%	109.4%	110.3%	82.8%	70.0%	73.5%
Total	**109.8%**	**84.3%**	**60.9%**	**65.1%**	**62.8%**	**62.3%**

URRES DISTRICT HEALTH DISTRICT MAP



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DURRES HOSPITAL SWOT ANALYSIS

Conduct: The consultants explained through the interpreter that the managers would be asked to provide their personal assessment of the hospitals strengths, weaknesses, opportunities and threats. They were handed ball point pens and pages that had been prepared in advance, headed with the appropriate title in Albanian and containing space for five numbered responses. Each assessment was conducted separately, so that the pages for strengths were collected before those for weaknesses were distributed, and so forth. The interpreter translated the responses while the respondents worked on the subsequent pages. At the end of the exercise, an oral summary was made of the responses to each element and a short discussion held. It should be noted that some of the respondents did not provide five items for each element.

Definitions:

- **Strengths** were explained as aspects of the hospital which they perceived to be major assets in achieving its objectives.
- **Weaknesses** were aspects that were preventing it from achieving its objectives.
- **Opportunities** are actions or qualities that could be undertaken to improve the hospital's ability to achieve its objectives.
- **Threats** are conditions inside or outside the hospital that may keep it from achieving its objectives.

Participation:

The following were present at the session:

- Hospital Medical Services Director (Chief of all the services),
- Maternity Director,
- Pediatrics Director,
- Surgery Director,
- Pharmacy Director,
- Laboratory Director.

Strengths

1. Building is very good.
2. I have good specialists who have completed university training.
3. The people who have finished high school are good workers.
4. Enough specialists.
5. The emergency room has enough personnel.

1. Physicians have a lot of experience.
2. Physicians are ready to help the patient.
3. In the department of pathology I have all the specialists needed.
4. House officer rounds are coordinated with others working at night.
5. All the services are very good.

1. I have enough staff.
2. Doctors in the emergency room are always there to give help.
3. The number of specialists in our hospital is enough.
4. My staff has good morale.
5. We have enough medicine now.

1. Enough personnel.
2. Good specialists.
3. The people in the laboratory are quite good.
4. The repairs in the laboratory.
5. Newly arrived machinery will allow us to do our work better.

1. Enough budget.
2. We have all the services for the population.
3. Enough staff for all the services.

1. Enough personnel-well trained.
2. Physicians with great experience, and loyal.
3. Well maintained documents.
4. Well located pharmacy.
5. Financial statement is good.

Weaknesses

1. Deficient services too far from each other.
2. Lack of equipment in medical intensive care and cardiac intensive care.
3. Equipment are very old and they are missing.
4. Cannot find blood easily.
5. Reports from the laboratory tests are not sufficient.

1. The lack of tools and equipment.
2. Not having running water.
3. Lack of ability (scope) to be comprehensive.
4. Lack of equipment in the medical intensive care unit.
5. Care givers (i.e., parents of children) take care of patients because of lack of staff.

1. Place where we work is not a good one - it is too old.
2. The equipment is very old.
3. Lack of electricity and water.
4. There is no recovery room for patients who have had an operation.

1. Lack of information.
2. Services are too far from each other.
3. Workers do not work the entire day.
4. Lack of equipment.
5. Lack of organization to solve our problems.

1. Some of my people are not well trained.
2. I am missing some of the supplies for analysis in the hospital.
3. Machinery is very old-outdated.
4. The methods we are using are too old and take too long.
5. I am missing glass and laboratory equipment.

1. Lack of western experience - how to organize the service.
2. Lack of literature for new drugs.
3. Not enough equipment and tools to work with.
4. Not enough possibilities to go to Europe to see how the pharmacy works.
5. Lack of electricity and water.

Opportunities

1. Building a new hospital.
2. Having all the services in one place.
3. Finding a better - how to collect the information you need.
4. Put more money into the services.
5. Improve the physical environment outside the hospital.

1. Building a new hospital in a European design.
2. New machinery will help us a lot to examine the patient.

1. We can buy goods from private sources.
2. To expand the area where we work (not enough room now).
3. Better coordination with administration only way to solve the problems.
4. We hope to buy some new equipment since the funds were already given to us.
5. To open pharmacy in surgery and OB/GYN hospitals.

1. We took advantage of the situation to improve the laboratory's environment.
2. With the new equipment which has just arrived, I think we will improve the quality of work and do new analyses.
3. If we build a new hospital, we will have the opportunity to build a new and modern laboratory.

1. If I could have all the tools and supplies required, I could do a qualified job.
2. Having a recovery room helps me to treat the patients who are really sick.
3. In regard to the hospital, the situation would change if we could have water.

1. The recovery room equipment in cardiology is better.
2. To build a new hospital that will have all these services: cardiology, pathology, and others.
3. A good recovery room.
4. To increase the salaries of personnel.
5. To allow the doctors to do two jobs.

DURRES HOSPITAL — SWOT ANALYSIS

Threats

1. In the case of reform (i.e., firing people), I will remain without financial resources. I am not able to open a private clinic.
2. House doctor (i.e., the doctor on-call) of a certain specialty faces a lot of obstacles when the emergency cases arrive.
3. In the case of epidemic, we do not have enough beds and drugs for the people who will ask us for admission.
4. The shortage of automobile ambulances in the case of a second emergency.

1. Environment in the hospital is getting worse.
2. Equipment in the hospital is very old, but we are still working with it.
3. Financial level of the doctors doesn't allow them to move forward.

1. Not to get all the drugs needed in time.
2. To reduce the number of workers.
3. Not to get all the money you need to run the budget.
4. All the good workers are leaving because of the poor salaries.

1. Utilities are not at a good level.
2. Shortage of personnel.

1. Lack of equipment and of water threatens the closure of the hospital.
2. To continue working in these conditions is a big threat to the spread of infectious diseases (e.g., AIDS).

1. Because of the lack of reagents and other equipment we cannot do a good part of the analysis.
2. In the case of social assistance, which will probably happen soon, it is threatened that only a few employees will remain and this will influence the quality of work.
3. I'm afraid I'm going to lose my job under the social system then I will go home and become a good housekeeper.

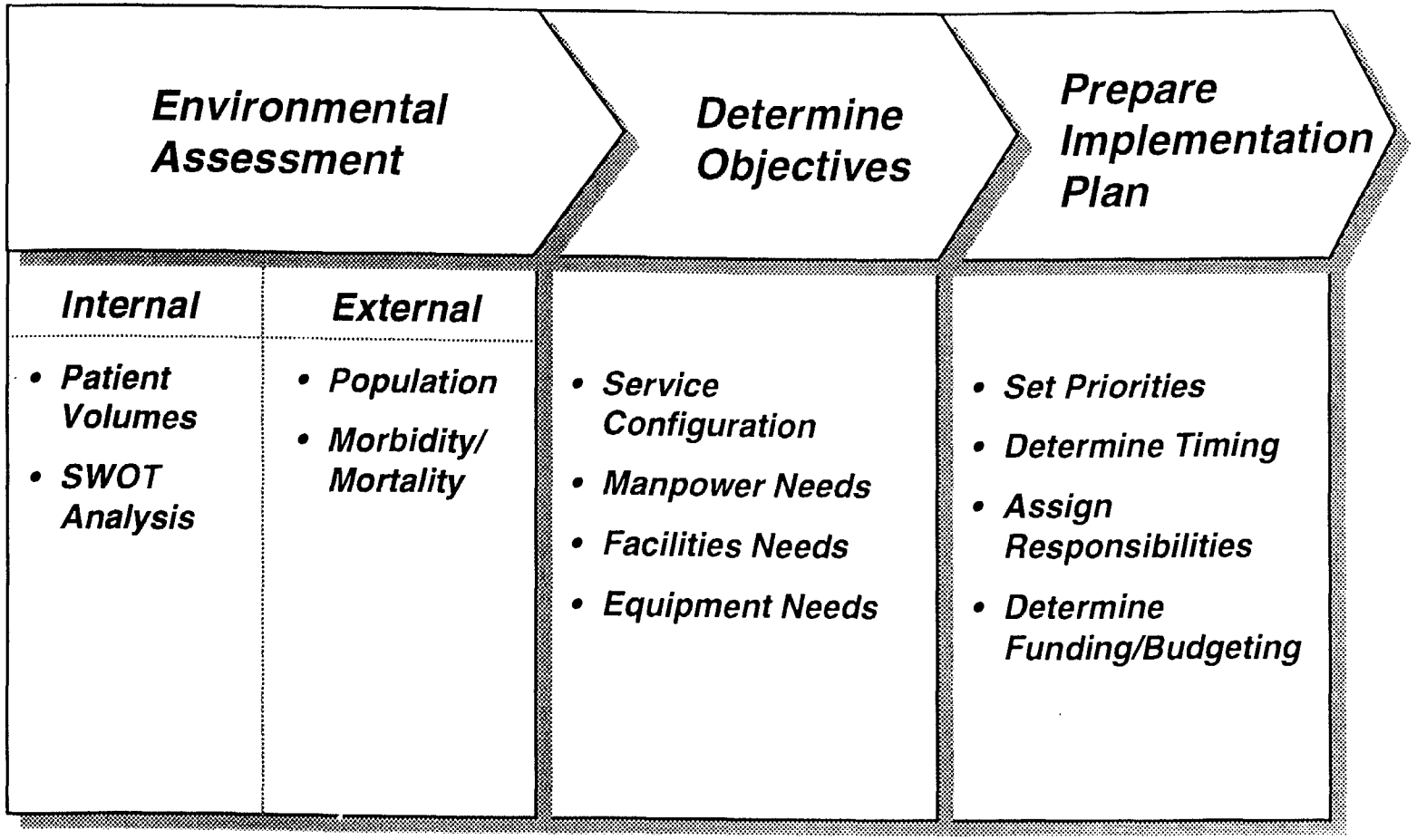
DURRES HOSPITAL
Durres, Albania

STRATEGIC PLAN

Presentation:
November 30 & December 1, 1995

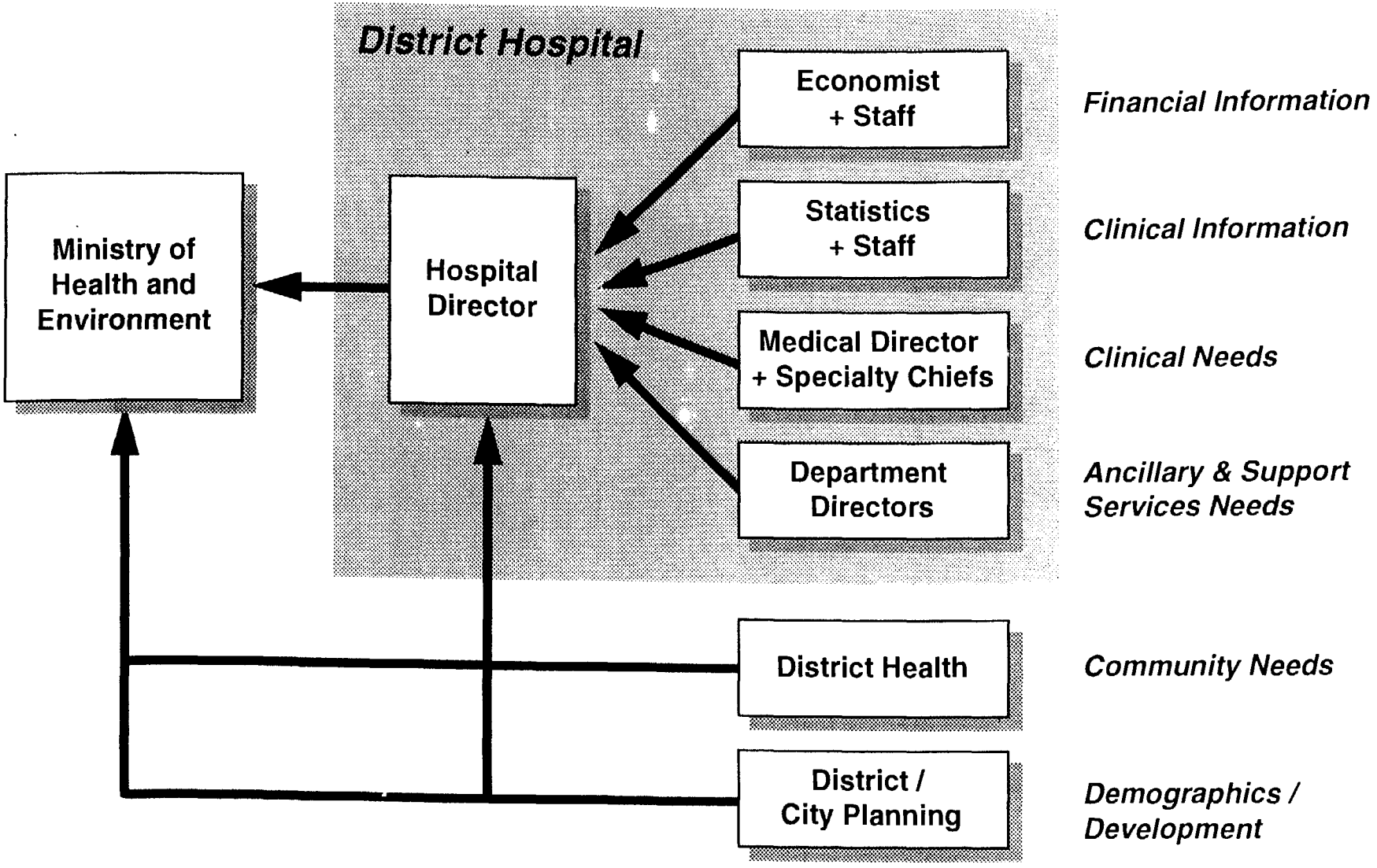
by
Dr. Mikel Noçka
Hospital Director

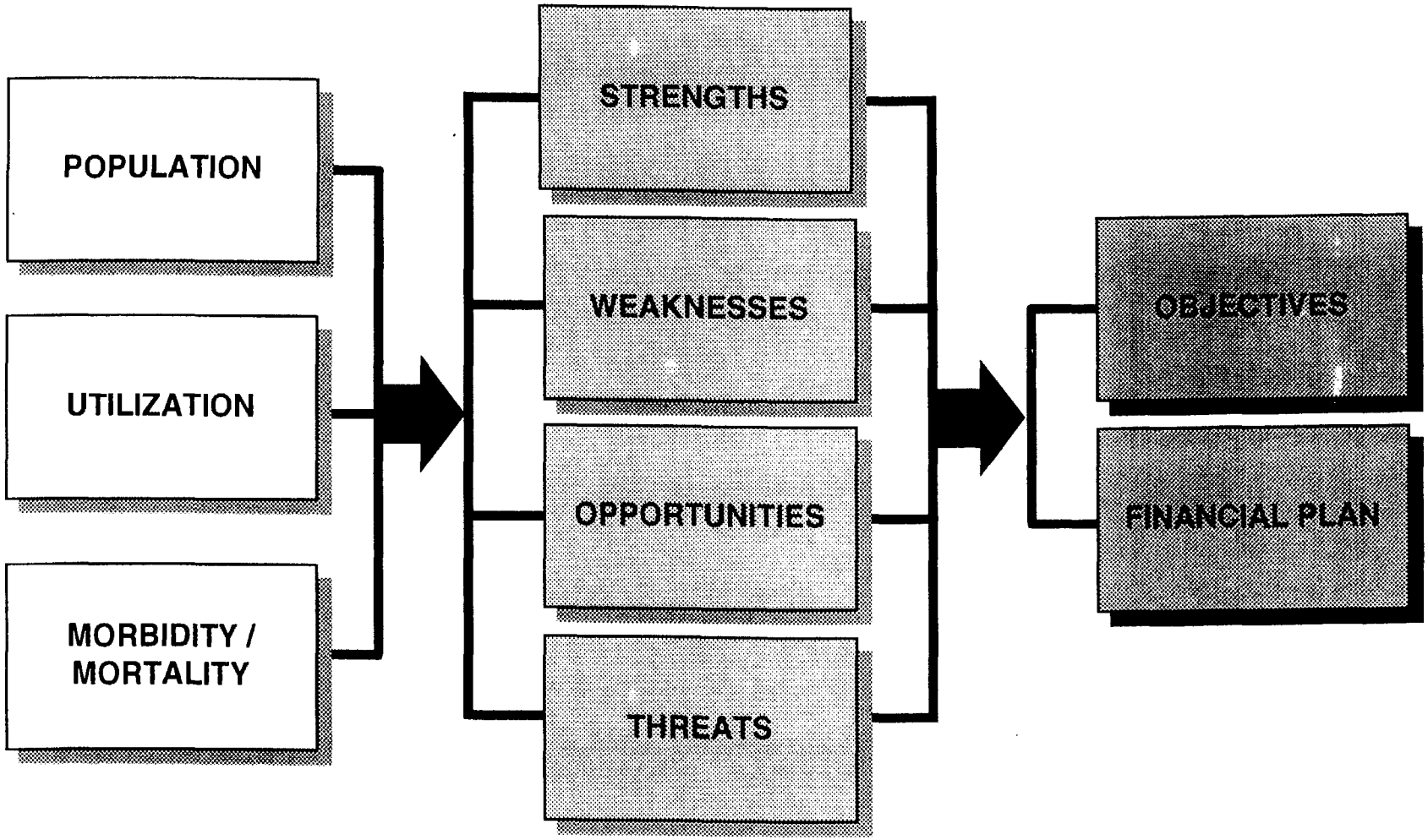
Work Steps


Environmental Assessment
Determine Objectives
Prepare Implementation Plan
Internal
External
• Patient Volumes
• SWOT Analysis
• Population
• Morbidity/ Mortality
• Service Configuration
• Manpower Needs
• Facilities Needs
• Equipment Needs
• Set Priorities
• Determine Timing
• Assign Responsibilities
• Determine Funding/Budgeting

Durres Hospital
Durres, Albania

Planning Organization



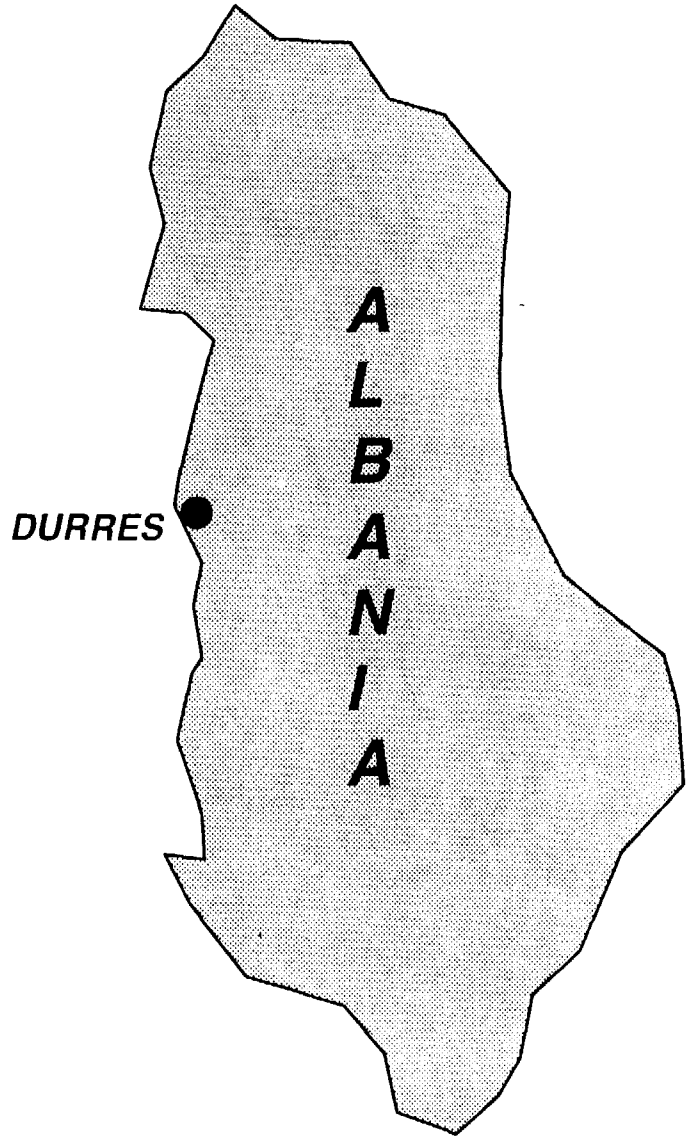

POPULATION
UTILIZATION
MORBIDITY / MORTALITY
STRENGTHS
WEAKNESSES
OPPORTUNITIES
THREATS
OBJECTIVES
FINANCIAL PLAN

	01/01/92	01/01/93	2000
ALBANIA	3,224,701	3,166,025	
DURRES DISTRICT	165,219	162,846	200,000 - 227,000

Source: Popullsia Sipas Rretheve. Gjate Vitit 1992 (VLERESIM)

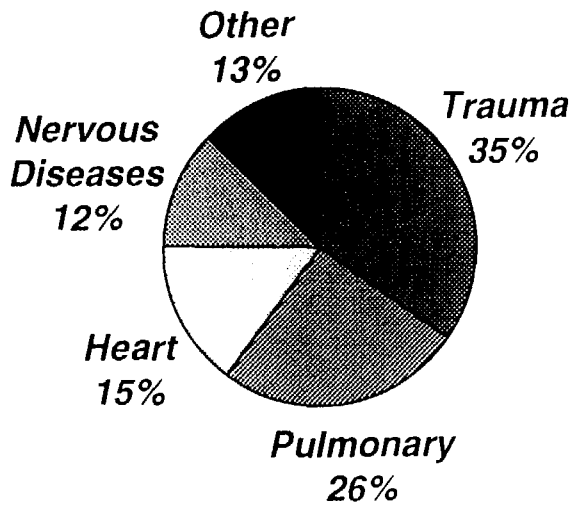
DISTRICT	POPULATION	FAMILIES
Sukthi	11,313	2,898
Katundi i Ri	10,761	2,712
Rrashbulli	14,344	3,065
Xhafzotaj	10,997	2,711
Gjepalaj	5,570	1,245
Ishmi	7,480	1,735
Maminas	5,839	1,355
Manez	8,695	1,561
TOTAL	**74,999**	**17,862**

Source: Raporti "Jetor i Keshillit Te Rjethit" 1994



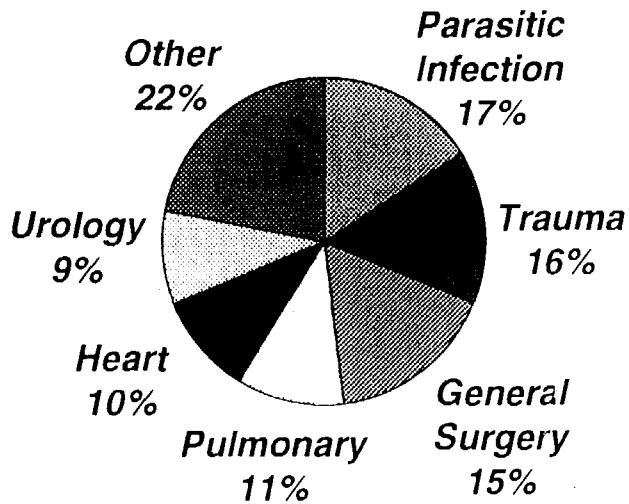
Causes of Death

Trauma	35 %
Pulmonary	26 %
Heart	15 %
Nervous Diseases	12 %
Other	13 %



Principal Diagnoses

Trauma	16 %
General Surgery	15 %
Parasitic Infection	17 %
Pulmonary	11 %
Heart	10 %
Urology	9 %
Other	22 %



Durres Hospital
Durres, Albania

SWOT Analysis

STRENGTHS

- *The hospital has performed well considering its budget constraints.*
- *Staffing levels are sufficient to handle the workload.*
- *The Hospital staff is well-trained and capable of providing quality care.*
- *The Hospital has no competition and is located in a large market.*

WEAKNESSES

- *Equipment is old and outdated.*
- *Salaries are low.*
- *Departmental budgets are small.*
- *Some departments have insufficient staff.*
- *Authority structure of Hospital does not allow local decision-making.*
- *Budget is consumed from patients out of district.*
- *There is a lack of appropriate standards.*
- *There is a lack of competition.*
- *Supply distribution and utility availability such as water and electricity are not dependable.*
- *There is poor physical coordination of services due to the separate building locations.*

OPPORTUNITIES

- *The planned new hospital building will improve facilities in Surgery, Pathology, Emergency, and Radiology, and improve the coordination of services by concentrating the acute care beds at one site.*
- *Privatization and liberalization of purchasing practices will improve the hospital's ability to obtain high quality, cost effective goods and services.*
- *Better management practices can be implemented, with defined standards.*
- *Costs can be decreased without a decrease in quality of care.*
- *Programs can be developed to care for tourists.*
- *Hospital funding can be obtained through charity efforts.*
- *New equipment can be purchased.*

THREATS

- *There will be a loss of job security as a result of the decentralization and privatization reforms.*
- *Low salaries will cause attrition at the Hospital.*
- *Budget constraints will not allow the Hospital to keep up with the demand for its services.*
- *Competition from private sources will emerge; patients will also seek health care at Tirana and abroad.*
- *Natural disasters (i.e. storms) can significantly affect the hospital's ability to provide care.*
- *MoH (Ministry of Health) will not permit autonomy of district hospitals*

The main objectives sought by the Hospital fall into the following four categories:

Clinical Services

- *Improve the level of clinical performance of physicians.*
- *Improve the level of clinical performance of nurses.*

Facilities / Equipment

- *Prepare a list of facility attributes and work to ensure their inclusion in the hospital building.*
- *Complete the functional and space programs for the new hospital building.*
- *Identify equipment that is obsolete; recommend and demonstrate new models that are cost-effective; order replacements.*

Manpower

- *Prepare a job evaluation process and implement the program.*
- *Devise job descriptions for all managerial positions and develop periodic performance reviews.*

Management

- *Explore outsourcing of hospital support services.*
- *Install and develop computer-assisted systems in Finance, Pharmacy, and Statistics.*
- *Consolidate hospital operations under a more efficient management structure.*
- *Develop a budget preparation process that identifies the needs of the departments.*
- *Implement JCAHO standards to improve medical record keeping.*
- *Study the accuracy and reliability of results reporting in the Pharmacy and Clinical Laboratory.*

Improve Performance of Physicians

- *Create a job description for the hospital's clinical director*
- *Monitor the performance of physicians through an audit of the medical records*
- *Develop an evaluation system in which the hospital director, clinical director, and service chiefs review the performance of the physicians.*

Improve Performance of Nurses

- *Appoint a nurse specialist to consult nurses on questions of patient management, sterile techniques, and nursing skills.*
- *Develop a means of rewarding nurses for improving their skills.*

List Desired Facility Attributes

Example:

- *Install an emergency generator for intensive care, operating rooms, and emergency department*
- *Install an emergency water supply*

Develop Functional and Space Programs

	# Beds	Condition*	Projected
Pathology	73	poor	80
Surgery	50	poor	65
Pediatrics	70	fair	70
Maternity	85	good	85
Infectious Disease	40	good	40
Durres Hospital	318	fair+	340
National Orthopedic	60	fair	60
Shijak	20	—	20
TOTAL	398		420

* *Range: poor—fair—good—excellent*

Improve Equipment

- *Identify equipment that is obsolete*
- *Recommend new models that are cost-effective*
- *Demonstrate new models to physicians and administrators*
- *Order a replacement*

Explore Outsourcing of Hospital Support Services

Examples:

- *Nutrition and Food Services*
- *Materials Management*
- *Housekeeping*
- *Hospital Maintenance*
- *Radiology*

* *An outline of specifications will be developed. Contact will be made with local vendors, followed by contract negotiations.*

Install and Develop Computer-Assisted Systems

Examples:

- *Finance*
- *Pharmacy*
- *Statistics*
- *Other Clinical and Support areas*

* *Computerized management reports will be developed to track actual vs. budgeted performance.*

Consolidate Hospital Operations

A solid management structure will be formed that will better utilize hospital resources through the sharing of equipment, space, and staff.

Devise Job Descriptions for All Managerial Positions

Examples:

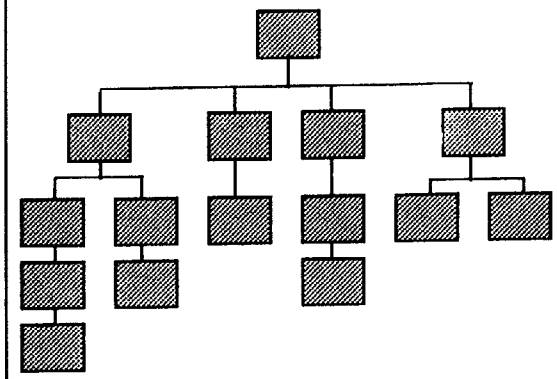
- *Facilities Manager*
- *Director of Pathology*
- *Director of Pediatrics*
- *Director of Rehabilitation*
- *Director of Surgical Services*
- *Director of Quality Assurance*
- *Director of Nursing*
- *Manager of Purchasing*
- *Director of Human Resources*
- *Director of Admitting*

Prepare Job Evaluation Process

Example:

- *Have the stated goals been attained?*
- *Did the department stay on budget?*
- *Is there noticeable improvement in the department?*
- *Is the department morale high?*
- *How many complaints have been filed against the department?*

Prepare Management Organization Chart



Develop Budget Preparation Process

The first step of the budget preparation process is to document and categorize all expenses for each department. This information will be used in the final budget to more accurately determine each department's monetary needs.

Improve Medical Records

JCAHO standards will be utilized in organizing the medical records files. A unit record number system will be in-place by January 1, 1996. A file folder system will also be installed that permits the convenient storage and retrieval of these numbered records.

Determine Accuracy and Reliability of Results

A study will be performed to determine the accuracy and reliability, as well as the timeliness, of results reporting from the time of the physician order.

	Year						Responsibility
	1	2	3	4	5	6	
Clinical Services							*Hospital Director, Medical Staff Director*
Facilities							*Hospital Director, New Hospital Commission*
Manpower							*Hospital Director, Medical Staff Director, Nursing Staff Director*
Management							*Hospital Director, Medical Staff Director, Chief Economist*

ALBANIAN CONFERENCE

November 30, 1995 - December 1, 1995
Triana, Albania

I. Introduction

A. Personal remarks

B. Philosophy of health care

1. A privilege
2. An individual right

II. Overview of US Government Programs

A. Medicare and Medicaid

B. Health Care Costs

III. Issues that influence health care delivery

A. What is included in "health care"?

B. Who receives health care?

C. What system or systems do we need to develop for health care delivery?

D. What does health care cost?

IV. Concluding Remarks

A. The medical record captures information to answer questions.

B. Discussion of the medical record project.

C. Thank you.

Introduction

I do not know exactly what philosophy Albania has as related to health care, except that it appears that everyone is eligible to receive health care. Even though I am not sure how your system works, you are to be complimented for providing care to all your citizens.

Because I know so little about your health care delivery system, I would like to briefly review with you my observations of health care delivery in the United States. You may draw comparisons to your own system.

Historically, universal health care was not always a right that everyone shared. Prior to World War II, many believed that health care was a privilege, not a right. That notion changed dramatically after World War II for reasons that I will not go into at this time.

In the 1960's, the United States became aware of the fact that many citizens (especially older citizens) did not have access to health care. So the government implemented the Medicare program, which provided health care to older citizens. Later, the government also implemented Medicaid, a health care program for low-income families. Medicare and Medicaid reduced the financial barriers that often kept many citizens of the United States from receiving the health care they needed.

As more and more citizens enrolled in the government-sponsored programs, the costs of the programs increased at an alarming rate. And the costs of health care and how best to control those costs are being debated in America today, even as we meet here in Albania.

The good thing about looking at health care delivery is that

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it makes us attempt to answer the following:

1. What do we mean by health care?
2. Who receives health care?
3. What system or systems do we utilize to provide health care?
4. What are the costs of health care?

I believe that the information needed to address the issues I just referred to is found in medical records.

It is the medical record that describes the illnesses, injuries, and abnormal health conditions that patients are treated for. It is the medical record that tells us what resources are used to "treat" the patient or alleviate his health problem/s. Did we utilize our resources carefully? Did we reach our health care outcomes with efficacy and efficiency? The answers should be in the patient's medical record.

So today, we want to share with you the work that has been done to develop medical records that ensure complete, accurate, and timely documentation of patient care.

I have worked with Dr. Natasha Celiku and Dr. Eduard Hashorva to develop a medical record model which will support the integration of clinical and financial information required to develop a health care delivery system that will meet the needs of the citizens of Albania. Dr. Hashorva and Dr. Celiku will discuss our work with you.

Thank you for the opportunity of allowing me to work with you as you determine the future of health care delivery in Albania. My best wishes to each of you.

Attachment C

National Conference on Advances in

Hospital Management

Natasha Celiku, M.D.

(In Collaboration with Roland Dale, RRA)

November 30, December 1,1995

Tirana, Albania

Health Statistics to Support Decisions in Hospital Management

Over the past two years the University Hospital Center of Tirana and Durres Hospital have participated in a hospital management project sponsored by USAID (United States Agency for International Development). The overall objective of the project was to improve the management of hospital resources in a changing health care environment, with focused attention to the areas of administration, finance, purchasing and medical records (health statistics).

Today, I want to share with you what I have learned and describe for you some of the changes I have made in the Department of Statistics to improve the information the department provides to administration for hospital management. The areas I want to review with you are:

- Unit Record Numbering/Patient Medical Record Number
- Master Patient Index (UPI)

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- Terminal Digit Filing and Retrieval
- Coding Diseases and Operation
- Disease and Operation Indexes
- Expanding Services of the Department
- Recommendations for Immediate Consideration

Unit Record Patient Medical Record Number

Every patient admitted to The University Hospital in 1995 received a unique patient identification number - simply called a "medical record number". The medical record number is used to specifically identify the patient every time he is admitted to the hospital for treatment or receives hospital clinic services.

For example, if a patient has an acute myocardial infarct (AMI) and is admitted for the first time to the Cardiology Service, the patient will be assigned his own unique medical record number. All the documentation of the services the patient receives during his stay at the hospital will be identified by the medical record number. All laboratory reports, all radiology reports, all progress notes, etc. will have the patient's medical record number on them. All of these reports will be filed in a folder that also has the patient's medical record number on it. Each patient admitted to the hospital or registered in the clinic will receive a unique medical record number that will be his only.

In the Statistics Department, each patient will have one folder, and all documentation of the care given to the patient during any episode of care will be in a folder that has the patient's medical record number printed on it. After the patient is discharged from the Cardiology Service, the patient's medical record folder and all documentation of the care received are sent to the Statistics Department for discharge processing and storage.

If the same patient is admitted to the hospital for surgery one year later, he will be given the same medical record number originally assigned in the Cardiology Service. All the services he receives during his admission for surgery will be identified by his medical record number, and all the documentation of services received by the patient will have the medical record number on it and will be kept in the patient's medical record folder.

The point I am making is that a patient has only one medical record number at The University Hospital of Tirana, and that number will be used every time he comes to the hospital. Also there is only one medical record folder in which the patient's health information is stored. The advantages of a single number and a single medical record folder for each patient are that

- continuity of patient care is improved
- duplication of data collection is reduced
- record processing becomes more efficient
- charge data can be retrieved more readily

We have been very pleased at The University Hospital Center with the unit record number as a unique patient identifier.

Master Patient Index (MPI)

The utilization of a unit medical record number allows the Statistics Department to develop a Master Patient Index (MPI) which will track all of the patient's inpatient and outpatient visits to the hospital. The MPI is computer-based and is kept as long as the hospital is in operation.

The Master Patient Index will maintain the following information on all patients seen and treated at the hospital:

- Medical record number;
- Name;
- Age;
- Sex;
- Admission/discharge date;
- Name of service;
- Name of Physician seen (optional);

If the patient forgets his medical record number or the clinic he was seen in, that information can be found in the computer-based Master Patient Index maintained by the Statistics Department and accessed by name and date of birth (DOB).

Terminal Digit Filing

For every patient admitted to the hospital, a medical record folder

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with the patient's name and medical record number is created by the Statistics Department. The Statistics Department has implemented a Terminal Digit Filing System using the medical record number for filing and retrieving patient information and the patient's medical record.

Let me demonstrate how the terminal digit filing system works using medical record Number 34-76-13. Number 13 is the "terminal" (primary) digit and Number 76 is the "secondary" digit, leaving Number 34 as the "tertiary" digit.

34	76	13
Tertiary	Secondary	Primary(terminal digit)

To retrieve a patient's medical record one would go to Section 13 of the central file. Section 13 is divided into 100 subsections from 00 to 99. In Number 34-76-13, we would look for Secondary Number 76 in terminal digit Section 13. Number 76 is also divided into 100 subsections, 00-99. So in subsection 76, we look for Tertiary Number 34. We read the number "backwards": 34-76-13 is accessed by reading the number 13, then 76, and then 34. The same process is used to file the patient's medical record or health information.

Coding Diseases and Operations

Coding medical records is the process of assigning a numerical code to the narrative description of a diagnosis or procedure. For

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example, *Diabetes Mellitus with Complication, Type I, Uncontrolled* is coded 250.03 in the ICD-9-CM. The University Hospital Center of Tirana will use both the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and Current Procedural Terminology, Fourth Edition (CPT-4) to assign codes. It must be emphasized that the correct assignment of codes depends very much upon the complete, accurate, and timely documentation provided by physicians in the patient's medical record and upon the coding skill of the coders.

Disease and Operation Indexes

Using the ICD-9 codes that were just discussed, indexes can be set up to capture the incidence of diseases treated or operations performed at The University Hospital. Through capturing such health data, we can determine the number of patients seen by each service and generate statistics monthly, quarterly, and annually. By tracking patients by diagnosis, service, and physician, the hospital can

- determine the resources used to treat specific disease or injury categories
- identify the costs associated with patient care
- project future needs for manpower, space, equipment, and finance.

The indexes will include both inpatient and outpatient encounters.

Expanding Services of the Statistics Department

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The foundation for health information systems has been developed and implemented as indicated in this presentation to you. The work was accomplished through the collaborative efforts of USAID and the Ministry of Health in Albania. However, it should be emphasized that this is only a beginning.

Building upon the basic health information system I have reviewed with you, the Statistics Department at The University Hospital will begin coding all outpatient encounter with ICD-9 and CPT-4 codes in January of 1996. Through coding, we will be able to provide hospital administration with data which indicates the health status of the population we serve in the metropolitan area of the University Hospital Center of Tirana.

Recommendations for the Immediate Future

There are two more areas I want to briefly comment upon. One relates to the storage of radiology film, and the other has to do with record retention.

- Radiology film should be kept in a folder separate from the medical record but filed in the Statistics Department.
- A formal retention policy for the retention of medical records should be developed. For external legal purposes, I recommend a retention period of twenty-five (25) years. However, for internal research and teaching needs, I recommend that medical records

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be kept indefinitely.

These recommendations should be discussed and policies and procedures should be developed to provide system-wide guidelines for the filing of radiology film and for the retention of medical records.

Attachment D

Albanian Conference
November 26-December 2,1995
Summary Remarks
Roland Dale, RRA
Medical Record Consultant

The Albanian Conference was very successful. From reviewing Attachment C,(See attached), one can note that the project culminated in the development and implementation of a basic health information system. Those system elements included a

Elements of Information System

- Unit Record System

  One medical record folder is assigned to a specific patient, medical record folder is used to store documentation of all health care received by the patient.

- Medical Record Number

  A unique, identifying number thatis assigne^ to a specific patient and links all documentation of patient health care (including hospital, outpatient emergency room and primary care records) to a single patient and identifies the patient's medical record number.

- Master Patient Index (MPI)

  An index (or log) that documents every encounter the patient has with the hospital, clinic, emergency room, or hospital physician.

- Terminal Digit Filing and Retrieval

  A system that uses the last two digits of the medical record number as a means of accessing and retrieving patient care information (admissions,discharges, dates of service, type of service, etc.)

- Coding

  Reading the written narrative description of a diagnosis and/or procedure and translating the description into a numerical equivalent (Example: Simple pneumonia = 486). The International Classification of Diseases, Revision, Clinical Modification (ICD-9-CM) and Current

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Procedural Terminology, Fourth Edition (CPT-4) will be used.

- Disease and Operation Indexes
  Indexes which document the number of illnesses, injuries, and other health problems treated by hospitals and clinics and the surgical and diagnostic procedures performed.

Needs Assessment for Continued Development of Project

- Equipment, material, and supplies

  Several conference participants expressed concerns over availability of funds for implement and main-training the hospital management concepts presented conference. They stated that it costs money to buy file folders, obtain computers, purchase software, and provide space for properly storing medical record information. Will funding and administrative support be available? Some hospitals have computer while others feel that they are lucky to have pencils and paper.

- Human Resources

  Several hospital directors stated that current staff member not have the background nor the skill level for information management as presented at the conference. What education and training programs can be provided to meet statistics personnel needs?

Education/Training

Several individuals expressed the need for more training and education in health information technology and management. I recommend the following·

- Basic training in health information technology, whether manual or computer-based.
- Use independent study modules and develop learning experience to meet individual needs.
- Develop a "train the trainer" education model for health information technology, using a career ladder concept.
- Develop a School of Allied Health Sciences at the University of Tirana.

Recommendations to the Ministry of Health

- Provide support for the development of legal applications as related to the storage, linkage, transfer, confidentiality and arching of health information at the national level.
- Determine whether or not it would be feasible for Albania to initiate a national medical record numbering system that can be utilized throughout the country to link all patient health care data.
- Begin to assess the appropriateness of Prospective Payment and Diagnosis Related Groups (DRG's) as a first step in projecting health care costs nationwide. The system can be applied to both inpatient and outpatient services and can serve as a tool for developing operating budgets of hospitals based upon patients served.

Conclusion:

On more than one occasion, the spokesperson for Albania and USAID stated that Phase I of the hospital management project has been quite successful, but it is only a beginning. I agree.

The foundation has been laid, at least in the medical records, to move forward with the development of a clinical and financial information system that is needed to make informed decisions in developing national health care programs.

If the United States government provides support for the continued development of the hospital management project, I would like to participate. Should there be additonal questions, I can be contacted at

Children's National Medical Center
Washingtion, D.C. 20010
Phone: (202) 884-5712 FAX: (202) 884-5991

Thanks for the opportunity to participate in the project.

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FINAL REPORT
UTILIZATION OF COMBINED ECONOMIC STRENGTHS IN PHARMACEUTICAL PURCHASING AND DISTRIBUTION

November 25 - December 2, 1995
Tirana, Albania

By:
Todd Ebert, R.Ph., MS

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Appendix A.....
Presentation (Albanian) by Aferdita Tafaj

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Presentation (Albanian) by Gentiana Metuli

Appendix C.....
Presentation Material (Albanian and English prepared by Todd Ebert).

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Introduction:

Over the past year, numerous Albanian Ministry of Health officials, hospital directors, economists and pharmacy personnel have been introduced to the principles of pharmaceutical group purchasing used in the United States. This process has included an evaluation of Albanian pharmacy product procurement procedures, presentations on the processes used in the United States, numerous discussions on the proposed process, explanations, examples and the development of a model for creating a meaningful Albanian Pharmacy Request For Proposal.

Great care was taken to describe an initial process which was nothing more that a combination of existing efforts relative to the purchasing of selected pharmaceuticals (a start small and go slow process).

On November 30 and December 1, 1995, a conference was held to describe and educate Albanian hospital directors regarding the group purchasing of pharmaceuticals in the country of Albania. Mrs Aferdita Tafaj and Ms. Gentiana Metuli presented the concept at a national health care conference.

The following is a report on this conference with a brief background of the events which lead up to the program.

Background:

October/November 1994:

The initial visit was one of fact finding, education, discussion and the development of a Request for Quotation (RFQ) for use by the newly formed Albanian Pharmacy Group Purchasing Organization. This RFQ was to be modified towards the needs of the participating facilities and within the scope of their capabilities. Goals and time lines were established for the participants to work towards.

Please see the October/November HEI report for complete details.

March 1995:

This "follow-up" visit was made to monitor the progress of the program as well as identify needs or obstacles in the path of progress. It was found that the new group purchasing concept had been thoroughly discussed, but was entangled in a maize of confusion, budget concerns and direction from the Ministry of Health.

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After numerous fact finding discussions and a presentation to the Director of Hospitals (Ministry of Health) with selected hospital directors, the program was back on track (Dr. Mikel Nocka, Director, Durres Hospital, was instrumental in the organization and success of this presentation). A pharmacy purchasing group commission was to be formed and discussions held towards the actualization of the program.

Please see the March 1995 HEI report for a complete report.

April 1995:

A contingency of Albanian pharmacy managers and others visited the United States to study the pharmacy group purchasing process, among other things. The process was again thoroughly explained and demonstrated. Study tours were made to the key representative participants in the group purchasing process (manufacturer, wholesaler and hospital) in order to place the entire process in a physical prospective. Follow-up discussions were held as action items were identified and plans developed for the continuation of the project in Albania.

Please see the April 1995, Developmental Associates report for complete details.

The work and effort of the above described sessions was to lead to a final conference in Tirana, Albania for health care managers which was to be presented by their peers. This conference was held on November 30 and December 1, 1995.

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November/December 1995--The National Health Care Conference-Pharmacy Program.

The initial portion of the week in Tirana was to evaluate the preparedness of the presenters, modify material if necessary, further prepare any presentation material, and assemble the presentation information for the participants. One entire day was devoted to the practice and "fine-tuning" of the presentations.

The Pharmacy Group Purchasing participants were well prepared for the conference. This was evidenced by their ability to answer questions and explain the process through the preliminary session. In preparation for the meetings and uncertainty regarding the final preparation of the presenters, the consultant prepared a presentation on the process (See Appendix C). This presentation, with minor modifications was used for the ministry of health described in the March 1995 visit. As described above, the pharmacy presenters were well prepared and this prepared document (translated into the Albania language) was only referred to during the closing comments of each session (Suggested as a guideline for use during their efforts towards group purchasing success).

The Albanian Pharmacy Group Purchasing Presenters, Mrs. Aferdita Tafaj (Presentation in Appendix A) and Ms. Gentiana Metalli (Presentation in Appendix B) were well prepared to lead the discussions. This was evidenced by their level of confidence and their ability to answer some tough well thought out questions. Each sessions participants (four in total) agreed with the concept described and the recommendations of the presenters, which was to continue with development of a pharmaceutical group purchasing program tailored to the Albanian system. In each session, there were many good questions which were addressed by the presenters.

Questions and concerns addressed by the participants and responded to by their Albanian peers included:

1. Is there support of the Ministry of Health? There must be some autonomy for the purchasing group to function.

   Comment: Work with the Ministry of Health, informing them of your needs and develop a program which meets the objectives of both organization.

2. How will the group purchasing commission be organized? Who will represent the largest and smallest of hospitals?

   Comment: Suggestion was made to keep the decision making unit small and thereby functional, however each hospital type should be represented (small, medium and large). All

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facilities should maintain flexibility to make and support decisions which are good for all participants and the group. An example was given relative to compromise, i.e. no facility may totally like the decision, but every facility can live with it to everyone's benefit.

3. What will become of Fufarma, the state partially subsidized wholesaler?

   Comment: They have the opportunity to be part of the competitive process as a supplier (manufacturer) or wholesaler.

4. Currency exchange, how will this occur?

   Note: There is a difference in experience between the larger hospitals and the smaller rural hospitals in the purchasing of product. For example, the larger hospitals have utilized foreign companies for the purchase of product and have overcome the challenges related to payment. Whereas, the smaller rural hospitals only utilize Fufarma as the drug supplier. The experiences the larger hospitals have in purchasing would be invaluable to the group and the smaller hospitals--another reason to work together.

   Comment: It can be done. check ith the University Hospital in Tirana.

Observation/Conclusion:

It is plainly evident that all hospitals in Albania purchase generically identical product at widely differing prices. Experience dictates that by combining volumes for purchasing of generically identical product from all of the Albanian hospitals, will provide one lower price for all. Using the contractual components which were previously identified and arranging the appropriate delivery of product to all hospitals (monthly, quarterly, etc.) with appropriate payment by each facility for the product they receive, this process/concept will work.

Selected generic drug products would be used as a starting point with five to six hospitals initially participating, with a contractual caveat that additional facilities could/would be added as the process proceeds. This "start small and go slow" approach should insure success through the efforts of Mrs. Tafaj and Ms. Metuli with the support and help from Mr. Fortuzi, Dr. Nocka and the Ministry of Health. Those in Albania who are familiar with the process now have all the tools required to plan and implement such a program. It is now their opportunity to move the process forward to success.

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Follow-up Steps:

1. **Program monitoring for success. Expectations should be set by the Ministry of Health for progress. This means that the Ministry gives the group process the support it requires, with the flexibility to learn and enhance the program as they continue. Small measurable steps towards combined purchasing should be viewed as a successful start which should be expanded. To this point the ministry is very supportive. (If the Ministry does not support the process, then there will be no immediate progress as a group).**

2. Hospital and Materials Management Inventory Management Program Initiative. It has been identified that on many occasions, hospitals purchase selected product at one time for an entire year. This process may have made sense in the past under limited supply/product shortage situations, however with the introduction of competition in Albania--many drug wholesalers and pharmaceutical companies wanting to "sell their wares", newer more efficient inventory purchasing management principles should be utilized.

   New inventory management and purchasing skills utilizing usage patterns, PAR levels, suggested order points, cost applications, cost of money and others; could and should be introduced to better utilize the funds available for inventory investment. These new concepts will allow them more efficiently meet the needs of the physicians and their patients. In fact they should be able to enhance their inventory services and have a wider variety of product available.

   These inventory management process can be introduced in a manual program which can be easily converted to a PC based system.

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Appendix A

Presentation (Albanian) by Mrs. Aferdita Tafaj

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Basic Guide to Group Pharmaceutical Purchasing
Prepared for the Albanian Hospital Pharmacy Group Purchasing Commission
By Todd Ebert, R.PH., MS

The Concept:

Simply put, the pharmaceutical group purchasing concept is to utilize the economic strengths associated with larger purchasing volumes. The purchasing volumes of many facilities are combined in the Request for Proposal (RFQ) and negotiation process to bring greater value to the participants. Value can be equated to lower pricing, enhanced distribution, higher quality product and/or greater inventory control.

The Purpose:

Group purchasing allows the individual hospitals to participate in the best pricing available by providing the hospitals a tool (competition) to leverage selected manufacturers.

Introduction:

Each Albanian hospital pharmacy, large or small, urban or rural; purchases many of the same types of pharmaceutical agents. Up until the introduction of group purchasing procedures, generically identical product was purchased from different sources at widely differing prices. See Appendix A., Individual hospital purchasing--Ampicillin for Injection.

Since all hospitals use Ampicillin for Injection, is it not possible to combine the volumes of all participating hospitals and select one brand of Ampicillin for Injection for all to use? In this approach, all hospitals are working together utilizing the combined strengths, described above, controlling the process while maintaining facility identity. See Appendix A. Multiple hospitals purchasing Ampicillin Inj., Albanian and American example.

The "group" is defined as a collection of hospitals which work together for the contracting of goods and services. In this case we will discuss pharmaceuticals, however the group can work towards developing contracts for all types of hospital supplies used in common. The "group process" is the actual functioning of the organization, working with manufacturers to achieve the desired results (suggested below).

Goal:

Start the group purchasing process in a small and manageable format, evaluating a few products for approximately 5 to 6 hospitals. Develop and distribute an RFQ (described below), allow the approved manufacturers to respond, select the most appropriate manufacturer (evaluating price, terms, delivery, etc.) and work with the program developing some experience. Once the program is up and running for the smaller "starter" group, then allow all hospitals to participate, if they choose. See Appendix A, Program Advantages and Suggested Albanian Group Purchasing Strategy.

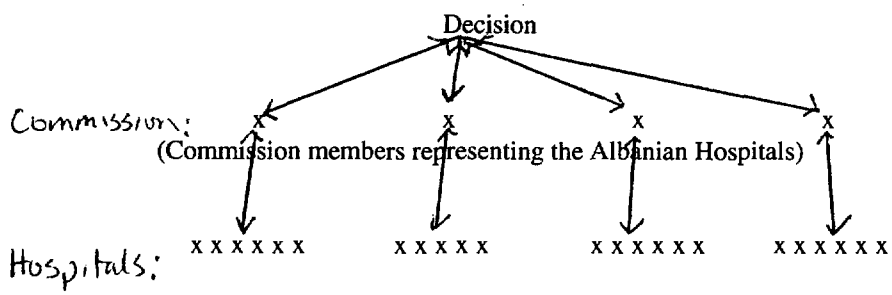
The next following pages describe the formation of the group purchasing organization and the process.

A. Develop and Define the Pharmacy Group Purchasing Commission:

The purchasing commission should be comprised of members who represent the types of hospitals participating; small, large, urban and rural. It is suggested that the commission have 6 to 8 members who can speak for their constituency and make decisions in their behalf. If the commission gets to large, it will quickly become ineffectual as decisions will be very difficult to make.

Each commission member must communicate with his/her constituency for input into the process. Input should mean seeking direction relative to which products to work towards a contracts, acceptable manufacturers and sharing information about current purchasing patterns or prices (competitive information). The commission and group must realize that decisions will be made in behalf of the group. Compromise means that you may not like a decision or choice, but you can live with and support it.

Example of the commission information flow process (a two way process):



Information Flow - A two way process

(Individual hospitals communicating with their commission representatives regarding discussion issues. The commission also, once decisions have been made, communicates to the group in writing, the results of the award. This includes the manufacturer, pricing, order and deliver points and others).

The commission should elect or appoint a discussion leader and secretary.

B. Understanding Value.

Value and Acceptable Vendors:

In the past many discussions have been held relative to the value of pharmaceutical products. It is widely believed that some manufacturers product is inferior to others and should not be used. However, more often than not, these inferior products are used, to the detriment of the patient, because the price is extremely low. The opposite has occurred when the price is high and therefore it is thought that the product must be of the highest quality.

The concept of value is the determination of a quality product at an acceptable price. Ask yourself these questions:

If the price is good, but the patients do not respond to the medication, or if the prices is high but the product is not any better than a less expensive but comparable product, are these acceptable? The answer is obviously--NO.

By developing minimally acceptable standards for manufacturers and their products, the group can be assured that a good quality product at a competitive price will be available for use on the patients they serve. While determining the acceptable criteria, the group must adhere to the standards set, which sends the message loud and clear to the manufacturer community of what you desire and what is required.

Minimal acceptable standards should include:

1. The company and all of their products which are to be sold in Albania should be registered with the National Center for Drug Control (NDC). There should be no exceptions to this rule!

2. The NDC has reviewed all samples of the drugs to be imported into the country and they are as they claim, i.e. the drug and concentration.

3. All product purchased by the group members must have a document of assay (name and strength) available for inspection at all times for each lot number (This may be a requirement for sale to group members).

4. All product should be clearly labeled in an acceptable language (group to determine) and contain a minimal set of information (product name, strength, expiration date, control/lot number and others required or deemed necessary).

5. Each product (bottle for orals and ampoule or vial for injectables) must be clearly labeled with product name, strength, lot/control number and expiration date.

6. All packaging conforms to minimal standards for the protection from light.

(These are suggested standards/criteria for use in improving the quality of product in Albania, you may wish to modify them if necessary. Some manufacturers which you have previously dealt with may not qualify, but if they want to do business with you, they will enhance their standards very quickly to meet your criteria. In some situations it may disqualify Profarma, they will then be forced to improve their standards. Note: Most manufacturers can meet these standards, DO NOT ACCEPT ANYTHING LESS).

C. The development of a Request For Proposal and the process:

Request For Proposal (RFQ) defined:

A Request For Proposal is a document (tool) supplied to each approved manufacturer inviting them to respond to a bid process. The document contains the standards or requirements which need to be addressed in the decision making process. Please note that the term "need to be addressed" was used. This terminology was used to allow for varied responses and minimal guidelines. Some producers will choose to go beyond the minimal requirements and others may merely choose to meet them. This gives the group commission the opportunity to evaluate the responses and make the intuitive decisions required based on the packages offered by the producers and the Albanian hospital needs.

(Please see Appendix B: RFQ developed for the Albanian Group Purchasing Program with a suggested timeline and Suggested Components of an RFQ).

1. Decide on an acceptable product which all participants (or most) will use. I would suggest Ampicillin for injection or Gentamicin for Injection.

2. Determine how much Ampicillin for Injection is used by each hospital on a yearly basis.

3. Qualify vendors using the criteria as stated above. Determine which vendors produce Ampicillin for Injection and are registered with the NDC. THESE VENDORS SHOULD BE THE ONLY ONES WHO RECEIVE AN RFQ. The only exception to this should be those manufacturers who will become registered by the time the RFQ is to be returned. If they are not registered they must be disqualified.

4. Determine the issues and criteria which need to be addressed in the RFQ. For example issues such as the length of contract, payment terms, order points, delivery terms, right of first refusal, pricing, etc. Please see the attached sample RFQ developed for the Albanian group purchasing pharmacy commission in November 1994 as well as the Suggested Components of an RFQ Documents. By following these guidelines and documents the group will protect themselves and set forth the expectations for the manufacturers.

5. Prepare the document. Use the attached examples as a template.

6. Distribute to each approved manufacturer. Responses to the RFQ should be directed to the Commission chairman--clearly spell this out .

7. Prepare to answer questions, provide the name and phone/fax number of the commission chairperson as a contact.

8. Receive the returned RFQ responses and prepare the data for evaluation by the commission.

9.. Evaluate and ask questions. Clarify or negotiate points if necessary--but not the pricing. Determine what is most important, i.e.: cheapest price, price plus free shipping, firm pricing for a year, etc. Determine the best deal for the participants.

10. Make a decision and notify the manufacturer. Make sure everything is in writing and agreed upon.

11. Notify members. This notification should include all of the information they require to purchase the product The notification should be in writing and identify, the products, price, length of contract, order and shipping specifics, etc.

12. Be prepared to communicate and work through problems. There will be some problems which do occur.

13. Maintain your commitment. If you do not maintain your commitment the group will never be taken seriously. The only time you do not maintain the commitment is when the vendor does not live up to their responsibilities. Be prepared to document this if necessary.

14. Determine other products which all can benefit from through this group process and do it again.

15. Good Luck!

Notes and Recommendations:

A. Ordering and Delivery: Historically the Albanian hospital pharmacies have placed one order for one delivery. With this new process, the group can expand their ordering and delivery period to an entire contract period. Negotiate or require four order and delivery points (this is merely an example, you may vary this section depending on your needs and requirements) for each hospital covered by the group contract. Each hospital can then order and receive 1/4 of their yearly usage of contracted product four times a year. Upon receipt of the goods, the hospital pays for the product. This issue can be tailored to the needs and comfort zone of the group.

B. Payment: All hospitals must immediately pay for the product received. Manufacturers who are not paid are under no obligation to continue to fulfill the contract.

C. Differentiation from the current process: This process only differs from the current process by the fact that volumes are combined for price and value. Each hospital places and receives orders for their own product as before at the group established rate. However, each participating hospital is expected to support the group and the contracted manufacturers.

D. Right of First Refusal: This process is used to insure your contracted product pricing remains competitive. Once a contract is awarded and the market prices decreases, you have an obligation to return to the awarded producer allowing them to meet the new lower market price. In this process the awarded producer would be given 20 to 30 days to lower the price or face losing the contract to the new lower price supplier (provide documentation-a bonafide offer). This approach allows the participating hospitals to keep current with the lower prices and provides the awarded vendor the opportunity to keep the business until the contract expires. If this process were not used, no one would bid seriously for the first attempt, because they would wait until the price has been set and then go to individual hospitals to beat the price and get some business. This concept is very important in the group process.

Important note: In many situations, the producers which did not win the bid/award will attempt to circumvent the group and approach individual hospitals asking them to buy their product at the new lower price. All participants should be encouraged to support the group and the group participants should discourage this type of behavior from the unsuccessful producers. The unsuccessful producers should be told to approach the group very seriously during the next round to product RFQ's. Again this will be a test of your commitment and credibility. If the unsuccessful producers are successful at this individual approach, your credibility will be questioned and future serious RFQ responses will be in jeopardy.

E. Communicate with the producers as this process begins. Albania is considered a good new market for many pharmaceutical companies. Use this opportunity to your advantage. As manufacturer discover this market and register with the NDC they will visit the hospitals in the country learning about your needs and the way business is conducted. On occasion, especially in the beginning phase of this process, have meetings with their representatives educating them about the group process, explain what will happen with the RFQ process and what you will require. For those producers who have not yet registered with the NDC, explain that only those who do will be considered. Again, adhere to your criteria as they will encourage the enhancement of quality and promote a fair and honest process.

December 15, 1994

Dear Pharmaceutical Vendor: Mail to all "commission" approved vendors.

Over the past few months, the hospitals of Durres, UHC and (add additional facilities) have evaluated purchasing similarities for the purpose of combining volumes and contracting for product on a long term basis. This new process which is known as "group purchasing" provides many benefits to the participants; both hospital and successful vendor. The hospitals will be able to control the quality of product, consistent supply, less frequent bids or offers and pricing. The successful vendor will be have the awarded business for a longer period of time which will enable you to manage your budgets more efficiently.

In the very near future, you will receive a Request for Proposal, this document contains the criteria we will utilize to complete the selection process and award products to vendors. It is extremely important that you read this document very carefully and answer all questions thoroughly. Unanswered questions or incomplete information may slow down the process or preclude your involvement in the process. If you have any questions, please do not hesitate to contact.....

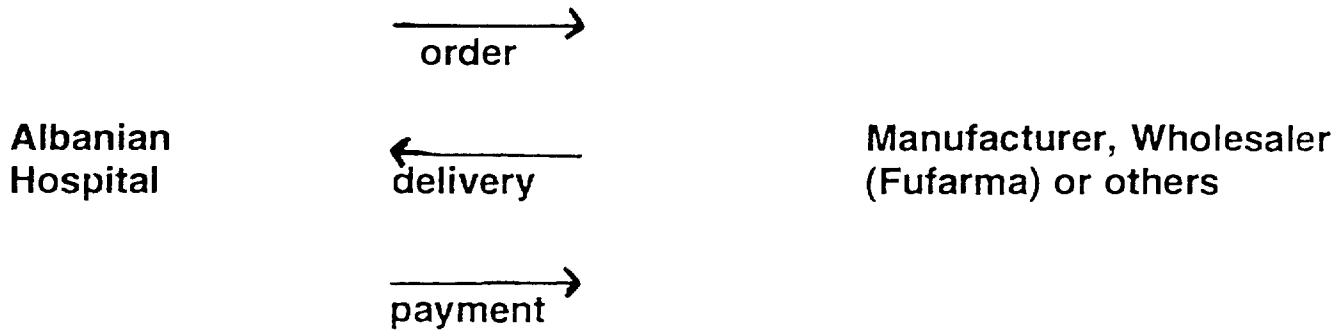
Please add the appropriate contact person and their phone/fax numbers.

The Albanian Hospital Pharmacy Purchasing group fully intends to have this program grow and prosper. As additional products are agreed upon they will be added to our program. Those who participate now will be considered eligible participants in the future.

Sincerely,

Key Contact person

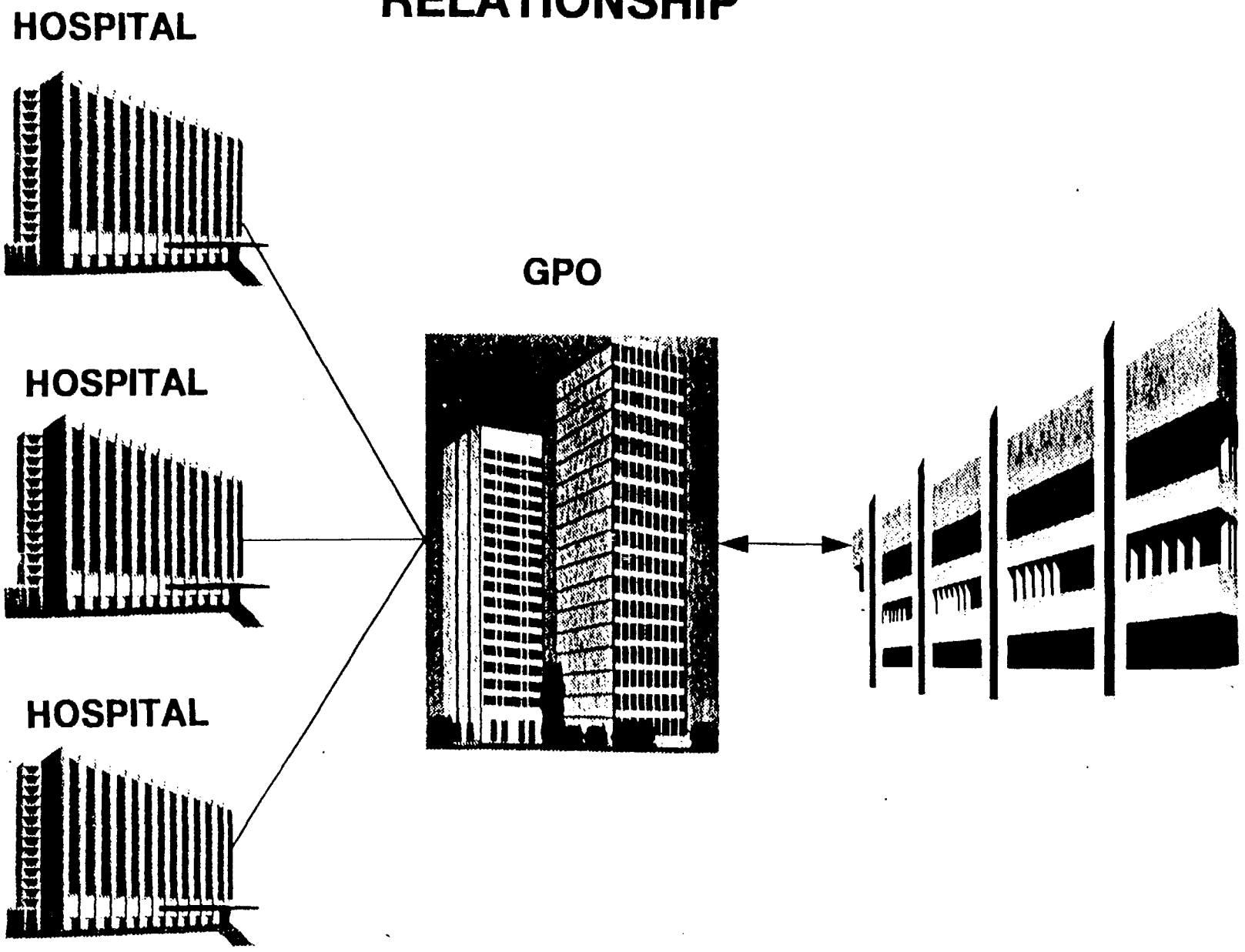
Current System
Single Hospital Pharmaceutical Purchasing



Narrative:

Accepts bids for product.
Selects product for purchase.
Orders product.
Delivery of product to hospital.
Payment made for product.

RELATIONSHIP



Current Albanian Example
Ampicillin 1 Gram Injection (Estimated numbers)

Hospital	Annual Quantity
The University Hospital Center	20,000 Grams
The Durres Hospital	10,000 Grams
The Elbasan Hospital	10,000 Grams
The Pulmonary Hospital	12,000 Grams
Total	52,000 Grams

Proposed order and receiving time line for contracted product.

0----------+----------+----------+----------1 yr

Example: One year contract, with negotiated order points.

Narrative:

- Total is greater than any one facility.
- All facilities participate in volume pricing.
- Each facility orders the appropriate amount for each quarter (inventory and financial control).
- If the group does not feel comfortable with a one year contract, at least combine volumes for a one-time Ampicillin purchase. Much will be saved by all. As comfort zone increases work on one-year agreements. Make it fit for the Albanian pharmacy group.

Program Advantages

- Decreased price or price stabilization.
- Increased control of purchasing process.
- Increased quality of product (as determined by the group purchasing commission).
- Increased inventory control.
- Product consistency.
- Increased organization of the purchasing process.
- Enhanced monetary management.

December 15, 1994

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Sincerely,

Key Contact person

REQUEST FOR PROPOSAL

PROPOSAL MUST BE RECEIVED NO LATER THAN 17:00 HOURS, FEBRUARY 2, 1995

For Information about this request contact: (fill in the name and method of contact -- phone #, fax # or mail address, of the response person--leader of the group purchasing commission).

This document constitutes a request for proposals, including prices, from qualified organizations to furnish products as described on attachment.

The Hospitals of Durres and University Health Center hereafter known as the "Group" invite you to submit a contract proposal to provide agreed upon products for 12 months, beginning April 1, 1995 until March 31, 1996.

Proposals must be signed, mailed and received by the group no later than February 2, 1995, 1700 hrs. at:

(provide name address of responsible person)

General Terms and Conditions:

1. The group reserves the right to add additional hospitals to this purchasing agreement at the identical agreed upon prices. The group will provide you with written notice of any changes to the participant list.

2. Proposals must be held firm until March 15, 1995 (2400hrs) allowing the group to analyze the data and test the product submitted.

3. If any or all of the proposal is accepted, the group will notify you by March 15, 1994.

4. The appropriate Albanian laws governing the import and sale medications shall be adhered to. (You may want to add more to this section, for example approval by the National Center for Drug Control and the Ministry of Health if appropriate). Documentation must be submitted.

Commission must review.....

5. Ordering procedures. You must specify where, when and how each participating facility places orders. The volumes represented on the attached page are anticipated annual volumes and each participating facility reserves the right to order any portion of a years supply as necessary.

   Specify any minimum ordering requirements.

3. Upon return of this request for proposal, your company must provide 100 vials/ampules per product for testing.

Contract Information:

1. The Group reserves the right to accept or reject any, any part of, or all proposals. If the vendor's proposal is accepted, the vendor shall be bound to supply the products specified for the duration of the agreement.

2. Upon award, the group will notify the vendor of the products awarded. The group will also provide you with this counter signed document identifying the products and conditions accepted.

3. The group will also notify the participating hospitals of the awarded products and vendors.

Products Offered For Proposal

(This document can be used to provide the proposed contract pricing)

Product Name and Description	Anticipated Annual Quantity	Price/unit
Gentamicin 80mg/2ml ampule/vial	125,000	_____
Ampicillin 1gm. vial	112,000	_____
Chloramphenicol 1gm. vial	90,000	_____
Fentanyl 10ml. ampule	11,000	_____
Kanamycin 1gm. vial.	4,000	_____
Penicillin G Crystalline 1 million units/vial	60,000	_____
Penicillin B 800,000 units/vial	100,000	_____
Cephaloridine 500mg. vial	104,000	_____
Ceftazidime 1gm. vial.	5,000	_____
Cefotaxime 1gm. vial	8,000	_____
Amikacin 1gm. vial	5,200	_____

Please return this entire document as directed to:

Commission must complete

Commission must select products.

Albanian Group Purchasing Organization Time line and Program Flow Sheet.
November 1994 through February 1995.

1. November 8, 1994: Todd to write a vendor introduction letter.

2. November 21, 1994: Finalize the participating hospitals.

   Responsibility: Albanian Pharmacy Group

3. November 21, 1994:

   Organize Group Purchasing Commission

   Name the group organization, give it a name.

   Finalize the medication bid list (keep it manageable). A large list will make it extremely difficult to manage for the first attempt. Finalize the companies which will receive an RFP. Addresses and phone/fax numbers are required.

   Finalize the terms and conditions.

   Responsibility: Albanian Pharmacy Group.

4. December 1, 1994: Fax to Todd Ebert through Jim Janeski the completed RFP in English for review and comment.

   Responsibility: Albanian Pharmacy Group.

5. December 5, 1994: Return Fax through Jim Janeski the finalized version.

   Responsibility: Todd Ebert

6. December 6 - 14, 1994. Prepare final document in Albanian and English.

   Responsibility: Albanian Pharmacy Group and Interpreter.

Suggested Components of a Request For Proposal (Can be in any order)

Introduction paragraph and general instructions for Request For Proposal

1. Deadline for returning signed proposal.

   Quotations held firm for a period of time.

   Where RFP should be returned.

2. Products to be contracted and volumes anticipated, if available.

   Proposals must be priced per product.

   No product substitution allowed without the written consent of the group.

   Describe how products will be packaged and shipped.

3. Facilities/hospitals participating--list.

   Additional facilities/hospitals can be added to the agreement with notification to the vendor.

4. Length of agreement (May be 3 to 6 months for initial period or 12 months at most). Want to start slow and gain momentum. A minimal contract period will allow the vendor to demonstrate ability to deliver. Contracts can be extended with experience. Note: Try to maintain every contract on the same time frame (expiration date), as it is much easier to manage.

5. Governing Laws of the Country of Albania.

16. Indemnification clause for facility for proper use of product.

17. Right of first refusal. If the market price decreases, vendor has a right to decrease price to meet the new market price. If the price is not acceptable, the group has the right to select an alternate product on a sole or dual award basis.

18. Information Dissemination.

19. Confidentiality.

20. Own use, product not for resale.

21. Other Information.

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Utilization of Combined Economic Strengths in Pharmaceutical Procurement and Distribution

Tirana International Hotel

Tirana, Albania

November 30 - December 1, 1995

153

Session Agenda

Utilization of Combined Economic Strengths in Pharmaceutical Procurement and Distribution

- Introduction
  - Agenda Review
- Background Review
- Value: Cost vs. Quality
- Current System - Single Hospital Pharmaceutical Purchasing
- Proposed Method - Many hospitals working together

Session Agenda (continued)

Utilization of Combined Economic Strengths in Pharmaceutical Procurement and Distribution

- Current Albanian Example - Ampicillin Injection
- United States Example - AmeriNet
- Program Advantages
- Suggested Albanian Pharmacy Purchasing Strategy
- Request for Proposal Review
- Call to Action

Utilization of Combined Economic Strengths in Pharmaceutical Procurement and Distribution

Goal:

- To introduce the pharmacy group purchasing concept to hospital pharmacists and pharmacy directors throughout Albania.
- Explain the process and demonstrate the results achieveable
- Call to action

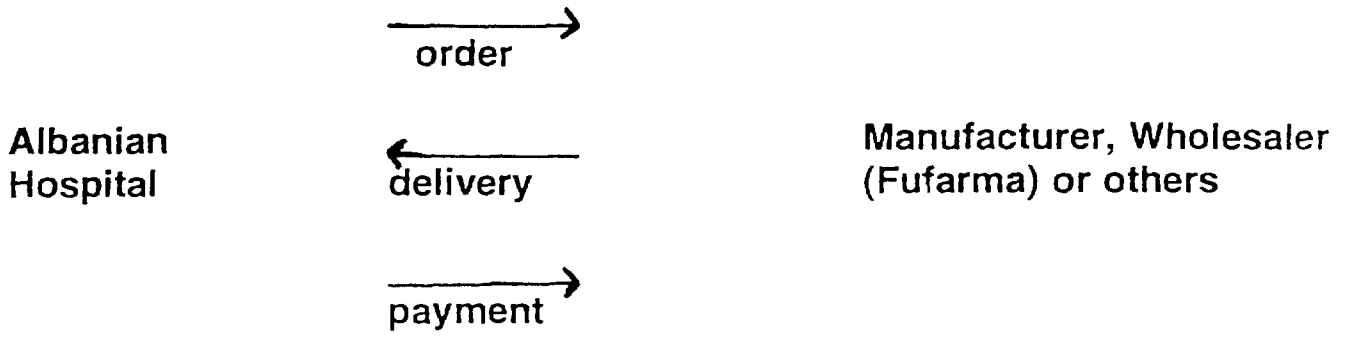
Value
Cost vs. Quality

Which product should you buy? The most or least expensive?

How do you determine quality?

When does price become the determinant?

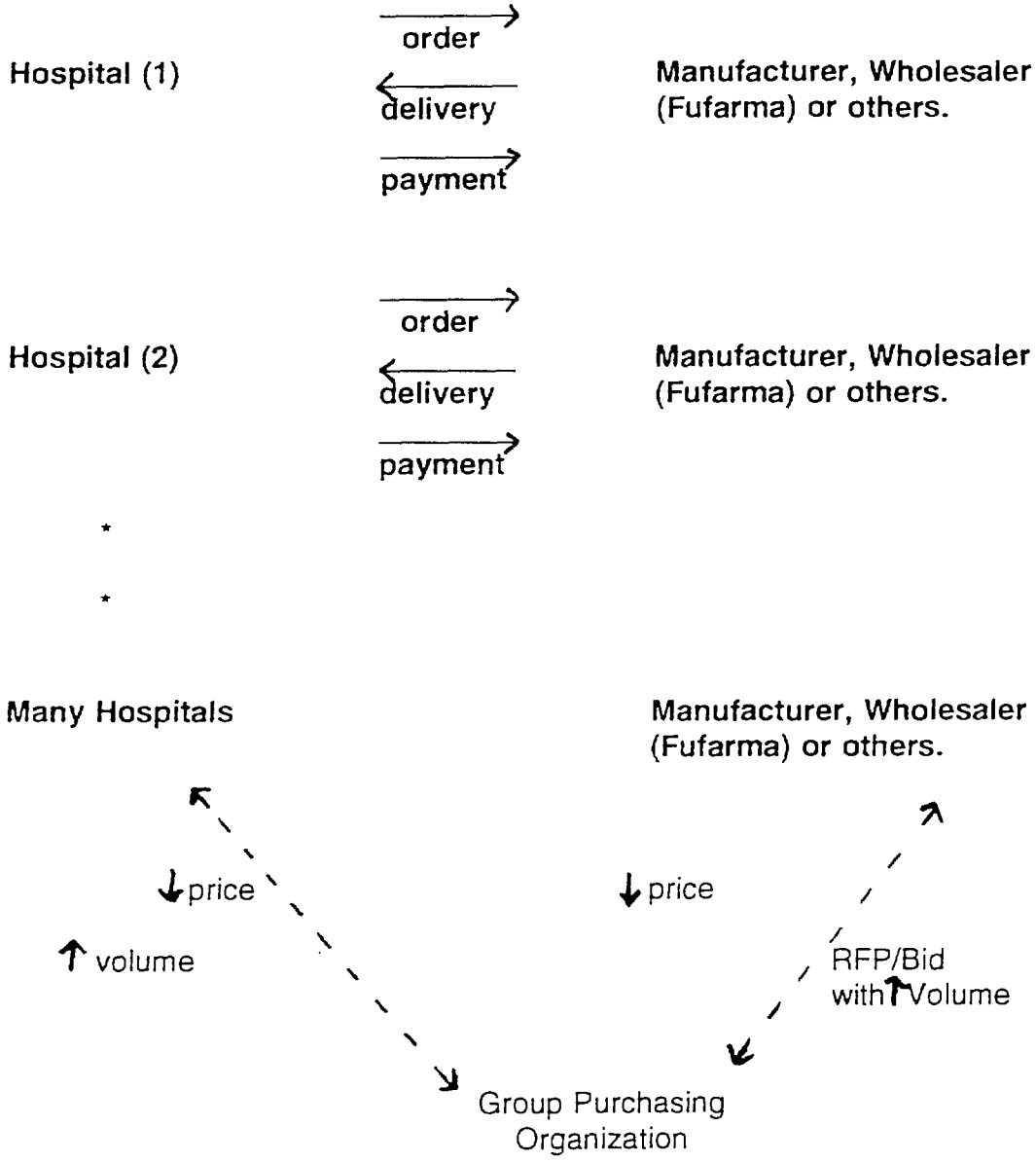
Current System
Single Hospital Pharmaceutical Purchasing



Narrative:

Accepts bids for product.
Selects product for purchase.
Orders product.
Delivery of product to hospital.
Payment made for product.

Proposed Method
Many Hospitals Working Together



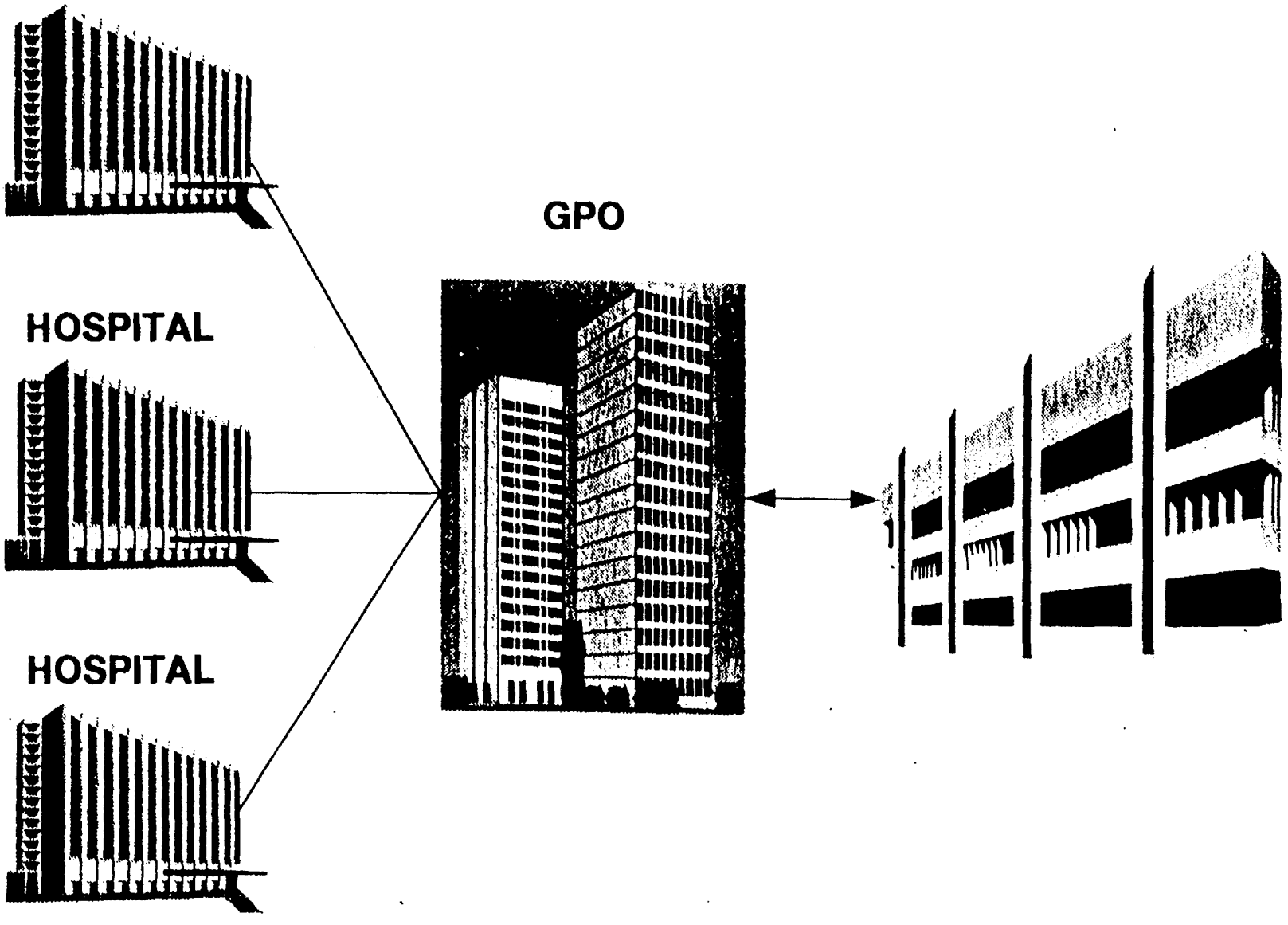
Narrative:

* Many hospitals participate--only with those products which are used by all/most. Unique products for selected facilities are not included. This recognizes that a University hospital differs from a rural hospital.

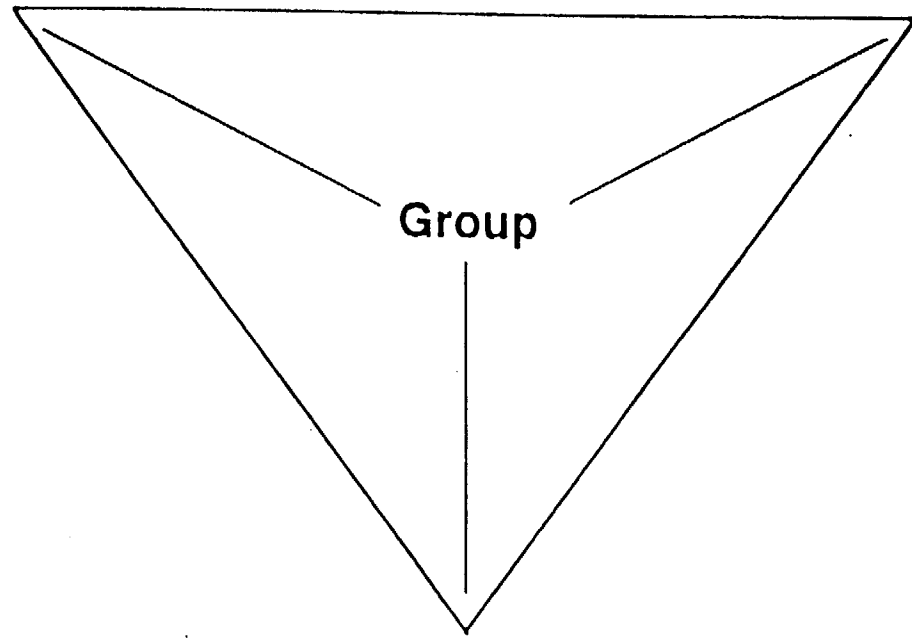
* Groups role is negotiate price, select product, disseminate information and maintain control and protection of process.

* Purchasing, delivery and payment occur as individual hospitals. Group can negotiate payment and delivery terms.

RELATIONSHIP



GROUP PURCHASING
(Volume Combination Purchasing)



Manufacturer

Product Supply

Contact Pricing

Distribution

Wholesaler

Distribution

Contract Pricing

Group

Formulary Development

Contract Development

Information Communication

Contract Management

Hospital

Group Participant

Contract Support/Product Use

Continue Formulary Development

Current Albanian Example
Ampicillin 1 Gram Injection (Estimated numbers)

Hospital	Annual Quantity
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0----------+----------+----------+----------1 yr

Example: One year contract, with negotiated order points.

Narrative:

- Total is greater than any one facility.
- All facilities participate in volume pricing.
- Each facility orders the appropriate amount for each quarter (inventory and financial control).
- If the group does not feel comfortable with a one year contract, at least combine volumes for a one-time Ampicillin purchase. Much will be saved by all. As comfort zone increases work on one-year agreements. Make it fit for the Albanian pharmacy group.

United States Example
AmeriNet, Inc.

- Number of hospitals in the United States: 5,000 plus.
- Number of hospitals which belong to the AmeriNet Group Purchasing Organization: 1,800

Product Example:

Ampicillin 1 Gram with no contract price:	$6.00
Ampicillin 1 Gram with contract price:	$1.10

Narrative:

- Process works for many products with good results.
- AmeriNet contracts for over 8,000 pharmacy items. Not suggesting that you start with this many, however over a 20 year period the process has expanded with experience.
- Expect problems and challenges. Be willing to communicate and discuss issues. Work with organizations which are trusted and deliver what is promised.

Program Advantages

- Decreased price or price stabilization.
- Increased control of purchasing process.
- Increased quality of product (as determined by the group purchasing commission).
- Increased inventory control.
- Product consistency.
- Increased organization of the purchasing process.
- Enhanced monetary management.

Suggested Albanian Pharmacy Purchasing Strategy

- Start very small with a few drug products.
  - Ampicillin Injection
  - ??? Gentamicin or Kanamycin (group choice)
- Small start to ensure success
- Add additional hospitals slowly. Make sure they understand the process and the commitments.
- Select a committee/commission to operate the process.
  (Suggest that the commission be appointed from the participating facilities).
- Expect positive results form the commission.
- Work with the potential vendors, let them know what the group is doing and the expectations for business success.
- Work through the problems (problems will surface).

December 15, 1994

Dear Pharmaceutical Vendor: Mail to all "commission" approved vendors.

Over the past few months, the hospitals of Durres, UHC and (add additional facilities) have evaluated purchasing similarities for the purpose of combining volumes and contracting for product on a long term basis. This new process which is known as "group purchasing" provides many benefits to the participants; both hospital and successful vendor. The hospitals will be able to control the quality of product, consistent supply, less frequent bids or offers and pricing. The successful vendor will be have the awarded business for a longer period of time which will enable you to manage your budgets more efficiently.

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4. The appropriate Albanian laws governing the import and sale medications shall be adhered to. (You may want to add more to this section, for example approval by the National Center for Drug Control and the Ministry of Health if appropriate). Documentation must be submitted.

Commission must review.....

5. Ordering procedures. You must specify where, when and how each participating facility places orders. The volumes represented on the attached page are anticipated annual volumes and each participating facility reserves the right to order any portion of a years supply as necessary.

   Specify any minimum ordering requirements.

6. Shipping: Shipping will be directly to the ordering hospital. The shipping carton will contain a packing slip or invoice with actual contract pricing at the time of delivery.

   Specify any shipping charges.

7. Payment. At the time the product is ordered and arrives in the country for customs approval, payment will be transferred by the participating hospital into the National Bank of Albania and held until product is tested and approved by the National Center for Drug Control. At the time of product approval and acceptance, the National Bank of Albania will be authorized to transfer payment. Conversion of Leke will be set at the day of approval for payment.

Must detail and check if this is the accepted method.

8. Right of First Refusal. If the market price declines on an awarded item. The awarded company has the first opportunity to reduce the price to the new market level. If this opportunity is not exercised within 45 days, the group reserves the right to re-award that product to another vendor.

9. Sanctions. Perfaqesuesi livron mallin 10 dite nga data e firmosjes se kontrates. Livrimi i mallit shtyhet vetem ne rastet e shakaktuara nga arsye medhore dhe objek ve qe nuk varen nga perfaquwsuwsi ai ndalm veprimesh bankare, konklikte rajonale etj. QSUT eshte e detyruar te livroje pagesen me marrjen e mallit ne dorezim.

10. Both vendors reserve the right to terminate the agreement within 30 days, with or without cause with written notification. The group reserves the right to terminate this agreement if the vendor is unable to financially carry out its obligations under this agreement.

11. Any exceptions to the requirements in this request for proposal will be considered a counter offer and we may except or reject at our discretion.

Submission Information:

1. All proposals must by priced per unit (vial, ampule, tablet, capsule etc) in Albanian Leke.

2. All products must contain the following and be labeled as such:

   Generic description, brand name description (if available), strength/ml or ampule/vial, total volume (if appropriate).

   Each individual vial or ampule must also have an identification/lot/control number and expiration date clearly marked on the vial/ampule.

3. Upon return of this request for proposal, your company must provide 100 vials/ampules per product for testing.

Contract Information:

1. The Group reserves the right to accept or reject any, any part of, or all proposals. If the vendor's proposal is accepted, the vendor shall be bound to supply the products specified for the duration of the agreement.

2. Upon award, the group will notify the vendor of the products awarded. The group will also provide you with this counter signed document identifying the products and conditions accepted.

3. The group will also notify the participating hospitals of the awarded products and vendors.

Acceptance by vendor:

The vendor hereby agrees to the terms of the Request for Proposal.

Vendor: _____
(company name)

BY: _____
(Authorized person's signature)

_____
(printed name)

Title: _____

Date: _____

Acceptance by Group:

Name: _____
(Authorized person to act on behalf of the group).

_____
(printed name)

Title: _____

Date: _____

Products Offered For Proposal

(This document can be used to provide the proposed contract pricing)

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Ampicillin 1gm. vial	112,000	_____
Chloramphenicol 1gm. vial	90,000	_____
Fentanyl 10ml. ampule	11,000	_____
Kanamycin 1gm. vial.	4,000	_____
Penicillin G Crystalline 1 million units/vial	60,000	_____
Penicillin B 800,000 units/vial	100,000	_____
Cephaloridine 500mg. vial	104,000	_____
Ceftazidime 1gm. vial.	5,000	_____
Cefotaxime 1gm. vial	8,000	_____
Amikacin 1gm. vial	5,200	_____

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Commission must select products.

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November 1994 through February 1995.

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   Finalize the terms and conditions.

   Responsibility. Albanian Pharmacy Group.

4. December 1, 1994: Fax to Todd Ebert through Jim Janeski the completed RFP in English for review and comment.

   Responsibility: Albanian Pharmacy Group.

5. December 5, 1994: Return Fax through Jim Janeski the finalized version.

   Responsibility: Todd Ebert

6. December 6 - 14, 1994. Prepare final document in Albanian and English.

   Responsibility: Albanian Pharmacy Group and Interpreter.

7. December 15, 1994. Mail or send RFP's to approved vendors. Suggest an RFP be sent in Albanian and English to the foreign (non-Albanian) companies.

   Responsibility: Albanian Pharmacy Group.

8. December 16, 1994 - February 2, 1995: Answer any questions that may be received about this process.

   Responsibility: Albanian Pharmacy Group.

   Follow-up with a reminder letter. January 14, 1995.

   Responsibility: Albanian Pharmacy Group, Todd Ebert will write.

9. February 5, 6, and 7, 1995. Awards meeting. Probably data preparation on 5 and 6 with awards on 7th. Prepare vendor notifications.

   Responsibility: Albanian Pharmacy Group and Todd Ebert.

10. Demonstration Seminar, February 8 and/or 9, (two days if necessary) to all hospitals.

    Responsibility: Todd Ebert and Albanian Pharmacy Group Participants.

11. April 1, 1995. Contracts become effective.

    Responsibility: Albanian Pharmacy Group

Suggested Components of a Request For Proposal (Can be in any order)

Introduction paragraph and general instructions for Request For Proposal

1. Deadline for returning signed proposal.

   Quotations held firm for a period of time.

   Where RFP should be returned.

2. Products to be contracted and volumes anticipated, if available.

   Proposals must be priced per product.

   No product substitution allowed without the written consent of the group.

   Describe how products will be packaged and shipped.

3. Facilities/hospitals participating--list.

   Additional facilities/hospitals can be added to the agreement with notification to the vendor.

4. Length of agreement (May be 3 to 6 months for initial period or 12 months at most). Want to start slow and gain momentum. A minimal contract period will allow the vendor to demonstrate ability to deliver. Contracts can be extended with experience. Note: Try to maintain every contract on the same time frame (expiration date), as it is much easier to manage.

5. Governing Laws of the Country of Albania.

6. Supply. Manufacturer must agree to maintain sufficient inventory of contracted product to meet the needs of participants.

   Guaranteed supply and price. If the contracted manufacturer cannot supply product and the facilities must purchase elsewhere, the contracted manufacturer will be required to pay the difference between the contract price and the actual purchase price to the facility. Facility must submit the appropriate documentation to the manufacturer (copy of back-ordered invoice from contracted manufacturer and copy of invoice with price and quantity of identical product acquired. Adequate time must be allowed to verify documentation and reimbursements made.

   Note: In this situation, if a manufacturer cannot supply product due to no fault of their own, the manufacturer is not required to make payments. Examples would include acts of war, violence, earthquakes or other situations beyond their control.

7. Delivery. Direct or wholesale. Specific agreed upon delivery terms.

   Vendor shall supply an invoice or packing slip with actual pricing at time of delivery.

8. Ordering. Where and when an order can be placed.

9. Returned goods policy.

10. Contract Escape Clause. Thirty days with written notification. (Can terminate within 24 hours if vendor is unable to financially carry out its obligations under this agreement.

    Alternate vendors if vendor cannot reasonably supply participants.

11. Contract person for questions (both organizations).

12. Reserve the right to reject any or all of the proposals.

15. Vendor will follow all applicable laws.

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16. Indemnification clause for facility for proper use of product.

17. Right of first refusal. If the market price decreases, vendor has a right to decrease price to meet the new market price. If the price is not acceptable, the group has the right to select an alternate product on a sole or dual award basis.

18. Information Dissemination.

19. Confidentiality.

20. Own use, product not for resale.

21. Other Information.

Compilation of Evaluation Responses - N=68

USAID/HEI
NATIONAL CONFERENCE ON ADVANCES IN HOSPITAL MANAGEMENT
IN THE REPUBLIC OF ALBANIA

November 30 and December 1, 1995

WORKSHOP EVALUATION

	% EXCELLENT	% SATISFACTORY	% POOR
APPLICATION OF ANALYTICAL TECHNIQUES TO FINANCIAL DECISION MAKING			
1. The workshop met the stated learning objectives	70.6	28.0	---
2. Our Hospital will benefit from the information presented	36.8	48.6	8.9
3. The HEI consultant gave a clear and logical presentation	91.2	5.9	---
4. The HEI consultant understood the subject matter	75.0	20.6	1.5
5. There was enough time for discussion and questions	44.2	51.5	4.5
STRATEGIC PLANNING			
1. This workshop met the stated learning objectives	63.3	32.1	1.5
2. Our Hospital will benefit from the information presented	29.5	44.2	5.9
3. The HEI consultant gave a clear and logical presentation	86.8	13.3	---
4. The HEI consultant understood the subject matter	75.0	17.7	1.5
5. There was enough time for discussion and questions	44.2	30.9	5.9
MEDICAL RECORDS MANAGEMENT			
1. This workshop met the stated learning objectives	54.5	36.8	---
2. Our Hospital will benefit from the information presented	53.0	42.7	11.8
3. The HEI consultant gave a clear and logical presentation	86.8	11.8	3.0
4. The HEI consultant understood the subject matter	76.5	17.7	1.5
5. There was enough time for discussion and questions	44.2	47.1	5.9

GROUP PURCHASING OF PHARMACEUTICALS

1. This workshop met the stated learning objectives	48.6	45.6	11.8
2. Our Hospital will benefit from the information presented	30.9	51.5	19.2
3. The HEI consultant gave a clear and logical presentation	73.6	16.2	4.5
4. The HEI consultant understood the subject matter	85.3	16.2	1.5
5. There was enough time for discussion and questions	47.1	32.4	11.8

HOW WOULD YOU RATE THE OTHER ASPECTS OF THIS SEMINAR?

1. Were the rooms	92.7	---	3.6
2. Was the service	91.2	11.8	1.5
3. Was the seminar	80.9	19.2	---
4. Could you hear all the speakers?	89.7	4.5	---

5. Any other comments?

CERTIFIKATE

Z/Znj_____

ka marre pjese ne

KONFERENCEN KOMBETARE MBI PERPARIMET
NE ADMINISTRIMIN SPITALOR NE REPUBLIKEN E SHQIPERISE

30 nentor & 1 dhjetor 1995

me *sponsorizimin e*
Agjencise Amerikane per Zhvillim Nderkombetar

Tirane, Shqiperi

Dianne Blane
Perfaqesuese e USAID-it
Tirane

James F. Janeski
Konsulent

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1 Dhjetor, 1995

8:00-10:00	**Sesioni III** Grupe të vogla nga 1 - 4
10:00-10:15	**Kafe**
10:15-12:15	**Sesioni IV** Grupe të vogla nga 1 - 4
12:15-13:15	**Kafe** Takim organizativ i udhëheqësave të grupeve
13:15-15:00	**Sesioni Plenar** (Të gjithë pjesmarrësit)

Prezantime nga udhëheqësit e grupeve

Vlerësimi i konferencës

- James Janeski
  Drejtues i programit

Fjala e mbylljes

- Dr. Maksim Cikul
  Ministër i Shëndetësisë
- Z. Diane Blane
  Përfaqësuese e USAID
- Dr. Teodor Todhe
  Drejtor i Spitaleve
  Ministria e Shëndetësisë

15:00-17:00	**Pritje**

Organizues

Healthcare Enterprise International, Inc.

(HEI)

Washington, D.C.

Sponsorizues

The United States Agency for

International Development

(U.S.A.I.D.)

USAID

KONFERENCA KOMBETARE

MBI PERPARIMET NE

DREJTIMIN E SPITALEVE

NE REPUBLIKEN E SHQIPERISE

30 Nëntor dhe 1 Dhjetor 1995

Dhoma Balsha

Tirana International Hotel

Tiranë - Shqipëri

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KONFERENCA KOMBETARE MBI PERPARIMET NE DREJTIMIN E SPITALEVE NE REPUBLIKEN E SHQIPERISE

Programi

30 Nëntor, 1995

8:00-9:00 **Rregjistrimi**

9:00-10:00 **Sesioni Plenar**
(Të gjithë pjesmarrësit)

Prezantimi:

- Z. Joseph Lake
  Ambasadori i Shteteve të bashkuare
- Dr. Maksim Cikuli
  Ministër i Shëndetësisë
- Z. Diane Blane
  Përfaqësuese e USAID
- Dr. Teodor Todhe
  Drejtor i Spitaleve
  Ministria e Shëndetësisë
- Dr. Mentor Petrela
  Drejtor, Qëndra Spitalore Universitare
- Z. James Janeski, FACHE
  Drejtues i programit HEI

10:00-10:20 **Kafe**

10:20-12:30 **Sesioni I**

Sesione në grupe të vegjël
(pjesmarrësit do të ndahen në 4 grupe që do të ndërrohen gjatë gjithë sesioneve)

Grupi 1
Aplikimi i Teknikave Analitike në marrjen e vendimeve financiare.

Udhëheqësit e grupit:

- Haki Çopani
  Drejtori ekonomik
  Spitali i Durrësit
- Nevila Karruku, Llogaritare
  Qëndra Spitalore Universitare
- Enzo Archetti, FNFMA
  Këshilltar i HEI

Grupi 2
Planifikimi strategjik për të ardhmen, nevojat aktuale dhe shfrytezimi sa më i mirë i burimeve.

Udhëheqësit e grupit:

- Dr. Mikel Noçka
  Drejtor, Spitali i Durrësit
- Christopher Newman, CHC; CHE
  Këshilltar i HEI

Grupi 3
Të dhënat mjekesore për marrjen e vendimit nga drejtuesit.

Udhëheqësit e grupit:

- Dr. Mehdi Alimehmeti,
  Zëvendësdrejtor i Çështjeve Mjekësore
  Qëndra Spitalore Universitare
- Dr. Natasha Celiku
  Shefe e statistikës
  Qëndra Spitalore Universitare
- Roland Dale, RRA
  Këshilltar i HEI

Grupi 4
Blerja në grup e barnave Farmaceutike

Udhëheqësit e grupit:

- Gentiana Metuli, Avokate
  Qëndra Spitalore Universitare
- Aferdita Tafaj
  Drejtori ekonomik
  Qëndra Spitalore Universitare
- Todd Ebert, R:Ph., M.S.
  Farmacist
  Këshilltar i HEI

12:30-13:00 **Kafe**

13:00-15:00 **Sesioni 2**
Grupe të vogla nga 1-4
(Sesione të njëjta si të mëngjesit, por pjesëmarrësit do të ndërrojnë grupe, gjatë gjithë konferencës.)

15:00 **Drekë**

USAID/HEI
KONFERENCA KOMBETARE MBI PERPARIMET NE DREJTIMIN E SPITALEVE NE REPUBLIKEN E SHQIPERISE

30 NENTOR DHE 1 DHJETOR 1995

VLERESIMI I SEMINARIT

	SHKELQYESHEM	MJAFTUESHEM	DOBET
APLIKIM I TEKNIKAVE ANALITIKE TE MARRJES SE VENDIMEVE FINANCIARE			
1. Seminari ia arriti qellimit te parashikuar per pervetesimin e mesimeve	_____	_____	_____
2. Spitali yne do te perfitoje nga informacioni i prezantuar ketu	_____	_____	_____
3. Keshilltari i HEI dha nje prezantim te qarte dhe llogjik	_____	_____	_____
4. Keshilltari i HEI e kuptoi se ku qendronte ceshtja	_____	_____	_____
5. Kishte kohe te mjaftueshme per diskutime dhe pyetje	_____	_____	_____
PLANIFIKIMI STRATEGJIK			
1. Seminari ia arriti qellimit te parashikuar per pervetesimin e mesimeve	_____	_____	_____
2. Spitali yne do te perfitoje nga informacioni i prezantuar ketu	_____	_____	_____
3. Keshilltari i HEI dha nje prezantim te qarte dhe llogjik	_____	_____	_____
4. Keshilltari i HEI e kuptoi se ku qendronte ceshtja	_____	_____	_____
5. Kishte kohe te mjaftueshme per diskutime dhe pyetje	_____	_____	_____
DREJTIMI I TE DHENAVE MJEKESORE			
1. Seminari ia arriti qellimit te parashikuar per pervetesimin e mesimeve	_____	_____	_____
2. Spitali yne do te perfitoje nga informacioni i prezantuar ketu	_____	_____	_____
3. Keshilltari i HEI dha nje prezantim te qarte dhe llogjik	_____	_____	_____

4. Keshilltari i HEI e kuptoi se ku qendronte ceshtja _____ _____ _____

5. Kishte kohe te mjaftueshme per diskutime dhe pyetje _____ _____ _____

BLERJA NE GRUP E BARNAVE FARMACEUTIKE

1. Seminari ia arriti qellimit te parashikuar per pervetesimin e mesimeve _____ _____ _____

2. Spitali yne do te perfitoje nga informacioni i prezantuar ketu _____ _____ _____

3. Keshilltari i HEI dha nje prezantim te qarte dhe llogjik _____ _____ _____

4. Keshilltari i HEI e kuptoi se ku qendronte ceshtja _____ _____ _____

5. Kishte kohe te mjaftueshme per diskutime dhe pyetje _____ _____ _____

SI DO T'I KLASIFIKONIT ASPEKTET E TJERA TE KETIJ SEMINARI?

1 Dhomat ishin të _____ _____ _____

2. Shërbimi ishte i _____ _____ _____

3. Seminari ishte i _____ _____ _____

4. Folësit dëgjoheshin _____ _____ _____

5. Komente të tjera?

_____
_____
_____
_____
_____
_____
_____

KONFERENCA KOMBETARE MBI PERPARIMET NE DREJTIMIN E SPITALEVE NE REPUBLIKEN E SHQIPERISE

Sponsorizues

U.S.A.I.D.

Tirana International Hotel

30 Nëntor dhe 1 Dhjetor 1995

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Parathënie

Materialet e paketuara plotësojnë presantimet e bëra në "Konferencën Kombëtare për përparimet në drejtimin e spitaleve në Republikën e Shqipërisë" sponsorisuar nga Agjensia e Shteteve të Bashkuara për Zhvillim Ndërkombëtar (U.S.A.I.D.). Konferenca u mbajt më 30 Nëntor dhe 1 Dhjetor 1995. Ajo ishte pika kulmore e trainingut për dregtimin e përkujdesjës shëndetësore që u krye në Shqipëri gjatë një periudhe dyvjëçare për drejtuesit e përkujdesjës shëndetësore. Presantimet e konferencës u përqëndruan në hatër projekte pilot që u kryen në Qëndrën Spitalore Universitare të Tiranës dhe në Spitalin e Durrësit, mbi temat e mëposhtme.

1: Aplikimi i Teknikave Analitike në marrjen e vendimeve financiare.

2: Planifikimi strategjik për të ardhmen, nevojat aktuale dhe shfrytzimi sa më i mirë i burimeve.

3: Të dhënat mjeksore për marrjen i vendimit nga drejtuesit.

4: Blerja në grup e barnave Farmaceutike

Pasqyra e lëndës

PJESA 1: Aplikimi i Teknikave Analitike në marrjen e vendimeve financiare.

PJESA 2: Planifikimi strategjik për të ardhmen, nevojat aktuale dhe shfrytzimi sa më i mirë i burimeve.

PJESA 3: Të dhënat mjeksore për marrjen i vendimit nga drejtuesit.

PJESA 4: Blerja në grup e barnave Farmaceutike

APLIKIMI I TEKNIKAVE ANALITIKE NE MARRJEN E VENDIMEVE FINANCIARE

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Univ ity Hospital Center at Tirana
1st Six Months 1994 Statistics

Total Hospitals

Services	# of Beds	# of Cases	# of days	Available Days	Percent of Occupancy	Average L.O.S.	Percent of Cases	Percent of Days
Nefrologji (Peds)	15	131	1384	2715	51.0%	10.56	0.79%	0.72%
Endokrinologji (Peds)	10	91	1208	1810	66.7%	13.27	0.55%	0.62%
Gastroeterologji (Peds)	10	32	923	1810	51.0%	28.84	0.19%	0.48%
Hematologji (Peds)	15	136	2030	2715	74.8%	14.93	0.82%	1.05%
Reanimacioni (Peds)	12	125	1377	2172	63.4%	11.02	0.75%	0.71%
Kati 1 (Contageous)	30	406	4056	5430	74.7%	9.99	2.44%	2.10%
Kati 2 (Contageous)	50	501	5498	9050	60.8%	10.97	3.01%	2.84%
Kati 3 (Contageous)	40	470	5451	7240	75.3%	11.60	2.82%	2.82%
Reanimacioni (Contagec	125	1408	15229	22625	67.3%	10.82	8.46%	7.87%
Kati 1 (Psych)	18	70	2341	3258	71.9%	33.44	0.42%	1.21%
Kati 2,3,4 (Psych)	80	330	10009	14480	69.1%	30.33	1.98%	5.17%
Riaftesimi (Psych)	40	137	5231	7240	72.3%	38.18	0.82%	2.70%
Children (Psych)	10	21	778	1810	43.0%	37.05	0.13%	0.40%
	1479	16646	193533	267699	72.3%	11.63	100.00%	100.00%

Univer y Hospital Center at Tirana
1st Six Months 1994 Statistics

Total Hospitals

Services	# of Beds	# of Cases	# of days	Available Days	Percent of Occupancy	Average L.O.S.	Percent of Cases	Percent of Days
Kardiologji	110	1221	16801	19910	84.4%	13.76	7.34%	8.68%
Hematologji	34	344	4646	6154	75.5%	13.51	2.07%	2.40%
Alergologji	25	296	3925	4525	86.7%	13.26	1.78%	2.03%
Hepato – gastro	55	491	7446	9955	74.8%	15.16	2.95%	3.85%
Endokrinologji	38	442	5583	6878	81.2%	12.63	2.66%	2.88%
Nefro – hipertoni	54	432	8380	9774	85.7%	19.40	2.60%	4.33%
Reumatologji	30	286	4768	5430	87.8%	16.67	1.72%	2.46%
O.R.L.	45	864	5964	8145	73.2%	6.90	5.19%	3.08%
Okulistika	50	891	5960	9050	65.9%	6.69	5.35%	3.08%
Stomatologji	17	184	2067	3077	67.2%	11.23	1.11%	1.07%
Dermatologji	40	391	5555	7240	76.7%	14.21	2.35%	2.87%
Sem Profesionale	25	310	3532	4525	78.1%	11.39	1.86%	1.83%
Klinika 1 (Surgery)	30	696	4277	5430	78.8%	6.15	4.18%	2.21%
Kardio–kirurgjia	40	273	4095	7240	56.6%	15.00	1.64%	2.12%
Klinika 2 (Surgery)	55	643	8946	9955	89.9%	13.91	3.86%	4.62%
Klinika 3 (Surgery)	50	813	6696	9050	74.0%	8.24	4.88%	3.46%
Plastika (Surgery)	70	706	11228	12670	88.6%	15.90	4.24%	5.80%
Neuro–kirurgjia	20	101	2291	3620	63.3%	22.68	0.61%	1.18%
Reparsi & persier (Peds)	13	304	2568	2353	109.1%	8.45	1.83%	1.33%
Pavioni 10 (Peds)	30	352	1634	5430	30.1%	4.64	2.11%	0.84%
Pavioni 8 (Peds)	35	138	1072	6335	16.9%	7.77	0.83%	0.55%
Hepatit viral (Peds)	25	212	2845	4525	62.9%	13.42	1.27%	1.47%
Sem aorogene (Peds)	23	432	3521	4163	84.6%	8.15	2.60%	1.82%
Pneumologji (Peds)	30	434	3772	5430	69.5%	8.69	2.61%	1.95%
Alergologji (Peds)	25	305	2693	4525	59.5%	8.83	1.83%	1.39%
Kirurgji (Peds)	23	656	3416	4163	82.1%	5.21	3.94%	1.77%
ORL (Peds)	12	329	1508	2172	69.4%	4.58	1.98%	0.78%
Kardiologji (Peds)	10	81	920	1810	50.8%	11.36	0.49%	0.48%
Neurologji (Peds)	10	161	1909	1810	105.5%	11.86	0.97%	0.99%

ASPEKTI TEORIK

00-----00----0----0000----000

I II III IV V

I.FUSHA E PARE.Percaktuesi i perberesve.

Prefiksi
00----------Organizata prind

01----------Spitali "A"

02----------Spitali "B" etj.

II.FUSHA E DYTE.Percaktuesi i fondeve.

Prefiksi
10----------Fondi i percaktuar nga buxheti

20----------Fondi i percaktuar per qellime specifike nga donatore te perkohshem me tej:

21----------Fondi i percaktuar per qellime specifike nga donatore te perkohshem ne valute

22----------Fondi i percaktuar per qellime specifike nga donatore te perkohshem ne leke

23----------Fondi i percaktuar per qellime specifike nga donatore te perkohshem europiane

24----------Fondi i percaktuar per qellime specifike nga shoqata bamiresie

01-20----------Fondi i percaktuar per qellime specifike nga donatore te perkohshem per spitalin"A"
I. II.

III.FUSHA E TRETE.Elementet financiare.

Prefiksi
1----------Aktivet

2----------Detyrimet

3----------Kapitali i vet

4----------Te atdhura nga pacienti

5----------Te ardhura te tjera

6----------Shpenzime te spitalit

7----------Humbja dhe fitimi i paparashikuar

ASPEKTI PRAKTIK(ZBATIMI)

0———0000———000

I II III

I.FUSHA E PARE.Percaktuesja e perberesve.

Prefiksi
0————Administrata

1————Sherbimi i pathollogjise(ish spitali nr.1)

2————Sherbimi i kirurgjise(ish spitali nr.2)

3————Sherbimi i pediatrise(ish spitali nr.3)

4————Sherbimi i semundjeve ifektive(ish spitali nr.4)

5————Sherbimi i neurologjise-neurokirurgjise(ish spitali nr.5)

6————Sherbimi i semundjeve onkologjike(ish spitali onkologjik)

II.FUSHA E DYTE.Elementet financiare dhe specifikimi i metejshem i tyre.

1.Aktivet

2.Detyrimet

3.Kapitali ivet

4.Te ardhura nga pacienti

5.Te ardhura te tjera

6.Shpenzimet

7.Humbjet dhe fitimet e paparashikuara

Pra 1000———Aktivet.Per specifikime te metejshme dote shohim faqen ne vazhdim.

1000----------AKTIVET

1100----------CASH

1110----------ARKA

1120----------BANKA

1200----------DETYRIME TE TE TJEREVE NDAJ NESH

1210----------KLIENTE

1220----------DEBITORE TE NDRYSHEM(DETYRIME TE PUNOJESVE TE SPITALIT)

1300----------MJETE TE TJERA JORRJEDHESE

1310----------IVENTARI

1320----------PARADHENIE

1400----------INVESTIMET AFATGJATE

1500----------TOKA,NDERTESA,PAISJE

1510----------TOKA

1520----------NDERTESAT

1530----------PAISJE FIKSE

1540----------MATERIALE KONSUMI

1550----------INVENTARI I IMET

1600----------AMORTIZIMI

1601----------AMORTIZIMI I NDERTESAVE

1602----------AMORTIZIMI I MJETEVE FIKSE

1603----------AMORTIZIMI I INVENTARIT TE IMET

1700----------NDERTIME NE PROCES

1800----------MJETE TE TJERA JORRJEDHESE

2000----------DETYRIMET

2100----------DETYRIMET NDAJ TE TRETEVE

2200----------KREDITORE TE TJERE

2210----------TAKSAT E SPITALIT

2220----------REDUKTIMET NE PAGESE

2230----------TAKSAT E PUNETOREVE

2231----------SIGURIMET SHOQERORE

2232----------SIGURIMET SHENDETESORE

5000----------TE ARDHURAT

5100----------TE ARDHURAT NGA DHENIA E GJAKUT

5200----------TE ARDHURA NGA EKO

5300----------TE ARDHURA NGA PARKINGU

5400----------TE ARDHURA NGA HOTELERIA

6000----------SHPENZIMET(klasifikimi natyror i tyre)

6100----------PAGAT

6101----------PAGAT E MJEKEVE

6102----------PAGAT E INFERMIEREVE

6103----------PAGA TE TJERA

6200----------SHPENZIME UDHETIMI

6201----------SHPENZ. UDHETIMI BRENDA VENDIT

6202----------SHPENZ. UDHETIMI JASHTE VENDIT

6300----------MATERIALE E FURNITURA

6310----------USHQIME

6320----------BARNA E MATERIALE MJEKIMI

6330----------KANCELERI

6340----------REAGENTE

6350----------TE TJERA

6400----------SHERBIME NGA TE TRETET

6410----------UJE

6420----------ENERGJI ELEKTRIKE

6430----------TELEFON

6440----------POST-TELEGRAF

6450----------KARBURANT

6460----------TE TJERA

SHERBIMI I PATHOLLOGJISE(ish SPITALI Nr.1)

KLINIKAT

001----------KARDIOLOGJI

002----------HEMATOLOGJI

003----------ALERGOLOGJI

004----------GASTROENTEROLOGJI

005----------NEFROHIPERTONI

006----------REOMATOLOGJI

007----------REOMATOLOGJI

008----------O.R.L

009----------OKULISTIKE

010----------STOMATOLOGJI

011----------SEMUNDJE PROFESIONALE

012----------DERMATOLOGJI

013----------LABORATORI KLINIK

014----------LABORATORI BIOKIMIK

SHERBIMI I KIRURGJISE(ish Spitali Nr.2)

KLINIKAT

020----------KLINIKA I.

021----------KARDIOKIRURGJI

022----------KLINIKA II.

023----------KLINIKA III.

024----------PLASTIKA

025----------KLINIKA VIII

013----------LABORATORI KLINIK

SHRBIMI I PEDIATRISE(ish Spitali Nr.3)

KLINIKAT

030——————————REPARTI I PERZIER

031——————————PAVIONI VIII.

032——————————PAVIONI X.

033——————————HEPATITI VIRAL

034——————————SEMUNDJET AEROGENE

035——————————PNEUMONOLOGJIA

003——————————ALERGOLORJIA

036——————————KIRURGJIA

008——————————O.R.L

001——————————KARDIOLOGJIA

037——————————NEUROOGJIA

038——————————NEFROLOGJIA

005——————————ENDOKRINOLOGJIA

004——————————GASTROENTEROLOGJIA

002——————————HEMATOLOGJIA

039——————————REANIMACIONI

013——————————LABORATORI KLINIK

014——————————LABORATORI BIOKIMIK

SHERBIMI I SEMUNDJEVE INFEKTIVE(ish.Spitali Nr.4)

KLINIKAT

040----------KATI I.

041----------KATI II.

042----------KATI III.

039----------REANIMACIONI

013----------LABORATORI KLINIK

SHERBIMI I NEUROLOGJI-NEUROKIRURGJI(ish Spitali Nr.5)

KLINIKAT

050----------KATI III.

051----------KATI IV.

039----------REANIMACIONI

037----------NEUROLOGJI

052----------RIAFTESIMI

053----------FEMIJET

054----------KATI I.

055----------KATI I.&II.&III.

056----------PSIQIATRIA

013----------LABORATORI KLINIK

SHERBIMI I SEMUNDJEVE ONKOLOGJIKE

KLINIKAT

036----------KIRURGJIA

060----------GJINEKOLOGJIA

061----------KYRITERAPIA

062----------RO...TERAPI

063----------KIMIOTERAPI

064----------REPARTI DITOR

013----------LABORATORI KLINIK

SHpenzimet e pacaktuara	80.000
Departamenti 1	100.000
Departamenti 2	60.000
Departamenti 3	40.000
Departamenti A	200.000
Departamenti B	250.000
Departamenti C	150.000
Total	**880.000**

200

	Departamenti 1	Departamenti 2	Departamenti 3
Depart.1	------	10%	--------
Depart.2	25%	-------	20%
Depart.3	15%	20%	--------
Depart.A	30%	40%	35%
Depart.B	20%	-------	45%
Depart.C	10%	30%	--------
Totalet	**100%**	**100%**	**100%**

Departamentet	Shpenzimet	P.specifike x	Shpenz.pacakt.	Alokimi
1.	100.000	12.50%	80.000	10.000
2.	60.000	7.50%	80.000	6.000
3.	40.000	5.00%	80.000	4.000
A.	200.000	25.00%	80.000	20.000
B.	250.000	31.25%	80.000	25.000
C.	150.000	18.75%	80.000	15.000
Totali	800.000	100.00%		580.000

	Nga bilanci	sh.pacakt.	subtotal	Dep.1	subtotal	Dep.2	subtotal	Dep.3	Kost.totale
shpenz.pacakt.	80,000	80,000							
Shpenz.indirekt.									
Depart.1	10,000	10,000	110,000	110,000					
Depart.2	60,000	6,000	66,000	27,500	93,500	93,500			
Depart.3	40,000	4,000	44,000	16,500	60,500	20,778	81,278	81,278	
shpenz.direkte									
Depart.A	200,000	20,000	220,000	33,000	25,300	41,556	294,556	35,559	330,115
Depart.B	250,000	25,000	275,000	32,000	297,000	-----	297,000	45,719	342,719
Depart.C	150,000	15,000	165,000	11,000	176,000	31,166	207,166	----	207,166
TOTALI	**880,000**	**80,000**	**880,000**	**110,000**	**880,000**	**93,500**	**81,278**	**81,278**	**880,000**

25%*110.000=27.500
15%*110.000=16.500
30%*110.000=33.000

	Departamentet qe shpemdajne shpenzime					
		DEP.1		DEP.2		DEP.3
Depart.1		---		10%		---
Depart.2		25%		---		20%
Depart.3		15%		20%		---
Depart.A		30%		40%		35%
Depart.B		20%		---		45%
Depart.C		10%		30%		---
TOTALI		**100%**		**100%**		**100%**

PER DEPARTAMENTIN E DYTE

2\9 *93.500=20.778
4\9 *93.500=41.556
—
3\9 *93.500=31.166
9\9

202

PLANIFIKIMI STRATEGJIK PER TE ARDHMEN, NEVOJAT AKTUALE DHE SHFRYTEZIMI SA ME I MIRE I BURIMEVE

Spitali i Durrësit
Durrës, Shqipëri

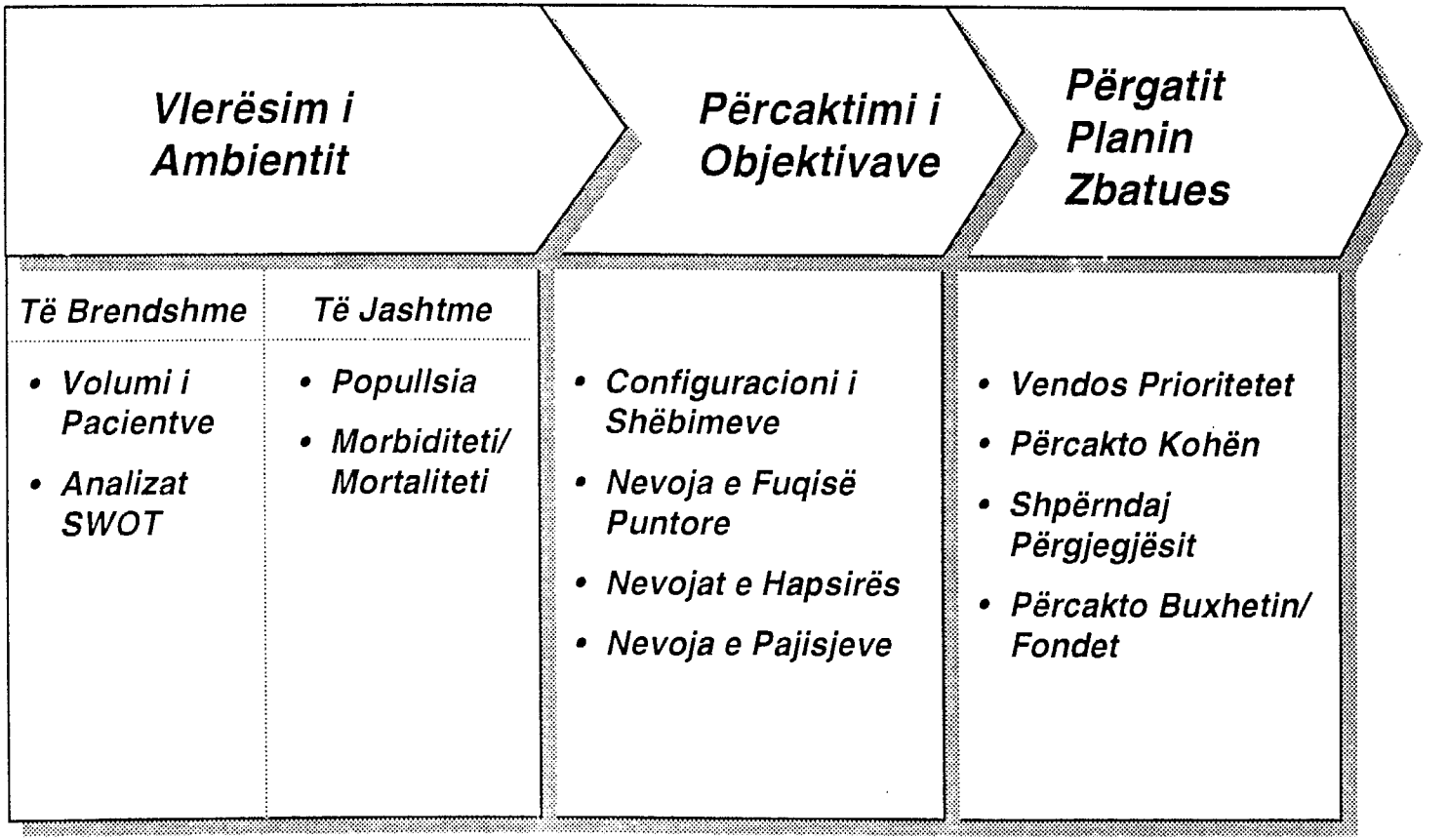
PLANI STRATEGJIK

Prezantimi:
30 Nëntor dhe 1 Dhjetor, 1995

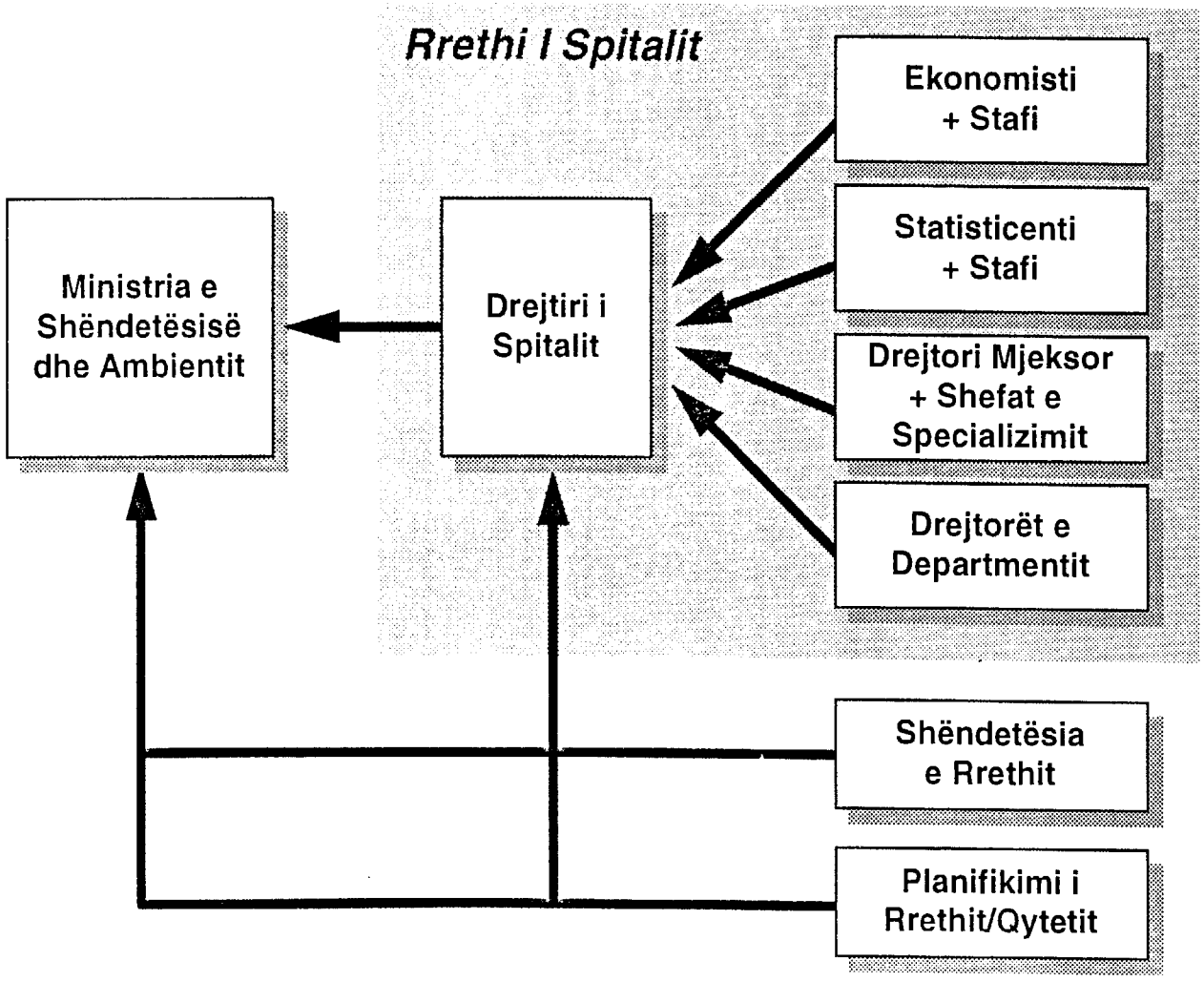
nga
Dr. Mikel Noçka
Drejtor, Spitali i Durrësit

204

Hapat e Punës



Organizimit I Planifikimit



Informacion Financiar

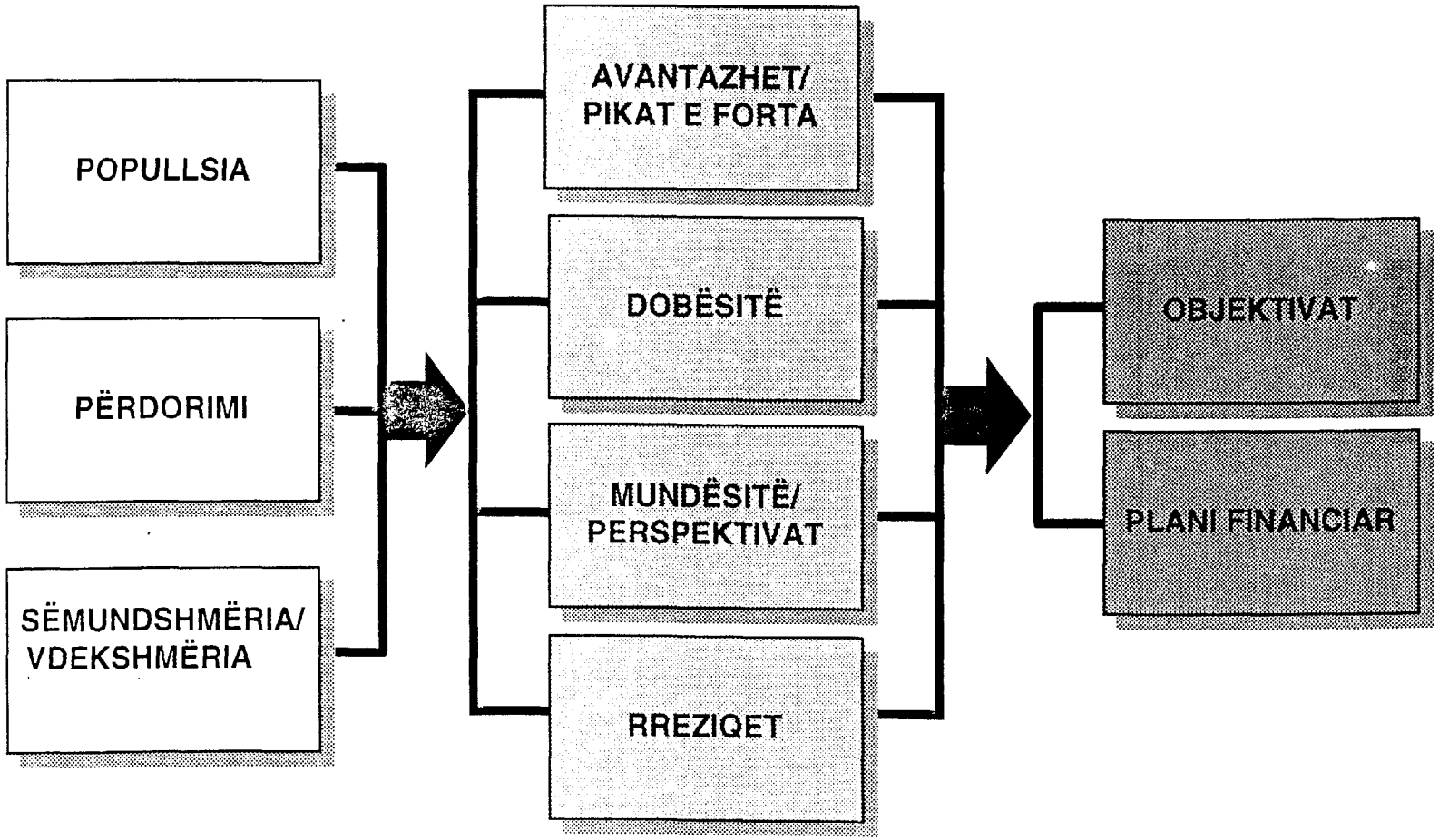
Informacion Clinik

Nevojat Klinike

Nevojat e Shërmimeve Mbëeshtetëse dhe Shtesë

Nevojat e Komunitetit

Demografia/Zhvillimi


POPULLSIA
PËRDORIMI
SËMUNDSHMËRIA/
VDEKSHMËRIA
AVANTAZHET/
PIKAT E FORTA
DOBËSITË
MUNDËSITË/
PERSPEKTIVAT
RREZIQET
OBJEKTIVAT
PLANI FINANCIAR

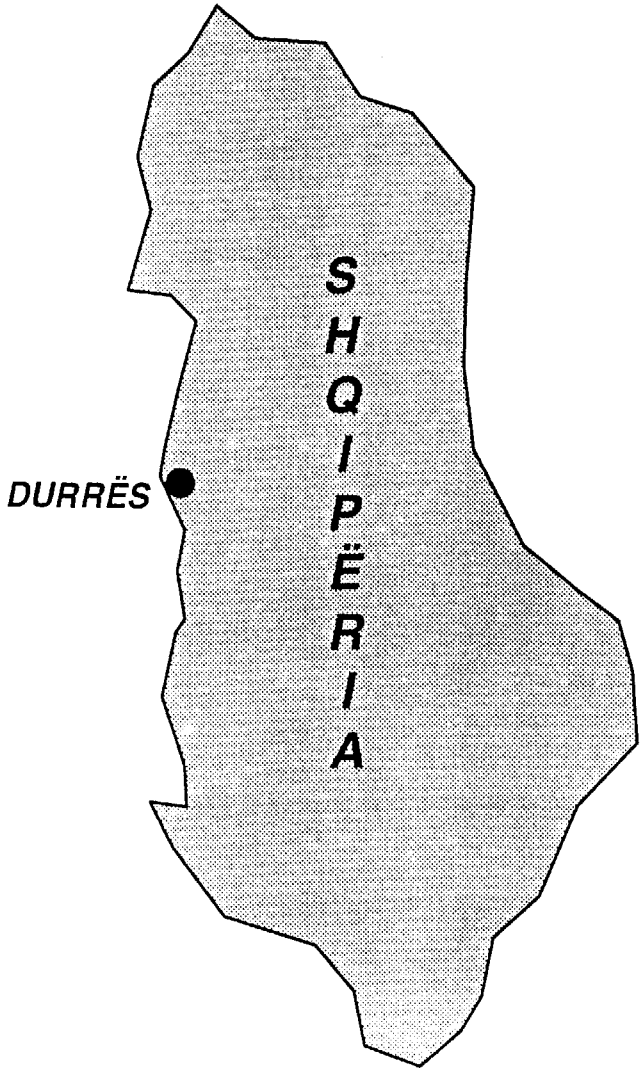
Statistikat E Popullsisë

	01/01/92	01/01/93	2000
SHQIPËRIA	3,224,701	3,166,025	
RRETHI I DURRËSIT	165,219	162,846	200,000 - 227,000

Burimi: Popullsia Sipas Rretheve. Gjate Vitit 1992 (VLERESIM)

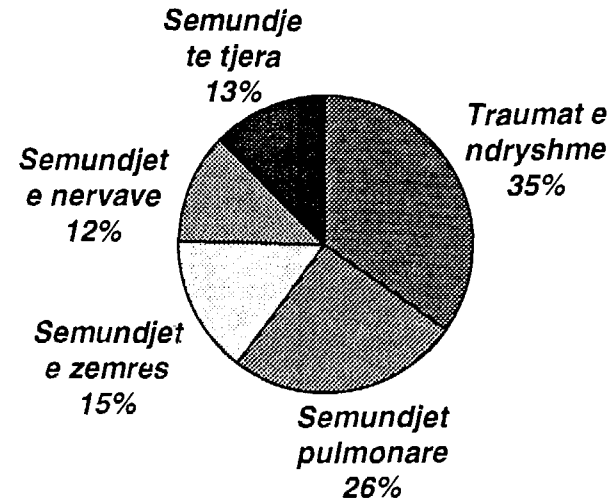
KOMUNA	BANORE	FAMILJE
Sukthi	11,313	2,898
Katundi i Ri	10,761	2,712
Rrashbulli	14,344	3,065
Xhafzotaj	10,997	2,711
Gjepalaj	5,570	1,245
Ishmi	7,480	1,735
Maminas	5,839	1,355
Manez	8,695	1,561
Gjithesej	**74,999**	**17,862**

Burimi: Raporti "Jetor i Keshillit Te Rjethit" 1994



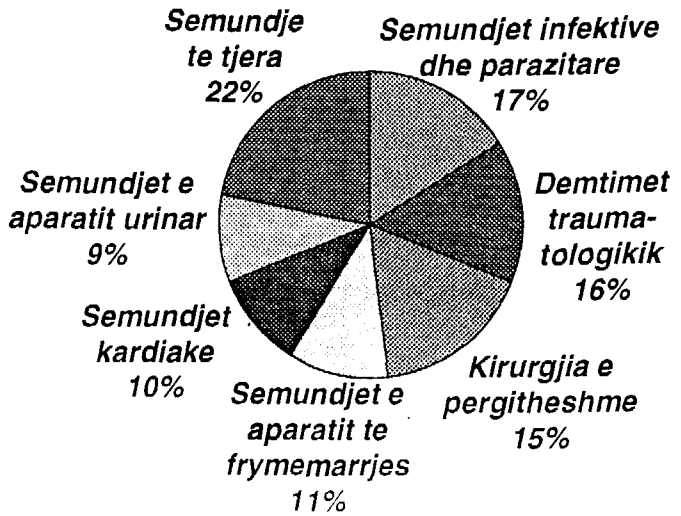
Shkaqet E Vdekjeve

Traumat e ndryshme	35 %
Semundjet pulmonare	26 %
Semundjet e zemres	15 %
Semundjet e nervave	12 %
Semundje te tjera	13 %



Diagnozat Kryesore

Demtimet traumatologjkike	16 %
Kirurgjia e pergitheshme	15 %
Semundjet infektive dhe parazitare	17 %
Semundjet e aparatit te frymemarrjes	11 %
Semundjet kardiake	10 %
Semundjet e aparatit urinar	9 %
Semundje te tjera	22 %



Analiza SWOT

AVANTAZHET/PIKAT E FORTA

- *Spitali ka punuar mirë, kur kemi parasysh kufizimet në buxhet.*
- *Numuri i punonjësve (niveli i punësimit) ka qenë i mjaftueshëm për të përballuar ngarkesën e shërbimeve.*
- *Punonjësit e spitalit janë mjaft të kuafilikuar dhe të aftë për të përballuar shërbim cilësor.*
- *Spitali nuk ka konkurrencë dhe është i vendosur pranë një tregu të gjerë.*

DOBËSITË/DISAVANTAZHET

- *Teknika është e vjetër dhe e amortizuar moralisht.*
- *Pagat janë të ulta.*
- *Buxhetet e departmenetve janë të vogla.*
- *Disa departamente kanë numër të pa mjaftueshëm punonjësish.*
- *Struktura e kierarkisë drejtuese të spitalit nuk lejon fleksibilitet në marrjen e vendimeve në nivelin lokal.*
- *Një pjesë e buxhetit konsumohet nga pacientë të zonave përreth.*
- *Ndihen mungesa në njohjen e standarteve të përshtatshme të unksionimit në një spital.*
- *Mungon konkurrenca.*
- *Shpërndarja e pajisjeve dhe shërbimeve si uji dhe energjia elektrike janë të pasigurta.*
- *Ekziston një koordinim i keq fizik i shërbimeve, për shkak të shpërndarjes së vendosjes së tyre në ndërtesa të veçanta.*

MUNDËSI/PERSPEKTIVA

- *Spitali i ri do të përmirësojë pajisjen e pavioneve të Kirurgjisë, Patologjisë, Urgjencës dhe Radiologjisë, si edhe do të përmirësojë koordinimin e shërbimeve duke i përqendruar shtretërit e të sëmurëve akutë në një pavion të veçantë.*
- *Priatizimi dhe liberalizimi i praktikave blerëse, do të përmirësojë aftësinë e spitalit për të siguruar shërbime e mjete të cilësisë së lartë dhe me kosto efektive.*
- *Mund të përdoren praktika më të mira drejtimi me standarte të përcaktuara qartë.*
- *Kostua (shpenzimet) mund të ulen pa dëmtuar cilësinë e shërbimit.*
- *Mund të përgatiten programe për kujdesin ndaj turistëve.*
- *Fondet e spitalit mund të rriten edhe nëpërmjet donatorëve.*
- *Mund të blihen pajisje të reja.*

RREZIQET

- *Reformat privatizuese e decentralizuese do të sjellin pasiguri për vendin e punës.*
- *Pagat e ulta do të shkaktojnë tërheqjen apo largimin e punonjësve nga spitali.*
- *Kufizimet në buxhet nuk do ta lejojnë spitalin t'u përgjigjet kërkesave për shërbime.*
- *Konkurrenca me shërbimet private do të shtohet, gjithashtu pacientët do të kërkojnë të kurohën në Tiranë ose jashtë shtetit.*
- *Fatkeqësitë natyrore, (si p.sh. furtunat,) mund të ndikojnë në mënyrë të konsiderueshmë në aftësinë e spitalit për të ofruar shërbime.*
- *MoH (Ministria e Shëndetësisë) nuk lejon autonomi për spitalet e rrethit.*

Objektivat kryesore që spitali i ka vënë vetes grupohen në këto katër kategori:

Shërbimet klinike

- *Të përmirësohet niveli i shërbimit klinik nga mjekët.*
- *Të përmirësohet niveli i shërbimit klinik të infermierëve.*

Pajisjet/mjediset e punës

- *Të përpilohet një listë mjedisesh (mjetesh) dhe të punohet për përfshirjen e tyre në ndërtesën e re të spitalit.*
- *Të përfundohen projektet për sistemimin funksional e hapsinor të ndertesës së re të spitalit.*
- *Të identifikohen pajisjet e vjetëruara/me mungesa teknike; të rekomandohen e paraqiten modele të reja me kosto efektive; të porositen zëvendësimet.*

Fuqia punëtore

- *Të përgatitet dhe zbatohet një program për vlerësimin e punës.*
- *Të përgatiten kode pune të hollësishëm për të gjitha vendet drejtuese/menaxheriale, dhe të bëhen kontrolle periodike të mbarëvajtjes në punë.*

Drejtimi/Menaxhimi

- *Të studiohet konsumimi i shërbimeve ndihmëse të spitalit.*
- *Të përpilohen e instalohen sisteme kompiuterike në Financë, Farmaci dhe Degën e Statistikave.*
- *Të konsolidohet funksionimi i spitalit nëpërmjet një strukture drejtimi më efikase.*
- *Të përpilohet një procedurë e përgatitjes së buxhetit e cila të përcaktojë nevaojat e departmenteve.*
- *Të zbatohen standartet JCAHO për të përmirësuar rregjistrimin e të dhënave nëpër kartela.*
- *Të studiohet saktësia dhe vërtetësia e rezultateve të raportuara nga Laboratori Klinik dhe Farmacia.*

Të Përmirësohet Puna E Mjekëve

- *Duke përpiluar një kod pune për drejtorin klinik.*
- *Duke regjistruar mbarëvajtjen në punë të mjekëve nëpërmjet kartelave mjekësore.*
- *Duke krijuar një sistem vlerësimi ku drejtori i spitalit, drejtori klinik dhe shefat e shërbimeve të kontrollojnë punën e mjekëve.*

Të Përmirësohet Puna E Infermierëve

- *Duke caktuar një infermiere të kualifikuar që do t'u përgjigjej pyetjeve të infermierëve lidhur me shërbimin ndaj pacientëve, teknikat e sterilizimit të instrumentave dhe të tjera nevoja kualifikuese.*
- *Duke gjetur një mënyrë përgëzimi/vlerësimi për infermierët që rrisin nivelin e shërbimit.*

Të Shënohen Mjetet E Dëshiruara

P.sh.:

- *Për raste reziku/gjendjeje të jashtëzakonshme, të instalohet një gjenerator energjie elektrike qe t'ju shërbejë pavioneve të shërbimit intensiv, sallave të operacionit dhe departmentit të urgjencave.*
- *Të instalohet një rezervoar uji për raste të jashtëzakonshme.*

Të Përpilohen Projekte Funksionale Dhe Hpsinore

	No. i Shtretërve	Gjendja	Parashikimi
Patologji	73	dobët	80
Kirurgji	50	dobët	65
Pediatri	70	mjaftueshëm	70
Materniteti	85	mirë	85
Infeksianistl	40	mirë	40
Spitali Durrës	318	mjaftueshëm+	340
Ortopedia Kombëtare	60	mjaftueshëm	60
Shijakut	20	—	20
Shuma gjithsej:	398		420

* *Shkalla: dobët—mjaftueshëm—mirë—shkëlqyeshëm*

Të Përmirësohen Pajisjet

- *Të përcaktohen pajisjet e vjetëruara.*
- *Të rekomandohen modele që kanë kosto efektive.*
- *T'ju bëhen të njohura mjekëve dhe administratorëve modele të reja.*
- *Të porositen zëvendësimet.*

Planimetria e vendosjes

Kati përdhes

Kati i parë

Kati i Dytë

Kati i tretë

Kati i katërt

Shënim: Ne do të dëshironim të paraqisnim departmentet më të mëdha si: Kirurgjinë, Urgjencën, hyrjen kryesore, etj.

Të Studiohen Burimet E Shërbimeve Ndihmëse Të Spitalit

Shembuj:

- *Ushqyeshmëria dhe përgatitja e ushqimit*
- *Organizimi i drejtimit material*
- *Niveli sanitar*
- *Mirëmbajtja e spitalit*
- *Radiologjia*

** (Do të përgatitet një renditje e detajuar. Do të kontaktohen shitësit lokalë dhe pastaj do të vazhdohet me diskutimin e kontratave.)*

Të Përpilohen Dhe Instalohen Sistemet Kompjutorike

Shembuj:

- *Financa*
- *Farmacia*
- *Statistika*
- *Në fusha të tjera klinike e ndihmëse*

** Drejtuesit/menaxhmenti, do përgatisë raporte të kompjutorizuara për të krahasuar shpenzimet buxhetore të planifikuara me ato reale.*

Konsolidimi I Veprimtarisë Së Spitalit

Një strukturë drejtuese solide do të përpilohet për të përdorur më mirë burimet spitalore nëpërmjet përdorimit bashkarisht të pajisjeve, hapsirës dhe punonjësve.

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Të Përpilohen Kode Pune/Përshkrime Të Detajuara, Për Të Gjitha Vendet Drejtuese

Shembuj:

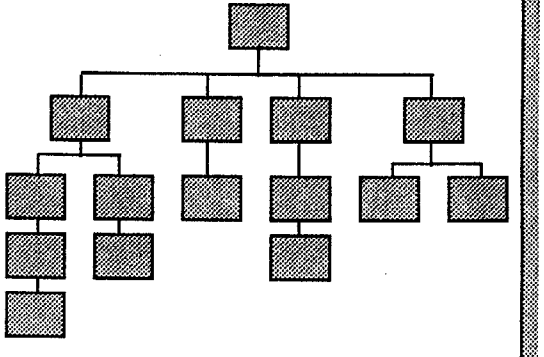
- *Menaxheri për mjetet e pajisjet*
- *Drejtori i Patologjisë*
- *Drejtori i Pediatrisë*
- *Drejtori i Rehabilituese*
- *Drejtori i Shërbimeve Kirurgjike*
- *Drejtori i Sigurimit Cilësor*
- *Drejtori për infermjerët*
- *Menaxheri i Blerjeve*
- *Drejtori i Kuadrit/Personelit*
- *Drejtori i Shtrimeve/Pranimeve*

Të Përgatitet Procedura E Vlerësimit Të Vendeve Të Punës

Shembuj:

- *A janë realizuar detyrat/synimet e parashikuara?*
- *A e ka respektuar departmenti kufirin buxhetor të shpenzimeve?*
- *A ka ndonjë përmirësim të dukshëm në department?*
- *A janë optimistë (është i lartë morali) në department?*
- *Sa ankesa janë bërë në adresë të departmentit?*

Të Përgatitet Struktura/ Kierarkia E Organizimit Të Drejtimit



Të Përpilohet Procedura E Përgatitjes Së Buxhetit

Hapi i parë në procesin e përgatitjes së buxhetit është dokumentimi/regjistrimi dhe klasifikimi i të gjitha llojeve të shpenzimeve për çdo department. Ky informacion do të përdoret në llogaritjen e buxhetit të përgjithshëm për të përcaktuar më me saktësi nevojat monetare të departmenteve.

Të Përmirësohen Kartelat Mjekësore

Për sistemimin e të dhënave në kartelat mjeksore do të përdoren standarted JCAHO. Deri më 1 janar të vitit 1996, do të ketë përfunduar regjistrimi i të dhënave sipas një sistemi numerik për njësi. Gjithashtu do të instalohet një sistem dosjesh/grupimesh, i cili do të lejojë magazinimin/regjistrimin dhe tërheqjen më lehtë të informacionit të regjistruar nëpër kartelat e sistemuara.

Të Përcaktohet Saktësia Dhe Vërtetësia E Analizave/Recetave

Do të kryhet një studim që do të përcaktojë saktësinë dhe nivelin e sigurisë së nxjerrjes së rezultateve, si edhe shpejtësinë e përgatitjes së tyre krahasuar me kohën e lëshimit të recetës nga mjeku.

	Viti						Përgjegjësia
	1	2	3	4	5	6	
Shërbimet Klinike							*Drejtori i spitalit, Drejtori i stafit mjekësor*
Komplekset							*Drejtori i spitalit, Komisioni i ri i spitalit*
Fuqia Punëtore							*Drejtori i spitalit, Drejtori i stafit mjekësor, Drejtori i stafit të infermierisë*
Menaxhmenti							*Drejtori i spitalit, Drejtori i stafit mjekësor, Kryeekonomisti*

DREJTORIA SPITALIT
DURRES

Spitali i Durrësit
Durrës, Shqipëri

Plan strategjik pesëvjeçar 1995 - 2000

Gusht 1995

Përgatitur me ndihmën e:
Metis Associates, Ltd.
Chicago • Dallas
U.S.A.

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PËRMBAJTJA

I. PËRBMLEDHJE EKZEKUTIV 1

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I. PËRMBLEDHJE EKZEKUTIV

Planifikimi strategjik përcakton rrugët për të arthmen. Ky plan strategjik pesëvjeçar, synon të japë një përmbledhje të kushteve të tanishme të shërbimit në spitalin e Durrësit nga ana klinike dhe financiare, si dhe të identifikojë inisiativat me prioritet më të lartë për tu realizuar nga drejtuesit e këtij institucioni. Përmbajtja dhe drejtimet e përcaktuara nga ky plan, përfaqësojne plotësisht, punën dhe vendosmërinë e grupit drejtues, pra menaxhmentit të spitalit. Konsulentë të jashtëm janë angazhuar për te lehtësuar procesin e planifikimit.

Spitali i Durrësit ndodhet në janë fazë të rëndësishme: brenda pesë vjetëve të ardhshëm, ai do ti nënshtrohet një ndryshimi thelbësor fizik me shtimin të një ndërtese të re në territorin e tij, i cili do të zevendësojë atë me 150 shtretër qe u dëmtua rëndë e pjesërisht u shemb, si rezultat i një përmbytjeje ne vitin 1992. Kjo ndertesë do të krijojë mundësi të konsiderueshme për të përmirësuar praktikat drejtuese, kjo veçanerisht sepse në njerën anë do të grumbullojë shtretërit për pranimin e pacientëve të shtrirë (inpatient beds), dhe nga ana tjetër, do të sigurojë edhe komunikimin fizik ndërmjet shërbimeve të Maternitetit, Patologjisë, Kirurgjisë dhe Shërbimeve Diagnostike, përfshirë këtu edhe Urgjencat. Gjithashtu do të krijojë një komunikim më të mirë ndërmjet Pediatrise dhe Pavionit të Sëmundjeve Infektive.

Praktikat drejtuese do të përmirësohen si rezultat i përvetësimit të koncepteve dhe kualifikimit bashkëkohor nëpërmjet kurseve në Shqipëri dhe vizitave studimore në Shtetet e Bashkuara të Amerikës. Përdorimi i kompjutorëve, do ti nxjerrë në pah këto përmirësime dhe do të luajë një rol mjaft të madh në lehtësimin e përgatitjes së informacioneve apo raporteve drejtuese dhe të buxhetit.

Nga pikëpamja e kujdesit shëndetsëor, Durrësi zë një vend të veçantë ne territorin e Shqipërisë. Ai ndodhet vetëm 39 km larg Tiranës, ku janë përqëndruar burimet më të sofistikuara të shërbimit shëndetsor në vend. Durrësi gjithashtu është edhe një port detar i rëndësishëm dhe qendër çlodhëse e zbavitëse në zhvillim, gjë që i dedikohet linjës së gjatë të pronave bregdetare në plazhe ende të pazhvilluara. Në këtë mënyrë, ndonëse i vendosur relativisht pranë shërbimeve të specializuara mbështetëse, kërkesat lokale për shërbime do të rriten në mënyrë të dukshme, paralelisht me zhvillimin ekonomik, duke bërë të domosdoshëm përmirësimin e shërbimeve shëndetsore me të njëjtat ritme.

Në drejtime të tjera, Durrësi është i ngjashëm me qytetet e tjera më të mëdha të Shqipërisë si: Elbasani, Korça, Shkodra, Vlora dhe Fieri, të cilët kanë një popullsi afërsisht sa 40% e Durrësit, ndërsa popullsia e Tiranës është dyfish më e madhe se ajo e çdo qyteti tjetër të madh. Nevojat e përbashkëta janë këto: përmirësimi i drejtimit në shpërndarjen e burimeve të kufizuara buxhetore me efektivitetin më të madh të mundshëm; koordinim i shërbimeve primare e sekondare në mënyrë që këto të fundit të mos mbingarkohen pa qenë e nevojshme; sigurimi adekuat i shërbimeve të specializuara në mënyrë që të plotësohen kërkesat në rritje të industrializimit të shtresës së mesme të popullsisë; modernizimi i pajisjeve dhe sherbimeve; dhe përmirësimi i nivelit të kualifikimit të punonjësve të shëndetësisë, përfshirë këtu mjekët dhe infermierët.

Duket sikur spitali i Durrësit në parim i shërben kryesisht popullatës së zonës, megjithatë, nuk dihet se deri në çfarë mase pacientët nga Durrësi shkojnë për t'u kuruar në Tiranë. Llojet më të shpeshta të shërbimeve janë: shtatëzanësia dhe lindjet, sëmundjet gastrointensinale, traumat, sëmundjet e mushkërive dhe të zemrës. Për sa i përket shërbimeve obstetrike e gjinekologjike, spitali i Durrësit ka arritur një nivel të lartë shërbimi. Megjithatë, duket se tani për tani, nuk ofrohet i njëjti nivel shërbimi në fusha të tjera ku nevojat për shërbime janë mjaft të mëdha. Kjo konstatohet menjëheë pasi e tregon grafiku i shpërndarjes së buxhetit sipas llojeve të shërbimeve; por, meqenëse nuk janë ekzaminuar të dhëna spitalore apo nga burime të tjera, është e pamundur qe të përcaktohen shkaqet specifike që përcaktojnë cilësinë e shërbimeve të ofruara.

Drejtuesit kanë përcaktuar fushat e mëposhtme si prioritare:

- Shërbimet klinike
- Pajisjet
- Fuqnë punëtore
- Drejtimi

Besohet se fondet e nevojshme për të realizuar përmirësimet në këto fusha do të sigurohen nga disa burime. Burimet kombëtare të shërbimit shëndetsor të buxhetit për spitalin e Durrësit do të sigurohen nëpërmjet organizatave e agjencive të ndryshme të huaja. Fondet e huasë për ndërtimin e objektit të ri spitalor janë pjesë e këtij buxheti.

II. VLERËSIMI I MJEDISIT

1. Popullsia që merr shërbimet

Spitali i Durrësit, së bashku me atë të Shijakut, i shërben rrethit të Durësit, i dyti qytet më i madh pas Tiranës. Numri i saktë i popullësisë së Durrësit është e pa mundur të llogaritet sepse një numër i konsiderueshëm njerëzish që banojnë në Durrës dhe në fshatrat përreth, nuk janë regjistruar. Sipas një vlerësimi të Këshillit Bashkiak të Durrësit, përveç 186,361 vetëve që janë regjistruar, ne rajon jetojnë edhe rreth 20,000 të tjerë. Pra numuri i përgjithshëm duhet të jetë mbi 200,000.

Dihet qe popullsia e regjistruar konsiston në 48,033 familje, me rreth 3,9 vetë për familje. Për popullsinë që jeton në Durrës dhe Shijak, që përfaqëson edhe shumicën e popullsisë së regjistruar, (p.sh. 100,000 në Durës dhe 11,000 në Shijak, ose rreth 60% e numrit të përgjithshëm,) janë 30,351 familje, ose 3,7 vetë për familje.

Tabela e mëposhtme tregon strukturën e popullisë sipas komunave:

Komuna	Banorë	Familje
Sukthi	11,313	2,898
Katundj i Ri	10,761	2,712
Rrashbulli	14,344	3,065
Shafzotaj	10,997	2,711
Gjepalaj	5,570	1,245
Ishmi	7,480	1,735
Maminas	5,839	1,355
Manez	8,695	1,561
Numri i përgjithshëm:	**74,999**	**17,282**

A. Studim i prejardhjes së pacientëve

Gjatë periudhës dhjetor 1994 - janar 1995, Departmenti i të Dhënave Mjekësore bëri një studim mbi prejardhjen e pacientëve. Pacientët nuk u zgjodhën sipas rastësisë. Megjithatë, kriteri i seleksionimit ishte brenda grupit të diagnozave që hasen më shpesh në seksionet spitalore, (p.sh. patologji, kirurgji e pediatri). U shqyrtuan shtatëdhjetë kartela të pacientëve. Struktura, sipas vendbanimit, është si vijon:

Origjina		Numri	Përqindja
Durrës			
Zona	1	3	
	3	1	
	4	3	
	5	4	
	6	3	
	7	2	
	8	5	
	10	3	
	11	2	
	12	5	
	13	2	
	14	2	
	15	1	
	16	4	
	17	3	
	18	3	
Qyteti i Durrësit, Numri i përgjithshëm:		46	66 për qind
Shijak		6	
Sukth		4	
Manja		1	
Rrashbulli		2	
Sallmone		1	
Të tjerë		3	
Gjithsej jashtë Durrësit		17	24 për qind
Rrethi i Durrësit		63	90 për qind
Kavaja		7	10 për qind
Numri iPërgjithshëm:		70	100 për qind

B. Portreti demografik dhe konstatime

Sipas regjistrimit të fundit, të bërë në Durrës në vitin 1989, mosha mesatare e popullsisë ishte 34 vjeç. Struktura është si më poshtë:

Mosha	Në pëqindje
Deri 18 vjeç	32%
18 - 60 vjeç	52.5%
Mbi 60 vjeç	15.5%

Pra, një e pesta e popullsisë është në moshën 25 deri 35 vjeç.

Lindjet e gjalla të regjistruara për vitin 1994 ishin 3,298 ndërsa vdekjët e foshnjave të regjistruara ishin 1,020. Vdekjet e foshnjave deri në moshën një vjeç. gjatë vitit 1994 për rrethin e Durrësit ishin 112, ose 0.6 për mijë. U regjistruan 19 raste vdekjeje të fëmijëve nga mosha një deri në katër vjeç. Nga totali, 40 vdekje të foshnjave (ose 30%) ishin në qytetin e Durrësit dhe vetëm një në qytetin e Shijakut.

Drejtuesit e spitalit mendojnë se brenda pesë vjetëve të ardhshëm, popullsia e Durrësit do të rritet së paku deri në 215,000 ose 220,000. Kjo shifër është e mundshme, ndonëse duhet të testohet nëpërmjet një analize më të aktë demografike të prirjeve karakteristike në lindshmëri, vdekjet fe foshnjave, si edhe vdekjet nga shkaqe të tjera të mundshme. Sidoqoftë, ne qoftë se supozojmë se numri real i popullsisë tani është rreth 206,000 banorë, me një rritje vjetore prej 2 për qind, brenda pesë vjetëve popullsia do të rritet në 227,000 banorë.

2. Institucionet dhe shërbimet shëndetsore

A. Spitalet

Spitali i Durrësit disponon shërbimet e numrin e mëpshtëm të shtretërve:

Ndërtesa	Lloji i shërbimit	Niveli	Shtretër
Maternitetl			85
	Obstetrikë	1	(8)
	Obstetrikë	2	20
	Gjinekologji	2	10
	Obstetrikë	3	20
	Obstetrikë	4	25
	Gjinekologji	3	10
Sëmundjet ngjitëse			40
	Sëmundje ngjitëse	2	20
	Sëmundje ngjitëse	3	20
Pediatria			70
	Qëndrime të shkurtëra	1	(6)
	Infeksione pediatrike	1	20
	Pediatri	2	50
Patologjia			73
	Kardiologji	3	10
	Sëmundjet pulmonare	3	8
	Neurologji	3	8
	Nefrologji	3	4
	Hipërtensioni	3	4
	Gastroenterologji	3	5
	Hematologji	3	5
	Alergjitë	3	4
	Reumatologji	3	5
	Endokrinologji	3	5
	Dermatologji	3	2
	Okulist	3	2
	Shërbim intensiv	3	6
	Urgjenca	3	5
Kirurgjia			50
	Otorino	1	5
	Kirurgji	1	10
	Kirurgji	2	35
Numri i përgjithshëm për Spitalin e Durrësit:			318
Spitali i Shijakut:			20
Ortopedia Kombëtare:			60
TOTALI:			398

(Shënim: Shtretërit e futur në kllapa nuk janë përfshirë në shifrën totale.)

Ndërtesa që u shkatërrua gjatë përmbytjes së vitit 1992 përmbante sa më poshtë:

Ndërtesa	Shërbimi	Niveli	Shtretër
Të shkatërruar ose të papërdorshëm			150
	Patologji	1	65
	Kirurgji	1	60
	Neurologji	2	10
	Okulist	2	15

B. Poliklinikat dhe Ambulancat (Qendrat Shëndetësore)

Spitali i Durrësit ka në varësi edhe Polikliniken që ndodhet në qytetin e Durrësit. Përmasat fizike dhe vendosja e saj nuk u egzaminuan si pjesë e këtij projekti; megjithatë, shërbimet e saj janë përfshirë me ato të spitalit dhe duhet të merren parasysh në kuadër të programeve që ofron spitali. Qendrat Shëndetësore Rajonale, (ambulancat) e qytetit të Durrësit, si edhe ato në zonat përreth, janë në varësi të një seksioni tjetër të Zyrës së Shërbimit Shëndetësor të Zonës. Ndonëse ato nuk bejnë pjesë direkt në këtë projekt, qellimi i shërbimeve që ato sigurojnë është i rëndësishëm, kur është fjala për shërbimet që sigurojnë Poliklinika dhe Shërbimet e urgjencës të spitalit të marra së bashku. Veç kësaj, pavioni i pediatrisë ka edhe një ndarje për qëndrime të shkurtëra, (p.sh. për pacientët që nuk qëndrojnë gjatë natës) i cili është ekuivalenti i një klinike ditore për pacientë që, ose s'duan, ose nuk kanë mundësi të kërkojnë ndihmën e poliklinikës apo ambulancave.

C. Të tjera

Shërbime të tjera si dentistë, shitje e shpërndarje medikamentesh, ose shërbime tlokale shëndetësore që nuk janë në kompetencë të spitaleve, nuk janë marrë në konsideratë nga ky projekt.

3. Projekte e kontrata kombëtare

Plane për përpilimin e një skeme sigurimesh dhe për përmirësimin e shërbimit të ndihmës së parë, vazhdojnë të jenë në proces në Ministrinë e Shëndetsisë dhe Mjedisit. Veç kësaj, pajisja sistematike me shtretër dhe përmirësimi fizik i mjediseve e pajisjeve, vazhdon që prej disa vjetësh.

Projekti i ri për riorganizimin e spitalit të Durrësit, është pjesë e këtij projekti të përmirësimit. Projekti kërkon:

Shërbime	Shtretër
Kirurgji	50
Trauma	(15)
Okulist-Otorino-Laringologji	15
Patologji fasciale-të gjitha specialitetet	80
Shuma	145

(Shënim: Shtretërit e futur në kllapa nuk janë përfshirë në shifrën totale.)

Me përfundimin e ndërtimit të spitalit të ri në vitin 1999, në qoftë se projekti do të përfundojë nga mesi i vitit 1996, kapaciteti i spitalit te Durrësit do të arrijë 340 shtretër. Ky numër shtretërish, bashkë ma ata të spitalit të Shijakut dhe të Spitalit Kombëtar Ortopedik. do të bëhet: 420 shtretër. Sidoqoftë, vazhdimi i furnizimit me shtrtetër për spitalin e Shijakut do të rishqyrtohet sepse ndodhet pranë spitalit të zonës. kurse numri i pacientëve është minimal.

Shtretëvit sipas Shërbimeve	
Materniteti	85
Obstetrikë	65
Gjinekologji	20
Pediatria	70
Pediatria përgiethsheme	50
Pediatria Infektive	20
Patologjia	120
Patologjia përgiethsheme	80
Patologjia Infektive	40
Kirurgjia	65
Kirurgjia përgiethsheme	50
Otorino-Laringologji	15
Riaffesimi Fizik Pediatrik	60
Spitali Shijakut	20
Shuma	420

4. Projekte e kontrata rajonale

Ekziston një lidhje e ngushtë midis shërbimeve të ambulancave, që janë të organizuara e drejtuara më vehte dhe raportojnë tek Zyra Rajonale e Shëndetësisë dhe poliklinika e spitaleve rajonale, që janë në varësi të Zyrës së Shërbimeve Spitalore. Zyrtarisht ose jo, koordinimi i këtyre shërbimeve duhet të bëhet patjetër, që të mund të përmirësohet efektiviteti i kostos dhe shërbimeve në të gjitha pikat, qofshin këto ambulanca, poliklinika apo spitale, sepse sipas mjekëve të spitalit të Durrësit, ka një fragmentizim të dukshëm të këtij procesi.

5. Sëmundshmëria dhe vdekshmëria

Diagnozat kryesore që spitali i Durrësit i ka raportuar Ministrisë së Shëndetësisë dhe Mjedisit në vitin 1993 ishin si më poshtë:

Numuri rendor	Diagnozat e daljeve	Përqindja kumulative
1	Lindje normale	15.95
2	Gastroenterit/Kolit	30.89
3	Bronkopneumoni	44.72
4	Enterrit	52.32
5	Ndërprerje barre	59.79
6	Tonsilitis Shtatëzanësi me	65.94
7	komplikacione	69.19
8	Aborte spontane	72.16
9	Hepatit viral	74.50
10	Bronkit (mbi 14 vjet)	76.76
11	Apendisit	78.31

Burimi i të dhënave: Raporti i Ministrisë së Shëndetësisë dhe Mjedisit, 1993.

Në këtë listë diagnozash në përgjithësi mungojnë rastet e veçanta, (ose vizitat tek specialisti), kirurgjitë traumatike, sëmundjet kanceroze dhe të qarkullimit të gjakut. Ka patur vështirësi edhe në diagnostikimin e saktë: p.sh.: apendisiti mund të quhet dhimbje abdominale me shkaqe të papërcaktuara, ose për të përshkruar një kontroll të përgjithshëm. Nga ana tjetër, rastet e veçanta mund t'u jenë referuar spitaleve të Tiranës, ose gjetkë, nga pacienti ose vetë mjekët. Të dhënat mbi origjinën e pacientëve të marra nga Qendra Spitalore e Universitetit, mund të qartëson shkallën e emigrimit nga Durësi ne Tiranë për vizita tek specialisti dhe ndoshta, edhe vizita rutinë.

Shkaqet e vdekshmërisë:

Sipas të dhënave spitalore, shkaqet që sjellin vdekjen janë si më poshtë:

Shkaqet kryesoe të vdekshmërissë popullsisë që kryen shërbime në spital janë:

Traumat e ndyshme	34.6%
Sëmundjet pulmonare	25.6
Sëmundjet e zemrës	15.2
Sëmundjet nervore	11.5
Sëmundje të tjera	13.1
Shuma	100.0%

Diagnozat e shtrimeve në spital janë si më poshtë:

Diagnozat kryesore:

Dëmtime traumatologjike	16%
Kirurgji e përgjithshme	15
Sëmundjet infektive dhe parazitare	17
Sëmundjet e aparatit të frymëmarrjes	11
Sëmundjet kardiake	10
Sëmundjet urologjike	9
Sëmundje të tjera	22
Shuma	100%

6. Nevoja për shtretër

Numri i shtretërve që do të jenë në shërbim në rrethin e Durrësit në vitin 2000 do të përfshinte 340 në Spitalin e Durrësit dhe 20 në Spitalin e Shijakut. Meqenëse Spitali i Shijakut ka mundësi të kufizuar dhe merret me trajtimin e rasteve shumë të vogla, shtretërit për te nuk duhet të konsideroheshin si shtretër të shërbimit akut. Kësisoji, popullata e rrethit që mund të ketë 200,000 banorë, do të ketë 1.7 shtretër të shërbimit akut për çdo 1,000 banorë.

Madjithëse ky proporcion është më I ulët se sa synimi kombëtar që paracheh 3 shtretër për 1,000 banorë, niveli I shtretërve të zënë tash për tash tregon se në rrethin e Durrësit kapaciteti I shtretërve është I mjaftueshëm. Arsyeja është pjesërisht sepse Tirana ka shpërdarë sasi të mëdha të shtretërve në lindje (Durrës) dhe gjithashtu ka ndihmuar edhe afërsia e spitalit të Kavajës në jug. Në të vërtetë, rastet e rënda, siç janë trauma e kokës dhe onkologjia, zakonisht dërgohen nga Durrësi në Tiranë. Në të ardhmen, me përmirësimin e kompleksëve të Spitali të Durrësit, këto raste nuk do të jetë nevoja që të transferohen më në Tiranë. Për shembull, dhoma e re e emergjences dhe kirurgjisë me siguri do të mundësojë që rastet e aksidenteve të trafikut të kurohen në Durrës. Gjithashtu sektori i ri i radioilogjisë do të zvogëlojë varësinë e spitalit të Durrësit me atë të Tiranës për diagnostifikim.

Numri i shtretërve të paraparë tash për tash tregon se spitali do të ketë kapacitet të mjaftueshme që të akomodojë prej 11,150 deir në 14,000 pranime dhe do të ketë mundësi rritjeje të mëtutjeshme. Kapacitieti i Spitalit të Durrësit (dhe Spitali Ortopedik Kombëtar) dhe kërkesat për akomodim në të ardhmeën janë paraqitur në Apendix A në kalkulimin e shtretërve të zënë (seksion k). Në vitin 2000, mesatarisht do të zihen 62.3% të shtretërve pa shërbime mbi 72% të tyre. Edhe nëse zvoglimi i kohëqëndrimit mesatar në spital (prej 7.8 ditë në 6.5 ditë) nuk arrihet zënia e shtretërve, nuk do të kalojë mesatarën mbi 75%. Mesatarisht në SHBA spitalet synojnë të kenë shtratzënien në nivelin prej 80% deri në 90%, varëshisht nga kombinimi i shërbimeve dhe proporcioni i dhomave të pacientëve me multi-zënie. Gjithashtu, me mesatarin e 6.5 ditë qëndrimi në spital, 340 shtretër me shërbim akut të paraparë për Spitalin Durrësit në vitin 2000 do të mund të akomodojnë mbi 19,000 pranime, që është 5,000 ose 36% më shumë se sa 14,000 pranimet e parapara.

III. VLERËSIMI INSTITUCIONAL

1. Vëllimi i pacientëve sipas shërbimeve

Shiko të dhënat në Appendix A. (Tabela A)

2. Paraqitja e veprimtarisë sipas buxhetit:

Shërbime	Kostua (miljë lekë)	Ditët e pacientëve	Kostua e shtrimit (miljë lekë)	Kostua/ lek/ditë pacienti
Kiurgjia	14,580	14,416	17,786	1,234
Materniteti	20,900	14,837	24,199	1,631
Patologjia	8,080	19,774	12,477	631
Pediatria	12,870	13,078	15,778	1,206
Sëmundjet infektive	4,760	9,169	6,799	742
Ortopedi	9,160	15,322	12,567	820
Urgjenca	3,580	3,007	4,249	1,413
Poliklinika	7,790	6,543	9,245	1,413
Të tjera	21,380			
SHUMA	103,100	96,146	103,100	1,072

[Shënim: Për Urgjencën dhe Poliklinikën llogaritjet janë = (shpenzime për shërbime/shuma e shpenzimeve) x (ditët reale të pacientit)].

Ndryshimet në koston ditore të pacientit, si pjesë e shërbimeve, u diskutua me drejtuesit e spitalit dhe drejtorin e maternitetit ku kostua për pacient është më e larta. Por, për të pëcaktuar arësyet e mosqëndrueshmërisë në kostot ditore të pacientëve, nevojiten studime të mëtejshme.

3. Analiza SWOT

Rezultatet e analizes SWOT me drejtuesit dhe stafin mjekësor dejtues të spitalit janë sa më poshtë (për të dhëna të plota nga analiza SWOT, shiko Tabelën C):

Avantazhe/pikat më të forta

- Veprimtaria sipas buxhetit
- Kualifikimi i punonjësve

Dobësitë:

- Pajisje të pamjaftueshme
- Mungesë e plotë ose e pjesshme mjetesh bazë të tilla si uji dhe energjia elektike.
- Koordinim i keq (i pamjaftueshëm) fizik i shërbimeve për shkak të vendosjes së tyre në ndërtesa të veçanta.

Mundësi/Perspektiva:

- Ndërtesa e re e planifikuar spitalore do të përmirësojë funksionimin e pavioneve të kirurgjisë, patologjisë, urgjencës e radiologjisë, dhe do të përmirësojë koordinimin e shërbimeve duke i përqendruar shtretërit e të sëmurëve me probleme akute në një pavion të veçantë.
- Privatizimi dhe lëbealiaimi i praktikave blerëse do të risë aftësinë e spitalit për të ruajtur një cilësi të lartë e me kosto efektive të produkteve e shëbimeve.

Rreziqe:

- Pasiguri në ruajtjen e vendit të punës, si rezultat i decentralizimit dhe reformave privatizuese.
- Pagat e ulta po i largojnë nga spitali mjekët dhe infermierët më të mirë.
- Kufizimet në buxhet do të vazhdojnë. Kjo do ta bëjë të pamundur qe spitali të mund t'i përgjigjet kërkesës në rritje për shëbime.

IV. INISIATIVAT STRATEGJIKE

1. Shërbimet Klinike

Dejtuesit e spitalit parashikojnë që brenda një periudhe pesë derin dhjetë vjeçare, numuri vjetor i lindjeve do të jetë 4,200 ndërsa i shtrimeve/pranimeve 14,000.

Stuktura e shtrimeve do të paraqitet si më poshtë:

Patologjia	1,978
Kirurgjia	2,581
Shërbimi infektiv	893
Pediatria	1,968
Obstetrika-Gjinekologjia	6,441
Ortopediku	139
Shuma	14,000

Zgjatja mesatare e kohë qëndrimit në spital parashikohet të jetë 6.5 ditë, ndërsa numri total në ditë-pacientë 91,000, për një census mesatar ditor prej 249. Si rezultat, shkalla e përdorimit të shtretërve do të arijë masën 68 për qind, nivel që lë vend për fluktuacionet ditore në census.

1.1. Identifikimi i pajisjeve që mungojnë dhe porositja e pajisjeve të reja pasi të jetë provuar se modeli i ri i rekomanduar ka kosto efektive.

1.2. Përmirësimi i nivelit të veprimtarisë klinike të mjekëve:

a. Duke pëpiluar pëshkrimin e kërkesave të vendit të punës për t'ia paraqitur drejtorit klinik të spitalit.
b. Duke kontrolluar efektivitetin e punës së mjekëve duke krijuar një kartotekë mjekësore ku rezultatet të vlerësohen nga drejtori i spitalit, drejtori klinik i spitalit dhe shefat e shëbimeve.
c. Duke përmirësuar kurset e kualifikimit; duke shfytëzuar për këtë qëllim vizitat që i bëhen spitalit nga mjekë/pedagogë të jashtëm, si edhe përvojën e mjekëve të stafit të spitalit që marrin pjesë në veprimtari të ndryshme apo japin leksione në Univesitetin e Tiranës ose jashtë shtetit.

1.3. Përmirësimi i nivelit të efektivitetit klinik të infemiereve nëpërmjet:

a. Zgjedhjes së një infemiereje të kualifikuar me të cilën të gjitha infermjeret të mund të konsultohen në çdo kohë lidhur me trajtimin e pacientëve, teknikat e sterilizimit dhe
b. njohuri të tjera.
Krijimin e një tabele njohëse ku të përgëzohen ato infemiere që kanë bërë pëmirësime të dukshme në kualifikimin e tyre.

2. Pajisjet

2.1 Të përgatitet një listë me pajisjet e nevojshme, karakteristikat e tyre dhe qellimin e pëdorimit, pë të siguuar pëfshijen e tyre në ndëtesën e re të spitalit. Kjo listë duhet të përfshijë:

a. Gjeneratoin e urgjencave për kujdesin intensiv dhe dhomat operacionale e të urgjencës.
b. Rezerva uji për raste fatkeqësish.

2.2 Të përfundohet projektimi e programimi sipëfaqësor e funksional i ndërtesës së re të spitalit duke bashkëpunuar me Komisionin e projektimit dhe konsulentët e zgjedhur për të ndihmuar përfundimin e projektimit.

3. Fuqia punëtore

3.1. Përpilimin e kërkesave të vendit të punës, për të gjitha vendet drejtuese dhe aktivizimin e një vlerësimi periodik të punës së së çdo individi nga shefi i tij i drejtpërdrejtë.

3.2. Përgatitjen e një procesi vlerësimi të punës dhe zbatimin e tij.

Për vitin e parë: Të përgatitet një sistem për organizimin e drejtimit/menaxhimit, të pajisur me një tabelë që pëshkruan përgjegjësitë kryesore dhe kualifikimin për çdo vend pune.

4. Drejtimi/Menaxhimi

4.1. Të studiohet shfrytëzimi maksimal i shërbimeve mbështetse në fusha të tilla si ushqyeshmëria dhe pëgatitja e ushqimit, drejtimi i materialeve, mirëmbajtja sanitare dhe spitalore, radiologjia, etj.

Viti i parë: Të përgatitet një përshkrim i karakteristikave të veçanta për shërbime të zgjedhura, si ato për pëgatitjen e ushqimit dhe mirëmbajtjen sanitare. Lidhja e kontakteve me shitësit lokalë.

Viti i dytë: Lidhja e kontratave me shitësit lokalë.

4.2. Të instalohen e zhvillohen sisteme të kompjutorizuar në financë, farmacitë, sektorin e statistikave e më vonë, në procedurat klinike dhe shërbime të tjera ndihmëse.

Viti i parë: Instalimi i tre kompjutorëve me printer në degët e financës, farmacisë dhe statistikave.

Viti i dyte: Përpilimi i rapoteve mujore të kompjuteizuara që të egjistojnë të dhënat reale buxhetore

4.3. Të krijohet dhe zbatohet një sistem periodik raportesh të drejtimit/manaxhimit, që të përshkruajë veprimtainë e departmenteve të ndryshme të spitalit.

4.4. Të përpilohet një metodikë e përgatitjes së buxhetit e cila do të përcaktojë nevojat e secilit department për kategoritë e veçanta të shpenzimeve.

4.5. Të përmirësohet regjistrimi i të dhënave nëpër kartela, nëpërmjët zbatimit të standarteve të Komisioni i Përbashkët i Akreditimit të Shëndetësisë Organizatat, Chicago, Illinois, U.S.A. gjattë përgatitjes dhe kontollit të tyre. Në mënyrë të veçantë:

a. Të zbatohet një numër për njësi regjistrimi sipas grafikëve mjekësorë, deri në janar 1996.

b. Të mbahet e të vihet në përdorim një sistem dosjesh informative që të bëjë të mundur grumbullimin dhe tërheqjen me lehtësi të të dhënave. Ky sistem duhet të jetë i vendosur në mbajtëse të tilla ku dosjet të jenë të vendosura vërtikalisht, në mënyrë që numurat të dallohen menjëherë.

4.6. Për famacinë dhe laboratoin klinik, të bëhet një studim që të përcaktojë saktësinë e besueshmërinë, si edhe kohën e zbatimit dhe marrjen e rezultateve, krahasuar me kohën kur ato janë kërkuar/porositur nga mjekët.

V. BUXHETI PESËVJEÇAR

Mbetet të përcaktohet...

SPITALI DURRES **TË DHËNA OPERUESE**

a. Buxheti (Pëu çolo kategori)	000/lekë
Stafi	**63,400**
Kirurgjia	8,960
Materniteti	12,250
Patologjia	4,660
Pediatria	10,040
Sëmundje infective	2,070
Ortopediku	4,350
Emergjenca	2,900
Poliklinika	5,750
Të tjera	12,420
Paisjet	**4,000**
Kirurgjia	500
Materniteti	760
Patologjia	180
Pediatria	250
Sëmundje infective	120
Ortopediku	310
Emergjenca	360
Poliklinika	220
Të tjera	1,300
Ushqimi	**6,500**
Kirurgjia	810
Materniteti	1,450
Patologjia	1,080
Pediatria	730
Sëmundje infective	620
Ortopediku	1,510
Emergjenca	--
Poliklinika	--
Të tjera	300
Medikamentet	**7,900**
Kirurgjia	1,980
Materniteti	2,440
Patologjia	860
Pediatria	950
Sëmundje infective	180
Ortopediku	160
Emergjenca	220
Poliklinika	600
Të tjera	510

SPITALI DURRES — TË DHËNA OPERUESE

a. Buxheti (Pëu çolo kategori)	000/lekë
Sherbirnet	**12,800**
Kirurgjia	1,980
Materniteti	3,850
Patologjia	950
Pediatria	850
Sëmundje infective	670
Ortopediku	1,480
Emergjenca	190
Poliklinika	230
Të tjera	2,600
Mirembajtja E Paisjeve	**8,500**
Kirurgjia	350
Materniteti	150
Patologjia	350
Pediatria	50
Sëmundje infective	1,100
Ortopediku	1,350
Emergjenca	50
Poliklinika	850
Të tjera	4,250
Bierja E Paisjeve / Investimeve	--
Kirurgjia	--
Materniteti	--
Patologjia	--
Pediatria	--
Sëmundje infective	--
Ortopediku	--
Emergjenca	--
Poliklinika	--
Të tjera	--
SHUMA	**103,100**
Kirurgjia	14,580
Materniteti	20,900
Patologjia	8,080
Pediatria	12,870
Sëmundje infective	4,760
Ortopediku	9,160
Emergjenca	3,720
Poliklinika	7,650
Të tjera	21,380

b. Stafi

Doktore	119
Kirurgjia	18
Materniteti	19
Patologjia	12
Pediatria	15
Sëmundje infective	3
Ortopediku	3
Emergjenca	9
Poliklinika	20
Të tjera	20

Infermiere	365
Kirurgjia	46
Materniteti	80
Patologjia	25
Pediatria	65
Sëmundje infective	13
Ortopediku	27
Emergjenca	15
Poliklinika	35
Të tjera	59

Sanitare	118
Kirurgjia	23
Materniteti	30
Patologjia	11
Pediatria	21
Sëmundje infective	8
Ortopediku	8
Emergjenca	3
Poliklinika	4
Të tjera	10

Stafi Moeshtetes (Kuskimë, lavanderi, siguria)	127
Kirurgjia	11
Materniteti	18
Patologjia	16
Pediatria	15
Sëmundje infective	2
Ortopediku	9
Emergjenca	5
Poliklinika	2
Të tjera	49

SPITALI DURRES — TË DHËNA OPERUESE

	1990	1991	1992	1993	1994	2000
c. Pranimet						
Kirurgjia	2,096	1,890	--	1,555	2,056	2,581
Matemiteti	6,118	6,478	5,293	5,735	5,131	6,441
Patologjia	1,378	1,250	780	1,461	1,576	1,978
Pediatria somatike	1,683	1,436	794	1,517	1,126	1,414
Pediatria infective	778	449	248	478	441	554
Sëmundje infective	1,187	940	564	670	711	893
Ortopediku	167	144	137	108	111	139
Shuma	**13,407**	**12,587**	**7,816**	**11,524**	**11,152**	**14,000**
d. Ditët e Pacientëve						
Kirurgjia	19,451	15,293	--	10,763	14,416	15,149
Matemiteti	34,327	32,212	24,248	15,857	14,837	15,592
Patologjia	19,842	19,125	7,630	18,057	19,774	20,780
Pediatria somatike	17,782	13,272	5,031	12,477	8,113	8,526
Pediatria infective	14,512	7,600	3,178	5,195	4,965	5,218
Sëmundje infective	16,282	13,090	8,710	9,306	9,169	9,635
Ortopediku	40,125	23,961	24,160	18,137	15,322	16,101
Shuma	**162,321**	**124,553**	**72,957**	**89,792**	**86,596**	**91,000**
e. Gjatësia e Qëndrimit						
Kirurgjia	9.4	16.4	--	8.0	7.1	5.9
Matemiteti	5.6	4.9	4.5	2.8	2.8	2.4
Patologjia	14.3	14.3	16.7	13.5	12.4	10.5
Pediatria somatike	10.5	9.3	6.5	8.9	7.5	6.0
Pediatria infective	17	15	13	11	11	9.4
Sëmundje infective	13.6	13.6	15.5	14.7	12.9	10.8
Ortopediku	256	180	183	146	161	116
Mesatar	**12.1**	**9.9**	**9.3**	**7.8**	**7.8**	**6.5**

SPITALI DURRES **TË DHËNA OPERUESE**

f. Vizitat në Pacientëve (testet) procedurat	1990	1991	1992	1993	1994
Emergjence - Urgjence					
Patologjia	450	415	260	485	525
Kirurgjia	1,200	1,120	--	940	1,180
Analizat Laboratorike					
Klinike	--	--	--	--	26,586
Biokimike	--	--	--	--	43,402
Artiviteti Radiologjik					
Rôlskopi Theracis	--	--	--	3,474	--
Rôlskopi Ventrikuli	--	--	--	715	--
Rôlgrafi Të	--	--	--	2,725	--

	Rôlskopi	Rôlgrafi	ECHO	Analiza luba Klinik-Biekinik
g. **G/mujori I 1993**				
Maternitieti			542(a) 490(b)	
Patologjia	1,980	379		--
Kirurgjia	437	1,536	327	3,746
Pediatria	1,824	517	--	--
G/mujori II 1994				
Patologjia	2,680	538	--	--
Kirurgjia	332	1,428	408	3,867
Pediatria	1,967	432	--	--

(a) 8 muaj, pacientë ambulatorë
(b) 8 muaj, pacientë të shtrirë

SPITALI DURRES — TË DHËNA OPERUESE

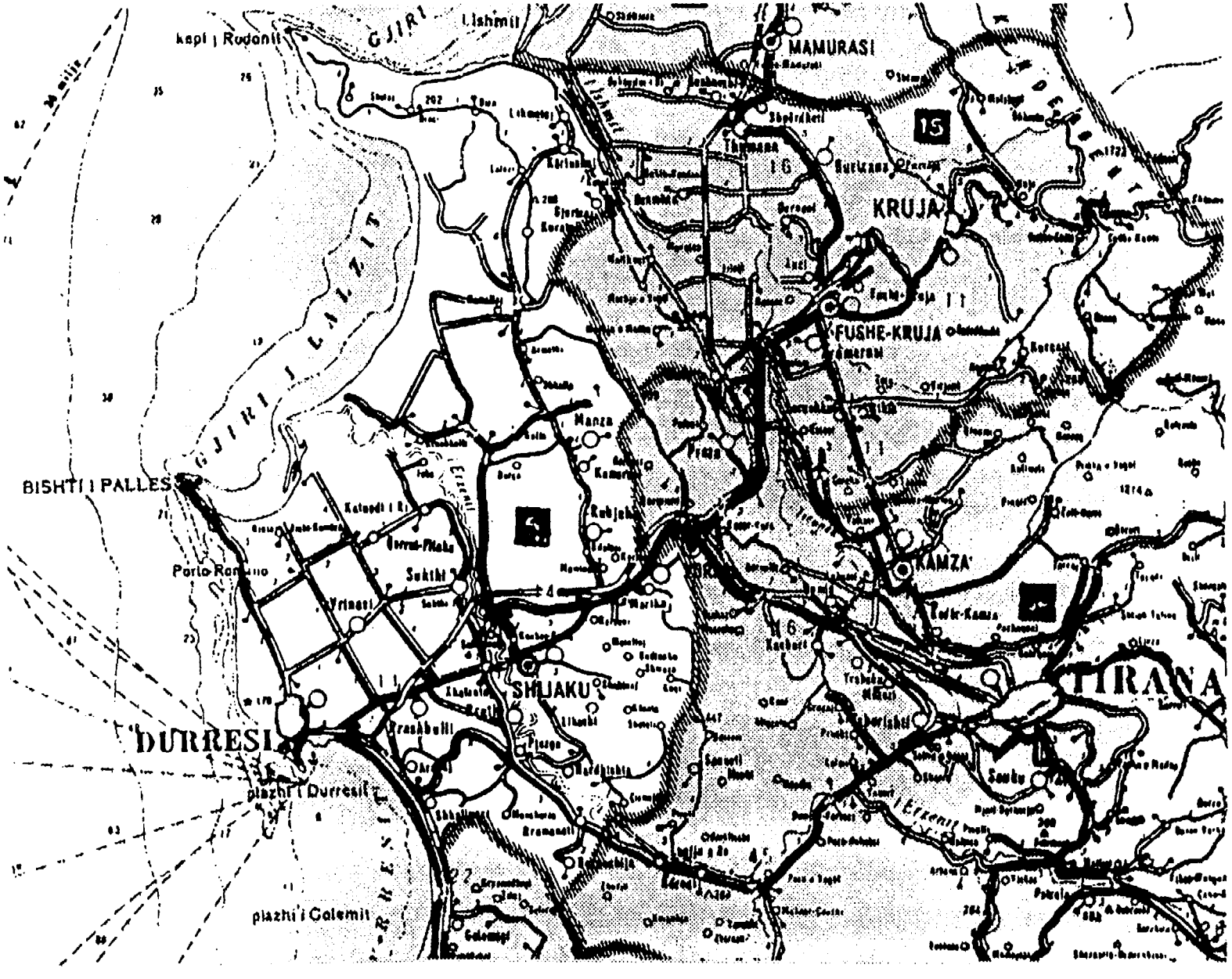
h. Vizitat në Poliklinika	1990	1991	1992	1993	1994
Reumatologji	--	9,919	9,113	8,764	1,733
Kirurgji	--	19,180	25,016	22,201	3,819
Psikiatri	--	3,798	4,145	3,146	1,053
Gastrohepatologji	--	5,398	7,093	3,747	623
Endokrinologji	--	4,146	4,790	3,759	1,420
Infeksianisti	--	1,120	604	1,910	1,030
Hematologji	--	1,798	3,265	4,954	854
Kardiologji	--	17,610	22,789	9,749	1,952
Hipertonia arteriate	--	6,791	6,015	4,984	812
Otorinoloringologji	--	20,880	15,948	16,382	3,828
Onkologji	--	3,380	3,745	4,652	1,575
Dermatologji	--	33,661	31,921	21,986	11,957
Okulistikë	--	17,519	21,333	18,709	6,078
Nefrologji	--	4,044	4,289	3,196	631
Neurologji	--	11,882	12,212	9,124	1,603
Alergologji	--	2,612	3,034	3,282	1,278
Radiologji	--	3,920	3,798	3,880	4,252
Ortopedi	--	6,908	1,680	--	--
		174,566	**180,790**	**144,425**	**44,498**

SPITALI DURRES — TË DHËNA OPERUESE

	1990	1991	1992	1993	1994	2000
***i.* Regjistrimi Mesatar Ditor**						
Kirurgjia	53.3	41.9		29.5	39.5	41.5
Materniteti	94.0	88.3	66.4	43.4	40.6	42.7
Patologjia	54.4	52.4	20.9	49.5	54.2	56.9
Pediatria somatike	48.7	36.4	13.8	34.2	22.2	23.4
Pediatria infective	39.8	20.8	8.7	14.2	13.6	14.3
Sëmundje infective	44.6	35.9	23.9	25.5	25.1	26.4
Ortopediku	109.9	65.6	66.2	49.7	42.0	44.1
Shuma	**444.7**	**341.2**	**199.9**	**246.0**	**237.2**	**249.3**
***j.* Gjithsejt Shtretër**						
Kirurgjia	75	75	0	50	50	65
Materniteti	85	85	85	85	85	85
Patologjia	75	75	73	73	73	80
Pediatria somatike	50	50	50	50	50	50
Pediatria infective	20	20	20	20	20	20
Sëmundje infective	40	40	40	40	40	40
Ortopediku	60	60	60	60	60	60
Shuma	**405**	**405**	**328**	**378**	**378**	**400**
***k.* Shtrat Zënia**						
Kirurgjia	71.1%	55.9%	-	59.0%	79.0%	63.8%
Materniteti	110.6%	103.9%	78.1%	51.1%	47.8%	50.2%
Patologjia	72.5%	69.9%	28.6%	67.8%	74.2%	71.1%
Pediatria somatike	97.4%	72.8%	27.6%	68.4%	44.4%	46.8%
Pediatria infective	199.0%	104.0%	43.5%	71.0%	68.0%	71.5%
Sëmundje infective	111.5%	89.8%	59.8%	63.8%	62.8%	66.0%
Ortopediku	183.2%	109.3%	110.3%	82.8%	70.0%	73.5%
Shuma	**109.8%**	**84.2%**	**60.9%**	**65.1%**	**62.8%**	**62.3%**

DURRËSIT

HARTA SHËNDETSORE RAJONALE



SPITALI DURRES — ANALIZAT SWOT

Veprimi: Konsulentët sqaruan përmes përkthyesit se do të kërkohej nga menaxherët vlerësimi I përparësive, dobësive, mundësive dhe rreziqeve të spitalit. Atyre iu dhanë lapsa kimikë dhe listat të cilat ishin përgatitur paraprakisht, me tituj në shqip dhe me hapësirë të mjaftueshme për pesë përgjigjet vijuese. Secili vlerësim është bërë veçmas, kështu që listat e përparësive janë mbledhur para se të shpërndahen ato të dobësive, e kështu me radhë. Përkthyesi përktheu përgjigjet deri sa kandidatët u angazhuan me listat e tjera që vijuan. Në fund të sesionit, u bë një përmbledhje, ku gojarisht u diskutua çdo përgjegje për çdo element dhe u mbajt një diskutim i shkurtër.

Data: Tetor 1994.

Definicionet:

- **Përparësitë** u shpjeguan si aspekte të spitalit, të cilat merreshin si elemnete kryesore për të arritur objecktivat.
- **Dobësitë** ishin aspektet, të cilat pengonin për arritjen e objecktivave.
- **Mundësitë** janë veprimet apo kualitetet qe do të mund të ndërmirren për të përmirësuar mënyrat e arritjes së objecktivave.
- **Rreziqet** janë kushtet brenda opo jashtë spitalit që e pengojnë atë për të arritur objektivat.

Të pranishëm në këtë sesion ishin:

- Drejtori i Shërbimeve Spitalore (Shefi i të gjitha shërbimeve),
- Drejtori i Maternitetit,
- Drejtori i Pidiastrisë,
- Drejtori i Kirugjisë,
- Drejtori i Farmacisë dhe
- Drejtori i Laboratorit.

Përparësitë

1. Objekti është shumë i mirë.
2. Kam specialistë që kanë kryer universitetin.
3. Punëtorët që kanë kryer shkollën e lartë janë të vyeshëm.
4. Mjaft specialistë.
5. Në emergjencë ka mjaft punëtorë.

1. Doktorët kanë mjaft eksperiencë.
2. Doktorët janë të gatshëm të ndihmojnë pacientët.
3. Në sektorin e patologjisë kam mjaftë specialistë.
4. Kujdestaria e natës është e koodinuar me të tjerët që punojnë natën.
5. Të gjitha shërbimet janë shumë të mira.

1. Kam staf të mjaftueshëm.
2. Doktorët në emergjencë janë çdo herë të gatshëm pë të ndihmuar.
3. Numri i specialistëve në spitalin tonë është i mjaftueshëm.
4. Stafi im ka moral të lartë pune.
5. Kam ilaçe të mjaftueshme tash për tash.

SPITALI DURRES — ANALIZAT SWOT

1. Personel të mjaftueshëm.
2. Specialistë të mirë.
3. Punëtorët e laboratorit janë mjaft të mirë.
4. Riparimet në laborator.
5. Pajisjet e reja do të na mundësojmë të bëjmë punë më të mirë.

1. Buxhet të mjaftueshëm.
2. Kemi shërbime të mjaftueshme për popullatën.
3. Staf të mjaftueshëm pë të gjitha shërbimet.

1. Personel të mjaftueshëm.
2. Doktorë me eksperiencë të madhe dhe të dedikuar ndaj punës.
3. Dokumentacion të mbajtur mirë.
4. Farmacia është në vend të mirë.
5. Gjendja financiare është e mirë.

Dobësitë

1. Shërbimet joefikase, pë shkak të largësisë njëra prej tjetrës.
2. Mungesa e pajisjeve adekuate në repartin e përkujdesit intesiv dhe kardiak.
3. Ka mungesë të pajisjeve të cilat janë shumë të vjetra.
4. Gjaku gjendet me veshtirësi.
5. Mungesa e stafit i detyron prindërit e femijëve që të kujdesen vetë për ta në spital.

1. Vendi ku punojmë nuk është shumë i mirë - është shumë i vjetër.
2. Nuk ka ujë.
3. Mungesa e mundësisë për të qenë komprihensive (i kuptushëm).
4. Mungesa e pajisjeve në repartin e përkujdesjes intensive.
5. Nuk ka dhomë të shërimit për pacientët e operuar.

1. Mungesë informacioni.
2. Shërbimet janë shumë larg njëra tjetrës.
3. Punëtorët e lëshojnë punën herët.
4. Mungesë pajisjesh.
5. Mungesë organizimi për zgjidhjen e problemeve.

1. Disa nga puntorët e mij nuk janë të ushturar si duhet.
2. Më mungojnë disa nga pajisjet për analiza në spital.
3. Stabilimentet janë shumë të vjetra.
4. Metodat e punës janë shumë të vjetra dhe marrin shumë kohë.
5. Më mungojnë pajisjet e laboratorit dhe qelqit (xhami).

1. Mjungesa e përvojës perëndimire - si të organizohen shërbimet.
2. Mungesea e literaturës pë ilaçe të reja.
3. Mungesa e pajisjeve dhe veglave për të punuar.
4. Pamundësia e shkuarjes në Evropë për të parë si funksionon famacia.
5. Mungesa e elektrikut dhe e ujit.

SPITALI DURRES — ANALIZAT SWOT

Mundësitë (Oportunitetet)

1. Ndërtimi i spitalit të ri.
2. Ekzistimi i të gjitha shërbimeve në të njejtin vend.
3. Gjetja e mënyrës se si të grumbullohet informacioni i nevojshëm.
4. Të shpenzohen më shumë lekë në shërbime.
5. Të përmirësohet ambienti fizik jashtë spitalit.

1. Ndtërtimi i spitalit të ri disenj evropian.
2. Stabilimentet e reja do të na ndihmonte shumë në ekzaminimin e pacientëve.

1. Mund të blejmë mjetët nga burimet private.
2. Të zgjerohet vendi i punës (tani nuk kemi vend të mjaftujshëm).
3. Koordinimi më i mirë i punës me administratën është e vetmja mënyrë për zgjidhjen e problemeve.
4. Shpresojmë të blejmë disa pajisje të reja, tash, kur fondet na janë dhënë.
5. Të hapen farmaci në kirurgji dhe në spitalet OB/GYN.

1. E shfrytëzuam rastin për të përmirësuar ambientin e laboratorëve.
2. Me pajisjet e raja që sa po kanë ardhur, mendoy se do të përmirësojmë kualitetin e punës dhe do të bëjmë edhe analiza të reja.
3. Po që se ndërtojmë spitalin e ri do të kemi mundësi të ndërtojmë laborator modern.

1. Po të kisha pajisje dhe vegla që kërkohen, do të bëja punë të kualifikuar.
2. Ekzistenca e një dhome shërimi do të më mundësonte përkujdesjen për pacientët e sëmurë shumë.
3. Në lidhje me spitalin, situata do të ishte ndryshe po të kishim ujë.

1. Pajisjet në dhomën e shërimit në kardiologji janë më të mira.
2. Të ndërtohet një spital që ka të gjitha shërbimet: kardiologji, patologji e të tjera.
3. Një dhomë të mirë shërimi.
4. Rritje e pagave të personelit.
5. Të lejohen mjekët që të bëjnë dy punë.

Rreziqet

1. Me rastin e reformës (p.sh. përjashtimi I punëtorëve nga puna), ne do të mbetemi pa burim financiar. Nuk jam në gjendje të hap klinikë private.
2. Doktori kujdestar i ndojnë lëmi të veçantë ballafaqohet me shumë pengesa, kur ka raste të emergjencës.
3. Në rast epidemie, nuk kemi shtretër dhe ilaçe të mjaftueshme për pacientë që duhet të shtrohen.
4. Mungesa e auomjeteve të ambulancës, në rast të një emergjence të dytë.

TE DHENAT MJEKESORE

PER MARRJEN E

VENDIMIT NGA

DREJTUESIT

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KONFERENCA SHQIPTARE

30 Nentor 1995 - 1 Dhjetor 1995

Tirane, Shqiperi

I. Hyrje

A. Kostatime personale

B. Filozofia e kujdesit shendetsor

1. Nje privilegj

2. Nje e drejte individuale

II. Veshtrim i programeve te qeverise amerikane

A. Mediker(kujdesi mjekesor) dhe Medikeid(ndihma mjekesore)

B. Kostoja e kujdesit shendetsor

III- Ceshtjet(problemet) qe influencojne ne dhenien e perkujdesjes shendetsore.

A. Cfare perfshihet ne "kujdesin shendetsor "?

B. Kush merr(siguron) perkujdesje shendetsore?

C. Cfare sistemi/ sistemesh na nevoitem per te zhvilluar dhenien e perkujdesjes shendetsore ?

IV. Konsiderata konkluduese

A. Dokumentacioni(statistika) mjekesore siguron informacion per tju pergjigjur pyetjeve(problemeve).

B. Diskutim i projektit te dokumentacionit mjekesor.

C. Faleminderit.

Hyrje

Une nuk e njoh me ekzaktesi filozofine e Shqiperise per kujdesin shendetsor, pervec faktit qe duket se secili ka te drejte te kete perkujdesje shendetsore. Edhe pse nuk jam i sigurt se si funktiononon sistemi juaj shendetsor, ju jeni per tju pergezuar per sigurimin (dhenien) e kujdesit shendetsor per te gjithe qytetaret tuaj.

Meqe une di kaq pak per sistemin tuaj te dhenies se perkujdesjes shendetsore, do te deshiroja tju beja nje perbledhje te shkurter te observimeve(vrojtimeve) te mia lidhur me dhenien e perkujdesjes shendetsore ne Shtetet e Bashkuara te Amerikes.

Historikisht,perkujdesja shendetsore universale(pra per te gjithe) nuk ka qene gjithmone nje e drejte qe mund ta gezonte(ta kishte) secili. Para Luftes se Dyte Boterore, shume njerze besonin se perkujdesja shendetsore ishte nje privilegj, dhe jo nje e drejte. Ky nocion ndryshoi dramatikisht(jashtezakonisht shume) pas Luftes se Dyte Boterore per shkaqe dhe arye ,te cilave une nuk do tju futem per ti trajtuar ne kete moment.

Ne vitet 1960 SHBA u bene te vetedijeshme per faktin se shume qytetare (sidomos qytetaret e moshuar) nuk kishin mundesi te siguronin perkujdesje shendetsore. Keshtu (per kete arsye) qeveria amerikane implimentoi (vuri ne zbatim) programin Mediker (programi i kujdesit shendetsor), i cili ju siguroi perkujdesje shendetsore qytetareve te moshuar. Me vone qeveria amerikane implimentoi programin Medikeid, program ky i kujdesit shendetsor per familiet me te ardhura te pakta(te ulta). Programi Mediker dhe Programi Medikeid zvogeluan barrierat (pengesat) financiare, te cilat i mbanin qytetaret e SHBA larg marrjes(sigurimit) te perkujdesjes shendetsore qe atyre u nevojitej.

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Me qe (ndersa) gjithnje e me shume qytetare u rregjistruan ne programet e sponsorizuara nga qeveria amerikane, shpenzimet per programet u rriten me shpejtesi alarmuese. Problemi i shpenzimeve (kostos) per perkujdesjen shendetsore dhe ceshtja se si te kontrollohen sa me mire keto shpenzime debatohen edhe aktualisht ne Amerike, bile edhe tani qe ne takohemi ketu ne Shqiperi.

E mira e shqyrtimit (shikimit) te dhenies se perkujdesjes shendetsore eshte se kjo gje na ben neve te perpiqemi tu pergjigjemi pyetjeve e ceshtjeve te meposhteme :

1. Cfare kuptojme me kujdes shendetsor ?
2. Kush merr perkujdesje shendetsore ?
3. Çfare sistemi/sistemesh shfrytezojme ne per te siguruar dhenien e perkujdesjes shendetsore ?
4. Cila eshte kostoja e perkujdesjes shendetsore ?

Une besoj (jam i bindur) se informacioni i duhur per tju adresuar ceshtjeve e problemeve, te cilave une sapo ju referova, gjendet ne dokumentacionin mjekesor.

Eshte dokumentacioni mjekesor(statistika mjekesore) ai qe pershkruan semundjet, lëndimet dhe kushtet jonormale shendetsore per te cilat trajtohen(kurohen) pacientet. Eshte dokumentacioni mjekesor ai qe na tregon se cfare burime e mjete jane perdorur(shfrytezuar) per te "trajtuar" pacientin ose per te lehtesuar(zbutur) problemet e tij shendetsore. A i shfrytezuam burimet dhe mjetet tona me kujdes ? A i arritem rezultatet tona te perkujdesjes shendetsore me efikasitet dhe efektshmeri(rendiment) ? Pergjigjet duhet te jene ne dokumentacionin mjekesor te pacientit .

Keshtu, sot ne duam tju tregojme juve per punen qe eshte bere per te zhvilluar(krijuar) dokumentacionet mjekesore, te cilat

garantojne(sigurojne) dokumentim te plote, te sakte dhe në kohe te kujdesit per pacientin.

Une kam punuar me Dr. Natasha Çeliku dhe me Dr. Eduard Hashorva per te krijuar nje dokumentim mjekesor model, i cili do te mbeshtese integrimin e informacionit klinik dhe financiar per te krijuar (zhvilluar) nje sistem te dhenies se kujdesit shendetsor, i cili do te permbush nejovat e qytetareve te Shqiperise. Dr. Celiku dhe Dr. Hashorva do ta diskutojne punen tone me ju.

Ju falnderoj per mundesine qe me dhate per te punuar me ju, në nje kohe qe ju percaktoni te ardhmen e ndertimit te kujdesit shendetsor ne Shqiperi. Urimet e mia me te mira per secilin prej jush.

Relacion mbi ndryshimet qe jane bere dhe do te behen ne Sektorin e Statistikes .

Ne baze te eksperiences dhe ndihmes qe na ka dhene Shoqata e Sherbimit Shendetesor Nderkombetar dhe Shoqata e Zhvillimit me qender ne SH.B.A. , e cila ka ardhur disa here ne vendin tone , dhe nga vizita studimore e bere ne disa spitale te New Jersey dhe New York menduam qe dhe ne ne sektorin e Statistikes te bejme disa ndryshime , ne menyre qe puna e ketij sektori te ngrihet ne menyre me cilesore. Ne ke te menyre ne i sherbejme me mire te semurit , nxjerim me ne pah aktivitetin e çdo sherbimi , punen e çdo mjeku dhe do te jemi ne gjendje te percaktojme koston per çdo te semure Kjo e fundit do te realizohet duke krijuar nje bashkepunim midis sektorit te Statistikes dhe Finances.

1- Çdo i semure qe eshte shtruar ne QSUT ka nje numer e cila e shoqeron te semurin sa here ai do te shtrohet ne spital . pamvarsisht se ne cilin specialitet ka qene i shtruar psh : Kardiollogji , Kirurgji , Neurollogji etj . Te gjithe kartelat mbasi dorezohen ne Statistike nga ana e pavioneve vendosen ne dosje te veçanta per secilin te semure dhe siper dosjes vendoset numri perkates qe ka i semuri , Te gjithe te semuret qe shtrohen per here te pare paisen me nje fletushke te vogel ku eshte shenuar

Nr -_____

Emri Atesia Mbiemri

_____

Date lindja Vend banimi

_____ _____

Tek mbiemri ne rastin e femrave te martuar vihen mbiemri i vajzerise dhe mbiemri qe ka tek i shoqi. Kete pacianti duhet ta kete gjithmon me vehte (duke ja shpeguar rolin qe ka kjo fletushke) dhe duhet ta paraqese sa here qe shtrohet ose kur kerkohet dosja e vet per te bere konsulte ambulatore. Ky sistem eshte i dobishem sepse ne kete menyre na jep mundesi per te njohur me mire gjendjen e paciantit se si ka shkuar ne dinamike. Per vitet e kalura kartelat do te vihen ne dosje gradualisht neqoftese pacianti

do te shtrohet ne spital. Per qytetet e vogla qe spitali eshte i lidhur me polikliniken mendoj qe i semuri te kete nje dosje ku ketu te jete dhe kartela e spitalit dhe ajo qe ai eshte shtruar ne spital dhe siper dosjes te vendoset nje numer .

Per te lehtesuar punen eshte krijuar Indeksi kryesor i te semurit . cili evidenton çdo lloj problemi qe ka pacineti.. Indeksi kryesor ka keto te dhena :

Nr dosjes Mbiemri Atesia Emri Mosha Vend banimi Klinika

Data shtrimit Data daljes Diagnoza e plote

Indeski eshte bere me mbiemra mbasi keshtu eshte me e lehte per tu gjetur. Per te gjetur nje dokument ne identifikojme emrin dhe numirn e pacientit . Kete sistem ne e kemi lidhur me kompjuterin duke i hedhur te gjithe te semuret. Neqoftese i semuri e ka humbur numrin ne e gjejme lehte tek indeski kryesor qe e kemi ne kompjuter. Mbas dite dhe naten ne e çojme librin ne urgjence te shoqeruara dhe me fletushkat , Ne kete menyre urgjenca çdo te semure qe shtrohet e pyet a ka qene i shtruar kete vite ne QSUT , nqs po i ve numrin e dosjes nqs jo e regjistron ne regjister dhe i jep dhe nurin perkates . Çdo mengjes ne shkojme ne urgjence dhe marim regjistrin e shtrimeve per ata qe kane qene shtruar gjate nates .

2- Rendesi ka dhe vendosja e dosjeve psh : I semuri me numer 347613 Kemi krijuar rafte me ndarje duke filluar nga 00 , 01 , 02 , 03 , 04 05 , ...99 . Marim vetem dy numrat e fundit psh 13 dhe e vendosim dosjen te rafti me numer 13 . Ne raftin me numer 13 kemi bere nje rindarje tjeter perseri nga 00 , 01 , 02 , 03 , 04 , 05 .....99 dhe kete kartele ne baze te dy numrave te dyta e vendosim ne numrin 76 . Po keshtu dhe tek ndarja 76 kemi krijuar nje ndarje tjeter perseri nga 00 , 01 , 02 , 03 , 04 , 05 .....99 dhe kete kartele e vendosim tek numri 34 . Pra per te gjetur nje kartele ne shkojme tek rafti me numer 13 pastaj tek ndarja 76 , pastaj tek 34 . Kjo menyre eshte mjaft e lehte per te gjetur nje dosje .

3- Tani po punohet per te bere nje kodifikim te ri te semundjeve , e cila do te filloje nga 1 Janari 1996 . Kodimi i semundjeve do te jete me 4 ose 5 shifra psh :
Infarkti akut i miokardit qe e ka nomeklaturen 410 , do te behet nje ndarje me e detajuar ;410.0 Infarkt miokardi anterolateral
410.1 Infarkt miokardi anterior.

410.2 Infarkt miokardi inferolateral.
410.3 Infarkt miokardi inferoposterior etj (pra sipas lokalizimeve)
Po keshtu do te behet kodifikimi e semundjeve te tjera shoqeruese dhe i komplikacioneve . Deri tani kodifikohej vetem semundjen kryesore.

Po qe te realizohet sa me mire kjo dhe qe te jete sa me e sakte duhet qe nga ana e mjekeve te preçizohet sa me mire se kush eshte diagnoza kryesore , diagnoza shoqeruese dhe komplikacionet . Si diagnoze kryesore mendoj se duhet te percaktohet
1- Nqs pacienti ka 2 ose me shume diagnoza per te cilat ai shtrohet , diagnoza kryesore e shte ajo per te cilen eshte kryer nje proçedure kirurgjikale ose jokirurgjikale.
2-Nqs nuk eshte kryer proçedure diagnoza kryesore do te jete ajo qe ka shpenzuar me shume.

Diagnoza kryesore eshte faktori kritik per te percaktuar drejt kodifikimin e semundjes dhe influencon ne percaktimin e kostos te te semurit Nqs kodifikimi eshte i gabuar atehere dhe informacioni do te jete i gabuar dhe kostoja e te semurit nuk do te jete e sakte. Gjithashtu kjo na jep jo vetem semundsherine por na jep dhe detaje reth semundjeve. . Nga kjo nxjerrim ne pah punen e çdo mjeku , sa te semure ka mjekuar per nje periudhe te caktuar kohe dhe me çfare diagnoze i ka patur . Ne baze te ketyre te dhenave ne mund te nxjerrim per çdo sherbim diagnozat qe predominojne , sa shtrime ka patur , nga cili reth etj .

Mbasi te realizohet kodifikimi i semundjeve duhet te behet Indeksi i semundjeve . Kjo mendoj te realizohet ne kete menyre :
250.00 Diabeti melitus . Poshte kesaj mendoj qe duhet te shenohen te gjithe te semuret e shtruar me kete diagnoze , duke vene dhe te dhena te tjera psh :

Mbiemri Emri Nr i pacintit Adresa Klinika Data e shtrimit Data e daljes dite qendrimi , kodet e semundjeve te tjera , gjendja ne dalje , mosha , seksi , lloji i shtrimit , Mjeku qe e ka mjekuar .

Kjo na ndihmon per te nxjerre te dhenat e nje sherbimi dhe njekohesisht ne fund te çdo muaji , 3 mujori , 6 mujori , 9 mujori dhe vjetore nxjerrim rastet si total per secilin diagnoze. Ne menyre qe kjo te realizohet sa me mire eshte e nevojshme qe te behet kodifikimi i sherbimeve , mjekeve , klinikave , llojit te shtrimit (urgjent apo i planifikuar)

4- Ne 1 janar 1996 do te filloje dhe kodifikimi i proçedurave te ndryshme qe

kryhen ne spital si psh : biopsi , Rinoplastike , Drenimi i abseseve , Vendosja e valvulave ne zemer , operacione te ndryshme , ekzaminimet radiologjike , testet laboratorike etj .

Kodifikimi i proçedurave ka rendesi :

1-Percaktohet numri i proçedurave te kryera ne spital .

2- Ne baze te numrit te proçedurave percaktohet kostoja e te semurit .

3- Nevojat per aparatura .

5-Mendohet qe ti hapet kartele jo vetem te semurit qe shtrohet ne spital por dhe çdo te semuri qe paraqitet ne konsulte per vizite ambulatore ose qe paraqitet ne urgjence. Kjo kartele duhet te kete shenimet e mjekut , mjekimet qe ka bere ne spital dhe proçedurat e ndryshme qe ka kryer. Mbasi mbaron pune i semuri kartela duhet te dorezohet ne Statistike dhe ti bashkengjitet dosjes personale te semurit (duke i vene po ate numer).

Spitali duhet te raportoje per numrin e vizitave ambulatore , Numrin e procedurave qe jane kryer gjate nje periudhe te caktuar kohe.

Nga ana e statistikes dhe per sherbimin ambulator duhet bere :

1=Kodimi i procedurave.

2-Kodimi i diagnozave.

3-Kodimi i sherbimeve te ndryshme.

6- Nje problem me rendesi eshte qe radiogafite duhet te mbahen vec nga kartelat , ne dosje te vecanta , sepse ne kete menyre eviton demtimet e kartelave . Keto mund te mbahen ne radiologji (duke krijuar nje statistike me vehte ,) ose te mbahen ne statistike. Numrin e dosjes qe ka dosja e pacientit mendoj qe duhet ti vendoset dhe dosjes se radiografive .

7- Rendesi ka dhe afati i ruajtjes se kartelave . Mendoj qe kartelat duhet te mbahen deri ne 25 vjet . Rendesi ka dhe mbjenti ku duhet te ruhen kartelat , ambjenti duhet te jete i thate , pa lageshtire , te mos jene afer tubacioneve te ndryshme se nje shperthim mund ti demtoje kartelat . Ne arshive nuk duhet te futen njerez te paautorizur.

Dr Natasha Çeliku Dr Mehdi Alimehmeti

ECURIA E KAPACITETIT TE Q.S.U.T. NGA VITET 1992 - 1995

Dr. Mehdi ALIMEHMETI
Dr. Natasha CANO

Gjate kater viteve te fundit, nje nga problemet kryesore te Stafit Drejtues te Q.S.U.T. ka qene edhe kapaciteti i Spitalit. Ne kemi konstatuar se shfrytezimi i shtreterve ne klinika te ndryshme ishte i ulet , per pasoje efikasiteti i spitalit ishte jo i kenaqshem .

Ne keto kushte Stafi Drejtus i Spitalit vendosi te beje reduktimin shkalle shkalle te numrit te shtreterve i cili eshte paraqitur ne pasqyren nr.1 dhe nr.2 .Keshtu ne vitin 1993 dhe 1994 u reduktuan 399 shtreter duke e cuar kapacitetin ne 1801 shtreter.

Ndonese u be nje reduktim i ndjeshem i shtreterve ne spital perseri konstatuam nje shfrytezim te ulet te shtreterve dhe kjo kryesisht ne Departamentin e Pediatrise , Psikiatrise dhe Infektivit te te rriturve.

Per vitin 1995 ne menduam dhe hodhem idene e bashkimit te disa klinikave ne nje klinike te vetme , pra duke bere nje organizim te ri ,i cili u perqendrua kryesisht ne Departamentin e Pediatrise.

Organizimi i ri qe konsiston ne bashkimin e tre ose kater klinikave ne nje klinike te vetme do te kete efektet e tij pozitive .

Dy vjet te shkuar Qeveria aprovoi kohen javore te punes prej 40 oresh .Kjo shkaktoi nje diskordance mes kohes se punes dhe mundesive tone reale , per tu krijuar mundesi punonjesve qe te benin 2 (dy) dite pushim , por bashkimi i pavioneve na krijoi forca te lira qe pas nje rimotivimi sot eshte bere i mundur qe stafi yne te beje 2 (dy) dite pushim ne jave .

Ne Qershor te vitit 1992 u krijua Q.S.U.T. nga bashkimi

- **Spitali Nr 1**
- **Spitali Nr 2**
- **Spitali Nr 3**
- **Spitali Nr 4**
- **Spitali Nr 5**
- **Onkologjik**

Kapaciteti 2200 shtreter.

Qendra Spitalore Universitare Tirane.

	VITI 1992		VITI 1993		VITI 1994		6 mujori pare 1995	
SHERBIMET	KAPACIT	%.D.SH.SH.	KAPACIT	%D.SH.SH	KAPACITI	%D.SH.SH	Kapaciteti	%D.Sh.S
KARDIOLOGJIA	110	89%	110	80.11%	110	82.94%	110	89.12
KATI 1	49	91.42%	49	74.27%	49	88.22%	49	97.18
KATI 2	53	87.90%	53	84.71%	53	77.13%	53	79.47
REANIMACIONI	8	77.03%	8	85.41%	8	89.10%	8	103.59
HEMATOLLOGJIA	34	78.50%	34	84.07%	34	75.52%	34	84.82
ALERGOLLOGJIA	25	82.80%	25	82.60%	25	84.39%	24	84.55
HEPATOLOGJIA	55	75.80%	55	76.78%	55	72.75%	50	71.86
ENDOKRINOLLOGJIA	38	75.90%	38	83.44%	38	83.02%	38	86.35
NEFRO -HYPERTONIA	54	82.80%	54	90.90%	54	82.62%	54	79.30
REUMATOLLOGJIA	30	104.80%	30	95.90%	30	91.73%	30	86.91
O.R.L.	60	66.81%	50	65.78%	50	72%	50	73.19
PAVIONI 1	30	69.28%	25	63.15%	25	67.85%	25	70.01
PAVIONI 2	30	64.37%	25	68.40%	25	76.14%	25	76.38
OKULISTIKA	50	83.10%	50	71.01%	50	65.67%	50	73.37
STOMATOLLOGJIA	17	74.60%	17	80.98%	17	66.94%	15	75.36
SEM PROFESIONALE	25	61.96%	25	73.19%	25	86.56%	25	72.09
DERMATOLLOGJIA	40	97.37%	40	102.98%	40	69.80%	40	81.93
KIRURGJIA E PERGJITH.	30	102.70%	30	81.32%	30	77.73%	30	70.73
KARDIO -KIRURGJIA	40	46.20%	40	44.34%	40	52.97%	40	53.37
KLINIKA 2	65	79.30%	65	83.53%	55	78.89%	55	71.21
KLINIKA 3	60	58.30%	55	72.68%	50	77.065	50	84.03
PLASTIKA	70	78.20%	70	89.22%	70	84.90%	70	71.90
NEURO KIRURGJI	20	64.21%	20	69.02%	20	58.15%	20	
PAVIONI 7(BURGU)	100	0	70	67.93%	80	81.19%	80	

REPARTI PERZIER	55	16.21%	25	29.19%	13	66.70%	13	52.23
REUMATOLOGJI	15	24.36%	5	77.47%	0	0	5	87.51
NEONATOLOGJI	15	27.67%	15	27.25%	0	0	0	
PAVIONI 8	65	69.35%	50	36.50%	30	37.27%	30	29.56
PAVIONI 10	65	31.05%	40	39.75%	35	44.18%	35	27.02
HEPATIT VIRAL	70	17.82%	40	46.12%	25	63.69%	25	43.12
PAVIONI 11	40	30.02%	35	47.19%	23	73.19%	23	81.41
PNEUMOLOGJI	55	40.97%	35	66.64%	30	60.84%	30	86.48
ALERGOLOGJIA	30	42.44%	25	81.64%	25	55.40%	25	76.93
KIRURGJI INFANTILE	40	28.55%	30	57.23%	23	80.19%	23	94.19
O.R.L. INFANTILE	15	55.58%	12	79.04%	12	73.94%	12	62.11
KARDIOLOGJI INFANTIL	15	30.99%	12	57.78%	10	60.10%	10	59.89
NEUROLOGJI	15	58.32%	15	54.41%	10	103.47%	10	79.45
NEFROLOGJI	20	51.54%	15	106.81%	15	60.43%	15	67.81
ENDOKRINOLOGJI	15	41.50%	12	48.31%	10	77.06%	10	91.88
GASTROETERITET	15	33.73%	10	63.23%	10	44.93%	10	35.52
HEMATOLOGJI	30	48.79%	25	44.75%	15	78.50%	15	60.07
REANIMACIONI	20	25.07%	12	40.38%	12	66.87%	12	59.12
	%DSHSH							
KATI 1 INFEKTIV	44	68%	44	55.15%	30	71.17%	30	72.38
KATI 2 INFEKTIV	80	53.70%	70	51.26%	50	65.54%	50	66.51
KATI 3 INFEKTIV	70	47%	60	52.07%	40	70.26%	40	51.08
REANIMACIONI	0	0	5	31.28%	5	27.34%	5	16.08
KATI 3 NEUROLOGJI	48	43.56%	45	49.68%	45	45.89%		
KATI 4 NEUROLOGJI	47	96.61%	44	72.24%	40	71%		
KATI 1 PSIQIATRI	18	36.44%	18	76.14%	18	59.58%	18	140.95
KATI 2.3 PSIQIATRI	75	50.86%	75	75.95%	80	69.39%	80	59.11
RIAFTESIMI	50	54.37%	50	57.17%	40	71.46%	40	57.02
REPARTI FEMIJVE	13	35.84%	13	37.38%	10	43.70%	10	66.13
KATI 4 PSIQIATRI	30	30.78%	0	0	0			
KRONIKET	25	97.44%	0	0	0			
	2200		1961		1801		1673	
			239		160		128	

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Gjate vitit 1992 - 1993 u konstatua:

- **Kapaciteti i madh**
- **Shfrytezimi i shtratit i ulur**
- **Personel mjekesor i lire**
- **Spitali pa efektivitet**

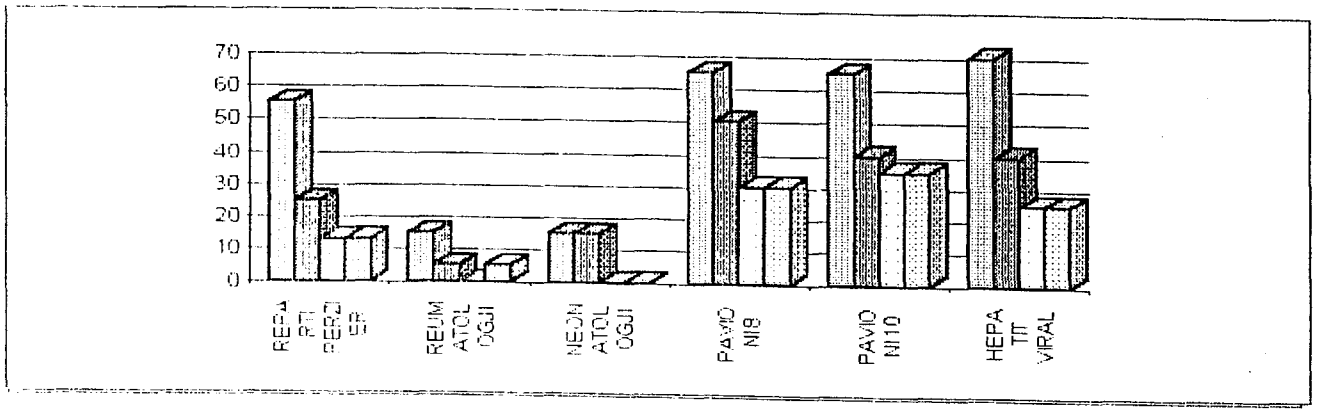
Me 1993 filloi reduktimi i shtreterve ne :

- **Departamentin e Pediatrise**
- **Departamentin e Psikiatrise**
- **Departamentin e Semundjeve Infektive**
- **Disa klinika te ndryshme te Pathollogjise,Kirurgjise,etj.**

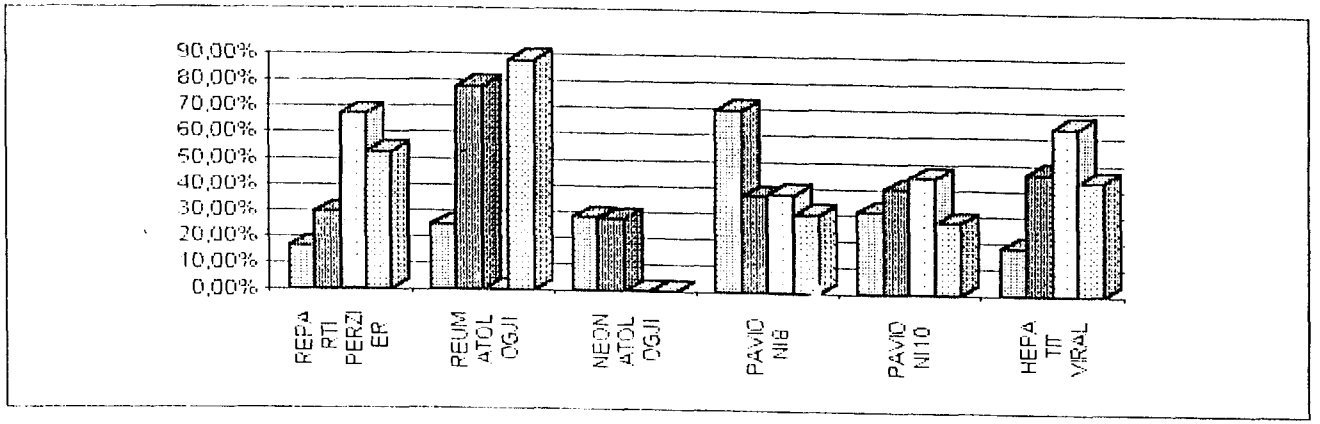
Me 1993 u shkurtuan 239 shtreter.

Kapaciteti 1961 shtreter.

Ndryshimet e kapaciteteve per vitet 1992 , 1993 , 1994 , 1995 Spitali nr 3.



Shfrytezimi i shtratit per vitin 1992 , 1993 , 1994 , 1995 .



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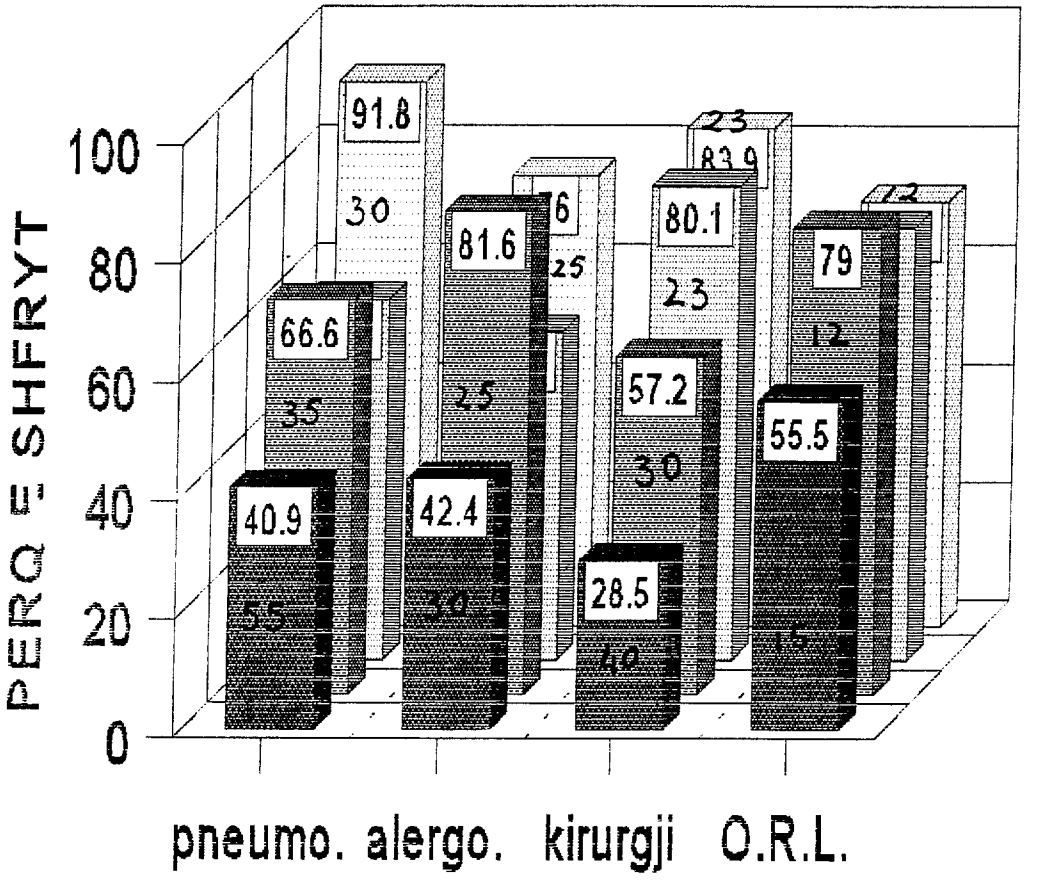
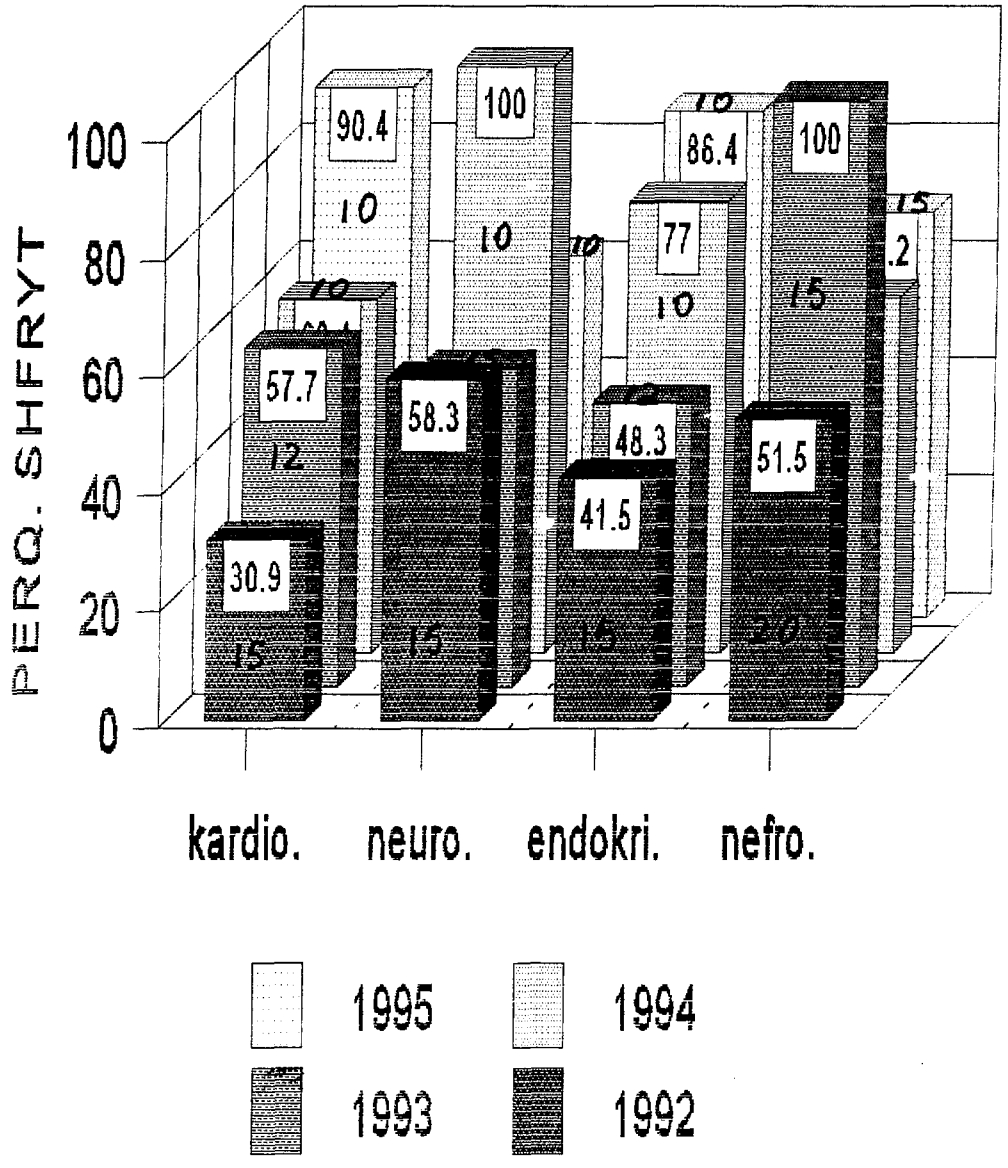
PEDIATRIA

KLINIKAT



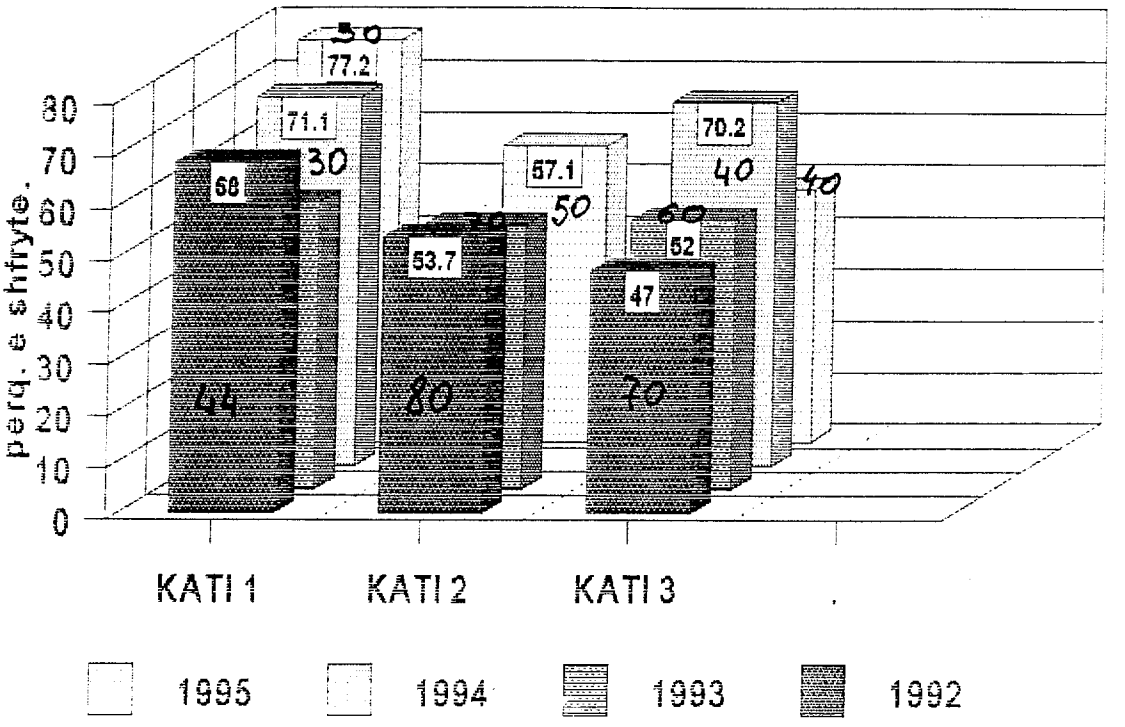
PEDIATRIA

KLINIKAT



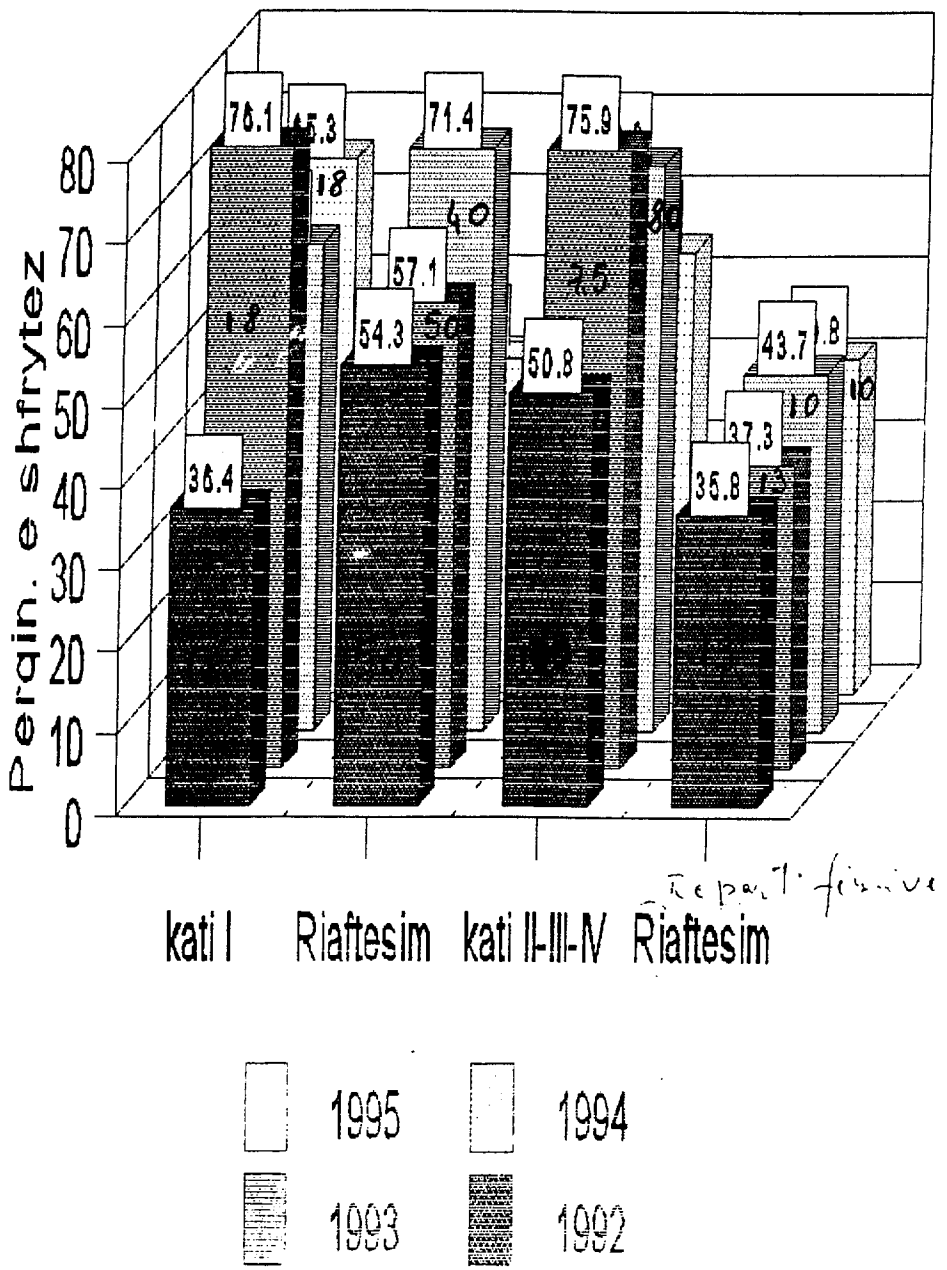
INFEKTIVI I TE RRITURVE

KLINIKAT



PSIKIATRIA

KLINIKAT



Me 1994 reduktuam 160 shtreter dhe kryesisht ne :

- *Departamentin e pediatrise*
- *Departamentin e Semundjeve Infektive*
- *Departamentin e Psikiatrise*

Kapaciteti 1801 shtreter.

Me 1995 krahas reduktimit ribashkim pavionesh.

REDUKTIMI DHE RIORGANIZIMI I SHTRETERVE NE PEDIATRI

EMERTIMI	KAPACITETI	SHKURTIME	EMERTIMI RI	KAPACITETI
KIRURGJIA INFATILE O.R.L.	23 (shtreter) 12 (shtreter)	5 (shtreter)	KIRURGJIA INFATILE	30 (shtreter)
PAVIONI 8,10 HEPATITET VIRALE GASTROENTERITET KRONIKE	65 (28 %) 25 (43 %) 10 (35 %)	60 (shtreter)	GASTROHEPATITI	40 (shtreter)
REPARTI PERZIER PNEUMOLOGJI ALERGOLOGJI	13 (52 %) 30 (40%-70%) 25 (42%-72%)	18 (shtreter)	PNEUMOLOGJI	50 (shtreter)
			REPARTI DITOR	17 (2 infektiv)

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KAPACITETI I DEPARTAMENTIT TE PEDIATRISE

(Organizimi i ri)

- KIRURGJIA INFANTILE	30	SHTRETER
- GASTROHEPATITET	40	"
- PNEUMOLOGJIA	50	"
- REPARTI DITOR	17	"
HEMATOLOGJI - ONKOLOGJI	15	"
- ENDOKRINOLOGJIA	10	"
- NEFROLOGJIA	15	"
- NEUROLOGJIA	10	"
- KARDIOLOGJIA + OBSERVACIONI + + REUMATOLOGJIA	20	"
- SEMUNDJET INFEKTIVE	23	"
	242	

Ndikimi do te jete ne :

-Rritjen e shfrytezimit te shtratit

-Rritjen e aktivitetit te personelit mjekesor

- te mjekeve
- te infermiereve
- te personelit tjeter ndihmes

- Personeli do te jete me i motivuar
- Rishperndarjen e personelit

= Rritje te efektivitetit.

BLERJA NE GRUP

E BARNAVE

FARMACEUTIKE

GRUP PROCESINGU

Ne keto vitet e fundit ka nje rritje interesi midis spitaleve - ne grup procesingu. Natyrisht, perfitimi i perpjekjeve te grupit duhet te jete i barabarte ose me i madh se koncesionet e bera nga anetaret e spitaleve. Dihet qe , tendenca e firmave furnizuese t'i jape cmimin grupit eshte shume perfituese per spitalet e vogla, i mire per spitalet mesatare.

Ky informacion tregon faktin qe grupi i procesingut eshte pikerisht nje metode e marrjes se cmimeve te mira nepermjet negociatave, por nuk eshte gjithshka per gjithe problemet e blerjes. Nganjehere nje kombinim i teknikave te ndryshme te blerjes mund te jape rezultate te mira.

Drejtimit material i nevojitet fleksibiliteti i zgjedhjes se blerjes se drejte, per te sjelle rezultatet e deshiruara ne cdo situate individuale.

Grupi i procesingut ka te beje me kombinimin e volumeve te medha te blerjes. Ne grup procesingu marrin pjese :

Se pari: Spitali qe ben organizimin ku ai vendos se do te bleje dhe merr pjese ne grupe blerje.
Se dyti: Prodhuesi, i cili merret me percaktimin e llojeve te prodhimit, cmimit dhe ben shperndarjen e tyre.
Se treti: Tregtaret e shitjes me shumice.

Roli i grupit eshte manovrimi i tre faktoreve te mesiperm, i cili :

1. Ben kontraktimet;
2. Jep informacion mbi spitalin me kerkesat e kontrates;
3. Pergatit kushte per kontrata te reja.

Duke krijuar grupe spitalesh eshte krijuar mundesia per te blere ilace me cmime me te ulta.

Rolin e grupit te procesingut e kemi pare tek MERCH COMPANY, domethene marredheniet ndermjet grupit te procesingut, Merc dhe spitalit.

SHITJA E PRODUKTIT
PRODUCT SALE

Puna fillon pasi eshte kryer kontrata. Cmimi i shitjes me shumice eshte i larte, sipas cmimit te caktuar 1000 $. Vendoset marreveshja qe cmimi i blerjes per spitalin eshte 900 $. Neqoftese tregu i shitjes me shumice ia shet spitalit, eshte caktuar 900 $ dhe keshtu tregtaret e shitjes me shumice marrin 900 $ + fitimin, i cili ndikohet nga sasite e medha te shitjes.

Neqoftese Merch do t'i shiste direkt spitalit, ne baze te cmimit te faturës 900 $ do te kishte humbje 100 $. Prandaj, i interesuari t'ia japë prodhimet e veta tregtarit te shitjes me shumice, i cili ia jep spitalit me cmim te faturuar 900 $ dhe i kthen Merch (chergeboch) 100 $, por realizon edhe fitimet e veta nga sasite e medha te shitjes.

Keshtu Merch nepermjet tregtarit te shitjes me shumive realizon katalogun e cmimeve:

1000 $ = 900 $ spitalit dhe 100 $ e merr nga tregu i shitjes me shumice.

Efiktiviteti qendron ne deskluzivitetin qe vendos kompania prodhuese, ne rastin tone Merch.

Merch Company, si prodhues, kerkon nga grupi i procesingut qe produktet e tyre te perdoren ne menyre eskluzive, e te mos perdoren lloje te tjera te firmave te tjera

Masiviteti i perdorimit,psh. ne cdo pese vete perdorin 2 ilace te Merch. Tregu i shitjes me shumice grumbullon 85-90 % te prodhimeve farmaceutike. Ne kete kuader vetem tregu i shitjes me shumice ben me efektivitet blerjen dhe shitjen e prodhimeve. Ne kete kuader spitaleve i intereson te lidhen me tregun e shitjes me shumice.

Sa me shume forcohet lidhja e spitalit me tregun e shitjes me shumice, aq me shume spitali ndjen perfitimet.

Cdo spital nuk ka mundesi te lidhet ne menyre individuale. prandaj eshte e rendesishme lidhja grup spitalesh.

Lidhja grup e blerjes dhe e tregut te shitjes me shumice eshte marredhenie qe fiksohet ne kontrate.

Ne kontrate fiksohet :

Hapi i pare : Afati i perdorimit, skadenca, lloji i firmes.
Hapi i dyte : Per sa kohe do te lidhet kontrata, cilesia.

Kompanite e prodhimit lidhen me ato treg shitjes me shumice, te cilet kane magazina, qe plotesojne kushte te mira sipas karakteristikave te vecanta.

Neqoftese magazinat nuk i permbushin keto kushte, nuk lidhin kontrate.

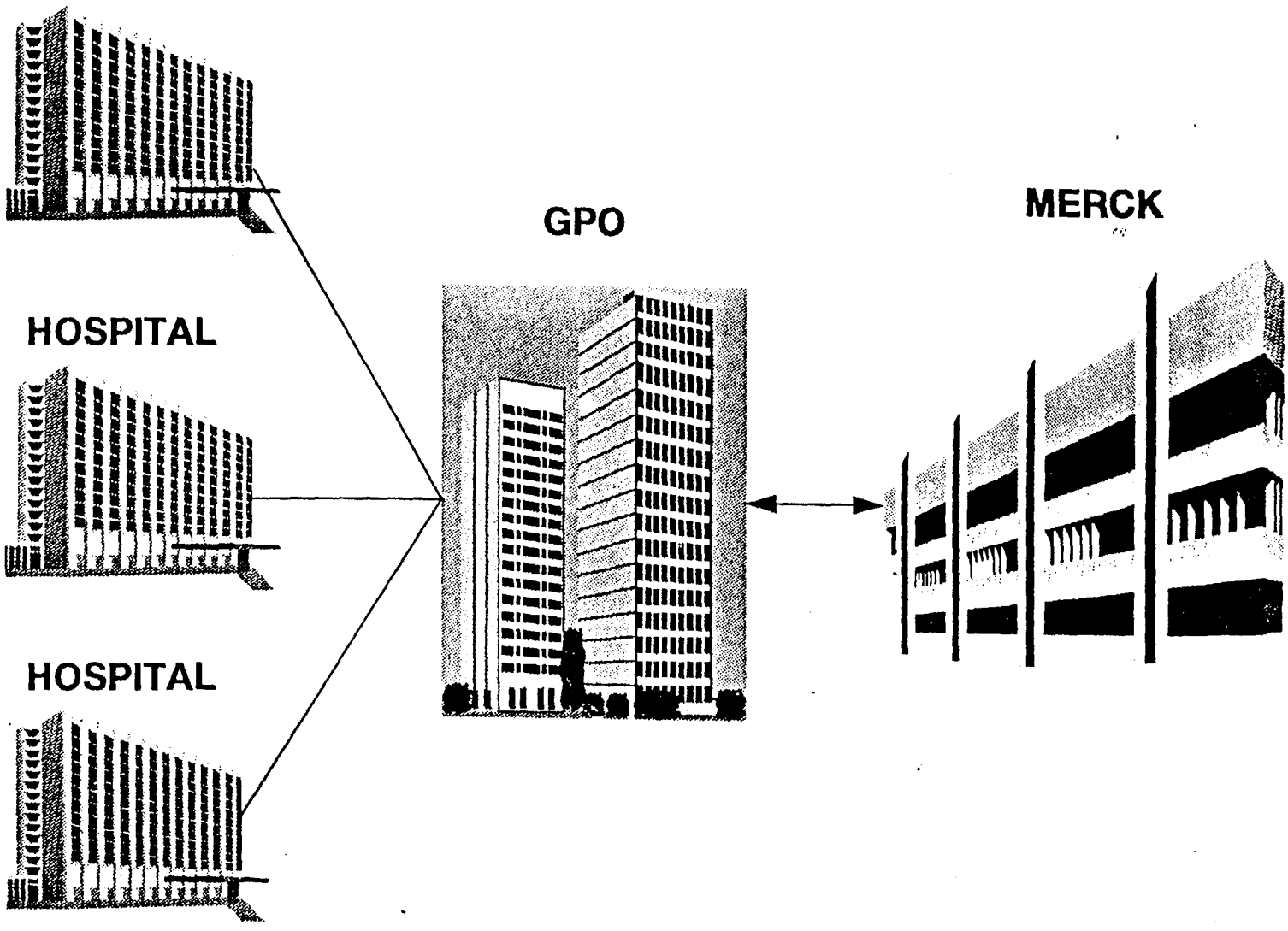
Orientimi i magazinave eshte i drejtuar nga levizja e qarkullimit te medikamenteve. Magazina porosit ate ilac qe qarkullon me shpejt dhe sheh zonen ku ajo qarkullon.

Rendesi ka vendosja e medikamenteve ne seksione dhe rafte sipas levizjes se tyre. Medikamentet qe levizin shpejt duhen vendosur prane transportuesit.

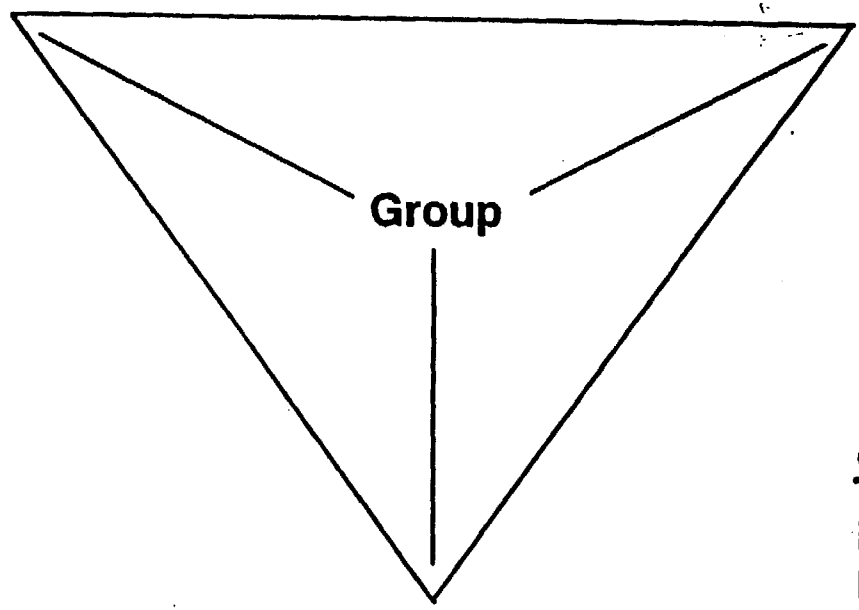
Materialet qe kane qarkullim te ngadalte duhen vendosur ne pozicion te dukshem, qe te kete mundesi te kontrollohet afati i skadences. Idea e vendosjes eshte ne funksion te levizjes. Cdo mall i shoqeruar me kartelen e tij duhet te kete nje numer te caktuar, i cili te tregoje pozicionin qe ndodhet medikamenti ne magazine, kohen e levrimit. sasine.

Pavaresisht se grupi i procesingut nuk ka marre forme ne vendin tone, duhet thene se per Q.S.U.T. jane bere hapa mjaft te rendesishme. Akordimi i nje fondi ne valute per Q.S.U.T. ka bere te mundur lidhjen direkt me firma te tilla si : AESCULAP, BRAUN, INTERPHARMACY, ALKABELLO, ISP SURGICAL PRODUCTS, SIGMA, DAKO, RADIOMETER, BIO.MERIEUX, SEAC, AVL, SCLAVO, JOHNSON $ JOHNSON, PENY, STORZ, duke blere direkt ne tregun e jashtem dhe duke siguruar nje efektivitet te tille, qe neqoftese keto blerje do te ishin realizuar nepermjet FUFARMES, shpenzimet do te ishin 30 % me te larta.

RELATIONSHIP



GROUP PURCHASING
(Volume Combination Purchasing)



Manufacturer

Product Supply

Contact Pricing

Distribution

Wholesaler

Distribution

Contract Pricing

Group

Formulary Development

Contract Development

Information Communication

Contract Management

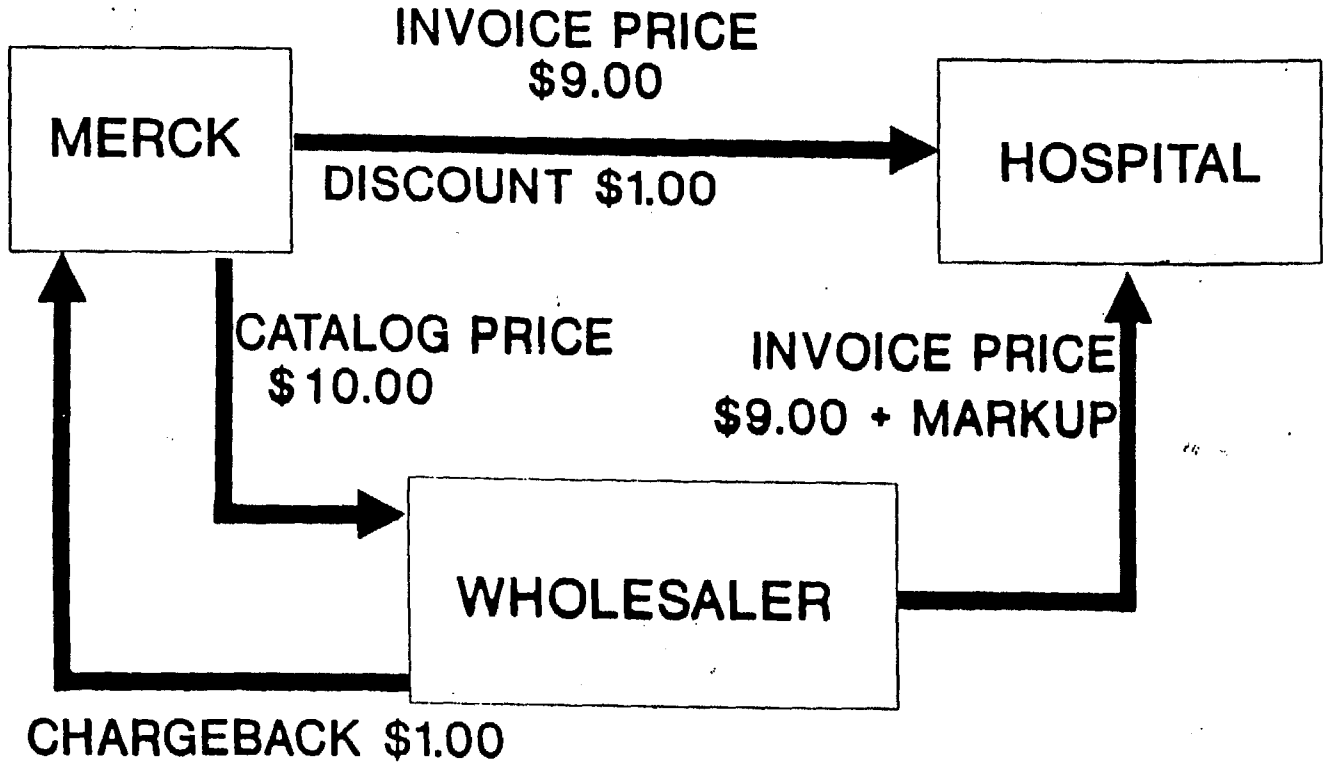
Hospital

Group Participant

Contract Support/Product Use

Continue Formulary Development

PRODUCT SALE



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REFERAT MBI VIZITEN NE SH.B.A. 1995

1. VIZITE NE KOMPANINE MERCH.
   EKSPOZE E KESAJ VIZITE.

2. CARDINAL HEALTH CARE.
   EKSPOZE E KESAJ VIZITE NE KETE DISTRIBUTOR.

3. MENYRA E FUNKSIONIMIT TE FARMACISE NE WAIN GENERAL HOSPITAL.

4. GROUP PURCHASING.

5. KRIJIMI I KETIJ GROUP PURCHASING DHE TEK NE.

6. MENYRA E FUNKSIONIMIT DHE E ORGANIZIMIT.

7. PARAQITJA E KETIJ PLANI PARAPRAK PER KETE GROUP PURCHASING NGA MBLEDHJET NE MINISTRI.

8. LIGJI NR. 7971 DT, 26.7.1995 PER PROKURIM PUBLIK.

2B

VIZITE NE KOMPANINE MERCH .EKSPOZE E KESAJ VIZITE.

a) MERCH KOMPANIA ME ME FAME NE BOTE DHE KRYESON LISTEN SI PRIMARE.

b) MENYRA E SHITJES SE PRODUKTEVE FARMACEUTIKE TE KESAJ KOMPANIE.

CARDINAL HEALTH CARE .EKSPOZE E KESAJ VIZITE

NE KETE DISTRIBUTOR.

a) CARDINAL HEALTH CARE DISTRIBUTOR SHUME I FUQISHEM E 31 NE U.S.A.

b) HISTORIK I SHKURTER I KRIJIMIT TE SAJ

c) BASHKEPUNON ME 30 VENDE NE U.S.A..

d) MENYRA E BASHKEPUNIMIT.

e) C.H.CARE SHERBEN DHE JASHTE KUFINJVE TE SH.B.A.

f) LIDHJA E C.H.CARE ME FABRIKAT FARMACEUTIKE TE NDRYSHME.

g) PARAQITJA E CMIMIT NE KATALOG.MARREVESHJA NDERMJET FABRIKAVE FARMACEUTIKE DHE DISTRIBUTOREVE (PRODUCT SALE)

MENYRA E FUNKSIONIMIT TE FARMACISE

NE WAIN GENERAL HOSPITAL.

a) WAIN GENERAL HOSPITAL

b) FUNKSIONIMI I FARMACISE NE KETE SPITAL.

GROUP PURCHASING

a) CILI ESHTE KUPTIMI I GROUP PURCHASING.

b) MENYRA E ORGANIZIMIT TE TIJ. GPO.

KRIJIMI I KETIJ GROUP PURCHASING DHE TEK NE .

a) CILI ESHTE REZULTATI I KRIJIMIT TE KETIJ GRUPI TEK NE.

MENYRA E FUNKSIONIMIT DHE E ORGANIZIMIT.

a) PROJEKT RREGULLORJA PER FUNKSIONIMIN E KOMISIONIT TE BLERJES SE BARNAVE.

PARAQITJA E KETIJ PLANI PARAPRAK PER KETE

GROUP PURCHASING NGA MBLEDHJET

NE MINSTRI.

a) LISTAT E MEDIKAMENTEVE TE PARAQITURA NGA

SPITALET TIRANE,DURRES,ELBASAN

SHKODER.

LIGJI NR. 7971 DT. 26.07.1995

PER PROKURIM PUBLIK.

NENI 5. RREGULLAT E PROKURIMIT.

a) KESHILLI I MINISTRAVE NGARKOHET TE HARTOJE DHE SHPALLE RREGULLAT E PROKURIMIT PER PLOTESIMIN E QELLIMIT DHE ZBATIMIN E DISPOZITAVE TE KETIJ LIGJI.

b) N.Q.S. ME SHUME SE NJE ENT PROKURUES KA NEVOJE PER TE NJEJTIN LLOJ MALLI ,NDERTIMI OSE SHERBIMI KESHILLI I MINISTRAVE MUND TI CAKTOJE NJERIT NGA ATO ENTE PROKURUESE DETYREN E PROKURIMIT

UNIVERSITY HOSPITAL CENTER OF TIRANA
Address: DIBRA Str., 370, TIRANA – ALBANIA
Tel. + 355-42-321-21
Tel/Fax: + 355-42-336-44

TIRANA, me 8.5.1995

PROJEKT RREGULLORE PER FUNKSIONIMIN E KOMISIONIT TE BLERJES SE BARNAVE NE GRUP.

Neni 1. Blerja e barnave dhe e materialeve te tjera mjekesore ne grup behet nga dy ose me shume spitale.

Neni 2. Per blerjen ne grup te barnave krijohet nje komision me perfaqesues farmaciste te te gjithe spitaleve pjesemarrese ne grup.

Neni 3. Ne komisionin e blerjeve marrin pjese detyrimisht dhe nje farmacist i Drejtorise se Farmacive prane Ministrise Shendetesise ,nje jurist dhe nje ekonomist.

Neni 4. Komisioni i blerjeve ne grupe mblidhet nje here ne muaj per te vendosur blerjet qe do te behen.

Neni 5. Komisioni i blerjes ka nje kryetar i cili organizon mbledhjen e tij.

Neni 6. Te gjithe anetaret e komisionit jane te barazvlefshem ne vendimet qe merren.

Neni 7. Komisioni i zhvillon mbledhjet e tij :

a) ne Farmacine Qendrore te Q.S.U.T. – se

b) ne Drejtorine e Farmacive prane Ministrise se Shendetesise.

Neni 8. Ne mbledhjet e komisionit caktohen barnat dhe materialet mjekesore qe do te blihen gjithmone,konform legjislacionit ne fuqi mbi barnat.

Neni 9. Kerkesat per ofertat publikohen ne shtypin periodik dhe ne rastin kur barnat jane regjistruar vetem nga nje firme atyre u behet kerkese direkte.

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Neni 10. Ofertat nga firmat e ndryshme paraqiten:

a) ne Drejtorine e Farmacive prane Ministrise Shendetesise

b) ne sekretarine e Farmacise Qendrore te Q.S.U.T.– se

c) ne farmacite e spitaleve pjesemarrese ne kete grup. Farmacisti anetar i komisionit te blerjeve ne grup i paraqet keto oferta ne mbledhjen e komisionit.

Ofertat duhet te jene te mbyllura dhe te regjistruara ne sekretarine e spitalit perkate

d) ne sekretarine e Farmacise Qendrore te Q.S.U.T. si dhe ne spitalet pjesemarrese ne kete grup.

Neni 11. Per te gjitha blerjet qe do te vendosi komisioni hartohet proces – verbal ne te cilin firmosin te gjithe anetaret e komisionit.

Neni 12. Per barnat qe blihen nga ky komision nuk mund te behen tendere te tjere ne spitalet qe bejne pjese ne kete grup.

Neni 13. Per cdo blerje qe vendos komisioni behet kontrata perkatese me firmen fituese.

Neni 14. Organizimi i shperndarjes se barnave te kerkuara behet nga firma kontraktuese ne cdo spital ne varesi te sasise se kerkuar nga ata.

Neni 15. Pagesa per barnat e porositura behet sipas sasive te kerkuara nga vete spitalet

QENDRA SPITALORE UNIVERSITARE TIRANE
Rr. DIBRËS, Nr. 370, TIRANE
Tel. + 355-42-321-21
Tel/Fax: + 355-42-336-44

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TIRANE, me 23.3.1995

MINISTRISË SË SHËNDETËSISË DHE TË RUAJTJES SË MJEDISIT.

DREJTORISË SË SPITALEVE

Edhe me viziten e dyte qe beri me Q.S.U.Tirane grupi i SPECIALISTAVE INTERNATIONAL i perbere nga Z.JIM JONESKI dhe TODD EBERT hodhen projekt - idenë per krijimin e komisionit te blerjes se barnave te perbashket per disa qytete te vendit tone. Kjo ide n'a u duk shume e drejte per realizimin e saj krijon disa probleme q mund te zgjidhen:

1. Duhet te lejohet te krijojme nje komision tjeter per blerjen e barnave gje qe legjislacionin ne fuqi cdo institucion ka vetem nje komision per blerjen e materia leve te ndryshme duke perfshire aty edhe barnat.

2. N.q.s. do te blihen barna ne vend problemi eshte i zgjidhur ,por n.q.s. duhet t blihen ato jashte vendit kjo do te jete e pamundur sepse do te kerkonte qe pagesa te behet me valute te huaj gje qe nuk e lejon mundesi.

3. N.q.s. keto dy probleme zgjidhen atehere si hap te pare Q.S.U.T. mund te filloj me blerjen e disa artikujve,p.sh :

CEPOLIN x 500 mg	50000	copa
BIPENICILIN x 600000 UI	30000	"
ULTRACOLTIN x 35 mg	35000	"

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QENDRA SPITALORE UNIVERSITARE TIRANË
Rr. DIBRËS Nr. 370, TIRANË
Tel. + 355-42-321-21
Tel/Fax: + 355-42-336-44

KENICETIN x 1 gr 30000 copë

Material qepës per kirurgjine

SYNACTHEN x 2 mg 1000 copë

CLAFORAN x 1 gr 5000 "

GLAZIDIM (Ceftazidim) x 1 gr 1000 copë

CALCIPARINE sub.cut. 5000 "

MEXIM FORTE tabl. 10000 copë.

ZYNACEF 5000 copë.

Shefi i Sherbimit Farmaceutik
te Q.S.U.T.
ILBER FORTUZI

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Schedule

[illegible] recommended [illegible]
10 [illegible] Kanamycin
[illegible] Oral [illegible]
[illegible] 6 months -

1. Benzathine 800,000 ui /# 50,000
2. Penicillin Kanamycin { N 1/2 15,000
   Sterile { N 8 20,000
3. Kanycetin 1 gm # 5,000
4. Ampicillin 1 gm # 10,000
5. Heparin 25 ui. x 5 ml. # 1000
6. Glucantin injection Amp 1000
7. Pot. gul. Plain sterile
   (0.25 ml) in Aqu. Dreamonice
   Number to administer
   N 1 2000
   N 2 2000
   N 3 2000
   N 0 1000
   N 1x0 1000
   N 2x0 1000
   N 3x0 1000
   N 4x0
8. Setta (Penicillin) Sterile
   Dose [illegible] in Hydr
   Number to administer
   N
   N 0 1000
   N 1x0 1000
   N 2x0 1000
   N 3x0 1000
   N 4x0 1000
   N 5x0 1000

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SPITALUL RASIN

Nr.	Medicamente	Sobia bjetare
1	Bipenicilline Streptozol	80,000
2	Ampicilline 1g flaka	40,000
3	Cefoxine 1g flaka	30,000
4	Tetracicline 1g flaka	50,000
5	Gentamicine 80mg	50,000
6	Novocaina 25mg	30,000
7	Analgine ampule	40,000
8	Penicilline G 1.000.000 U.I.	50,000
9	Streptomicine 1g	20,000
10	Set (Anestezie epidurala)	
11		

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13.4.95

FARMACIA E SPITALIT
DURRES

LISTA E BARNAVE QE DO BLEHEN NGA TENDER
TE PERBASHKET PE PERIUDHEN PRILL - QERSHOR
1995

Nr. RENDI	ARTIKULLI	NJESIA	SASIA
1	DOREZA KIRURGJIKALE Nr. 7,5, 8	ARKE	10.000
2	CAT-GUTE DHE FIJESINTETIKE Nr. 0, 1, 2	CUPE	15.000
3	SUL. GLUCOSE 5% 500"	FL	30.000
4	" Na-CHLORATI 9% 500"	"	30.000
5	ULTRACORTEN 25 mg	AMP	8000
6	SISTEME PERFUZIONI MONOUSO	CUPE	30.000
	SIRINGA 2", 5" " "	"	60.000
8	OXITOCINA 10 UI	AMP	2000
9	PAVULONE	"	1000
10	FIOPENTAL 500 mg	FL	1000

FARMACISTI
Nikol Pëllumbi

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Përdorimi i aftësive të kombinuara ekonomike në gjetjen dhe shprndarjen e produkteve farmaceutike

Hoteli internacional TIRANA Tiranë Shqipëri 30 Nëntor - 1 Dhjetor 1995.

Rendi i ditës i sesionit
Përdorimi i aftësive të kombinuarara ekonomike në gjetjen dhe shpërndarjën e produkteve farmaceutike

Hyrje
Rishikimi i rendit të ditës
Rishikim i problemit Vlera : kosto kundrejt cilësisë Sistemi aktual - Blerje nga një spital i vetëm i produkteve farmaceutike
Metoda e propozuar - Shumë spitale që punojnë së bashku.

Rendi i ditës (Vazhdim)

Përdorimi i aftësive të kombinuara ekonomike për gjetjen dhe shpërndarjen e produkteve farmaceutike

* **Shembulli aktual shqiptar - Ampicilina injeksion**
* **Shembulli i Shteteve të Bashkuara të Amerikës - Rrjeti amerikan**
* **Avantazhet e programit**
* **Strategjia e propozuar për blerjën e produkteve farmaceutike**
* **Kërkesë për rishikimin e propozimit**
* **Thirrje për veprim**

Përdorimi i aftësive ekonomike të kombinuara në gjetjen dhe shpërndarjën e produkteve farmaceutike

Qëllimi

*** Të paraqesim konceptin e blerjësme grup të produkteve farmaceutike,tek farmacistët e spitaleve dhe drejtuesit e farmacive kudo në Shqipëri. Të spjegojmë procesin dhe të demonstrojmë rezultatet e arritura.**

*** Thirrje për veprim.**

Vlera
Kostoja kundrejt cilësisë
Cilin produkt duhet të blini ?
Më të shtrenjtin apo më të lirin ?
Si e përcaktoni cilësinë ?
Kur bëhet çmimi përcaktues ?

Sistemi aktual
Blerje e produkteve farmaceutike nga një spital i veçantë

Porosia

Spitali shqiptar

Prodhuesi, shitësi me shumicë, (ndërmarrja e prodhimeve farmaceutike) ose të tjerë

Dërgimi

Pagesa

Përshkrim: Pranon porosinë për produktin,
Zgjedh produktin për blerje,
Porosit produktin,
Shpërndan produktin në spital,
Bën pagesën për produkt.

Metodë e propozuar
Shumë spitale që punojnë së bashku

Spitali (1) Prodhuesi, shitësi me shumicë ,
porosit prodhuesi farmaceutik, ose të tjerë.

dërgon

paguan

Spitali (2) Prodhuesi, shitësi me shumicë,
porosit prodhuesi farmaceutik, ose të tjerë.

Dërgon

paguan

Shumë spitale Prodhuesi, shitësi me shumicë,
prodhuesi farmaceutik, ose të tjerë.

Çmimi Çmimi
Volumi Kërkesa për propozim / oferta

Përshkrim: Shumë spitale marrin pjesë vetëm për ato produkte që janë të perdorshëm nga të gjithë ose nga shumica. Produktet unike për institucione të veçanta nuk janë të përfshira. Kjo duket qartë në ndryshimin e një spitali Universiteti nga një spital fshati.

Roli i grupit është që të bëj negociata pë çmimin, të zgjedh produktin, të shpërndajë informacionin dhe të mbajë kontrollin dhe mbrojë proçesin.

Blerja, shpërndarja dhe pagesa bëhet për çdo spital veçmas.
Grupi mund të bëj negociata për kushtet e shpërndarjes dhe të pagesës.

Marrëdhënia

Spitali

Spitali
Spitali
Spitali
Organizata e blerjës me grup
Merck (Prodhuesi, shitësime shumicë, prodhuesi farmaceutik, ose të tjerë.)

Blerje në grup
(Volume kombinimi blerjeje)

Prodhuesi

Shitësi me shumicë

Dërgimi
Kontraktim i çmimit

Grupi
Punimet me anën formale

Grupi

Berje e kontratës
Informacion
Komunikim
Kontaktim
Drejtim

Sigurimi i produktit Kontakt për përcaktimin e çmimit Dërgimi Spitali P~esëmarrësit e grupit Përkrahësit e kontratës/ përdoruesit e produktit Vazhdim i formaliteteve Zhvillim

Shembulli i tanishëm shqiptar
1 gram ampicilin injeksion (shifra të përafërta)

Spitali	Sasia vjetore
Qendra spitalore universitare	20 000 gram
Spitali i Durrësit	10 000 gram
Spitali i Elbasanit	10 000 gram
Spitali polmunar	12 000 gram

Shuma totale: 52 000 gram

Porosi e propozuar dhe koha e marrjës së produktit të kontraktuar
0----------/-------/-----/-------1 vit
Shembull: Një vit kontratë më pika bisedimesh për porosinë

Përshkrim:
* Sasia totale është më e madhe se ajo e çdo institucioni të veçantë.
* Të gjitha institucionet marrin pjesë në përcaktimin e çmimit për njësi.
* Çdo institucion porosit sasinë e nevojshme për çdo tre mujor (ben kontroll financiar dhe inventar)
* Në qoftë se grupi nuk është i kenaqur me kontratë një vjeçare minimumi do të kombinojë sasinë për një blerje të veçantë të ampicilines. Shumë më tepër do të kursehet nga e gjitha kjo. Sa më shumë zgjerohet zona e interesave të përbashkëta aq më mirë mund të punohet për një marrëveshje një vjeçare. Bëjeni këtë marrveshje t'i përshtatet kërkesave dhe interesave të grupi shqiptar blerës të produkteve farmaceutike.

Shëmbull i Shteteve të Bashkuara të Amerikës.
Korporata e rrjetit amerikan.

* Numri i spitaleve të Shteteve të Bashkuara të Amerikës: 5000 ose me shumë.
* Numri i spitaleve që i përkasin rrjetit amerikan të organizatës
së blerjës me grup: 1800

Një produkt shembull

Ampicilin 1 gram me çmim të pakontraktuar:	$ 6.00
Ampicilin 1 gram me çmim të kontraktuar:	$ 1.10

Përshkrim:

* Ky proces jep rezultat për shumë produkte
* Rrjeti amerikan kontrakton për më shumë se 8000 artikuj farmaceutike. Nuk po ju sugjerojmë që ju të filloni me një numër kaq të madh, sidoqoftë pas një periudhe prej 20 vjetësh ky proces do t'a këtë zgjëruar eksperiencën.

* Parashikoni probleme dhe sfida. Tregohuni të gatshëm për të komunikuar dhe diskutuar çështjet. Punoni me organizata që janë të besueshme dhe sigurojnë ato produkte që kanë premtuar.

Avantazhet e programit

* Ulje ose stabilizim i çmimit
* Rritje e kontrollit mbi procesin e lerjes
* Rritje e cilësisë së produktit (siç përcaktohet nga komisioni i grupit blerës)
* Zgjërim i kontrollit inventar
* Vazhdimësi e produktit
* Zgjërim i procesit të blerjës
* Zgjërim i drejtimit monetar

Strategjia e propozuar për Shqipërinë për blerjën e produkteve farmaceutike.

Fillim me sasi të vogla të produkteve farmaceutike
Ampicilin injksion
???Gentamicin ose kanamicin (zgjedhje që e bën grupi)
Fillohet më sasi të vogla për të siguruar sukses.
Shtoni numrin e spitaleve në mënyrë të ngadalshme
Sigurohuni që ata e kuptojnë procesin dhe detyrimet
Zgjidhni një komitet apo komision për ta kryer këtë proces
Parashikoni rezultate pozitive nga komisioni
Punoni me shitësit që keni aktualisht, bëjini të njohur atë që grupi është duke bërë dhe rezultatet e parashikuara për një biznes të suksesshëm
Punoni me problemet (probleme që do të dalin në sipërfaqe)

Dhjetor 15, 1994

Të dashur Shitës Farmaceutikë: Postuar të gjithë shitësve të aprovuar me "komision".

Gjatë pak muajve, spitalet e Durrësit. UHC dhe (shtoni lehtësira të tjera) kanë vlerësuar ngjashmëritë e shitjes me qëllim kombinimin e volumeve dhe vendosjen e kontratave për produktet me baza afatgjata. Ky proçes i ri i njohur si "Shitje në grup" parashikon shumë përfitime për pjesëmarrësit, të spitaleve dhe shitësve të suksesshëm. Spitalet do të jenë në gjëndje të kontrollojnë cilësinë e produkteve, pjesëve përbërëse, me pak lidhje ose oferta dhe çmim. Shitësit të suksesshëm do t'i zgjatet biznesi për një periudhë më të gjatë kohore e cila do te ndihmojë që ju të përdorni buxhetet tuaja në mënyrë më të efektshme.

Në të ardhmen e afert, ju do të merrni një Kërkesë për Projekt-ide (propozim), ky dokument përmban kriteret që ne do të përdorim. Gjatë proçesit të seleksionimit dhe në dhurimin e produkteve, shitësve, është jashtëzakonisht e rëndësishme që ju të lexoni këtë dokument me kujdes dhe tu përgjigjeni të ghitha pyetjeve. Pyetjet e papërgjigjura dhe informacioni jo i plotë mund të ngadalsojnë proçesin ose përfshirjen tuaj në të. Nëse keni ndonjë pyetje, ju lutemi të mos hezitoni të na kontaktoni...

Ju lutem shënoni personat e përshtatshëm për kontakt dhe numrat e tyre te telefonit/ fax-it.

Grupi shitës i farmacisë së spitalit Shqiptar është i angazhuar në rritjen dhe pasurimin e këtij proçesi. Ndërsa do të bihet dakord për produktet shtesë, ato do t'i shtohen programit tonë. Ata që marrin pjesë tani do të konsiderohen pjesëmarrrës të zedhshëm në të ardhmen.

Me sinqeritet,

Personi që do të kontaktojë

KERKESE PER PROPOZIM

Propozimet duhet të merren jo më vonë se 17:00 orë, 2 Shkurt 1995

Për informacionin e mësipërm kjo kërkesë kontakton: (plotëso në emër dhe medotë e kontaktit-telefonit # faksit# ose adresa e përsonit përgjegjës-udhëheqësi i grupit të komisionit të blerjes.

Ky dokument përmban një kërkesë për propozim, përfshi çmimet, që nga organizatat më të kualifikuara për të furnizuar me produkte siç janë përshkruar në fletët që janë bashkangjitur.

Spitali i Durrësit dhe Qëndra Shëndetsore Universitare, që tani e tutje njihen si "grup" për të siguruar produktet që kemi rënë dakord për 12 mujat, duke filluar nga 1 Prill 1995 deri në 31 Mars 1996.

Propozimet duhet të firmosen, postohen, dhe të merren nga grupi jo më vonë se 2 Shkurt 1995, 17:00 orë në:

(sigurohu për adresën e personit, emrin)

TERMAT E PERGJITHSHME DHE KUSHTET

1. Grupit i lejohet që të shtojë edhe spitale të tjera, për këtë marrëveshje blerjeje, duke rënë dakord edhe për çmimet. Grupi do tja sigurojë juve në një shënim të shkruar për çdo ndryshim që mund të ndodhi në listën e pjesmarrësve.

2. Propozimet duhet të mbahen, të qëndrojnë të qëndrueshëm deri në 15 Mars 1995 (24:00 orë) duke lejuar grupin të analizojë të dhënat dhe të testojë produktet e shqyrtuara/të paraqitura.

3. Në qoftë se njëri ose të gjithë propozimet pranohen, grupi do tju njoftojë juve deri në 15 Mars, 1994.

4. Duhet të merren parasysh dhe të shikohen edhe ligjet shqiptare, përsa i përket importit të medikamenteve. (N.q.s. do të dëshironi që të shtoni disa ilaçe të tjera në listë, këto dukuri të aprovohen nga Qëndra Kombëtare për kontrollin e ilaçeve, dhe Ministria e Shëndetësisë). Dokumentacioni duhet të shqyrtohet.

5. Proçedurat e urdhëruara: (porositë që bëhen), duhet të

specifikoni, kur dhe si, secili nga pjesmarrësit lehtëson në lidhje me vendet e urdhëruara. Urdhëresat mund të jepen për një vit nga spitali i caktuar dhe secili nga pjesmarrësit ka të drejtë të porositë për sa kohë që ai do. Specifikoni njëkohtësisht edhe për ndonjë minimum kërkese për urdhëresë (pagesë).

6. Ngarkesa: Malli duhet çuar direkt tek spitali që ka bërë porosinë. Çdo karton duhet që të jetë i shoqëruar me fletën përkatëse dhe faturën me kontratë aktuale, me çmimet e kohës së shpërndarjes. Specifikoni çmimet (pagesat) e ngarkesës.

7. Pagesa: Në kohën që produkti është porositur dhe ka arritur në vend, për tju bërë kontrolli doganor nga spitalet pjesmarrëse, me Bankën Kombëtare Shqiptare, dhe ato duhet që të mbahen aty deri sa të bëhet testimi i kampionëve nga Qëndra Kombëtare për kontrollin e ilaçeve. Në kohën që testi rezulton pozitiv (i mirë), atëherë do të urdhërohet Banka Kombëtare të transferojë paratë, për të bërë pagesën. Shkëmbimi i parave do të vendoset ditën e aprovimit të pagesës. Duhet të detajoni dhe kontrolloni, n.q.s. kjo është metoda e aprovuar.

8. E drejta për refuzimin e parë: Në qoftë se çmimet e tregut bien për një artikull të porositur, kompania ka shansin e para për të ulur çmimet në nivelin e ri të tregut. N.q.s. ky rast nuk zbatohet brenda 45 ditëve, grupi ka të drejtë që të riblejë produktet tek një tregtarë tjetër.

9. Sanksionet: Përfaqësuesi kuron mallin 10 ditë nga data e firmosjes së kontratës, lëvrimi i mallit shtyhet vetëm në rastet e shkaktuara nga arsye madhore, dhe objektet që nuk varen nga përfaqësuesi, ai ndalon veprimet bankare, konflikte rajonale etj. O.S.U.T. është e detyruar të lëvrojë pagesën me marrjen e mallit në dorëzim.

10. Të dy (gjithë) tregtarët rezervojnë të drejtën të përfundojnë marrëveshjen brenda 30 ditëve, me ose pa shkak për njoftimin e shkruar. Grupi ka të drejtë ta përfundojë këtë marrëveshje, n.q.s. tregtarët nuk janë në gjendje financiare për të përmbushur detyrimet e tyre, që parashtrohen nën marrëveshje.

11. Çdo parim tek çfarë është kërkuar më lart në këtë kërkesë për propozim do të konsiderohet si një ofertë të kundërt dhe ne mund të pranojmë ose të refuzojmë.

PARASHTRIMI I INFORMACIONIT

1. Të gjitha propozimet duhet të kenë çmimet për njësi, për shishe, ampulë, tabletë, kapsulë etj. në lekë shqiptar.

2. Të gjitha produktet duhet të përmbajnë gjërat e mëposhtme dhe të shënohen si: Përshkrimi i përgjithshëm, markën e fabrikës (po qe e mundur) fortësinë/ml ose ampulë/shishe/ volumi total (n.q.s. është i caktuar).

Çdo shishe ose ampulë individuale duhet gjithashtu që të ketë një identifikim/sasia/numrin e kontrollit dhe datën e skadencës, e cila duhet të duket qartë në shishe dhe në ampulë

3. Përsa i përket kthimit të kërkesës për propozim, kompania juaj duhet të sigurojë 100 shishe/ampula për produkt, për testim.

INFORMACIONI I KONTRATES:

1. Grupi rezervon të drejtën për të pranuar ose kundërshtuar ndonjë propozim, një pjesë të propozimit, ose në tërësi. N.q.s. propozimi i tregtarit pranohet, tregtari duhet të përmbushë detyrimet për të gjitha produktet që janë parashikuar në kontratë, në lidhje me kohëzgjatjen e lëvrimit të mallit.

2. Në bazë të çmimit, grupi do të njoftojë tregtarin për produktet e dhëna. Grupi gjithashtu, do tju sigurojë juve në këtë dokument kthimi të firmosur, identifikimin e produkteve dhe kushtet e pranuara.

3. Grupi gjithashtu do të caktojë spitalet pjesmarrëse për dhënjen e produkteve dhe çmimet tregtarët.

PRANIMI NGA SHITESIT

SHITESI BIE DAKORD PER TERMAT ÇESHTJET E KERKESES PER PROPOZIM

TREGTARI _____
(emri i kompanisë)

NGA _____
firma e personit të autorizuar

DATA _____

PRANUAR NGA GRUPI:

EMRI: _____
personi i autorizuar me emër të grupit

_____
emri i printuar

TITULLI/POZICIONI _____

DATA _____

PRODUKTET E OFRUARA PER PROPOZIM

(Ky dokument mund të përdoret për të siguruar çmimin e kontratës së propozuar)

EMRI I PRODHIMIT/ILACIT DHE PERSHKRIMI SASIA/VITI ÇMIMI/NJESIA

Gentamicina	80 mg/	105,000
Ampicilina	1 gm.vial	112,000
Kloranfenikol	1 gm.vial	90,000
Fentanyl	10 ml.ampulë	11,000
Kanamicin	1 gm.vial	4,000
Penicilin 1 milion	G. Kristalinë units/vial	60,000
Penicilin B 800,000	units/vial	100,000
Kefaloridine	500 mg,vial	104,000
Keftazidime	1 gm.vial	5,000
Kefotaksime	1 gm.vial	8,000
Amikacin	1 gm.vial	5,200

Ju lutemi ktheni këtë dokument të plotë si drejtohet tek:

Komisioni duhet të perfundojë

Komisicni duhet të zgjedhë produktet

HEI

1. 8 Nëntor 1994: Todd do të shkruajë një letër
(Ajo që ju shpjeqoi Toddi gjatë vizites së tij në TIRANE)

2. 21 Nëntor 1994: Të finalizojnë spitalet pjesëmarrëse në grup.

Përgjejgjës: Grupi Farmeceutik Shqiptar

3. 21 Nëntor 1994:

Organizimi i Komisionit të Blerjes
Emërtimi i Organizatës.

Përfundoni listen e medikamenteve. Një liste e madhe do të bënte jashtëzakonisht të vështirë për t'ia dalë që në përpjekjen e parë. Përcaktoni Kompanitë që do të marrin KPP (kërkesë për propozim). Kërkohen adresa dhe numri i telefon/
faks.

Përcaktoni termat dhe kushtet.

Përgjejgjësia: Grupi Farmaceutik Shqiptar

4. 1 Dhjetor 1994: Faks për Todd Ebert nëpërmjet Jim Janeski për përfundimin e KPP në Anglisht për tu rishikuar e komentuar.

Përgjegjësia: Grupi Farmaceutik Shqiptar

5. 5 Dhjetor 1994: Kthimi i faksit nga Jim Janeski versioni i fundit.

Pergjejgjesia: Todd Ebert

6. 6-14 Dhjetor 1994: Pergatitja e dokumentit perfundimtar ne Shqip e Anglisht.

Pergjejgjesia: Grupi Farmaceutik Shqiptar dhe Perkthyesi.

7. 15 Dhjetor 1994: Postoni ose dërgoni KPP të tregtarit e miratuar. Sugjeroni që materiali t'u dërgohet atyre në Shqip e Anglisht si dhe Kompanive (joshqiptare) të huaja.

   Përgjejgjësia: Grupi Farmaceutik Shqiptar.

8. 16 Dhjetor 1994 - 2 Shkurt 1995 : Përgjigje për ndonjë pyetje që mund të lindë gjatë këtij procesi.

   Përgjejgjësia: Grupi Farmaceutik Shqiptar.

   Sipas një promemerje të datës 14 Janar 1995.

   Përgjegjësia: Grupi Farmaceutik Shqiptar do të shkruaj Todd Ebert.

9. 5,6,dhe 7 shkurt 1995: Mbledhja e përurimit pas. Mundësisht të dhënat përgatitore më 5 dhe 6 bashkë më ato të datës 7. Përgatitni njoftimet e tregtarëve.

   Përgjejgjësia: Grupi Farmaceutik Shqiptar dhe Todd Ebert.

10. Seminar demonstrimi më 8 ose 9 Shkurt (nëse janë të pevojshme 2 ditë) për të gjitha spitalet.

    Përgjejgjësia: Todd Ebert dhe pjesëmarrësit e Grupit Farmaceutik Shqiptar.

11. 1 Prill 1995: Kontratat bëhen efektive.

    Përgjejgjësia: Grupi Farmaceutik Shqiptar.

Sugjerime për komponentet e kërkesës për propozim
(sugjerimet mund të jenë në çdo lloj rendi)

Paragraf hyrës dhe instruksione të përgjithshme për kërkesën për propozim.

1. Afati përfundimtar në të cilin duhet kthyer propozimi i firmosur. Citim i firmës së hedhur për periudhën në fjalë. Ku duhet kthyer kërkesa për propozim.
2. Produktet të cilat do të kontraktohen dhe volumet që parashikoni në se është e mundshme.
Propozimet duhet të kenë çmim për çdo produkt.
Asnjë produkt zëvendësues nuk lejohet pa pasur kontratë të shkruar të grupit.
Përshkruani mënyren se si do të paketohet produkti dhe mënyrën se si do të dërgohet.
3. Lista e institucioneve dhe spitaleve që do të marrin pjesë. Institucionet dhe spitalet shtesë që mund të shtohen në marrëveshje me shitësin.
4. Kohëzgjatja e marrëveshjës (mund të jetë 3 muaj deri në 6 muaj për periudhën fillestare, ose 12 muaj maksimumi).Eshtë mirë të fillohet më ngadalë deri sa të arrihet momenti i duhur. Një
periudhë kontraktuese minimale mund të lejojë shitësin të
demonstrojë aftesitë për shpërndarje.Kontratat mund të
zgjaten në varësi të eksperiencës.

Vërejtje: Mundohuni të mirëmbani çdo kontratë brenda kohës së përcaktuar(brenda afatit përfundimtar) në këtë mënyrë do të jetë shumë më e lehtë për ta realizuar kontratën.

5. Përdorimi i aftësive ekonomike të kombinuara në gjetjen dhe shpërndarjen e produkteve farmaceutike.

6. Pajisja. Prodhuesi duhet të bierë dakord të sigurojë inventar të mjaftueshëm të produkteve të kontraktuara në mënyrë që të plotesojë kërkesat e konsumatorit. Pajisjet e garantuara dhe çmimet. Në qoftë se prodhuesi i kontraktuar nuk mund të sigurojë produktet dhe institucionet duhet të blejnë prodhimet në vende të tjera, prodhuesi me të cilin keni kontraktuar duhet t'i paguajë institucionit diferencën midis çmimit të blerjes dhe çmimit të kontraktuar.Institucioni duhet t'i paraqesë dokumentacion prodhuesit (nje kopje të faturës së porosisë së anulluar nga prodhuesi i kontraktuar dhe një kopje të faturës me çmim dhe sasi të produktit identik të porositur) Kohë e mjaftueshme i duhet lënë për verifikim të dokumentave dhe për pagesën.

Vërejtje : Në këtë situatë, në qoftë se prodhuesit nuk mund të sigurojë produktin e kërkuar për arsye që nuk janë për faj të tyre,prodhuesi nuk është i detyruar të paguajë. Këto raste do

të përfshinin rastet e luftës, dhunës, tërmete ose situata të tjera që janë jashtë kontrollit të tyre.
7. Shpërndarja. Direkte ose shitje me shumicë .
Bihet dakort menjëherë me t'u marrë në dorëzim.
Shitësi duhet të pajisë me faturë ose etiketë mbi pakëtim çmimin aktual në kohën e dorëzimit të produktit.

8. Porositja. Ku dhe kur një porosi mund të bëhet.

9. Politika që ndiqet për mallrat e kthyera.

10. Traktati i daljes nga kontrata. Tridhjetë ditë më paralajmërim me shkrim. (Mund të përfundohet brenda 24 orësh në qoftë se shitësi nuk është i aftë të ndjekë detyrimet e tij financiare sipas marrëveshjes.

11. Personi i kontraktuar për pyetje (për të dyja organizatat).

12. Rezervimi i të drejtës për të kundërshtuar disa ose të gjitha propozimet.

15. Shitësi do të ndjekë të gjitha rregullat që aplikohen në të tilla raste.

16. Traktati i zhdëmtimit për përdorimin a rregullt të produktit nga institucioni.

17. E drejta për të kundërshtuar për herë të parë. Në qoftë se çmimi në treg ulet, shitësi ka të drejtë që të ulë çmimin në mënyrë që të ketë të njejtin çmim si në treg. Në qoftë se çmimi nuk është i pranueshem, grupi ka të drejtë që të zgjedhë një produkt tjetër mbi baza të njejta ose dyfishë.

18. Shpërndarja e informacionit.

19. Ruajtja e sekretit.

20. Përdorim i brendshëm, produkt jo për shitje.

21. Informacion tjetër.