



ZdravReform
ЗдравРеформ

TRIP REPORT NO. CAR/KYR-15

**HEALTH FACILITY LICENSING AND ACCREDITATION
AND UPDATE ON FAMILY GROUP PRACTICES AND THE
MANDATORY HEALTH INSURANCE FUND
IN ISSYK-KUL OBLAST**

**Karakol, Kyrgyzstan
January 22–February 16, 1996**

Prepared under Task Order 227 by:
George P. Purvis, III

Submitted by the *ZdravReform* Program to:
AID/ENI/HR/HP

AID Contract No. CCN-0004-C-00-4023-00
Managed by Abt Associates Inc.
with offices in: Bethesda, Maryland, U.S.A.
Moscow, Russia; Almaty, Kazakhstan; Kiev, Ukraine

EXECUTIVE SUMMARY

The health system of the Issyk-kul Oblast Intensive Demonstration Site (IDS) is in the process of undergoing a major transition from the traditional Soviet model, dominated by medical specialists, to a primary care oriented family medicine delivery system. A Mandatory Health Insurance Fund (MHIF), with a capitated rate to cover the family practitioner population, and a per case payment system for hospitals is being established. The present system is built heavily on a number of specialty hospitals, polyclinics, and dispensaries. This rapidly changing system is in need of an effective and efficient process of licensing and accreditation (L&A) of health facilities. The major objective of the visit was to assist with the further development and refinement of the *Licensing and Accreditation Manual for Hospitals* (developed by ZRP/Kyrgyzstan Ministry of Health), and to develop an implementation process of licensing and accreditation which is relevant to the needs and capabilities of the Oblast Health Department (OHD) in the Intensive Demonstration Site (IDS).

The other objectives of this third consulting trip to the Karakol IDS were to continue to assist with the design and development of an information, accounting, and financial system that would meet the needs of both the newly formed family group practices (FGPs), provide information to the MHIF, and form a baseline for evaluation of this aspect of the program. A further objective was to continue development of both the case-based inpatient payment system and the fundholding system for the family group physicians.

The results of these consulting activities were as follows:

- The modification and refinement of the *Licensing and Accreditation Manual for Hospitals* and the development and initial implementation of a process to license and accredit all hospitals in the IDS over the next year.
- The refinement of the implementation of the medical information system (MIS) for FGP's utilizing a physician's charge/data sheet designed to capture data (office visit, home visits, hospital visits, CPT-4 coded procedures, referrals to specialists and hospitals, and ICD-9 diagnosis codes) is working effectively.
- Additional progress was made on designing and developing the MHIF Organizational Structure and Fundholding System, with coordination of control and authority of the MHIF with the Oblast Health Department (OHD).
- Assistance in the area of organizational development was provided to the Almaty City Mandatory Health Insurance Fund (ACMHIF).

BACKGROUND

This trip report is a review of the work that occurred January 22–February 22, 1996. The major focus of the trip is the continuing design, development, and implementation of a manual and a process for licensing and accreditation of hospitals in the Issyk-kul Oblast Intensive Demonstration Site, Kyrgyzstan. A number of previous reports on the overall developmental needs of the licensing and accreditation process were completed during 1994–1995, and are listed in the bibliography of this report. The major objective for this consultant was to continue the institutionalization process of licensing and accreditation for health facilities. In addition, continuing efforts were to be made to develop the Mandatory Health Insurance payment regulations for the new hospital payment system. A further initial objective was to work with the various counterparts at the regional office and at the health department to develop action plans for implementation of both the new payment system and the licensing and accreditation process. The definitive objectives and scope of work (SOW) for this consultancy are listed below, and also appear in Annex B.

OBJECTIVES

The SOW, major objectives, tasks, and outputs for this consultant were as follows:

- Review and revise the *Licensing and Accreditation Manual for Hospitals*.
- Develop an action plan for implementation of licensing and accreditation and initiate start-up process for implementation.
- Continue to refine and improve the financial systems and MIS for the family group practices.
- Work with counterparts to prepare for implementation of the new hospital payment system by April 1, 1996.

FINDINGS AND RECOMMENDATIONS

Health Facility Licensing and Accreditation

1. Background

The development and implementation of a *Licensing and Accreditation Manual for Hospitals* and a national implementation process has been one of the priorities of ZRP since the beginning of the project. The implementation of this process in the Issyk-kul Oblast IDS was a secondary objective, but was of major importance due to the number of related activities being implemented (rationalization, capitation, per case payment, and primary care development).

Significant effort has gone into the development of this program, and Abt with the assistance of the Joint Commission on Accreditation of Health Care Organizations (JCAHO), has conducted a number of studies and workshops in Bishkek and Karakol during 1995. The result of this effort is a

Licensing and Accreditation Manual for Hospitals (published separately). This manual was modeled after the JCAHO manual which was developed in the United States and other countries over a period of 40 years with participation of more than 5,000 hospitals, and covers all of the various departments and areas of hospital accreditation standards. This model was then modified by the *ZdravReform* Program to meet the general needs of licensing and accreditation (L&A) in Kyrgyzstan.

“Licensing” of health facilities is normally a federal or state regulatory process and is usually carried out by the state. It involves documenting the minimum resources and “capacity” of a facility to perform certain functions and provide certain health care services to the general public. The result is usually certification that the facility has a specific type and number of inpatient beds, specific types of services and quantities of equipment, instruments, and staff—all of which can be provided to the public in a generally “safe” environment. If a facility cannot meet the licensing requirements, the institution is normally requested to close its doors, although this seldom happens. The cost of performing the licensing function is usually funded by the state.

“Accreditation” of hospitals is normally the result of an insurance process and is carried out to ensure insurance payers that facilities are able to perform specific functions in a manner consistent with providing insured patients high quality of care in a safe environment. Accreditation is normally carried out by an independent body, not the state or the ministry of health. The result is the award of an accreditation certificate, if the facility meets the minimum standards, or a partial accreditation or no accreditation with some specified time frame to rectify deficiencies. If the institution can not meet accreditation standards it usually means that they will no longer receive insurance reimbursement from the payer. The cost of performing the accreditation function is usually funded by the facilities themselves through the charging of an accreditation fee.

In the United States and many other countries, the *licensing* function normally takes no longer than one day to carry out often by a single inspector. The *accreditation* function normally takes weeks of preparation, includes a facility survey of at least three days by three-person surveyor team, and results in a significant amount of follow-up activity to immediately rectify any deficiencies and to ensure retention of accreditation status for the facility. The loss of accreditation usually results in financial inviability for the institution.

2. Needs, Requirements, and Capabilities

The Karakol IDS is undergoing a major shift from the old Soviet system, where there are too many hospitals, a surplus of physicians, an unusually high rate of referrals to specialists, and a general lack of effective, efficient, and efficacious primary medical care. The ZRP Program is attempting to implement a Mandatory Health Insurance Fund with a new hospital case payment system in conjunction with a capitation program for primary care. Many new family group practices have been set up and are operating. The Oblast Health Department has begun the process of rationalizing facilities and services in order to develop a more cost-effective delivery system. Within this environment there is a great deal of change, and all parties are extremely busy trying to

get these new systems in place and working effectively. *The issue of adding a new licensing and accreditation process to an already too busy OHD is an item of major concern to project management.*

Due to the nature of the Program and the IDS, a simple, effective, and efficient process is needed for both licensing and accreditation. The present process, as outlined in the existing *Licensing and Accreditation Manual for Hospitals*, is too complex and too sophisticated for the needs of the OHD. The manual is an excellent document and will be the future model for the OHD. However, modifications are needed to make the manual more country- and facility-specific. *The recommendations that follow were developed to meet these local needs and are more in line with the present capabilities of the OHD.*

In Kyrgyzstan, “hospital” essentially means only “inpatient” care and does not include outpatient care, which is normally performed in polyclinics. Hospitals in Kyrgyzstan do not have organized emergency care departments. Emergency care is performed by a separate emergency care service (ambulance-based), which is also not part of the hospital. Hospitals in Kyrgyzstan do not have organized environmental health departments in the hospital. This function is performed by the Sanitation, Epidemiology and Environmental Service (SES), which is a completely separate organization of the Ministry of Health (MOH). Maternal and child health is not an organized department in most hospitals (the Western concept of a general hospital does not exist). Specialty hospitals provide the majority of maternity and pediatric care. There are a number of other country variations. Hospitals do not have organized nursing departments or boards of directors. Hospitals have not yet initiated a number of patient rights’ activities, and the finance functions are primarily accounting or bookkeeping activities. Although some of these are being considered for future development and implementation, they are not yet ready to be included as part of a licensing and accreditation process. *All of these factors, as stated above, plus a number of other country operating and organizational differences had to be taken into account during this assignment.*

The task was to take the licensing and accreditation material and make it even more *country- and facility-specific*, to work out any “bugs” in the manual, and to “field test” the manual and the proposed process of licensing and accreditation in the Karakol IDS and surrounding areas. This required reviewing the manual “line by line” with local technical personnel, deleting areas and standards which do not readily apply and can not be attained in a reasonable length of time, rewriting and developing new standards as required, and then testing out the manual and process in a few hospitals to ensure that it could work effectively in the present environment of scarce resources and other higher IDS project priorities.

All of this does not mean that the existing manual is not effective, but rather that it is presently too advanced and too sophisticated to begin the process of licensing and accreditation within the IDS. As previously noted, the manual is excellent, but represents a state of development which took forty years to reach in the United States. It will continue to be the model and reference work which the OHD will utilize in refining and improving their process over the coming decade. The original

manual will be available in both Russian and English version for reference by the OHD, and are published separately.

At the present time, neither the Issyk-kul Oblast Health Department, nor the Ministry of Health of Kyrgyzstan, have a formal process of licensing or accreditation. Hospitals in Kyrgyzstan belong to a variety of administrative entities (municipal, rayon, oblast, and federal). This produces numerous problems in managing health care services and facilities. However, as all hospitals are public, it is generally assumed that all hospitals are functioning adequately and that no formal L&A mechanism is required. While this was acceptable in the prior environment of essentially “free” health care services for all, it is no longer acceptable in an “insurance fund” environment, which raise major concerns about cost effectiveness and quality of care at specific institutions. This L&A process will be invaluable in assisting the MHIF and the OHD in selecting and improving institutions for specific types of services. It may also assist the OHD in the process of rationalizing (closing, merging) health facilities in an environment of critically scarce resources in the health sector. Although numerous attempts were made to conduct a preliminary inspection with the project personnel this proved impossible due to other events.

3. Recommendations

a. *The Licensing and Accreditation Manual for Hospitals*

The recommendations which follow are related primarily to the materials and processes in the *Licensing and Accreditation Manual for Hospitals, Ministry of Health, Kyrgyz Republic*:

- The Introduction was shortened and consolidated.
- The definitions, guiding principles, and general descriptions were left as presented, except all references to the deficiencies of Medical Economic Standards (MES) were deleted.
- The flowchart of operations was left as presented.
- The time frames for accreditation and the awards for accreditation, as well as the Accreditation Commission were deleted.
- The Accreditation Process was modified to reduce and delete those sections which not longer apply and are for future development.
- The Purpose and Philosophy were left as presented.
- The sponsorship and organization, board of directors, funding mechanism, staffing, and scoring were deleted or modified.
- The Hospital Licensing Standards were modified and expanded (see Exhibit 2).
- The Licensing and Accreditation Function were left as two separate functions, but were combined into one process with only one visit to a facility to carry out both functions at the same time, by one administrative body—the OHD.
- The length of the visit to the facilities was shortened from 5-7 days to 1-3 days.
- Specific sections (finance and economic management) were deleted from the modified manual, but will remain as a goal for future use.

- Specific sections that are *not* hospital departments in Kyrgyzstan (emergency care, public health, epidemiology and environmental control, outpatient care, maternal and child health) were moved to the Appendix section to be used for future development and implementation.
- Specific sections (patient rights and hospital development) were modified and moved to Annex section to be added in the future.
- All sections were modified to delete items not applicable (e.g., no formal nursing department now exists in the hospitals, no hospital has a board of directors), and all sections were modified to eliminate specific tests, services, or equipment which do not exist in Kyrgyzstan.
- The Table of Contents was modified to reflect the above changes (see Exhibit 1)

Due to the volume of these changes and the fact that these modifications are still being made to both the English and Russian versions of the text, these changes do not appear in this report.

b. The Hospital Licensing Standards

The revised list of Hospital Licensing Standards appears in Exhibit 2 at the end of this report. It was revised and modified with input from the technical personnel in the project and personnel from the OHD. As previously highlighted in the Background section of this report, Licensing and Accreditation are very different functions, usually carried out by different groups. For purposes of the Issyk-kul Oblast IDS, it is recommended that these two functions be carried out together by one group: the OHD. Although the two functions have been separated, and the two have different standards, it is recommended that they be carried out at the same time during the same visit to a facility. The reasons for this are primarily financial and operational. At this time a separate “Licensing” group and a separate “Accreditation Committee” as outlined in the reference manual are not possible due to other priorities and a lack of funding.

The major changes to the originally proposed list of licensing standards, as developed by the ZdravReform Program with the assistance of the JCAHO, are as follows:

- A change in emphasis from “hospitals not meeting these standards **must** be closed” to “hospitals not meeting these standards **should** be closed, **or steps taken to immediately rectify these deficiencies**”.
- The addition of further delineation of the standard on “potable” drinking water, to include compliance if the facility “boils” the drinking water before use.
- The addition of electricity, lighting, heat, and pharmaceuticals to the list of standards.
- The addition of sterilization of instruments, materials and supplies, as well as inspection of laundry services to the standards.
- A further delineation of the standard on SNIP codes (state code of public health, environmental, epidemiological norms and regulations) to allow compliance when financial constraints are a problem.
- The number of standards was increased from 11 to 15 and a validation section outlining what information should be requested was added.

As highlighted in a later section of this report, the OHD personnel have great difficulty distinguishing the difference between licensing and accreditation. This was a big difficulty during the two L&A seminars in Bishkek (July '96) and Karakol (October '96). This consultant also found this to be true during his discussions with OHD personnel in Karakol. Consequently, as highlighted later in this report, some consideration should be given to possibly combining these two processes into one process for the immediate future, with a long term goal of separating the two at some future date.

c. The Hospital Accreditation Standards

Outlined below are the major changes to the Hospital Accreditation Standards as outlined in the *Licensing and Accreditation Manual for Hospitals, Ministry of Health, Kyrgyz Republic*. It is impossible to list all of the changes as there are literally hundreds of standards and a review of the Revised Manual against the Model Manual is necessary to note all of the changes. However, listed below are the major refinements, deletions, and additions. Also listed are the changes in process, procedure, organization, implementation, and a schedule and workplan for the next twelve months:

- Refer to the Table of Contents (Exhibit 1) to note the rearrangement of various sections, as well as the addition of an Appendix which contains the sections which do **not** pertain (at present) to the operation of hospitals in Kyrgyzstan.
- As previously noted: In Kyrgyzstan “hospital” essentially means only “inpatient” care and does **not** include outpatient care, which is normally done in Polyclinics and other ambulatory settings. Consequently, the outpatient standards were moved to an Appendix, to be implemented at a later date.
- Hospitals in Kyrgyzstan do not have organized emergency care departments. This function is performed by a separate emergency care service (ambulance-based) and again is not part of the hospital. Consequently, the emergency care standards were moved to an Appendix to the existing Manual to be implemented at a later date.
- Hospitals in Kyrgyzstan do not have organized environmental health departments. This function is performed by a separate sanitation, epidemiology and environmental service (SES) that is a totally separate organization of the MOH and not the OHD. While some of these activities are done in hospitals, they are done by a separate organizational group of the OHD, and are being considered for review and inclusion possibly during the next year.
- Maternal and child health is not an organized department in hospitals, as the western concept of a general hospital does not exist, and these functions and activities are operated as specialty hospitals who do the majority of the care for maternity and pediatrics. Consequently, these were moved to an Appendix section.
- There are a number of other variations, e.g., hospitals do not have an organized nursing department, do not have a board of directors for the hospital, have not as yet initiated a number of patient rights activities, and the finance function is primarily an accounting or bookkeeping activity. Although some of these are being considered for future development and implementation, they are not as yet ready to be included as part of a licensing and accreditation process.

- A number of other operating and organizational differences in the methods of running hospitals in Kyrgyzstan were taken into account and either added to the standards or deleted from the manual.

d. Revision of the Number of Standards

The number of standards was decreased from a total of 528 individual standards (as developed by ZdravReform Program, MOH/Kyrgyzstan, and with assistance of the JCAHO) to approximately 307 individual standards (a 40 percent reduction) in the newly revised edition of the Manual for the IDS. The breakdown by area/department is as follows:

As previously mentioned, the finance and economics section was deleted completely, and the other nonrelevant sections moved to the Appendixes of the Manual for future development. The only exception is the maternal and child health (pediatrics), which are specialty hospitals and have also been put into the Appendix of the Manual, but just as easily could fit in the general section.

e. The “How To” Procedure of Licensing and Accreditation

The revised manual for L&A (2/1/96) contains a “How To” procedure (see Exhibit 3), which outlines the process and procedure for conducting the audit of hospitals in the IDS. The process has three phases: 1) a pre-audit questionnaire sent or delivered to the hospital 2 to 4 weeks before the audit; 2) the audit itself, which can take from 1 to 3 days to complete depending on the size and type of hospital; 3) the post audit report sent or delivered to the hospital after the audit. Exhibit 3 contains all of the needed information.

NUMBER OF ACCREDITATION STANDARDS

<u>SECTION TITLE:</u>	<u>ORIGINAL MANUAL:</u>	<u>REVISED MANUAL:</u>
MANAGEMENT	57 Standards	21 Standards
STAFF POLICY	69	45
IN-PATIENT	62	62
SURGERY/ANESTHESIA	33	28
PARACLINICAL	38	32
MIS/STATISTICAL	24	15
PLANT/FACILITY	19	16
<hr/>		
MATERNAL/CHILD HEALTH	89	86 (APPENDIX)
PATIENT RIGHTS	10	13 (APPENDIX)
EMERGENCY CARE	22	22 (APPENDIX)
OUT-PATIENT	24	22 (APPENDIX)

PUBLIC HEALTH/S.E.S	30	30 (APPENDIX)
FINANCE/ECONOMICS	51	0 (DELETED)
TOTALS:	528 Standards	307 Standards

f. Work Plan and Schedule for Implementation

Outlined below is a generalized workplan and schedule for the implementation of the Licensing and Accreditation in the Issyk-kul Oblast IDS. The total implementation will take approximately 8 to 10 months from the approval and initiation of the project. The various steps in the plan, with approximate time frames for completion are as follows:

Work Plan and Schedule for Implementation

<u>Item/Activity</u>	<u>Approximate Time Frame</u>
1. Secure agreement and approval from OHD and MOH;	one month
2. Identify and Interview candidates for 4-5 Inspector positions;	one month
3. Train Inspectors and review/refine standards;	one month
4. Conduct two workshops/seminars (2 days) for Hospital Chiefs and Deputy Chiefs to review process and standards: 1-workshop for Karakol IDS hospital physicians 1-workshop for Oblast hospital physicians	one month
5. Initiate Licensing Process: (2 inspection teams) -Twenty Hospitals in Karakol IDS at 4-6 per week -Twenty Hospitals in Oblast at 4-6 per week	one month one month
6. Initiate Accreditation Process: (2 inspection teams) -Twenty Hospitals in Karakol IDS at 2-3 per week -Twenty Hospitals in Oblast at 2-3 per week	two months two months
7. Alternative or Option to 5. and 6: Carry out licensing and accreditation process at the same time with only one visit to each facility	(2-3 months less)
8. Full Implementation:	Total time frame: 8-10 months

g. Selection and Training of OHD/MOH Personnel as Licensing/Accreditation Inspectors

The selection and training of the “inspectors”(the American term is “surveyors,” but this does not translate into Russian), is a critical activity of the total L&A process. It will be important to attract and train the best possible personnel. A critical determinant should be a positive, helpful, educational attitude of the inspectors. While technical skills are important, the individual personality or educational attitude is more important. The process is not meant to be punitive, and selecting personnel who can work with this positive, helping, improving attitude is most important.

After selection and reassignment of the personnel (it is assumed that they will be existing OHD personnel), a training course will be necessary. While this need not be too sophisticated, it should be based on the materials in the L&A manual. This could be done by local *ZdravReform* Program employees, possibly with some input from Almaty or, if necessary, some short-term consulting assistance. The training should consist primarily of reviewing and refining the existing standards to ensure that they will fit the local situation. A thorough understanding of the intent of the standards, as well as the meaning of the standards is critical. The second critical item is the verification document necessary to meet the standards. In each case a written document should be the basis for verification that the standards are being applied. The JCAHO has a long standing belief that if something is written down it is more likely to be applied than if it is just verbal communication. While writing it down is not enough, as it must be communicated to all staff and applied, and reviewed periodically, the fact that it is written is the basis for verification that the standards are being used. The training of inspectors should include a thorough understanding and development of a list of the key documents to be reviewed.

Another critical element of the training process is teaching the inspectors how to score the compliance of the standard (full compliance, partial compliance, no compliance, or in some cases not applicable). Some specific guidelines on this distinction will have to be developed by the inspection group. The development of a final total scoring system will have to be devised, and although the manual has some guidelines, this should best be left to local development.

The development of a deficiency list or worksheet will also have to be developed, and is best left to local development. This is the sheet which is sent back to the facility at the end of the inspection, outlining those areas which were deficient or partially deficient. A few examples are as follows:

- “A review of 50 medical records shows that physicians are not recording a discharge diagnosis in 38 percent of the medical records reviewed.”
- “A review of 25 personnel records shows that performance evaluations are not being completed on 23 percent of the personnel in the radiology department”.
- “A review of the Mortality Journal shows that in 31 percent of the cases of death in the hospital, an autopsy was not completed.”
- “A review of the management and organizational structure of the surgery department shows that the organizational chart has not been reviewed and updated for three years”

After the inspectors become familiar with the existing standards, some attempt should be made to continue to update and add new standards from the reference manual. This will be especially important with respect to nursing, which in all probability will be given new emphasis and the formation of a formal nursing department will become a priority in the near future. As this occurs, the inspectors can pull out the standards from the reference manual for this area and modify these to their own needs.

As previous highlighted, the OHD/MOH personnel have difficulty distinguishing between licensing and accreditation as two separate functions. Considering that there are only 15 licensing standards and over 300 accreditation standards, it may be advantageous to combine these two distinctly (Western view) different functions into one function for ease of implementation. A future goal of separating these two functions at some later date could be explicitly stated and understood by all parties. The combining of these two areas may make the L&A process less difficult to implement at the present time.

h. Future Considerations - Expansion to Other Health Facilities

The existing revised manual is only for hospitals, and has been designed and modified to apply to the definition of hospitals in Kyrgyzstan, which as previously noted means inpatient care. The Appendix section of the revised manual contains separate sections on outpatient, public health and sanitation, emergency care, patients rights, and maternal and child health. Again, as previously noted, these activities are not usually done in hospitals (with the exception of maternal and child Health) which are done in specialty hospitals of the oblast. These sections could be further developed and refined as the L&A process becomes fully implemented.

It would not be difficult to transfer hospital standards to polyclinics, emergency services, and public health/sanitation services. As most of these standards exist they could be brought into the L&A process without much difficulty. Once these areas are under the L&A umbrella, further steps would be to bring in the SVA, feldsher units (FOB's), and any other health facilities also should not prove to be too difficult. With a degree of determination and some additional resources all of the health facilities in Kyrgyzstan could be brought under the L&A process within three to five years from initiation of L&A for hospitals.

The political will and the resources to complete this task is, of course, another matter outside the scope of this report. Considering the large number of changes that are presently in process at both the Issyk-kul Oblast and national levels, the implementation of a L&A process may be a low priority. However, the materials and processes are available if and when the decision is made to move ahead.

B. Family Group Practice (FGP) Update and Future Activities and Workplans

Considerable activity and success has been made in getting the Family Group Practices (FGP's) up and operating in their new environment. Funds have been secured for renovations and equipment and locations have been established and many FGP's are working effectively. Marketing plans and programs are underway and a target date to enroll the entire population in Karakol has been established. Enrollment in one of the rayons (Dzhety-Oguz) has already reached a 72 percent rate. The existing FGPs plus some other primary care physicians in the polyclinics are filling out and submitting the primary care worksheets which are the basis of the medical information system (MIS) and the baseline data set for the evaluation of the project. While much has been done, much still needs to be completed.

Outlined below is a new list of activities/workplan to fully operationize the FGPs over the next eleven (11) months. This is similar to the list from the first visit in July and second visit in October 1995, but has been updated to add new information.

SHORT-TERM (WITHIN NEXT THREE MONTHS):

1. Specific Activities to be Completed by Karakol Office Staff Prior to Consultant's Next Visit (APRIL/MAY '96)

- The Karakol office staff will need to continue to modify the form as needed to improve the form on an ongoing basis.
- The input work to the new computer program for developing a database from these worksheets will need Andre to train the input person. **(In-process)**
- The database should be used to generate reports to physicians in the FGPs on their workload, referrals, ICD-9 disease codes, and to get them more involved with the collection, reporting, interpretation, and utilization of the data.
- A final version of the worksheet will need to be approved (Dean and Tokon) and printed locally if possible. Some initial order quantity will need to be determined, possibly a one-two months supply for existing and new FGPs.
- It will be necessary to decide who and how these forms should be collected, and who will tabulate or input to the computer program it at the end of the day, or at the end of the week, or end of the month. Bakyt can assist temporarily, but the office managers or the MHI will need to pick up this function.
- The enrollment campaign for Karakol is scheduled for April through May and will need to be completed to begin the accounting and fundholding process.

2. Three Months to Six Months Activities/Workplan:

- Develop and implement a professional association and begin meeting regularly and discussing key issues and making decisions **(Completed)**
- Develop agreement on legal structure for professional association **(In-Process)**.
- Decide on new name for primary care groups **(completed on 6-6-95: FGP's)**.
- Develop and agree on legal structure for FGPs **(under discussion)**.

- Form voluntary agreements among individual physicians about voluntary choices for group partners (**under discussion**).
- Form a number of different models for FGPs (**In-Process**).
- Decide on number/location of FGPs in rural and urban areas (**In-Process**).
- Identify locations and secure space for group practices (**In-Process**).
- Conduct marketing campaign to sign up for MHI enrollment (**In-Process**).
- Begin to form new FGP groups and put more into operation as conditions permit (**13 functional and operating in the three Rayons, with 3 operating in Karakol and 13 in process of forming in Karakol and suburbs, with total of 32 planned for the immediate future and possibly going to 110 for total Oblast**).
- Secure necessary equipment/supplies to operationalize FGPs (**In-Process**).
- Initiate training and educational programs for physicians in primary care techniques (**In-Process with full time Family Practice Trainer for one year being recruited**).
- Develop course materials and initiate training for physicians in Office Practice Management process and procedure.
- Make decision on group practice managers (**completed**), and begin interview and selection process (**In-Process with candidates being identified**).
- Develop course materials and initiate training of group practice managers in Office Practice Management and accounting, business, finance, and information systems.
- Implement basic structure of accounting, finance, and information systems (**In-Process with Stage I being implemented**).
- Continue to develop Stage II and III of accounting and financial management systems for FGPs. (**In planning stage**)
- Implement data and information systems reporting to the MHI to/from the FGP.
- Develop a schedule of standardized user fees and initiate training and implementation.
- Develop a business plan and monthly and annual budget for each practice.
- Initiate standardized registration, and referral form, data collection and reporting process (specialists, ancillary services-lab, x-ray, etc.), and hospital admissions procedures.
- Establish a bank account for each established FGP and coordinate it with the FGP accounting system.
- Determine which costs (rent, overhead, supplies, equipment, etc.) will be charged to the FGPs and which will be absorbed by the OHD/MHI.
- Develop and implement contracts between OHD and MHI Fund and each FGP.
- Initiate capitation payments as funds become available.
- Develop feasibility for a revolving drug fund (RDF) with assistance of Mercy Corps. Input of start-up funds for pharmaceuticals (**In-Process**).

3. Six to Eleven Month Activities/Workplan

- Continue training in primary care treatment and techniques.
- Bring more group practices on-line and slowly increase the number of operational units both in rural and urban areas (**possibly 110 total**).

- Develop and implement standardized staffing patterns, medical records input/output and office routine procedures.
- Implement reductions in all the various data books in each FGPs, which contain large amounts of data, some now reported to the OHD and never utilized.
- Continue to look for new office locations in rural and urban areas **(In-Process)**.
- Continue training of office practice managers.
- Hire and train new office managers as FGPs begin to form.
- Continue to renovate/refurbish office locations, and add equipment and supplies.
- Develop physician and group practice productivity reports.
- Begin to analyze data from FGPs and MHI with respect to changing behavior.
- Begin to bring the outpatient specialty and hospital payment scheme into the fundholding system.
- Initiate rationalization and consolidation/merger of hospital/polyclinic facilities as education and treatment changes begin to take effect **(In-Process)**.

C. MHIF Fundholding Management Update

1. Background

The development of a fundholding system for the MHIF has been discussed and worked on from the beginning of the project in Karakol. The major changes in the provider payment systems are a global budget, case based system for inpatient, and a capitation system for the FGPs. Development of a fundholding structure for the FGPs within the MHIF and in conjunction with the management of the OHD is a major organizational concern. While progress has been made in this area, the decision of organizational form (MHIF/OHD) has not as yet been made, a variety of legal and regulatory issues remain unresolved, and significant amounts of work are required in the operational areas. Outlined below are some of the carry over activities and some new items to be completed.

2. Organizational Issues

The organizational structure and relationships within the MHIF have been proposed and follow some of the general concepts from Kemerovo, Russia. While all of the positions, functions, and reporting has **not** been finalized or approved, an update of the most recent thinking is as follows:

- There is a need for some type of *Policy Board* to oversee the MHIF activities and ensure that the interest of the total community are being represented. **(see Exhibit 5)**.
- There is a need for two *Deputy Directors*, one for *Operations* and one for *Finance* **(see Exhibit 5)**.
- There is a need for a reorientation to computer payment systems and the creations of a statistics and computer department with various staff overseeing the medical statistics, monitoring and reporting **(see Exhibit 5)**.

- There is a need for the OHD/MHIF to move toward a “product orientation” in their business development and away for a public health service orientation to conducting the operations of the MHIF. (see Exhibit 5)

3. Carryover Recommendations

In previous trip reports (July and October 1995), this consultant has reviewed the various organizational issues and structures, and has made recommendations and work plans for both management and the board of directors (policy board) to follow. Consequently, there is no need to repeat those items here. However, there is some value in repetition of *key* concerns and advice, and outlined below are some of those especially critical and relevant issues from prior reports:

In the process of developing a combined organizational structure for the OHD and the MHIF, the organization should be clear of the joint objectives of the two groups together. Outlined below are some proposed **joint objectives** for the two groups:

- **To develop a cohesive structure for coordination and cooperation in decision making.**
- **To develop strong communication systems between the two groups to reduce conflict in the process of rationalizing facilities and services.**
- **To develop a structure which allows each group to do “what they do best” without undue interference from the other group.**
- **To minimize the cost of new positions and new functions in setting up the MHIF.**

Organizing and operating a health insurance fund is **very** different from running a health department and everyone will need time to adjust to the new demands. If a decision to implement a policy board is made, then some work activities are as follows:

Work Items for the Policy Board:

- The working structure and membership for board, and board committees needs to be outlined and developed.
- The board committees should consist of the normal oversight functions of **finance, quality assurance, audit (both medical and financial), fundholding, community/public relations**, and possibly **rationalization** and others as the need develops, as well as a small **Executive committee** (3-5 persons) for timely decision making when the full board can not meet.
- **The fundholding committee** should have representatives from each specialty making up the FGPs, plus finance and medical/quality assurance personnel, and the committee should have responsibilities (along with the finance committee) for reviewing recommended budget capitation rates, utilization statistics (referrals, laboratory, etc.), changes to the size of group practice enrollments or catchment areas, and other issues related to physician payment and compensation.

The functioning of a MHIF **Board** is very **different** from the functioning of a management **committee** and a workshop should be planned to allow all participants to understand the similarities and differences.

Work Items for Management:

- Organizational and staffing issues such as the development of job/position descriptions for all of the new and proposed positions.
- There are a variety of board/management issues such as distinguishing the different roles, responsibilities and authority of each element of the governance/management process. A workshop/retreat to discuss these issues should be planned.
- The MHI Board and management will also need to begin thinking about strategic issues and it is not too early to consider a board retreat to do some strategic planning.
- Another key task for management to begin working on the contracts between the Fund and each of the Primary Care Group Practices and the contracts between the Fund and each of the hospital/polyclinics and other providers having some relationship with the MHI Fund.
- Some consideration and planning needs to be focused on the development of information that will be going to top management and the board. While it is early in the development of the MHI, and it is the understanding of this consultant that significant work has already gone into the development of an IS and MIS, the level and detail of information at each level needs to be developed.
- Reports for HMO Institutions normally fall into the following classifications:
 - a. Board-level Reports (Membership, P&L, Balance Sheet, Cash Flow Statement)
 - b. Membership and Marketing Reports
 - c. Financial Management Reports (very detailed)
 - d. Health Service Reports

note: List is from (*HMO Critical Performance Measures for HMO Management and Board*, published by Birch and Davis)

4. Concluding Summary

While much progress has been made with the development of the MHIF/OHD structure and systems, there is still a great deal to be completed before, during, and after the MHIF begins to distribute moneys to the various providers in the Issyk-kul IDS. The development of provider payment systems and primary care improvements have taken the majority of the time and energy over the past year. Many activities related to development of regulations, explicit payment schemes, funds flow, operational procedures, calculation of base rates, cost accounting, billing, collection, payment, determination of which facilities are in and which are out, training of MHI and provider staff, and a variety of legal and regulatory issues are still unresolved. While all of these are being worked on, December 1996 is less than eleven months away and the completion of this phase of the project.

D. Organizational Development of Almaty City Mandatory Health Insurance Fund

During the trip to Karakol and Almaty, the consultant was requested to assist with some organizational development issues for the new Almaty City Mandatory Health Insurance Fund (ACMHIF). This followed from a meeting with the General Director of the Fund. **Exhibit 5** outlines the various issues and recommendations.

MONITORING AND EVALUATION

The process of monitoring normally involves a review of actual accomplishments against the original plans. Discussion centers around what went well and what did not, as well as why they did or did not go well, and finally making adjustments to future plans. Often, a report is written to outline the “lessons learned” which is shared with colleagues and other similar projects.

The consultant’s experience with monitoring and evaluation is, that while it is an important management tool, it is best kept simple, done frequently, and used as an adjustment tool to current plans as the project goes along, rather than one mid term and one final evaluation exercise. With these thoughts in mind, a simple effective evaluation process is outlined below:

With respect to the consultant’s Findings and Recommendations:

- Were the findings and recommendations reviewed in a timely manner with Almaty, Bethesda, the Oblast Health Department, and USAID? A period of 6–8 weeks (March 15–30) would be considered timely but possibly 8 to 10 weeks with translation difficulties (April 15–30).
- Were decisions taken in a timely manner with respect to the recommendation, and were any follow-up studies conducted to verify or develop further? A period of 3–4 months would be reasonable (May 15–June 15).
- Were the findings and recommendation on the health facility licensing and accreditation reviewed and acted upon in a timely manner? Was action taken?
- Were the items requested to be completed between trip three (February) and four (May) actually done?
- Were the findings and recommendations on the MHIF payment system reviewed and decisions taken in a timely manner?

TRIP ACTIVITIES

January 20/21: Travel from Philadelphia to Almaty via Washington and Frankfurt.

January 22/23: Travel from Almaty to Karakol overland with one night in Bishkek due to the weather, and met with Dean Millslagle and Sheila O'Dougherty and the Office Staff to review progress and plans.

January 24: Reviewed plans for Licensing and Accreditation with Dean Millslagle and Sheila O'Dougherty. Reviewed materials with Sasha Danilenko and began making changes to materials developed by Greg Becker and Bruce Ente (JCAHO) in order to simplify process for ease of implementation

January 25: Met with Office Staff to review materials and to solicit suggestions on improving the Licensing and Accreditation Manual and process, as well as the initiation of implementation of the survey.

January 26: Met with office staff to review marketing plans as well as the progress on charge/data sheets developments of CPT-4 and ICD-9 codes and charge/information sheet for the FGP's. Reviewed progress on charge sheet changes and CPT-4 procedure codes.

January 27/28: Worked on Licensing and Accreditation consolidation and revision of manual and developed worksheets.

January 29: Worked on Licensing and Accreditation and project plans, and reviewed FGP progress and MIS progress.

January 30: Worked with counterparts on Accreditation standards.

January 31: Worked with staff on Licensing and Accreditation standards. Reviewed and revised CPT-4 codes on charge/data sheets, and met with office staff to review implementation and training procedures

February 1: Visited Oblast Hospital to review propose standards with Chief Physician and other staff. Met with Saliva Damira, Director OHD to review plans for Licensing and Accreditation implementation.

February 2: Reviewed and revised licensing and accreditation standards with input from Oblast Hospital. Visited Rayon Hospital in Dzhety-Oguz and met with chief doctor to review L&A standards.

February 3/4: Worked on L&A standards and began writing Trip Report Sections.

February 5: Worked on L&A Sections and prepared for presentations to the Technical Coordinating Committee (TCC) of World Bank.

February 6: Met with TCC group from Bishkek and presented various items.

February 7: Met with TCC group from Bishkek and traveled to visit the various Family Group Practices in Karakol in order to review the operation and the data collection. Discussed various related issues with Sheila and Dean.

February 8: Worked on refinements of L&A manual and FGP materials.

February 9: Travel to Almaty, met with Almaty Office personnel on a number of project issues and concerns, including scheduling of future activities.

February 10/11: Worked on future plans and priorities for Karakol and Kazakstan.

February 12: Worked with Almaty office personnel on a number of project planning and related issues, and met with local Almaty City MHIF Director to discuss organizational development issues.

February 13: Spent time on rationalization plans, data requests for rural rayon in Talgar and SVA/SUB rationalization and payment issues.

February 14: Worked on a variety of project related activities.

February 15: Traveled from Almaty to Philadelphia via Frankfurt

BIBLIOGRAPHY

- Bader, B. and Matheny, M., "Understanding Capitation and At-Risk Contracting," *Health Systems Leader*, March 1994.
- Beard, P. L., *How to Negotiate Capitation (Without losing your head.)*, PROstat Resource Group, 1994.
- Beck, Leif C., "The Physician's Office: a guide to planning and managing a successful medical practice," *Excerpta Medica*, 1977.
- Becker, G. and Bruce Ente, Health Facility Licensing and Accreditation Administrative Policies and Procedures, Krygyz Republic, Ministry of Health, July 1995.*
- Carter, Grace., *Trip Report*, Karakol, Issyk-Kul Hospital Payment Systems, Sept. 1995.
- Dawes, E. and Bender, A.D., "Understanding Practice Costs: A Critical Step to Negotiating Capitation," *The Journal of Medical Practice Management*, September/October 1994.
- D'Antuono, R., "Managed Care: The Transition to Capitation: Assessing Your Organizational Readiness," *GFP Notes*, Spring 1994.
- Davison, J., "Thirty (30) Points to Evaluate Managed Care Contracts," *Medical Office Manager*, March 1994.
- Haycock, J., Assignment Report, Health Financing Kyrgyzstan, July 1994.
- Katz, Paul M., "Establishing a Physician Incentive System," *Top Health Care Financing*, 1993.
- Langenbrunner, J., Financial Management Reforms, Kyrgyzstan, Draft (March 1995)
- Recommendations: Strategy for Health Facility Accreditation (no author cited)*
- Telyukov, A. V., *Research Report: The Flow-of-Funds Analysis in a Perspective of Mandatory Health Insurance: The Case of Issyk-Kul Oblast, Kyrgyzstan*, May 1995.

PERSONS CONTACTED

ZdravReform Program/Almaty:

Michael Borowitz, MD, Regional Director
Rebecca Copeland, Deputy Director
Sheila O'Dougherty, MIS Specialist
Sasha Danilenko, Interpreter and Technical Coordinator

NMHIF:

Talapker Imanbayev, DG NHIF
Karima Akhmetova, Director of External Relations

ZdravReform Program/Karakol:

Dean Millslagle, Demonstration Site Director
Naripa Mukanova, Office Manager
Kylych Abdyrahmanov, Administrative Staff
Tokon Ismailova, Physician Statistician
Bakyt Akmatov, Research Assistant
Abdrayeva Shaken, Clinical Quality Specialist

Republic of Kyrgyzstan, Ministry of Health, Commission on Issyk-Kul Demo

Ainagul Shaykmetova, Head Basic Health Insurance
Madamin M. Karataiev, Coordinator for Medical Care Provider Payment
Mambetov, Department of Preventive and Clinical Services
Kulaieva, Coordinator
Nazarkina, Deputy Director, Bishkek CHD
Koshmuratov, Chui Oblast, Deputy Director
Rysalieva, Ministry of Finance, Deputy Director
Omorova, Department of Prognosis and MHI, Chief Specialist

Representing some of the above members of commission:

Shayakhmetova,
Ileev,
Subanbaieva,
Bondareva,
Sultanmuratov,

Oblast Department of Health:

Saliva Damira, Oblast Health Department Director

Ryspayev Kozhobil, Deputy Director, OHD
Tolon Kyrgyzhayev, Former Director OHD
Kurmanaliev Beishenbek, Oblast Hospital Head Physician
Chynybaev Sadyr, Dzhetysay Center Rayon Hospital Chief Physician

Annex A

LIST OF ACRONYMS

ALOS	Average Length of Stay
APTK	Russian acronym for a primary care group practice, consisting of (A) an obstetrician-gynecologist, (P) a pediatrician, (T) a therapist or internist, and in some areas (particularly rural sites) a mid-level practitioner or physician extender (known as a Feldsher, and (K) for complex (APTK)
BHI	Mandatory Health Insurance Fund, also MHI, also Kassa
FGP	Family Group Practice (new name for APTK or PCGP)
GP	Group Practice or General Practitioner
IDS	Intensive Demonstration Site
IS	Information Systems
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
KASSA	Cash-holding agency, Mandatory Health Insurance Fund, MHI, BHI
L&A	Licensing and Accreditation
MHIF	Mandatory Health Insurance Fund
MIS	Management Information Systems, or Medical Information System
MOF	Ministry of Finance
MOH	Ministry of Health
OHD	Oblast Health Department
PHC	Primary Health Care
TCC	Technical Coordinating Committee of the World Bank Loan Program
USAID	United States Agency for International Development

Annex B

SCOPE OF WORK

ZDRAVREFORM PROGRAM CONSULTANT SCOPE OF WORK

NAME: George P. Purvis

DATES OF VISIT: January 22–February 16, 1996 (4 Weeks)

COLLABORATING ZDRAVREFORM TEAM MEMBERS:

Sheila O’Dougherty/Dean Millslagle, Dr. Shaken, Regional Clinical Quality Specialist

WORK SITES: Karakol, Kyrgyzstan

TASKS:

1. To prepare draft regulations for the BHI Fund and health providers to implement new payment systems for hospitals.
2. To work with Dr. Shaken and the BHI Fund to review final version of Licensing and Accreditation Manual, and to develop action plan for implementation, as well as to initiate the start-up of implementation.
3. To work with counterparts to prepare them for implementation of the new hospital payment systems.
4. To review and update the progress with the financial and MIS for the FGPs

OUTPUTS:

1. Draft regulation on new hospital payment system for BHI Fund and health providers for review by the Oblast Health Department and other appropriate counterparts.
2. Assessment of counterpart assistance and needs and detailed activity plan to implement Licensing and Accreditation systems in pilot area.
3. Assessment of counterpart assistance needs and detailed activity plan to operationalize the payment system by April 1, 1996.
4. Assessment of progress on development of MIS for FGPs.

BACKGROUND OF THE CONSULTANT:

George P. Purvis is an international health and hospital management consultant who has worked in twenty countries in Europe, Asia, and Africa. Originally trained as an industrial engineer, with an MBA in Finance, he has spent his entire career working on the issues of revenue, cost and quality in health and medical institutions and with governments. He has held positions as Chief Financial Officer, Chief Operations Officer, and Chief Executive Officer for a number of domestic and international health care organizations, as well as being a consultant to physician offices, hospitals, polyclinics, HMO's, PHC programs, developmental foundations, and Ministries of Health. He is a fellow of both the American College of Healthcare Executives (ACHE) and the Healthcare Financial Management Association (HFMA). He has developed Health Facility Licensing and Accreditation Regulation and Procedures as well as conducted L&A workshops in a number of countries.

Annex C

EXHIBITS

- EXHIBIT 1 LICENSING AND ACCREDITATION MANUAL FOR HOSPITALS:
TABLE OF CONTENTS**
- EXHIBIT 2 HOSPITAL LICENSING STANDARDS**
- EXHIBIT 3 HOSPITAL LICENSING AND ACCREDITATION: “HOW TO”
PROCEDURE AND PROCESS**
- EXHIBIT 4 HOSPITAL ACCREDITATION STANDARDS**
- EXHIBIT 5 ORGANIZATIONAL DEVELOPMENT ISSUES FOR ALMATY CITY
MANDATORY HEALTH INSURANCE FUND (ACMHIF)**
- EXHIBIT 6 PROPOSED ORGANIZATIONAL CONSIDERATIONS: OBLAST
HEALTH DEPARTMENT AND MANDATORY HEALTH INSURANCE
FUND**

EXHIBIT 1

LICENSING AND ACCREDITATION MANUAL FOR HOSPITALS

TABLE OF CONTENTS

I. INTRODUCTION

II. GUIDING PRINCIPLES FOR LICENSING AND ACCREDITATION

III. LICENSING AND ACCREDITATION PROCESS AND PROCEDURAL CHART **FLOW**

IV. HOSPITAL LICENSING STANDARDS

V. ACCREDITATION PROCESS

VI. SPECIFIC HOSPITAL ACCREDITATION STANDARDS:

SECTION 1: HOSPITAL MANAGEMENT

SECTION 2: STAFF POLICY, NURSING AND PHYSICIAN ROLES

SECTION 3: IN-PATIENT CARE

SECTION 4: SURGERY AND ANESTHESIA

SECTION 5: PARACLINICAL SERVICES

SECTION 6: MEDICAL STATISTICS AND INFORMATION

SECTION 7: PLANT AND FACILITY STANDARDS

VII. APPENDIX

SECTION A: MATERNAL AND CHILD HEALTH

SECTION B: OUT-PATIENT CARE

SECTION C: EMERGENCY CARE

SECTION D: PUBLIC HEALTH, EPIDEMIOLOGY/ENVIRONMENT

SECTION E: PATIENT RIGHTS

EXHIBIT 2

HOSPITAL LICENSING STANDARDS

The following licensing standards are to be applied to all hospitals in the Republic of Kyrgyzstan. These standards represent the absolute minimum structure that must be present in order for the hospital to deliver care to patients. Any hospital not meeting these minimum standards should be closed, or immediate steps taken to rectify the deficiencies.

Definition of a Hospital: *Hospitals are locations where persons suffering physical or mental ailments are provided medicine, surgery, or other forms of therapy while being housed in a location other than their own home for a continuous period of 24 hours or longer.*

HOSPITALS MUST HAVE:

1. A licensed physician who is responsible for assuring that every patient is diagnosed as to the nature of his or her ailment and receives either effective therapy to alleviate the malady, or palliative care in cases where effective therapy is not available.

Validation: Request to see copy of license/diploma.

2. Nursing care on duty any time there are patients in the facility.

Validation: Request to see Nursing work schedule for 24 hour period.

3. A bed is occupied by one single individual except in extreme situations of need or emergency or crisis where beds may be shared by more than one person. At no time may more than one person occupy a bed when such sharing would result in an adverse medical outcome for any of the persons (such as communicable or infectious disease). Beds may not be shared by person of opposite sex except in case of infant or children under five years of age.

Validation: Verbal statement plus making rounds (tour) of facility and observing condition in all wards and all patient rooms.

4. Sufficient disinfecting, sanitary, and garbage/waste equipment and facilities are available to prevent the spread of fecal-borne diseases.

Validation: Request to see records kept by head nurse and observe working condition of sanitary equipment, waste disposals and toilets. Also request to see records of SES (Environmental Sanitation Service) and check frequency and dates of compliance to ensure frequency of application.

5. Potable drinking water should be available or arrangements are made to boil all drinking water before use.

Validation: Verbal statement plus asking nursing personnel during tour of facility to verify accuracy of statement.

6. Food service with meals that are appropriate to the needs of patients, adequate cooking facilities, or arrangement where food is provided to patients by outside sources such as family or outside contractors.

Validation: Request to see Special Dietary Nurse and review registration book, and tour facility and observe condition of kitchen and other dietary facilities.

7. Regular electricity supply and appropriate lighting conditions to carry out various medical and surgical procedures and to conduct physician and nursing functions.

Validation: Verbal statement plus observation of conditions at time of tour of facility.

8. Functioning heating systems during conditions of cold and Winter weather.

Validation: Request to see heating equipment, and fuel storage facilities unless facility is on a central heating system.

9. Accessible and reliable transport, either as an ambulance or automobile which is able to transport patients and emergency drugs or equipment.

Validation: Request to see vehicle and vehicle registration.

10. A regularly working telephone line and telephone sets available to medical and nursing personnel.

Validation: Request to see telephones and check for dial tone, and request verbal estimate of percentage of time the system is working.

11. A minimum set of emergency pharmaceuticals and drugs to meet minimum hospital needs.

Validation: Request to see Pharmacy records as well as visual inspection of cabinets and pharmaceutical stock to ensure compliance with standard.

12. A minimum set of medical equipment and surgical instruments required by National norms.

Validation: Request to see inventory records as well as visual inspection of Operating Room supplies

13. Sterilization of medical and surgical instruments and supplies.

Validation: Request to see records on sterilizes and disinfecting equipment, as well as visual inspection to see if equipment is in working condition and has regular maintenance checks and preventive maintenance when required.

14. Laundry (in-house or outside service), linens, bed supplies, and other hotel type services should be clean and in good condition, with the utilization of proper disinfectants and detergents.

Validation: Request records and visual inspection of laundry, linen rooms and bed linen.

15. Hospital facilities and equipment should comply with SNIP Codes (State Code of Public Health, Environmental. Epidemiological Norms and Regulations) when these are available and when funds have been appropriated to bring facilities up to new standards developed since the original construction of the facility.

Validation: In reality this will be difficult or impossible to validate, but recognition of the problem and some attempt to comply should be shown.

EXHIBIT 3

HOSPITAL LICENSING AND ACCREDITATION HOW TO PROCEDURE AND PROCESS

It is important to remember that the objective of “accreditation” is primarily *educational* and all procedures and processes should relate to this overall goal. The process of conducting a Hospital Licensing and Accreditation Inspection contains three major phases:

PHASE I: THE PRE-AUDIT QUESTIONNAIRE

Prior to conducting the audit, the inspection group will send a notice of the coming inspection to the respective hospital to be audited. This should be done 4-6 weeks prior to the audit in order to allow the hospital time to prepare for the audit.

The questionnaire sent to the hospital contains a cover sheet notifying the hospital of the dates of the visit, lists the personnel to be interviewed (Hospital Chief, Deputy Chiefs, Chief Nurse, etc.), requests their availability on those dates, and lists the names of the inspectors whom will be coming to do the inspection. The information sent ahead of time also includes a list of the licensing standards for accreditation (from the revised manual). *This questionnaire includes is a list of the documents (organization charts, personnel records, medical records, budget, quality assurance reports, journals, etc.), and any other pertinent information which will be reviewed during the inspection. The exact form of this questionnaire will have to be designed by the Inspection Organization, but most of the information is in the revised manual.*

At the facility, the pre-audit questionnaire is normally broken up and the various sections or departments and distributed to the respective areas. This information gives the institution an opportunity to prepare themselves for the inspection, to call the inspectors ahead of time if there are questions, and allows the institution time to organize the information in a readily available form for easy retrieval when the inspectors arrive. *As **written documentation** is the key to the compliance process, the identification ahead of time by the facility of the location and condition of records, files, journals, etc., is a major step in the institution’s preparation for the inspection..*

PHASE II: CONDUCTING THE AUDIT IN THE FACILITY

The process of conducting the licensing and accreditation inspection is meant to be carried out in an educational, positive, helpful manner, and is not meant to be a punitive experience for the facility. Inspectors should always be positive and should make suggestions for improvements in those areas they notice are deficient. All of this should be carried out in a helping environment, attempting to improve the quality of care in the institution through education over the long term.

The inspectors will usually call the facility one week before the audit to ensure that everything is being arranged and that personnel will be available on the requested dates. The inspection

organization should develop a simple check-off sheet (x) for the inspectors using the standards in the manual, to ensure ease of notation of compliance and deficiencies to be noted.

At the facility, the inspectors should begin with a general meeting of the key staff members (chief physician, deputies, chief nurse, etc.) and will explain the process and procedure of the next 1 to 3 days, handing out a schedule of when they will visit which departments (e.g., surgery at 10 AM, radiology at 2 PM, etc.), and answer any questions the staff may have about the inspection process.

The inspectors (usually two persons for large facilities and one person for smaller facilities), will split up the various departments to be reviewed and will go from department to department conducting the audit. The specific order of departments is not important, but every department should be visited during the audit.

The inspectors will complete the audit process as follows:

1. Meet with the respective deputy chief physician, and along with the specific department head, they will review the questionnaire, securing answers to each standard through a process of questioning various procedures, reviewing records, inspecting equipment, reviewing manuals, journals, or policy manuals of rules and regulations, and visually checking for the various criteria necessary to meet the compliance with the standard.
2. The results of reviewing each **licensing** standard is done **first**, but may be done in coordination with the **accreditation** audit. After securing the information and validating the required information for licensing, the information for each **accreditation standard** is recorded as:
 - 1) **full compliance,**
 - 2) **partial compliance,**
 - 3) **non-compliance, or**
 - 4) **not applicable.**
3. During the audit, the inspectors will note down the area of non-compliance or discrepancies (e.g., no records being kept of specific quality assurance activities, or records not up-to-date on sanitary inspection, or specific types of information not recorded in the medical record, etc.- see section on selection and training of inspectors in trip report for examples).
4. Two areas of special review by the inspectors are patient medical records and personnel records. The inspectors will need to be provided space to review the requested standard, and should be allowed to pull a random sample of these records to review. The inspector will review not less than 25 personnel records and not less than 50 patient medical records to ensure themselves that the requested information is or is not being recorded properly.
5. Inspectors should attempt to request some form of **written documentation** (operating manual, organizational chart, journals, records, etc.) to verify compliance with each standard. This

written document, plus visual inspection, and some “common sense”, will allow the inspectors to verify if the institution is in compliance with the standard.

The development of a Deficiency List or Worksheet will also have to be developed, and is best left to local development. This is the sheet which is sent back to the facility at the end of the inspection which outlines those areas which were deficient or partially deficient. A few examples are as follows:

- “A review of 50 medical records shows that physicians are not recording a discharge diagnosis in 38 percent of the medical records reviewed.”
 - “A review of 25 personnel records shows that performance evaluations are not being completed on 23 percent of the personnel in the Radiology Department”.
 - “A review of the Mortality Journal shows that in 31 percent of the cases of death in the hospital, an autopsy was not completed”.
 - “A review of the Management and Organization Structure of the Surgery Department shows that the organizational chart has not been reviewed and updated for three years”
6. At the conclusion of the audit, the inspectors request a general meeting with the key staff and review in general the results of the inspection. This is meant to be done in a positive, helping, quality improvement and educational style, and is not meant to be a punitive experience for the institution. The focus should be on helping the institution to improve the quality of care through an educational and learning process over the long term. During this meeting the inspectors may want to suggest methods of meeting the standards in those areas where the institution is felt to be deficient.

PHASE III: THE POST-INSPECTION REPORT

Within one week of completing the inspection, the inspectors will submit a report to the facility which outlines the results of the audit. It is important for the inspectors to review their findings after the inspection to insure they have covered all of the deficiencies and outlined what areas need to be improved. The report itself should follow the format of the questionnaire, beginning with the section on management and ending with the section on facilities and plant.

The scoring of the report usually follows the listing of deficiencies and a total score is computed to determine a percentage rating for the facility. This scoring will determine the final rating for the institution and will be part of the final report.

The final report is then usually sent or delivered to the facility, but the inspectors may want to hold a meeting with the chief physician if they feel the deficiencies are serious enough to warrant a face-to-face meeting. A certificate of compliance with the score clearly marked is sent along with the report, along with the license certificate. Once again, the objective of accreditation is educational and all processes should relate to this overall goal of improving the institution through education.

EXHIBIT 4

HOSPITAL ACCREDITATION STANDARDS

THIS SECTION IS STILL BEING EDITED IN ALMATY AND KARAKOL AND IS AVAILABLE IN BOTH THE ENGLISH AND RUSSIAN VERSIONS AT THE ABT OFFICE IN BOTH LOCATIONS

EXHIBIT 5

ORGANIZATIONAL DEVELOPMENT ISSUES FOR ALMATY CITY MANDATORY HEALTH INSURANCE FUND (ACMHIF)

I. BACKGROUND

The Almaty City Mandatory Health Insurance Fund (ACMHIF) is presently in the stage of building an organizational structure, staff, and systems for the overall management, administration, collection of insurance premiums, and provider payment for health services for part of the population of Almaty . The objective of this paper is to provide some knowledge and the past experience of others in the areas of organizational development of health insurance funds to the General Director of the ACMHIF.

The ACMHIF's organizational structure has been defined by the overall model recommended by the National Mandatory Health Insurance Fund (NMHIF), and consists of six key departments (Health Insurance, Finance/Economics, Accounting, Medical Affairs, Information Services/Computers, and Administration). This paper will review the experience of other similar health funds and make recommendations in the management of three of these departments (Finance/Economics, Medical Affairs, and Information Services/Computers). The other three departments (Accounting, Health Insurance/Contracting, and Administration) have not been included as these normally have very special legal, regulatory, cultural, and organizational issues specific to the country of origin.

At the present time the ACMIF has approximately 47 personnel, with plans to eventually increase staffing to approximately 60 or more personnel. The numbers of personnel in the various departments are outlined below. This paper will discuss the various functions normally conducted by a Health Insurance Fund, and will recommend various types of positions, their importance to the overall objectives of the Fund, their relationship and value to the Fund, and the approximate distribution of total personnel in the Fund by department.

The recommendations submitted have resulted from Abt Associates Inc's and the *ZdravReform* Program's experience in many NIS countries as well as experience in a number of countries in Asia, Eastern Europe and other Western countries with developed and developing health insurance programs.

II. ORGANIZATIONAL AND OPERATIONAL ISSUES AND CONCERNS

A number of immediate issues and operational problems are facing the ACMHIF:

1. Organizing and operating a Health Insurance Fund to serve the city of Almaty with approximately 1 million population;
2. Signing contracts with 47,000 different enterprises;
3. Collecting funds from these 47,000 enterprises;
4. Signing contracts with providers (hospitals and polyclinics), both public and private;
5. Designing provider payment systems for both hospitals and polyclinics;
6. Making payments to these providers for health services;
7. Identifying accredited providers and monitoring quality of medical care;
8. Various other related issues.

Experience in other countries and in emerging Oblast Health Funds in Kazakhstan has shown that “Finance” will be the major issue and will dominate all other issues for the immediate future. *The design of effective and efficient provider payment systems will be the single biggest concern in both the short term and over the long term.*

Experience elsewhere has shown that the signing of contracts with enterprises is usually a “one-time” issue and will take some months to complete, but then it will be over. Collection of health insurance premiums will always be a major problem and will not go away, and this issue will dominate future strategies. Quality assurance and monitoring of provider behavior while important should become less of an issue over time as effective systems are developed to handle these quality and utilization issues. Signing contracts with providers and making payments on a routine basis will be a relatively minor issue and once begun, will be of little on-going concern. With these thoughts in mind, and the experience of others as a basis, the following recommendations for the three departments (Finance/Economics, Medical Affairs, and Information Systems/Computers) are listed below:

III. RECOMMENDATIONS FOR ORGANIZATIONAL DEVELOPMENT

Experience in other countries has shown that usually two deputy directors are required on a health insurance fund, as Finance is such an overwhelming area that it needs its own senior deputy director. Other departmental issues are as follows:

A. Departmental Descriptions and Functions

1. Department of Finance, Planning and Economics

This department should be responsible for all “Sources and Uses” of funds, ensuring that all premiums are collected, that all payments are made, and managing the allocation of surpluses or deficits. A clear distinction between who is actually doing the collection needs to be made. Experience has shown that the collection function fits best under this department and should not

be part of a separate Health Insurance Department. The major function of this department is to ensure the long term financial viability of the fund. Its functions are primarily planning, economic, provider payment development and financial. The Department of Finance's concerns are mainly financial performance, and it should ensure that it operates by sound financial principles including an annual and monthly financial budget/ plan/forecast, a "sources and uses" of funds document, a cash flow plan, an investment plan, a capital development plan, a collection, pricing, and payment strategy, as well as the various financial planning and control tools. In conjunction with the Accounting Department, it is responsible to ensure that all various financial, audit and accounting functions are carried out according to law, and that all necessary financial reports for various agencies are prepared accurately and in a timely manner. There should also be close coordination between this department and the Information Systems/Computer Department, and if possible the Information Systems/Computer Department should report to the Deputy Director of this department.

This department is the single most important function of the fund, and the success or failure of the fund will depend on the effective management of this department. The number of personnel should depend on the activities of the department, but in general, it should have the largest number of personnel in the fund. The present organization structure is broken into two sections, ("Hospitals" and "Polyclinics"), with 5 employees assigned to each section, with a present total of 8 employee and 10 positions. This is an appropriate way of beginning, but the final distribution of the number of employees will depend on the provider payment system implemented for In-Patient and Out-Patient care. Experience elsewhere has shown that the total payment amounts (outlays) are larger on the hospital side, but the volume of activity (workload) is greater on the polyclinic side. Consequently, the polyclinic section will probably end up having more employees in total.

Possible position titles in this department are as follows: Billing Clerk, Collections Clerk, Provider Payment Specialist, Hospital Reimbursement Specialist, Polyclinic Payment Specialist, Audit Clerk, as well as other related positions.

It would be expected that over the long term, the total number of personnel in the department could increase from 10 positions to 25 to 30 positions depending on the payment system adopted.

2. Department of Medical Affairs

This department should be responsible for all medical activities and functions of the Mandatory Health Insurance Fund. It is normally responsible for all Quality Assurance/Quality Control, Utilization Review, Medical norms, standards, protocols, as well as admission and discharge criteria. Its function is to ensure that the patients diagnosed and treated, and the payments being made are in line with accepted medical practices. Its responsibilities include making sure that the limited resources available are being utilized effectively, efficiently, and efficaciously. The department is usually staffed by medical and clinical personnel, including physicians, surgeons, nurses, medical records clerks, and statisticians.

The two major functions of this department are Quality Assurance and Utilization Review. Quality Assurance (QA) is a process defined and executed by physicians, nurses and other medical personnel which defines acceptable levels of medical care, measures that care through accepted methods, and reports the findings, as well as developing training and educational programs to improve care. Utilization Review (UR) is a process defined and executed by medical personnel whereby the quality, quantity, level and appropriateness of medical care services are established, monitored and controlled. Both of these functions require physician leadership on 1) standards; 2) appropriate measurements; 3) priorities for review; and 4) compliance and reward measures. The process of review is based on accurate and timely data to both define and measure performance.

Position titles in this Department are usually as follows: Surgeon, Pediatrician, Internists, Obstetrician/Gynecologist, Quality Assurance Nurse, Utilization Review Specialist, Audit Clerk, and Statistician, as well as other related positions.

While the activities of this department are important, they are secondary to the financial functions. The establishment of norms, standards, and practices are often difficult and time consuming to develop and set up, usually once they are set up they usually function smoothly on an on-going basis, and only, monitoring is needed.

Staffing of this department may be heavy in the beginning stages (until protocols are developed), but usually can be reduced in later stages. The total personnel in this department, in the long term, should not account for more than 10 to 15 percent of the total employees in the fund. Using a full staffing capacity of 60 total personnel for the Fund, this would mean not more than 6 to 8 personnel in this department.

3. Information Systems/Computer Department

This department should be responsible for all collection and reporting of all data, information and statistics for the Fund. The responsibilities of the Information Systems/Computer Department would normally include the design of data systems, information and database storage and retrieval, computer selection, utilization, operation and repair of all computer systems. The function of this department is to provide the fund with accurate and timely data and information which the various departments need to carry out their activities. There is a need for a close connection between this department and the Finance, Economics and Planning Department, and it is preferred for the Information Systems Department report to the Deputy Director for Finance.

Health insurance funds operate primarily on large volumes of data and information. The cost of computer hardware and software has been reduced significantly during the last five years. Relatively inexpensive systems are now available, and personnel can be readily trained to operate these information systems. The Fund should invest significant amount of funds in equipment and personnel in this important area.

Position titles in this department are usually as follows: Information Systems Specialist, Computer Systems Programmer, Programmer, Operator, Data Input Clerk, as well as other related positions.

While there is a shortage of information systems/computer personnel in Kazakstan, the Fund should attempt to quickly hire and train personnel to fill these critical positions. Due to the shortage and the value of these types of personnel the salary is usually high in relationship to other personnel. These positions are critical, and it would be expected that the total number of personnel in this department could be 10 to 15 percent of the total, or 6 to 8 personnel at full staffing.

EXHIBIT 6

PROPOSED ORGANIZATIONAL CONSIDERATIONS - OBLAST HEALTH DEPARTMENT AND MANDATORY HEALTH INSURANCE FUND

The development and implementation of the new Mandatory Health Insurance Fund (MHIF) in conjunction with the continuing operation of the Oblast Health Department (OHD), will present new problems, challenges, and opportunities in the delivery of health care services in the Issyk-Kul Oblast. This paper, plus the attached organization chart, briefly outline the issues, challenges, and recommendations for the management of these two organizational entities in both an effective and efficient way.

There are four major organizational issues which must be considered together:

1. THE NEED FOR A POLICY BOARD

Community Mandatory Health Insurance Funds traditional have an oversight body, usually called a Board of Directors, Board of Trustees, Steering Committee, or Supervisory Committee. The basic role and function of this group is to provide “advice and counsel” to the Chief Executive Officer (CEO), and to oversee the financial control, policy formulation, and decision making of major policy items developed by the management of the fund. This group can be a sounding board for the CEO, can provide professional input and expertise, and provide the support the CEO may need in implementing difficult or key management and organizational decisions (financial, rationalization, personnel, quality control, etc.). These groups usually work on a consensus basis, giving support for difficult issues, and our usually made up of key representatives of the community (industrial enterprises, trade unions, Oblast Department of Health, bankers, attorneys, etc.).

2. THE NEED FOR TWO DEPUTY DIRECTOR POSITIONS

As outlined on the attached organization chart, there is a need for both a Deputy Director for Operations and a Deputy Director for Finance. Both of these positions are critical to the success of the total organization. The traditional OHD activities of public health, quality assurance, access, cost, and information need someone to manage the day to day operation. The new MHIF is primarily a “finance” driven organization which will need a strong leader with excellent accounting, financial and economics skills, as well as some knowledge of computers and information systems. There needs to be a good balance between these two positions as they will often be sharing staff, information, computer systems, and budget. While in many ways these two positions will be competitive with each other, the competition needs to be “healthy” competition and there should be a healthy tension between the two organizational positions.

3. THE NEED FOR A REORIENTATION TO PAYMENT SYSTEMS AND COMPUTERS

The new MHIF will require that the total organization go through a reorientation from a major focus on “budget” issues and priorities to a major focus on “payment systems” and “information systems utilizing computers. This is a major change and will require a different type of orientation to information, payment, collection, and computerization. This will also require some new personnel in the information systems and computer area, and these personnel will have to work for both deputy directors, as their work input and output will cut across all areas of the organization.

4. THE MOVEMENT TOWARD A BUSINESS “PRODUCT” ORIENTATION

With the major shift from a “ budget” payment system to a “capitation and case based” system, the total organization will need to begin to move toward a “product” or “business “ type organization. This is a major change from the traditional “service” type organization of the OHD. A product type organization is more concerned with developing a product line orientation (capitation for Family Group Practices, case based for Hospitals, Licensing and Accreditation, Immunization, etc.). Each section of the organization will be more interested in selling their products instead of just providing a service. organization.

Организационная структура Областного Управления Здравоохранения/с Кассой Здоровья

