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TRIP REPORT NO. CAR/KYR-?

**RECENT DEVELOPMENTS IN  
FAMILY GROUP PRACTICE (FGP)  
AND  
MANDATORY HEALTH INSURANCE FUND (MHIF)  
IN THE ISSYK-KUL OBLAST,  
KARAKOL, KYRGYZSTAN**

**April 21 - May 11, 1996  
Karakol, Kyrgyzstan**

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## FGP/MHIF DEVELOPMENTS IN ISSYK-KUL OBLAST

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## **I. EXECUTIVE SUMMARY:**

The health system of the Issyk-Kul Oblast Intensive Demonstration Site 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. This rapidly changing system is in need of an effective and efficient Clinical, Financial and Management Information System (MIS) to provide data and information to the MHIF and the FGP's on workload, referrals, admissions, diagnosis, revenues, expenses, and a variety of other areas.

The objectives of this fourth consulting trip to the IDS in Karakol were to continue to assist with the design and development of an information, accounting, and financial system which would meet the needs of both the newly formed FGP's, would provide information to the MHIF, and would form a baseline for evaluation of this aspect of the program. A further objective was to continue development of both the Case Based In-Patient Payment System and the Fundholding System for the family group physicians, and the Out-Patient Fee Schedule and structure for Polyclinics. Coincident with these objectives was the need to do some training with the new Office Practice Managers in the areas of accounting, finance, budgeting, and productivity.

The results of these consulting activities were as follows:

- 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. with 7000+ forms generated.
- The initial development and implementation of a manual accounting and financial system for the FGP's, which is Stage II of the MIS, and the initial development and implementation of a budget system for the FGP's.
- A review of the In-Patient Billing System and Out-Patient Fee Schedule for both the hospitals and polyclinics.
- A review of the entire financial system with some initial review of a beginning draft of a "Sources and Uses" of Funds.
- Conducting a one day training program for the new Office Practice Managers in the areas of Accounting, Finance, Budgeting, and Physician Productivity.
- Conduct review and training of counterparts on Licensing and Accreditation for health facilities.

## **II. BACKGROUND:**

This trip report is a review of the work which occurred during the period 21 April through 11 May, 1996. This was the consultant's fourth visit to the beautiful city of Karakol and the Issyk-Kul Oblast and IDS. The major focus of this trip was the continuing design, development, and implementation of Family Group Practices (FGP's) and the Fundholding and Hospital Payment System in the Issyk-Kul Oblast Demonstration Areas, Kyrgyzstan. A number of previous reports on the overall developmental needs of the IDS project were carried out during 1994-1995, and are listed in the Reference Section of this report. The major objective for this consultant's visit was to continue the institutionalization process of the FGP's in relationship to the development of the Mandatory Health Insurance Fund (MHIF) payment regulations for the new hospital payment and fundholding system for physicians. The definitive objectives and Scope of Work (SOW) are listed below, and also appear in the Appendix Section of this report..

## **III. OBJECTIVES:**

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

- Finalize the development and implementation of Stage II of the Clinical, Management and Financial Information System for the FGP's;
- Train the newly hired practice managers in FGP financial and clinical management information systems;
- Monitor the "paper" development and implementation of the hospital payment system;
- Assist with the development of the "paper" outpatient payment system including fundholding and the outpatient fee schedule;
- Conduct workshops as necessary for the new Office Practice Managers and other counterparts on various issues and programs.
- Continue activity on the Licensing and Accreditation of Health Facilities.

## **IV. FINDINGS AND RECOMMENDATIONS**

### **A. FAMILY GROUP PRACTICE UPDATE AND FUTURE ACTIVITIES**

#### **1. BACKGROUND**

One of the major components of the Issyk-Kul IDS is the development of primary care Family Group Practices (FGP's) in order to move the system away from a specialty care orientation toward more primary medical care. This FGP's will be paid from the MHIF on a capitation basis and will be the "gatekeepers" for the total medical system. Considerable activity and success has been made in getting the FGP's up and operating in this new environment. Funds have been secured for renovations, equipment, and new locations have been established and many FGP's are working effectively. Marketing plans and population enrollment programs are underway and a target date to enroll the entire population in Karkol has been planned for May 1996. Enrollment in one of the Raions (Dzhety-Oguz) has already reached a 72% enrollment rate. Practice Managers (PM's) have been hired at the rate of one PM to cover two FGP's and are beginning to function effectively. The FGP component of the project is moving along smoothly and is functioning effectively at this stage of project development. While much has been accomplished much is still to be done.

#### **2. POSITION DESCRIPTION OF THE PRACTICE MANAGERS**

A review of the existing Position Description was conducted and a number of new elements were added in conjunction with the on-going development of the position. These new elements consisted of more responsibility and activity in financial analysis, audit, internal control, banking transactions, physician productivity, supplies, equipment, analysis, reporting, and coordination of staff meetings - see Exhibit 1 for details.

#### **3. TRAINING SESSION FOR PRACTICE MANAGERS**

A one day session for new Practice Managers was developed and conducted on Friday, May 3, 1996 - see Exhibit 2 for details and agenda of this session and appendix for list of names of trainees..

#### **4.. FGP CLINICAL, FINANCIAL, AND MANAGEMENT INFO SYSTEM**

##### **A. STAGE I**

Stage I of the Clinical, Financial, and Management Information System was begun in October 1995 with the development and implementation of the Data Worksheet for FGP's which is being filled out on each patient and includes information on the type of visit, the referrals to specialists, ancillary services, and hospital admissions, as well as information on the diagnosis using the ICD-9 classifications. The existing FGP's, plus some other primary care physicians in the polyclinics, are filling out and submitting these Primary Care Clinical Data Worksheets as of April 1996) which is the basis of the Clinical, Medical, Financial and Management Information System and baseline data set

for the evaluation of the project. The computerization of these sheets has begun and they have almost completed data entry of 7000+ worksheets which have been collected. It is critical to the evaluation phase of the project that these get completed as soon as possible. and that reports begin to be generated on the data for review and analysis by physicians in the FGP's and the MHIF- see Exhibit 3 for list of data worksheet uses.

These data worksheets form the basis for the total information system and will be critical to the understanding of the possible behavior change which is expected. As previously stated, the sheet was designed to cover three critical areas: workload, referrals, and disease information. The development of a reporting and analysis software program which will assist this process is underway. Once completed, the Practice Managers, who will be inputting the data, and who will be generating and analyzing the reports along with the FGP practitioners, will begin to see trends and differences between physicians in the group and between groups. Once this data is available the process of feedback and corrective behavior to and from physicians should begin. As this process will be supplemented by training for the FGP's, we should expect to begin to see changes in referral patterns and hospital admissions within a short period of time. As the data has been collected since October 1995, it will be interesting to note if any changes have occurred and are occurring at the present time. We might expect some "Hawthorne Effect" early on in the project and in fact may already be occurring. As soon as the reports are generated, some initial review of the data should be made by Tokon and Michael.

## **B. STAGE II AND STAGE III**

Stage II of the MIS is the development and implementation of a Accounting and Financial System for the FGP's. This is necessary to identify revenues and expenses as well as to provide budget vs. actual information, and to generate reports on productivity, income statements, a balance sheet, and other management information for the FGP's.

The original study and recommendations of the Accounting and Financial System for FGP's was conducted in July and October 1995 and appears in those trip reports. Stage I of the system was designed to be a modification of the "Pegboard" Manual Business System. Stage II of the MIS was originally planned to follow the Pegboard design and begin to collect income and expenses in the Pegboard format. This has been revised due to the nature of the needs of the system and will now follow directly from the existing Accounting System used by the OHD and familiar to everyone now in the system. The same Accounting chapters and account classifications as presently exist will be used with some modification. The system will begin with a manual process to be completed by each Practice Manager and is designed to be easily computerized in Stage III. Lena is developing the basic accounting system and this consultant has reviewed the formats and data flows.

## **C. BUDGETING SYSTEMS FOR FGP's**

The basis for most management accounting and financial systems is the development and implementation of a budget process for the entity. Budgets are the most basis

planning tool and provide the vehicle for control systems to ensure things are going as planned, or to identify areas for correction. The FGP's are in need of an effective budget system to provide the MHIF/OHD with information on each FGP and on the FGP's as a whole. The budget system has been designed to capture most of the key information needed to effectively manage the practice and to provide the MHIF/OHD with important information. The budget system has been designed to forecast and to track on a monthly basis the key indicators in the clinical, financial, and management information system:

- 1.) workload: (visits, procedures, and other indicators now on the data sheet);
- 2.) referrals: (to specialists, to paraclinical services, and admissions to hospitals);
- 3.) disease information: (using ICD-9 coding).
- 4.) Revenues: (MHIF, User Fees, OHD, other)
- 5.) Expenses: (Salaries, Taxes, Supplies, Rent, Capital Items, etc.)
- 6.) Cash: (Inflows and outflow forecast and actual)

An example of these reports were developed with the assistance of Lena and Bakyt and were reviewed with the PM during the training session except cash which will come later..

The second key component of an effective budget system is the development and implementation of a monthly budget variance reporting system. This is a necessary component of the system in order to highlight budget vs. actual differences, and to verify variances from budget (the plan), the degree of variance, the reasons for the variance, and what if any action needs to be taken. An effective budget vs. actual reporting system has been developed and will be put into effect when the funds begin to flow and some actual variances can be noted and explained by the Practice Managers. The Office Practice Managers have been trained in the development and implementation of a budget system and variance reporting system for each FGP. The report format and an example of this report appears in Exhibit 4 in the Appendix.

#### **D. PRODUCTIVITY AND PERFORMANCE REPORTS**

The development of an effective accounting and budgeting system will prepare the way for the development of productivity and performance reports for the FGP. With capitated and managed care systems, especially in a group practice, it is important to monitor the productivity and performance of each physician in the practice. As the total net income of the group practice is dependent on the performance of each physician, it is important to note which physician(s) are exhibiting the "preferred" types of behavior and which are not. Monitoring this performance will allow physicians to learn from each other and to take corrective action when necessary. As an example, if one physician has a referral rate of twice the group average then there "could be" a problem with his/her practice methods. In the process of monitoring workload, referrals, admissions, and diagnosis the PM can assist in alerting the physicians of possible areas of concern. The performance reports are designed to monitor workload, referrals, disease information, as well as income/expense for each physician. While we know that different types of physicians have different referral and admission rates, the concept of Family Group Practice should allow each physician to be gravitate "toward the mean" in

practice behavior. In reviewing data with physicians, they can see for themselves who is pulling their weight and who is not, and this often acts as a self correcting mechanism. An example of this report and a suggested report format is presented in Exhibit 5 in the Appendix of this trip report.

#### **E. FOLLOW UP ISSUES AND CONCERNS**

There was only enough time to begin to develop and implement Stage II of the Clinical, Accounting, Financial, and Management Information System during this visit. While counterparts were given specific assignments upon departure of the consultant, it is important for management to follow up on each of these items during the next few months. Some of the components of the total MIS were implemented and the PM's are working to collect the necessary information, posting and record it in the formats requested. This is especially true for the accounting and budgeting systems. However, although some training was done in budget variance reporting and physician productivity reporting, these were not fully implemented and will need to be followed up by management. Sample reports were reviewed and suggested formats were reviewed with counterparts (see exhibits 4-5), but the on-going needs of the system, and the speed of installation, will dictate when, how, and what form these two reports should take over the next few months.

As the total MHIF/FGP system are not yet in place, and only a paper analysis and paper flow can presently be conducted, it is important to keep an eye on the total system and all the component parts with respect to internal control one the funds do begin to flow and a real audit can be conducted. Management should keep internal control in mind as they move into the full implementation phase - see discussion in next session on key aspects of internal control.

#### **5. UPDATE ON ACTIVITIES AND WORKPLANS**

Outlined below is a new list of activities/workplan to fully operationize the FGP's over the next eight (8) months (May-December 1996) which is the tentative ending of the project. This list is similar to the various lists from the consultant's first visit in July, the second visit in October 1995, and the third visit in February 1996 but has been updated to add any new information since the last visit.

## **A. SHORT TERM:**

### **1. SPECIFIC ACTIVITIES TO BE COMPLETED BY KARAKOL STAFF PRIOR TO CONSULTANT'S NEXT VISIT (JULY/AUGUST '96)**

- The Karakol office staff (with input from the Practice Managers) will need to continue to modify the clinical data form to improve the form on an on-going basis.
- The backlog of data input work to the database computer program from these 7000+ worksheets will need to be completed as soon as possible.
- A database reporting program still needs to be written (or a canned package purchased) and should be used to generate reports to PM's and physicians in the FGP's on their workload, referrals, ICD-9 disease codes, and to get the physicians more involved with the collection, reporting, interpretation, and utilization of this data on an on-going basis(see exhibit 3 for worksheet uses).
- The PM's will need to collect, verify, tabulate and input these forms to the computer program at the end of each day, or at least by the end of each week.
- Develop a monthly and annual budget for each practice, including monthly statistical, revenue, and expense categories.
- Implement basic structure of accounting and management information systems for FGP's as designed during this visit.
- Continue to develop and implement Stage II and III of accounting and financial management systems for FGP's.
- Develop a monthly budget variance report. as designed during this visit and presented during the PM training program (see exhibit 4).
- Develop physician and group practice productivity reports as designed during this visit and reviewed during the PM training. (see exhibit 5).
- Establish a bank account for each established FGP and coordinate it with the FGP accounting system .

### **2. TWO MONTHS TO FOUR MONTHS (June-August) ACTIVITIES:**

- Develop an Out-Patient Fee Schedule for Polyclinics and other out-patient services **(In-Process)**
- Implement data and information systems reporting to/from the MHIF and the FGP's.
- Develop and implement an internal audit and control system for referrals, ancillary tests, and hospital admissions between MHIF and FGP's.
- Develop and Implement Internal Control Systems into the BHIF and FGP cash collection and financial systems.
- Develop and implement a "punitive" payment system to eliminate self-referrals to specialists **(under discussion)**.
- Develop a method of updating and working with the "prekazes" in order to ensure that they do not offset the overall objectives of the project for reducing the number of referrals to specialists and subspecialists **(In-Process)**.
- Develop a detailed "Sources and Uses" of Funds Budget to ensure all items in the total health/medical systems are being considered.

- Develop a schedule of standardized user fees and initiate training and implementation.
- Initiate standardized registration, and referral form, data collection and reporting process (specialists, ancillary services-lab, xray, etc.), and hospital admissions procedures **(In-Process)**.
- Determine which expenses (rent, overhead, supplies, equipment, etc.) will be charged to the FGP's and which will be absorbed by the OHD/MHIF **(In-Process)**.
- 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 FGP's **(still under discussion)**.
- Form voluntary agreements among individual physicians about voluntary choices for group partners **(under discussion)**.
- Form a number of different models for FGP's **(In-Process)**.
- Decide on number/location of FGP's in rural and urban areas **(Complete)**.
- Identify locations and secure space for more 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 **(23 functional and operating in the three Raions, with 15 operating in Karakol, 4 in Dzhety-Oguz, 4 in Tyuup, with total of 58 projected for the immediate future including SVA/SUB conversions, for a possible total of 81 FGP's by end of project)**.
- Secure necessary equipment/supplies to operationalize FGP's **(In-Process)**.
- Initiate training and educational programs for physicians in primary care techniques **(In-Process with full time Family Practice Trainer -Dr. Idar Rommen- coming June 1 for a four month period)**.
- Develop course materials and initiate training for physicians in Office Practice Management procedure **(In-process)**
- Make decision on group practice managers **(completed)**, and begin interview and selection process **(completed)**.
- Develop course materials and initiate training of group practice managers in Office Practice Management and accounting, business, finance, and information systems **(In-process and on-going )**.
- Develop feasibility for a revolving drug fund (RDF) with assistance of outside donor for input of start up funds for pharmaceuticals **(In-Process)**.

### **3. FOUR MONTHS UNTIL END OF PROJECT (December) ACTIVITIES**

- Initiate capitation payments as funds become available.
- Begin to bring the out-patient specialty and hospital payment scheme into the Fundholding System.
- 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.

- Develop and implement standardized staffing patterns, medical records input/output and office routine procedures.
- Begin an audit program of the internal control systems of the BHIF and FGP financial systems.
- Implement reductions in all the various Data Books in each FGP's 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
- Continue training of Office Practice Managers
- Hire and train new Office Managers as new FGP's begin to form.
- Develop and implement contracts between OHD and MHI fund and each FGP as FGP's move more toward independence.
- Continue to renovate/refurbish office locations, and add equipment and supplies.
- Begin to analyze data from FGP's and MHI with respect to changing behavior.
- Initiate rationalization and consolidation/merger of hospital/polyclinic facilities as education and treatment changes begin to take effect.

## **B. MHIF FUNDHOLDING MANAGEMENT UPDATE**

### **1. BACKGROUND**

The development of a Fundholding System for the MHIF has been a major component from the beginning of the project. The major changes in the provider payment systems are a global budget based on capitation, case based system for in-patient, an out-patient fee schedule, and a capitation system for the FGP's. Development of a fundholding structure for the FGP's within the MHIF and in conjunction with the management of the OHD is a major organizational issue. Considerable progress has been made in this area and the decision of an organizational form (MHIF/OHD) has finally been made. Outline below are some of the carryover activities, key questions, and some new items to be discussed:

### **2. KEY QUESTIONS ARISING FROM SYSTEMS REVIEW 4/25/96**

The following list of questions and concerns was generated during a review of the total systems with key counterparts in the project on April 25, 1996:

1. What is the amount of possible total Oblast budget funds for 1996? Is it the Soms 53 million (as with 1994) or is it the Soms 44 million mentioned by Saliva, or is the 44 million the amount just to go in the Kassa with the 9 million difference the amount for the OHD administration, dispensaries, ambulance service, SES, etc.?
2. Are the dispensaries to be in or out of the Kassa in the long term, as previously stated, or is this just an interim step for 1996?
3. Are all the municipal health funds pooled or are they in/out of the Kassa funds?
4. Are all the funds being pooled (especially Raion funds), including the funds for FAP's and SVA's? Are the FAP/SVA's in or out of the 44 million Kassa fund?
5. What about budget funding for the rural FGP's, and do they include the SVA's/FAP's?
6. What are the "sources and uses" of funds pre and post implementation for each facility and unit of the OHD? This is needed to begin to allow the facilities to plan for the transition.
7. Will there be a out-patient fee schedule for FGP's, which might include preventative service, or is this included in the capitation rate?
8. Will there be a minimum basic package of benefits and/or can user fees be charged for items above this package or for any other services (e.g., inoculations)?
9. There is a need for a clear transition plan for the first year of the changes, in order to give everyone time to plan and begin implementing the changes.

10. What will the polyclinics look like after the change and all the physicians from the FGP's have moved out? Are plans being made for restructuring into smaller units?

### **3. SOURCES AND USES OF FUNDS**

Due to the rapidly changing nature of the funding levels in the project, it is important that a continuing process of developing a "Sources and Uses of Funds" Document be a continuing priority for management. Considerable effort has already gone into this activity, but its continuing importance needs to be highlighted here. This function is normally one of the major functions of a Chief Financial Officer (CFO). Considering that no formal decision on this key position has been made, it is important to assign this activity to someone to oversee as a major part of their responsibilities. *It is recommended that Lena, the economist now on the staff of Abt be assigned this responsibility and in essence be the CFO.*

During this consultant's visit some time and energy was spent in reviewing the existing information in this area (primarily uses and not sources of funding).. Outlined below are some preliminary findings and questions from this review. The information base is primarily that supplied by Sheila O'Daugherty prior to her departure in early April. The following statements and questions are mean to be "preliminary" and should be viewed as "helpful" not critical to the tremendous amount of work that has previously been done:

#### **A review of the data has shown the following:**

- A need to breakout the FGP's from the existing Polyclinic financial data;
- Some understanding of how the SVA's/FAP's and SUB's being converted to FGP's will be funded;
- A need to identify pre and post implementation funding for each unit within the Oblast;
- A clear understanding of which units have been closed and which will be closed during FY 1996;
- A detailed break out of the amount of funds and the percentage of total, that went to polyclinics and hospitals, for the pre and post implementation;
- Some idea how bad the funding will be for the remaining polyclinics;
- Some calculation on a per capita basis of what each Raion will receive;
- The per capita calculations in the report do not appear to relate to the figures shown, and this needs to be explained or rectified.

### **4. IN-PATIENT BILLING SYSTEM**

A brief review of the In-Patient Billing System has shown that things are progressing as planned. The hospitals are submitting for review to Lena the calculations of their various step down costs and corrections or changes are being made as required. This consultant was unable to verify if these were correct.

### **5. OUT-PATIENT BILLING AND FEE SCHEDULE**

A brief review of the Out-Patient Billing System has shown that things are progressing as planned. The committee on Out-Patient Fee Development is meeting regularly and developing a final list of fees. The polyclinics are being trained on the cost allocation and step-down procedure, and while there are some minor problems in the interpretation of the Telykov methodology ( the ratio of direct cost to indirect costs was the same in each department and which Purvis was unable to explain for the counterparts), things appear to be going along as planned. The consultant did not have time to do an in-depth review of this area but preliminary discussions with key counterparts showed that the process was on track and moving along smoothly. Some time was spent on the development of the out-patient referral forms which will be required for each referral to a laboratory, radiology unit, physiotherapy, other ancillary services, as well as to the various specialties in the various polyclinics. A small trial run of the new forms was recommended.

## **6. OTHER ISSUES AND CONCERNS**

### **INTERNAL CONTROL**

There is a need to begin to develop and to implement internal control systems for the BHIF and FGP financial and information systems. As there will be cash collected for user fees in the FGP there is a need for a strong cash control system. There is also a need to develop internal controls over the BHIF/FGP information system, as integrity is critical to the reimbursement process, and the number of referral, admissions, enrollment and other key data is critical to the overall system. Some key aspect of Internal Control Systems are as follows:

- Complete separation of the function of receiving cash from the function of disbursing cash;
- Definitive and clear cut assignment to designated individuals as the responsibility of cash management;
- Establishment of definite and separate routines for managing the inflows of cash and managing the outflows of cash
- Separating the handling of cash from the accounting for cash. Keeping those who handle cash away from the records of cash and vice-versa;
- Ensuring that all cash is deposited on a daily basis;
- Ensuring that all payments should be made on numbered checks and all receipts be on number stubs. The person who authorize a check should not be the one who signs the check. This should be the same for receivable. The person who assigns the price should not be the one who collects the money;
- Internal control is only as good as the level of its consistent application.

The failure to not develop and implement internal control processes and procedures means that theft and possible fraud will occur at some point in the future.

### **TRANSITION PLANNING**

There is a need to develop a transition plan from the old system to the new system. Due to the wide variety of changes in funding, budget, number and types of facilities, Raion and Oblast differences, and a host of other issues and concerns, it is important that some overall systems transition plan be developed as well as individual component (hospitals, polyclinics, FGP's) transition plans. These transition plans should outline funding changes as well as highlighting areas for change planning and implementation. Failure to develop effective transition plans will mean significantly more confusion, frustration, and possible crisis at some point during the implementation. Transition planning will allow management to take early steps for communication, problem solving, and implementation.

While there are a host of other issues and concerns in such a large and complex project which is a major change for a Soviet oriented system. The consultant was able to gain a strong feeling and understanding that the various subsystems (data, accounting, financial, primary care development, computerization, organizational, etc.) are coming together nicely and the project is on track with the various components.

### **C. LICENSING AND ACCREDITATION OF HEALTH FACILITIES**

Part of the SOW for this visit was to continue the process of Licensing and Accreditation of Health Facilities which was the major focus of the consultant's third visit in February 1996 (see prior trip report). The technical staff in Almaty has completed the translation of the changes in standards proposed during the last visit. Due to the unusually large number of holidays (3) during this visit it was difficult to schedule very much time with the counterparts and the facilities in order to carry this out. However, during the third week we were able to spend some part of two days with counterparts reviewing the standards and visiting a facility. The visit was to the Oblast Adult Hospital in Karakol and a paper review (not a facility visit) of Raion hospital of Dzhety-Oguz. We were able to preview with counterparts the Licensing and Accreditation Process by reviewing the various standards with both Chief Doctors. This continuing activity was effective and presented for the counterparts the actual review process and gave them an idea of how the facility review is conducted. During the review we were able to note which of the standards were applicable at the Raion level and which were not, thus allowing the reviewers to note these for future use. While there are some difference between oblast and raion these are not major and need not be a reason for concern.

#### **RECOMMENDATIONS:**

1. The only remaining issue is the OHD priority list for the development and implementation of a Licensing and Accreditation Policy and Procedure for Health Facilities. While everyone acknowledges the importance and inevitability of such a function, the issues of timing, resources and priority will remain for counterparts to decide on their own. In any case the information, the plan, the process and the standards are available for their use when they are ready. With the implementation of the MHIF and the eventual competition for patients, the need to identify higher quality institutions from lower quality institutions will push the licensing and accreditation process, and it will become more important and eventually be implemented by the OHD in their own way at their own time. However, project management will need to stay on top of the priority issue and keep this in front of OHD/MHIF management to ensure that it becomes a priority before the end of the project.
2. The new Licensing and Accreditation Manual should be bound and circulated for comments to the OHD/MHIF and other relevant parties including the MOH in Bishkek. Perhaps plans for rollout could also be started before the end of the project in December 1996.

#### **3. REVISED 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. This is a revised plan from the February 1996 report and combines the two functions into one process and allows the OHD to implement the program before the end of the project. The total implementation will take approximately 6-8 months from the approval and initiation of

the program. The various steps in the plan, with approximate time frames for completion are as follows:

<u>Item/Activity</u>	<u>Approximate Time Frame</u>
a. Secure agreement and approval from OHD and MOH;	one month
b. Identify and Interview candidates for 4-5 Inspector positions;	one month
c. Train Inspectors and review/refine standards;	one month
d. Conduct two workshops/seminars (2 days) for Hospital Chiefs and Deputy Chiefs to review process and standards:	one month
1-workshop for Karakol IDS hospital physicians	
1-workshop for Oblast hospital physicians	
e. Initiate Licensing and Accreditation Process: (2 inspection teams)	
-Twenty Hospitals in Karakol IDS at 4-6 per week	one month
-Twenty Hospitals in Obast at 4-6 per week	one month
<b>f. Full Implementation:</b>	<b>Total time frame: 6-8 months</b>

4. The above schedule combines the “licensing” and the “accreditation” process into one inspection survey using the same inspectors for both. While this is a departure from the traditional separation of the two functions, it fits the needs of the OHD and provides better utilization of personnel, equipment, supplies, and limited resources.

## **V. 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 (July 15-30 )would be considered timely but possibly 8-10 weeks with translation difficulties (August 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 (June 15-July 15).
- Were the findings and recommendation on the FGP’s reviewed and acted upon in a timely manner ? Was action taken?
- Were the items requested to be completed between trip fourth (May) and fifth (July) actually done ?
- Were the findings and recommendations on the MHIF payment system reviewed and decisions taken in a timely manner ?

## **VI. TRIP ACTIVITIES:**

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

**April 22:** Met with Michael Borowitz and Almaty office staff; Travel from Almaty to Karakol and met with Dean Milslagel to review plans and priorities.

**April 23/24:** Met with Karakol staff to review progress on various issues since last visit in February. Met with key counterparts to review status of in-patient billing, out-patient fee schedules, FGP's and other various projects.

**April 25:** Met with translators and counterparts to review out-patient fee schedule and plan translations of various FGP accounting and budget materials.

**April 26:** Met with FGP physicians and counterparts to review ideas for Stage II of data system with small presentation of system issues at FGP staff meeting.

**April 27/28:** .Worked on a variety of project areas as well as Trip Report.

**April 29:** Met with counterparts on Accounting and Budget Development. issues.

**April 30:** Met with key counterparts to design and develop MIS materials.

**May 1: Holiday:** Worked on a variety of reporting and MIS issues

**May 2:.** Prepared materials for workshop and reviewed with counterparts.

**May 3:** Conducted training program for Practice Managers

**May 4/5:** Worked on various workshop outputs and Trip Report.

**May 6:** Met with Shasha Danilenko and key counterparts on L&A activities.

**May 7:** .Met with key counterparts on L&A activities.

**May 8:** Worked on Standards and Licensing activities,. and traveled Karakol to Almaty by automobile.

**May 9: Holiday:** Worked on Trip Report and L&A Report

**May 10: Holiday:** Met with Michael Borowitz and Almaty staff on key project issues, the project evaluation process, finalized draft trip report and L&A report.

**May 11:** Travel from Almaty to Philadelphia via Frankfurt and Washington

## **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 Insurance, Group Practices, and Health Finance Programs in a number of countries.

## VI. REFERENCES:

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## **B. PERSONS CONTACTED**

### **Almaty:**

#### **Abt Office:**

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

### **Karakol:**

#### **Abt Office:**

Dean Milslagle, Demonstration Site Director  
Naripa Mukanova, Office Manager  
Kylch Abdurahmanov, Administrative Staff  
Tokon Ismailova, Physician Statistician  
Bakyt Akmatov, Research Assistant  
Abdrayeva Shaken, Clinical Quality Specialist  
Lena ? , Economist Consultant

### **Oblast Department of Health:**

Salieva Damira, Oblast Health Department Director  
Ryspayev Kozhobil, Deputy Director, OHD  
Evelina Menshikova, Chief Economist Karakol Polyclinic  
Tatyana Indyukova, Chief Economist Oblast Teaching Hospital  
Medet T. Iyazaliev, Head Physician, Oblast Regional Hospital

### **Practice Manager Training Program on May 3, 1996:**

Cholpon Dzanibekova, Karakol FGP #1-2  
Izat Bolponov, Karakol FGP #3-4  
Zhyldyz Asanbekova, Karakol #5-6  
Nurlan Asankojoev, Karakol #8-9  
Becktash Omurzakov. Karakol FGP #10-11  
Guldzan Bekturova, Karakol FGP #12-13  
Ashyra Dzudemishova, Karakol FGP #14-15  
Genadiy Pleshakov, Karakol FGP #16 and #7  
Gulmira Turdalieva, Tup FGP #1-2  
Kenesh uulu Bakyt, Tup #4 and Santash  
Aidai Bedelbaeva, Tup #3 and Taldy-Suu  
Shermadin ?, Dzhety-Oguz FGP  
Salima ?, Dzhety-Oguz FGP

#### **D. LIST OF ACRONYMS**

<b>ALOS</b>	Average Length of Stay
<b>APTK</b>	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 midlevel practitioner or physician extender (known as a Feldsher, and (K) for complex (APTK)
<b>BHIF</b>	Mandatory Health Insurance Fund, also MHI, also Kassa
<b>FGP</b>	Family Group Practice (new name for APTK or PCGP)
<b>GP</b>	Group Practice or General Practitioner
<b>IDS</b>	Intensive Demonstration Site
<b>IS</b>	Information Systems
<b>KASSA</b>	Cash-holding agency, Mandatory Health Insurance Fund, MHI, BHI
<b>MHIF</b>	Mandatory Health Insurance Fund
<b>MIS</b>	Management Information Systems of Medical Information System
<b>MOF</b>	Ministry of Finance
<b>MOH</b>	Ministry of Health
<b>OHD</b>	Oblast Health Department
<b>PHC</b>	Primary Health Care
<b>PM</b>	Practice Manager or Office Practice Manager
<b>SOW</b>	Scope of Work
<b>USAID</b>	United States Agency for International Development

## **VII. ANNEXES**

### **A. SCOPE OF WORK**

#### **ZDRAVREFORM PROGRAM CONSULTANT SCOPE OF WORK**

**NAME:** George P. Purvis

**DATES OF VISIT:** April 21 - May 11, 1996

**COLLABORATING ZDRAVREFORM MEMBERS:** Borowitz/Milslagle

**WORK SITES:** Karakol, Kyrgyzstan

#### **TASKS:**

1. Monitor the “paper” implementation of the hospital payment system.
2. Finalize development and implementation of Stage II of the Clinical, MIS for FGP’s, including budgeting and accounting processes required for primary care portion of the fundholding system - physicians salaries, rent, supplies, etc.
3. Train the newly hired practice managers in FGP financial and clinical information systems.
4. Continue development of the “paper” outpatient payment systems including fundholding and the outpatient fee schedule.
5. To develop plans for implementation of management autonomy within the Oblast Administration, OHD and health facilities in the IDS.
6. To continue the Licensing and Accreditation implementation processs for health facilities in the IDS.
7. To conduct workshops as necessary for provider payment systems or management autonomy.

#### **OUTPUTS:**

1. Report summarizing progress on implementation of the “paper” hospital payment system, outpatient payment system, and licensing and accreditation.
2. Recommendations on the development on Stage II of the Clinical Info System
3. Recommendations on implementation of management autonomy in the OHD.
4. Materials for any workshops on provider payment or management autonomy.

## **B. EXHIBITS**

### **EXHIBIT 1**

#### **POSITION DESCRIPTION OF PRACTICE MANAGER**

**POSITION TITLE: PRACTICE MANAGER**

**REPORTS TO: FGP HEAD PHYSICIAN AND ABT ECONOMIST**

#### **POSITION DESCRIPTION:**

The Practice Manager will maintain financial and clinical information systems for the Family Group Practice (FGP) and provide the physicians with information for decision making. They will submit the required financial statement and clinical information to the Oblast Health Department and other State structures in accordance with current Kyrgyz legislation. They are responsible for internal control and financial integrity of all data and financial systems and will have the authority for second signatures required for banking transactions.

#### **POSITION ELEMENTS:**

1. Obtain clinical information forms from physicians and enter data in the computerized clinical information system daily and weekly.
2. Analyze the clinical data, evaluate trends and provide information to the physicians on the type of medical services the FGP provides and the level of referrals for other medical services. Prepares and presents statistical and management reports based on data analysis to FGP and MHIF/OHD.
3. Develop a budget for the FGP and prepare a monthly variance report showing actual and budgeted revenues and expenses. This report should identify potential financial concerns and make recommendations for correction.
4. Purchase supplies, equipment, and other office items in accordance with the budget and is responsible for their safekeeping. Maintains an inventory of all equipment by source, ownership, date of acquisition, and condition.
5. Maintain an accounting system to record revenues and expenses of the FGP, and prepare required financial statements for the FGP to submit to the MHI/OHD. . Analyze funds flow received from MHIF/OHD and verifies fund transactions to other medical specialists, health facilities, polyclinics, hospitals, diagnostic centers, laboratories and other paraclinical services.
6. Prepare an audit of the referral and funds flow reports from the MHIF/OHD on referrals to specialists, paraclinical services, and hospital admissions, and verifies the accuracy of these reports noting discrepancies in a discrepancy report.

7. Develop performance and productivity reports for the FGP which compares physicians within the group on key indicators.
8. Initiate and participate in strategic planning for the FGP. This includes the development of a Policy and Procedure Manual for the FGP, following format and principles of the Policy and Procedure Manual guidelines prepared by the Family Group Practice Association.
9. Evaluate patient and information flows and recommend improvements in operating procedures, including processes for patient scheduling, referral and filing of information.
10. Develop agenda for FGP staff meetings, in conjunction with FGP head physician, schedules meeting with staff, and participates in problem solving and decision making discussions.
11. Performs all other FGP required duties as assigned by FGP head physician or Abt economist

NOTE: SECTIONS WHICH ARE UNDERLINED ARE PROPOSED ADDITIONS

Note: Considerable concern exists among the PM's about who is responsible for hiring and firing them after the exit of Abt Associates

**EXHIBIT 2**

**AGENDA FOR PRACTICE MANAGERS TRAINING  
FRIDAY, MAY 3, 1996  
4TH FLOOR CONFERENCE ROOM MUNICIPAL POLYCLINIC**

**1. OVERVIEW OF TODAY'S ACTIVITIES**

**2...BRIEF REVIEW OF:**

- A. HEALTH SYSTEM CHANGES**
- B. FUNDS FLOW ANALYSIS AND SYSTEM COMPONENTS**

**3.. NEW POSITION DESCRIPTION AND REPORTING RELATIONSHIPS**

**4. THE ACCOUNTING SYSTEM FOR FGP'S**

- A. THE EXISTING OHD SYSTEM**
- B. ACCOUNTING CHAPTERS**
- C. RECORDING REVENUES AND EXPENSES**
- D. ACCOUNTING REPORTS**
- E. MONTHLY BUDGET VARIANCE REPORTS**

**5. THE BUDGET SYSTEM FOR FGP'S**

- A. BUDGET COMPONENTS:**
  - 1. WORKLOAD AND ACTIVITY**
  - 2. REVENUES**
  - 3. EXPENSES**
  - 4. CASH**
  - 5. CAPITAL**
  - 6. ANNUAL AND MONTHLY**
  - 7. MONTHLY BUDGET VARIANCE REPORTING**
  - 8. BUDGET REPORTS**

**6. PRODUCTIVITY REPORTS**

**7. OTHER ITEMS**

## **EXHIBIT 3**

**DATE: 30 APRIL 1996**

**TO: REBECCA COPELAND  
ABT ASSOCIATES, ALMATY**

**FROM: GEORGE PURVIS  
KARAKOL OFFICE**

**RE: LIST OF POSSIBLE USES OF CLINICAL DATA WORKSHEET**

Outlined below is a list of the possible uses for the Clinical Data Worksheet. For a variety of reasons it would be ideal if this information was entered and reported on a daily basis, as well as generating weekly, monthly, quarterly, and annual reports on the key data. I have never thought all this through in any systematic way before, so I hope all of this helps to answer you questions. I am sure I have missed some things but here are my thoughts:

### **1. Monitoring Workload:**

The left hand column is used to capture, report and monitor workload for each physician in the practice (Pediatricians, Internists, and Ob/Gyn) and for the total FGP. These include all of the areas listed (office visits, office procedures, home visits and procedures, and hospital visits). This will be important to determine between physicians in the same practice and between practices, who is doing what, how much are they doing, as well as what are the max., min., and median points.

### **2. Monitor Referrals:**

The middle column is used to capture, report and monitor referrals (special procedures for ancillary services, laboratory, referrals to specialists, and hospital admissions). This will be critical to identify problem physicians and problem areas.

### **3. Monitor Diagnosis and Disease Information:**

The right-hand column is used to capture, monitor and report diagnosis and disease information by type of physician and for the total practice. Michael can help more here.

### **4. Verification to MHIF of referrals and hospitalizations and date of service:**

As the system is designed to penalize unnecessary referrals, the information in the middle column and the left-hand column will be needed by the MHIF to verify that a specific patient was referred to a specific specialist or for ancillary services, and why the patient was referred (diagnosis) as well as where specifically admitted and why (diagnosis). The date of service will also be an important item.

## **5. Patient enrollment verification:**

The FGP, MHIF, all hospitals and polyclinics will need to verify the patient name, patient number, and date of birth against enrollment information and master enrollment lists.

## **6. FGP Physician, Specialist, Hospital, and Polyclinic codes**

There will be a need to sort data by specific FGP physician, specific type of FGP physician, FGP as a group, specialist, hospital, and polyclinic in order to identify referral patterns, workload, and trends or changes in behavior. the MHIF will want to look at all Pediatricians, Internists, Ob/Gyn as a group to look at variations in behavior.

## **7. Diagnosis and Disease Data (again)**

There will be a need to sort data by specific ICD-9 codes and by minor and major categories in order to fulfill OHD reporting information, disease trends, etc. Michael can be of more help on this one.

## **8. Family Data within a FGP**

Dean mentioned that the visiting consultants highlighted the need for the FGP to see family data together to identify and monitor disease trends and practice behavior. This would mean sorting the data by family.

## **9. Project Evaluation**

The form was designed as a critical data collection device to determine the final evaluation of the project with respect to changes in practice behavior of the FGP's including referrals, admissions and disease information.

## **10. Other Areas:**

I am sure there are other areas I do not know about. The form was originally developed to be used as a billing, financial, and management tool. It was meant to eventually add user fees to the blank columns on the form (as user fees come into being), but the form has been modified a number of times for a variety of other interests which have made it even more valuable to a variety of groups.

Once again, I hope you find all of this helpful.

**EXHIBIT 4**

**FGP BUDGET/ACTUAL VARIANCE REPORT**

The basis of an effective reporting system for variances in actual activity in comparison to budget (planned) activity is known as a Budget Variance Report. Outlined below is a simplified example and the key elements in the report format. Once the MHIF begins to move into full operation, and funds are dispersed to various components of the system, the Practice Mangers (PM's) will begin to generate a monthly, quarterly, and annual Budget Variance Report. The variance report will contain all of the key elements of the budget system (statistics, revenues, and expenses). The key to generating an effective report is an understanding of the numbers going into the budget (the original plan), the reporting of actual activity, and most important an explanation of the reasons for the variances reported. Presented below is a simplified example of the key information and the suggested format. Management in coordination with the PM's will want to develop a final version of the report at time of full implementation.

**BUDGET VARIANCE REPORT FOR MONTH: \_\_\_\_\_, 1996**

<b>CATEGORY</b>	<b>BUDGET</b>	<b>ACTUAL</b>	<b>VARIANCE</b>	<b>REASON</b>
<u>STATISTICS</u>				
1.VISITS	425	350	-75	2 HOLIDAYS
2.REFERRAL	50	40	-10	2 HOLIDAYS
3.ADM'S				
<u>REVENUES:</u>				
1.MHIF	2000	2000	0	
2.OHD				
3.CASH				
<u>EXPENSES:</u>				
1.SALARIES	1500	1800	+300	EXTRA BONUS PAY
2.SUPPLIES	200	200	0	
3.				
<u>OTHER:</u>				
1.				
2.				

**PLEASE NOTE: THIS IS ONLY AN EXAMPLE**

**EXHIBIT 5**

**FGP PERFORMANCE/PRODUCTIVITY REPORT**

One of the key reports in an effective family group practice (FGP) is a performance or productivity report which outlines the differences between the physicians in the group. The report is designed to provide the FGP with information on workload, referrals, admissions, and other pertinent information for each physician and shows the differences between physicians. Upon the full implementation of the MHIF, management will want to develop and implement this report to provide information to physicians in the group on their activity. The report is meant to highlight difference in practice behavior which the group may want to discuss and take action upon (e.g., uneven distribution in workload, apparent excessive referrals, etc.). Outlined below is a sample report which management may want to adapt to meet their own needs and the FGP's develop over time. An example of the type of information which might be included is provided for reference purposes.

**FGP PRODUCTIVITY REPORT FOR THE MONTH: \_\_\_\_\_, 1996**

<b>CATEGORY</b>	<b>DOCTOR A</b>	<b>DOCTOR B</b>	<b>DOCTOR C</b>	<b>NOTES:</b>
<b><u>WORKLOAD</u></b>				
OFC VISITS	200	190	92	VACATION DR. C 1 WK.
OFC PROCS	150	60	90	
HOME VISIT	120	100	55	
HOME PROC	100	90	95	
<b><u>REFERRALS</u></b>				
XRAY	15	22	15	
LAB	68	117	78	
PHYS. THPY	54	22	92	
SPECIALIST	67	38	67	
<b><u>ADMISSION</u></b>				
HOSP #1	10	8	16	
HOSP #2	3	6	1	
HOSP #3	6	3	11	
TOTALS:	19	17	28	
<b><u>OTHER:</u></b>				

**PLEASE NOTE: THIS IS ONLY AN EXAMPLE.**