The Center for Medical Missions' *e-Pistle* July 2008

Welcome to July's *e-Pistle*. In these warm summer days in Tennessee we continue to find ourselves thinking of each of you who are serving in some of the most difficult place in the world. Thank you for all you are doing to make a difference in the lives of people whose needs are so great.

Please pass along this reminder to those who may be coming to work with you. The next annual "Orientation for the New Medical Missionary: Preparing for the Future" will be held April 17-19, 2008 in Bristol, TN at our national headquarters building. This is a valuable time or preparation for the new missionary and should be attended by the spouse if married. More information is available on the CMDA website at www.cmda.org/Meetings. We would also ask that you encourage your sending organization to make this part of the mandatory preparation for healthcare missionaries.

We want to again remind you of the next CMDA National Convention to be held September 24-27, 2009 in Ashville, NC. This will be held at Lifeway's Ridgecrest Conference Center. This will be a lower cost and family friendly venue with excellent speakers, so we hope if you are in the States on home assignment at that time, you will plan to participate. Again, more information is available on the CMDA website.

Thank you again to those who participated in the malpractice survey. We are researching various options which may provide opportunity for professional liability insurance. While malpractice suits are rare in most of the countries you serve in there is not doubt this is a growing issue. We hope to have an updated report to you in the next two months.

We hope you find this newsletter helpful, and we would love to hear some comments from you. Please respond to susan.carter@cmda.org.

Budgeting...and the Missionary Doctor

By David Stevens, MD

Yes, I'm going to sleep too! No single word makes me more lethargic than the word "budgeting!" It works better than Ambien!

Yet, budgeting is like the correct insulin dosage for a Type 1 diabetic. If you don't figure it out they are going to have short and long term problems.

If you already have a budgeting process in place, you probably can improve it and if not, these suggestions will help you start one that will serve you well:

1. Develop Your Budget - The first step is to deciding how you will develop your budget by setting up income and expense centers. What organizational level will give you enough information to make good decisions without being too burdensome?

   One principle I follow is to go down the administrative structure to the level where I want individual staff to be accountable. Usually that is down to the department level. Some departments may only have expenditures and you don't monitor their income since it comes in globally through patient fees. On the other hand, you may want to allocate income to departments so you see which ones are profitable or not.

   The other principle is that an area usually needs to be a cost center if they have the authority to spend funds. With that authority, they need to know where their limits are and have a way to monitor how they are doing.

   Name each cost center and enter it onto a spread sheet.

2. Review Previous Expenses - You next need to attach an income and/or expense projection to each cost center for the first year. To do that you need to first decide the individual budget lines that each cost center will have – salaries, benefits, supplies, equipment, postage, repairs or whatever. You standardize these for your organization so each cost center uses the same naming of budget lines though they may not have amounts to enter into every line. (That way the salary budget from every department can roll up into the global salary cost for your whole organization.) Your projections are based on your experience in your last complete financial year. This is a significant undertaking but is easier in subsequent years because you have kept financial records in the proper budget format.
3. Make Your Budget Assumptions - For your new budget there are global decisions that will affect everyone who is involved in the budgeting process. Will there be a cost of living increase in salaries in the next budget and what amount will that percentage be? Will there be merit raises in the next year? If so, what range of increases will be allowed and what is the total amount that will be allocated for this? What changes will there be in non-salary costs for each employee – health benefits, insurance, government taxes, etc. How much is income going up because of an increase in fees? What are the projections on outpatient and inpatient admissions? Is the average bill amount going up or down? All such budget items, predetermined by the central administration, must be included when budget worksheets are given to the ones who will do departmental budgets.
4. Bottoms Up - Get the individuals that implement the budget involved in establishing it. In other words, the budget process should start from the ground up so that the person that has the most intimate knowledge of the resources and needs of an income and/or expense area is involved in forming their part of the budget proposal.

   For example, the information technology center supervisor is going to have the best knowledge of the personnel, supply, equipment and vendor needs of the department and

what each item will cost. For this reason, each cost center's budget items are distributed to them on a spread sheet showing the amount spent or received to date in the current financial year as well as a projection of what that amount will be at the end of the financial year. On the same line should be a column for showing this year's budget and a column for next year's budget projection.

5. Budget Line Justifications – It is not enough to pick a number out of thin air that changes the previous year's expense or income budget, either up or down, without justifying it with a short rationale in a note column.
6. Budget Roll Up – Sections of the budget are rolled up to the senior staff level. All items are reviewed to make sure the budget line projection is reasonable and accomplishes the stated mission, goals and objectives of your organization.
7. Budget Balancing – Someone has to do the final roll up review and be the arbitrator. This year at CMDA we had hundreds of thousands of projected expenses more than projected income. Some things were obvious to cut. I wasn't getting a CMDA-owned Porsche to drive! (Just kidding!)

   But the red pencil came out and certain things that were not needed or were over budgeted for were adjusted or eliminated. Each department head was brought in to discuss the changes in their budget and to look at other less obvious areas that were being considered for adjustments. Sometimes the final arbitrator had to make a decision about what was more important than something else that was genuinely needed.

8. More Than Balancing – It is not enough to balance the budget. An organization needs to budget for a cushion to insure adequate reserves against a shortfall and to build up some cash reserves for emergencies or bad years. You may want to pick an amount or a percentage of your overall budget. The smaller that amount, the harder it is to end the year in the black because the "target" is so small.
9. Budget Approval – The overall budget needs to be reviewed and approved by your board or other supervisory body that holds fiduciary responsibility for the organization before the new budget year begins.
10. Budget Line Transfers – No matter how well you budget, you will not project everything correctly. Some things will cost less than projected and other areas will cost more. It is a good policy to allow savings one place in the budget to cancel out short falls in other areas within limits. Within a major budget category, for example, Global Health Outreach, we place no limits on how budget income and expense lines can be adjusted as long as the overall department budget meets its bottom line projections. Between major budget centers, the administration is allowed by the board to shift up or down 10% as long as the whole budget bottom line remains constant. If we need to go outside those limits, we need to get board approval.
11. Monitoring – A well-prepared budget is a tool to guide spending and monitor your financial health. You can have the fanciest blood pressure cuff in the world but it does no good if you don't use it. A budget is only helpful if there is a monthly trial balance that is reviewed in comparison to the budget. If income is significantly behind budget projections, you may need to focus on increasing income or decreasing expenses. If a cost

center is over budget, there is time to address that with the decision maker in that cost center or look for expense savings in other areas to offset it.

Budgeting is a long and laborious process, but worth the effort. Without it, you cannot make good organizational decisions, plan for the future or avoid financial crises. If you are just starting a budgeting process, find an institution like yours that has a good budget process in place. Visit them, ask for the electronic file for the budget categories they use and ask their financial director what they would do with their own process to improve it. Taking time to learn from others will save you lots of time and headaches.

Okay, now I can go back to sleep. B..u..d…g….e…..t….i……n……g……..

Cura Animarum: Getting Radical About Church

Acts 17:1-9

By Rev. Stan Key

During summer vacation, while Katy and I were spending a night in a motel, we found ourselves channel surfing on a television that had far more viewer options that any one person should see in a lifetime! What caught our attention that night, however, were the religious programs being offered.

On one channel was a preacher dressed in a silky, ultra-chic suit. Wealth, fashion and celebrity were the unspoken themes. Frankly, the platform and persons on it looked more like the set for the Academy Awards than a service of worship. "God can fix all your problems and make you happy and wealthy like me…" That was the message I heard.

On another channel there was a rotund woman with industrial-strength mascara and a hair style that must have cost a month's wages. With eyes closed and hands raised she sang high intensity praise to the Lamb of God as an adulating crowd said "Amen".

The next channel was a funeral service for a young girl who had been kidnapped and killed in California. In one of the major "evangelical" churches of our nation, I watched as speakers from Islam, Judaism, Christian Science and other faiths came to the pulpit, spoke, and then lit a candle. I waited, and watched…wondering when the name of Jesus would get at least honorable mention. I waited in vain.

The final zap of the remote sent me to a Texas arena filled with thousands and thousands of people. The man on the platform had trance-like eyes that made me shiver. The climax of the service came as he placed his hands on peoples' heads and saw them fall to the floor. The crowd erupted with praises and hallelujahs as each person was "slain" in the Spirit.

"What a bunch of charlatans, fakes, greedy pretenders," I smugly said to myself. And then, I piously prayed, "Lord, I thank you that I am not like them. I praise you that my church is not like that!" That was my first reaction.

My second reaction, several hours later, was far more troubling. “God, what do YOU see when You look at me…at us? Are we fakes? Are we obsessed with image and perks and blessings and self-absorption? Are we pretenders?”

We worship today before an Audience of One. God is watching this performance here today. And only He has the right to properly evaluate our performance. I wonder what He will think of this hour that we spend together.

Worldwide Lab Software Solutions (WWLSS)

By Ed Boss

Since 1995, Worldwide Lab Improvement (WWLAB) staff have traveled to many countries and observed the inefficiencies of current communication systems. Most mission hospitals use manual paper systems. We have talked to physicians who have written their own software as well as some attempting to install U.S. out-of-the-box systems. Those written by individuals on the field work for them but are dependent on that individual for support. If that person leaves the field, the system becomes difficult to maintain, and it cannot be reproduced and installed elsewhere. The commercially available systems are too expensive, sophisticated and cumbersome requiring things like a Social Security number, date of birth and insurance provider.

The goal of WWLSS is to provide a simple, affordable system that can be installed in any developing country to solve these problems.

It will function in a one doctor clinic as well as a 250 bed hospital. WWLAB assists in training key trainers and staff. When a new version is developed, all locations will receive the upgrade free. With all locations on the same version the maintainability and supportability is enhanced.

Software features:

- Patient registration system includes a "Thumb Print" option to help ID the correct patient each time he or she presents themselves to the system, because spelling may vary by visit.
- Payment can be required prior to providing lab tests or prescriptions.
- Laboratory requisition, reporting, record keeping and many more in-lab management tools.
- Pharmacy ordering, dispensing and inventory control by expiration date.
- A hospital wide inventory system, by department.
- Medical history by visit date including lab results, prescriptions, case notes and ICD-9 codes.
- Training database.
- Pages for procedures and policies.
- Patient scheduling for multi-departmental procedures.
- A tickler files system for future reminders.
- Screen that tracks Out Patient Lab Orders completion status.

- Reports of various types and formats can be requested and printed.
- Download database to a laptop to take to a remote clinic.

Software support is provided from the U.S. by BlueGranite, the software developer, for a monthly fee.

Hardware: Site specific to be defined, server or peer-to-peer [3-6 users] set up.

Contact WWLAB for cost and other installation questions.

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What Can I Learn From The Impact Of Faith-Based Health Care In Africa…?

By Daniel Tolan, MD

There is little doubt in anyone's mind who knows something of health care in Africa that faith-based organizations providing health care have had a major role in Africa in the last 100 years. However, to date, good data does not exist to define, quantify or adequately describe the nature and collective impact of faith-based work. The University of Cape Town is working together with several other organizations to obtain good data to measure this impact. They are just completing a study looking in depth at two countries and have made some valuable preliminary observations and recommendations. The following are a few key points I gleaned from the preliminary release of this study that can be applied to most cross-cultural settings where you work.

Much more information is known about facility-based health services (hospitals, clinics, etc.) than about services provided outside of facilities such as community health, hospice, HIV care and traditional medicine. Some countries have an identified body or organization (example: Christian Health Association of Kenya) offering some coordination of efforts and capacity development and acting as a funding vehicle. However, even these bodies know little about the scope of non-facility based efforts. Faith-based organizations need to make a more concerted effort together to make known to the outside world what is taking place and what they are doing. This would help lead to a more comprehensive database which would help leaders make decisions in resource allocation. While some countries such as Zambia have 30%, or more, of health facilities aligned with faith-based organizations, others such as Mali have less than 2%. It is not possible to make general blanket statements about faith-based presence that applies to all of Africa because of the wide variation of presence from one country to another. In addition, within countries the presence of faith-based healthcare can vary widely from one region to another.

Faith-based organizations and those who work at their facilities often make statements of "better" quality of care at these facilities. Studies and research must be done to substantiate these claims and to apply the lessons learned. Could the lessons learned, especially in resource poor areas, impact a much greater population than just those served by a faith-based facility if indeed the claims of "better" care are true? In Mali, where the existence of faith-based work is rare, an employee [of government health policy initiative] states, "We need more clinics, but why faith-based ones?" Could we not attempt to quantify data in some way to give a solid answer to this question? I know I would have anecdotal answers but could we, as a community of faith-based healthcare workers, give a better answer?

I mentioned the presence of agencies such as CHAK that "represent" or "coordinate" the efforts of faith-based networks within a country. The recognition and support by government of these bodies varies widely from country to country and even within countries depending on circumstances. This results in poor or less collaboration than optimal which eventually further compromises already stretched healthcare resources and adversely affects the health of communities we attempt to serve. While I suspect the fault lies on both sides (faith-based and public systems, including government and non-government groups) this plays itself out in unhealthy competition for patients, resources and personnel. This results in duplication of efforts and lack of trust between various parties involved in healthcare. Having been involved with faith-based international healthcare I feel I have a responsibility to critically examine our own attitudes and actions. Could it be we too often present an attitude of not wanting to work closely with national ministries of health to strengthen health systems? Do we use (some have suggested "flaunt") our outside resources to drive our own personal agendas rather than looking for the common good for a greater number across the public health spectrum? I am convinced that when I was medical superintendent of a large mission hospital in Africa I could have and should have done a better job attuning myself and the hospital leadership to the policies and goals of the ministry of health, and been available to listen to, plan for and to help attain their goals.

A shortage in human resources in health care is one of the greatest crises and problems faced across much of the world. This is an especially severe problem in countries already faced with little or diminishing resources for healthcare. Across most of Africa, this is a long-term and chronic problem that seems to be worsening every year. Competition for scarce human resources is intense from both within Africa and from without where workers often migrate hoping to find better pay and working conditions. Little coordination has taken place at the national level between healthcare policy makers and faith-based leadership to address these issues. Additionally, we often fault donors saying they do not put enough emphasis on human resource development. We need to apply pressure to policy makers, donors and leadership to address how the faith-based institutions can be part of the training and retention process to help with the human resource shortage.

Finally, we need to form cooperative networks to formalize the non-facility based healthcare work we are providing. Huge amounts of money and other resources are poured into healthcare efforts apart from the Western systems we bring. I do not support the continued and rapid growth of those who take advantage of a person's illness for financial gain with unsupported and exaggerated false claims to healing. Nor do I support the continued and growing demand for healers and spiritualists involved in the evil spirit world. However, I am concerned that demand

for services outside of what we provide continues to grow while access to the care we are trained to provide (bio-medical care) is still a luxury for the majority of Africa. I am also aware of the fact that long before I arrived on the scene in Africa, "untrained" individuals were trying to do their best for their communities in traditional medicine. And, many care(d) as much as I about those they serve(d). Could we somehow do better in empowering these and others through simple education, cooperation and learning from one another? I am also acutely aware that when funding runs out, especially for our non-facility based programs, we too often disappear. However, these other individuals remain. Is it possible to challenge ourselves in faith-based work and to challenge national health-care systems, especially in resource poor countries, to find ways to bring together those we often compete with or are at odds with?

These are issues we must wrestle with in the future of medical missions. Gone are the days when we left our home country and worked for years in an isolated location with little or no communication from the world outside our chosen area of service. No longer do we operate in a vacuum. I am no longer surprised when I hear a ring in the middle of the African tundra and from beneath a blanket is pulled a cell phone. We live and operate in a different world today where communication, collaboration and cooperation are essential and good.

I encourage you to look beyond your own "walls," many of which are necessary and good, to see where you can make a broader and deeper impact for His sake.

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