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**DAFTAR REFERENSI
TESIS**

**ANALISIS PENYELESAIAN KLAIM BPJS RAWAT INAP BERBASIS
LEAN HOSPITAL DI RSIA MUTIARA BUNDA PADANG**

OLEH :

ADISTI NINGDIA
NIM 2120322034



**PROGRAM STUDI S2 KESEHATAN MASYARAKAT
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2024**

1. Adellia, Y., Setyanto, N.W. and Tantrika, C.F.M. (2014)

**PENDEKATAN *LEAN HEALTHCARE* UNTUK MEMINIMASI WASTE DI
RUMAH SAKIT ISLAM UNISMA MALANG**

**LEAN HEALTHCARE APPROACH FOR WASTE MINIMIZATION AT
MALANG ISLAMIC HOSPITAL OF UNISMA**

Yolla Adellia¹⁾, Nasir Widha Setyanto²⁾, Ceria Farela Mada Tantrika³⁾

Jurusan Teknik Industri Fakultas Teknik Universitas Brawijaya

Jalan MT. Haryono 167, Malang 65145, Indonesia

E-mail: jolachan@yahoo.com¹⁾, nazzyr_lin@ub.ac.id²⁾, ceria_fmt@ub.ac.id³⁾

Abstrak

Lean adalah suatu upaya terus-menerus untuk menghilangkan pemborosan (*waste*) dan meningkatkan nilai tambah (*value added*) produk, baik barang maupun jasa, kepada pelanggan. *Lean* yang diterapkan dalam industri kesehatan disebut juga *lean healthcare*. Salah satu Rumah Sakit swasta yang ada di daerah Malang yakni Rumah Sakit Islam Unisma. Penelitian ini akan difokuskan pada *waste* yang ditemukan di Unit Rawat Jalan dan Rawat Inap, yang mana kondisi saat ini masih terdapat aktivitas yang tergolong *waste*. Pada penelitian ini *Big Picture Mapping* digunakan untuk mengidentifikasi proses yang ada di dalam instalasi rawat jalan dan rawat inap. Identifikasi aktivitas sepanjang *big picture mapping* bertujuan untuk mengetahui dan menghitung presentase aktivitas-aktivitas yang termasuk kategori aktivitas yang memberikan nilai tambah, aktivitas yang penting namun tidak memberikan nilai tambah, dan aktivitas yang tidak memberikan nilai tambah. *Fishbone Diagram* digunakan untuk menganalisis sebab dan akibat suatu permasalahan sehingga ditemukan akar permasalahan dari *waste* kritis yang terjadi. *FMEA* digunakan untuk mengidentifikasi dan memberikan prioritas kegagalan. Hasil dari *FMEA* menunjukkan penyebab kritis dari *waste motion* adalah kondisi tata letak dokumen dalam rak pada ruang penyimpanan status rekam medis belum ergonomis, penyebab kritis dari *waste transportation* adalah petunjuk ruang kurang jelas, penyebab kritis dari *waste waiting* adalah penulisan keterangan obat di rak kurang jelas dan sudah jelek, penataan kertas resep obat tidak rapi, hanya ada satu loket resep obat, sedangkan penyebab kritis dari *waste defect* adalah tulisan petunjuk ruang berwarna sama dengan warna pintu dan petunjuk ruang terlalu kecil. Alternatif solusi yang diusulkan yakni peletakan dokumen pada rak ruang penyimpanan status rekam medis pada tempat yang jauh lebih ergonomis, pembuatan alat kontrol visual, pengkondisian meja pegawai, denah rumah sakit yang dilengkapi dengan detail foto, diagram alir pelayanan, perbaikan papan nama, pembedaan loket resep racikan dan non racikan, pemberian nomer antrian, dan pelabelan pada rak obat.

Kata Kunci : *Big Picture Mapping*, *Fishbone*, *FMEA* dan *Lean Healthcare*.

1. Pendahuluan

Rumah sakit saat ini mengalami persaingan yang semakin ketat dengan semakin bertambahnya rumah sakit yang ada, sehingga rumah sakit dituntut untuk semakin berkompetensi dengan meningkatkan pelayanan yang ada, seperti halnya memberikan pelayanan kesehatan yang sebaik-baiknya kepada masyarakat dan berorientasi pada kesehatan individu.

Salah Satu Rumah sakit swasta yang ada di daerah Malang yakni Rumah Sakit Islam Unisma. Berdasarkan hasil wawancara terhadap pegawai rumah sakit dan pasien juga berdasarkan pengamatan yakni masih terdapat permasalahan adanya antrian yang meliputi waktu menunggu aktivitas administrasi, waktu menunggu proses pemeriksaan oleh dokter, untuk lebih jelasnya dapat dilihat pada tabel 1

yang merupakan waktu tunggu pada praktek dokter spesialis THT, praktek dokter spesialis Kulit dan Kelamin, praktek dokter spesialis Pasien Penyakit Dalam, lama proses menunggu termasuk dalam hal yang mempengaruhi tingkat kepuasan pelanggan. Selain itu masih terdapat aktivitas yang tidak efektif seperti penulisan kembali data pasien lama dikarenakan data tidak ada atau hilangnya data pasien lama dan juga transportasi dari pegawai informasi untuk mengirim berkas rekam medis, untuk lebih jelasnya dapat dilihat pada tabel 2. Semua permasalahan tersebut merupakan pemborosan (*waste*) yang tidak memberikan nilai tambah (*non value added*).

2. Agustin, R.U., Erawantini, F. and Roziqin, M.C. (2020)

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**FAKTOR KETERLAMBATAN PENGEMBALIAN BERKAS REKAM MEDIS
RAWAT INAP DI RSUP KARIADI SEMARANG**

Riza Umami Agustin¹, Feby Erawantini², Mochammad Choirur Roziqin³

Jurusan Kesehatan, Politeknik Negeri Jember, Indonesia^{1,2,3}

*e-mail: umamirzh@gmail.com

Abstrak

Keterlambatan pengembalian berkas rekam medis rawat inap dapat menghambat proses pelayanan rekam medis seperti kegiatan assembling, filling, koding, serta kemungkinan menyebabkan hilang atau rusaknya berkas rekam medis. Pengembalian berkas rekam medis rawat inap RSUP Dr. Kariadi Semarang masih mengalami keterlambatan. Berdasarkan hasil observasi dan wawancara yang dilakukan oleh peneliti terjadi keterlambatan dibagian PJRM atau Assembling. Tujuan dari penelitian ini adalah melaksanakan menganalisis faktor apa saja yang menyebabkan terjadinya keterlambatan pengembalian berkas rekam medis rawat inap. Jenis penelitian yang digunakan yaitu kualitatif. Penelitian ini menggunakan teori Lawreens Green dengan variabel *Predisposing Factors*, *Enabling Factors*, *Reinforcing Factors* dan keterlambatan pengembalian berkas rekam medis yang dilakukan melalui wawancara, observasi. Teknik pengumpulan data terdiri dari wawancara dan observasi. Hasil penelitian menunjukkan keterlambatan pengembalian berkas rekam medis rawat inap disebabkan oleh kompetensi individu yaitu pengetahuan serta sikap petugas terhadap pengembalian berkas rekam medis, yang kedua disebabkan oleh sarana dan prasarana yang sangat mendukung namun masih saja terjadi keterlambatan pengembalian serta kurangnya motivasi yang diberikan kepada petugas. Menyikapi hal tersebut perlu diadakan rapat rutin yang khusus membahas tentang keterlambatan pengembalian berkas rekam medis agar tidak terjadi masalah keterlambatan berkas rekam medis.

Kata Kunci: Berkas Rekam Medis, Keterlambatan, Pengembalian.

Abstract

That delay file medical record in-patient could impede the service event assembling, medical record filling, koding, cause to be lost or damaged and probably file. medical recordThat file medical record in-patient rsup. drAre still experiencing keterlambatan. kariadi semarangBased on the observations and the interviews conducted by researchers implementation has been delayed at pjrm. assembling orThe purpose of this research is conducting apa saja analyzing the factors that cause the repayment record. in-patient medical fileThe kind of research used the qualitative.This study using theory lawreens green variable, predisposing factors enabling, factors reinforcing factors and the repayment of file medical record by, through interviews. The research results show delays in the repayment of file medical record in-patient caused by individual competence the attitude the repayment of knowledge and the officer to file medical record , the second caused by of facilities and infrastructure who are supporting yet there still implementation has been delayed return and the lack of a motivation that granted to officers .In reaction to this, should be created a routine meeting that special committee to discuss about delays in the repayment of medical record file so that they do not file medical record delays there was a problem .

Keywords: Delay, Health center, Medical Record File

1. Pendahuluan

Menurut Kemenkes No. 129 Tahun 2008 Standar Pelayanan Minimal Rumah Sakit, rekam medis yang lengkap adalah rekam medis yang telah diisi lengkap oleh dokter dalam waktu maksimal 1x24 jam setelah selesai pelayanan rawat jalan atau setelah pasien rawat inap diputuskan untuk pulang, yang meliputi identitas pasien, anamnesis, rencana asuhan, pelaksanaan asuhan, tidnadk lanjut dan resume. Menurut Depkes RI Dirjen Yamed 2006 menjelaskan bahwa Standart pengembalian rekam medis pasien pulang rawat adalah maksimal 2x24 jam. Waktu 2 hari adalah waktu maksimum dalam pengembalian berkas rekam medis dari unit pelayanan ke unit rekam medis. Rekam medis sebagai catatan perjalanan penyakit pasien merupakan berkas rekam medis penting yang pengisiannya harus terjamin terisi secara lengkap sebelum dikembalikan ke unit rekam medis. Keterlambatan berkas rekam medis pada pelayanan akan mengakibatkan waktu pengkodean dan grouping jadi tebeda dikarenakan harus menunggu berkas dari unit PJRM. Langkah yang dapat dilakukan untuk menghindari beberapa dampak yang ada adalah rumah sakit harus menerapkan sasaran mutu 100% untuk pengembalian berkas rekam medis, tidak terkecuali RSUP Dr. Kariadi Semarang.

**DAMPAK KETERLAMBATAN PEMBAYARAN
KLAIM BPJS KESEHATAN TERHADAP MUTU PELAYANAN
RUMAH SAKIT ISLAM JAKARTA SUKAPURA**

¹Devi Anyaprita, ²Kemal N. Siregar, ³Budi Hartono,
⁴Muhammad Fachri, ⁵Fajar Ariyanti

¹
Program Studi Magister kesehatan Masyarakat, Fakultas Kesehatan Masyarakat
Universitas Muhammadiyah Jakarta

ABSTRAK

Latar Belakang: Keterlambatan pembayaran klaim BPJS berdampak pada peningkatan beban biaya yang tinggi bagi rumah sakit yang akan mempengaruhi mutu pelayanan kesehatan yang diberikan.

Tujuan: Penelitian ini bertujuan untuk mengetahui secara mendalam keterlambatan pembayaran klaim BPJS Kesehatan dan bagaimana dampaknya terhadap mutu pelayanan RSII Sukapura.

Metode: Penelitian ini merupakan studi kualitatif dengan menggali informasi dari Kaur Administrasi

Pasien, Ketua Casemix, Kaur Penagihan, Kaur Perbendaharaan, Kaur Farmasi, Kaur Laboratorium, Kaur Radiologi, Kepala Ruangan Rawat Jalan dan Rawat Inap, dan Dokter dengan menggunakan pedoman wawancara yang dikembangkan.

Hasil: Pengajuan klaim BPJS Kesehatan di RSII Sukapura dipengaruhi berbagai faktor, yaitu pertama adalah pengumpulan berkas kelengkapan administrasi klaim di administrasi pasien, yang kedua adalah keterlambatan pada pengkodean berkas klaim di unit casemix, dan ketiga pengumpulan serta pengiriman berkas klaim oleh unit penagihan. Keterlambatan pembayaran klaim BPJS kesehatan, berkisar antara 7 - 45 hari setelah jatuh tempo. Keterlambatan klaim mempengaruhi arus kas keuangan rumah sakit, akibatnya rumah sakit memprioritaskan pembayaran tagihan yang bersifat krusial dulu. Tampak bahwa kebijakan ini akan sangat mempengaruhi kualitas mutu layanan di RSII Sukapura.

Kesimpulan: Keterlambatan pembayaran klaim berdampak pada kompetensi, efektivitas, efisiensi, keamanan dan kenyamanan pelayanan.

Saran: Perlu mengubah alur pengiriman berkas klaim BPJS Kesehatan, meningkatkan koordinasi dan komunikasi antar unit yang berhubungan dengan klaim BPJS Kesehatan, serta mengoptimalkan manajemen mutu pelayanan dan manajemen piutang rumah sakit.

Kata kunci: Asuransi Sosial, Keterlambatan Klaim, Mutu Pelayanan, BPJS Kesehatan

Digitalization of Outpatient Services Based on Lean Management to Reduce Waiting Time in Government Hospital

Adila Kasni Astiena^{a,*}, Rika Ampuh Hadiguna^b, Acim Heri Iswanto^c, Hardisman^b

^a Department of Administration and Public Health Policy, Faculty of Public Health, Universitas Andalas, Padang, 25163, Indonesia

^b Universitas Andalas, Kampus Unand Limau Manis, Padang, 25163, Indonesia

^c Universitas Pembangunan Nasional Veteran Jakarta, South Jakarta, 12450, Indonesia

Corresponding author: *adila@ph.unand.ac.id; dr.adilakasni@gmail.com

Abstract— Hospital outpatient waiting times in Indonesia do not meet the standards. Lean management reduces waste, while digitalization plays a role in managing service complexity. Implementing lean in parallel with digitalization increases the opportunities for improvements, but empirical research on this is still limited. This study aimed to generate an analytical study of the impact of Lean application in reducing the waste of waiting time for outpatient services at a government hospital. The research design was pre- and post-intervention. The study was conducted in a regional government hospital with 60 people as a sample who was recruited by systematic random sampling. Data collection was carried out through observation and mapping the flow of patient service time from booking to completion of a doctor's consultation using the time stamp. Efforts to reduce waiting time are carried out through a simulation of the Lean-based digitalization model. The variables are the number of Service Steps, Lead Time, Waiting Time, Value-Added Activities, Non-Value-Added Activities and Value-Added Ratio (VAR). The results showed that lean-based service digitalization was able to reduce service steps from 10 to 4 steps, waste waiting from 5 to 2 steps, and Lead Time from 336 to 39 minutes (-88.4%), increasing the VAR from 5.1% to 20.5%. This research is limited to the implementation of lean digitally. It is important to statistically compare the impact of digital and non-digital lean implementation in some hospitals.

Keywords— Lean-based digitalization; waiting time; outpatient.

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I. INTRODUCTION

To achieve the SDG's targets, Universal Health Coverage is a system that brings safe, affordable, and effective health services for the community to be achieved by every country by 2030. The sustainability of health services is the main prerequisite to achieving the SDGs if the quality of health services can be guaranteed [1]. Since 2014, the Indonesian government has issued a National Health Insurance System (NHIS) that makes the Bureau of Social Insurance Provider (BPJS) the world's largest health insurance payer. With the number of participants continuing to increase, in 2017, BPJS paid 223.4 million consultations for health services [2]. Increased utilization of health services causes an imbalance in health service supply and demand, impacting service quality [3]. This is reflected in the increase in hospital outpatient's waiting time. Outpatient waiting time is from registering until getting a doctor's consultation with a standard of equal to or less than 60 minutes, based on the Indonesian Ministry of

Health. World health organization (WHO) set the maximum time limit for patients to be served by doctors is 30 minutes from the promised consultation schedule [4]. As a referral hospital for the surrounding area, regional public hospitals have more specialist and equipment than private hospitals. It makes regional general hospitals to have a large number of patients, therefore it has an impact on waiting times that are not up to standard.

Hospital sustainability is reflected by the quality and the level of productivity. Irwandy and Syaf [5] found that the productivity level of hospitals has continued to decline since the implementation of BPJS health insurance in Indonesia. Besides that, several studies showed that since the entry into force of BPJS, health service quality and waiting time (WT) in some hospitals did not meet the standard [6]–[8]. West Sumatera is a province with a low HDI compared to other provinces in Indonesia. Waiting time at a Regional General Hospital in Padang, the capital city of West Sumatera was 239 minutes in 2018. It can be improved by 122 minutes in 2019, but it did not meet the standard [9].

5. Ayu Putri, N.K., Karjono, K. and Uktutias, S.A. (2019)

**Faktor Penyebab Keterlambatan Pengajuan Klaim BPJS Kesehatan
Pasien Rawat Inap**

***The Causative Factors of Submission Delay in Claiming BPJS Health
Insurance for the In-patients***

Nevy Kusumaning Ayu Putri*, Karjono*, Sendy Ayu Mitra Uktutias*

***Prodi Administrasi Rumah Sakit**

STIKES Yayasan Rumah Sakit Dr. Soetomo, Surabaya

**Email : nevyayuputri12071@gmail.com, masjon_mars@yahoo.com,
ndyayuuktutias@gmail.com**

ABSTRAK

Masalah yang didapat bahwa pelaksanaan klaim BPJS dalam penyerahan berkas klaim pasien rawat inap kepada kantor BPJS Kesehatan masih mengalami keterlambatan yang jauh dari tanggal yang sudah ditetapkan oleh BPJS Kesehatan. Penelitian ini bertujuan menganalisis faktor-faktor penyebab terjadinya keterlambatan pengajuan klaim BPJS Kesehatan pasien rawat inap di RSUD Dr. R. Sosodoro Djatikoesoemo Bojonegoro. Jenis penelitian ini menggunakan penelitian kualitatif deskriptif dengan menggunakan rancangan *cross sectional*. Subyek penelitian adalah Kepala Instalasi Pelayanan Administrasi Terpadu, Kepala Sub Bagian Verifikasi dan Akuntansi, Petugas klaim pasien rawat inap. Hasil penelitian waktu penyelesaian 1 berkas klaim petugas verifikasi administrasi sampai berkas dientry membutuhkan waktu selama 18:39:03 per berkas. Kelengkapan persyaratan berkas klaim terdapat 35 % persyaratan berkas klaim tidak lengkap dan harus dikembalikan lagi keruang perawatan, kembalinya berkas klaim ke ruang perawatan yang berpotensi menyebabkan keterlambatan dalam pengajuan klaim. Dilihat dari jumlah dan kompetensi sumber daya manusia petugas pengelolaan klaim berpotensi menyebabkan keterlambatan dalam pengajuan klaim dan masih ada beberapa petugas pengelolaan klaim yang masih belum mengikuti pelatihan yang sesuai dengan jabatannya.

Kata kunci : BPJS, Keterlambatan Pengajuan Klaim, Pasien Rawat Inap

ABSTRACT

The problem culminates on the implementation of health insurance claims, which is in handing over the in-patient claim files to the bureau still experiencing delays far from the date set by the Social Security Administrator (BPJS) for Health. This research aims to analyze the causative factors of the delay in submitting claims of BPJS health insurance for the in-patients at Dr. RSUD R. Sosodoro Djatikoesoemo Bojonegoro. This research uses descriptive qualitative research by applying cross sectional design. Research subjects are including the Head of Integrated Administration Services Installation, the Head of the Verification and Accounting Subdivision, and the claim officers of the in-patients. The results of the research show that the completion time for 1 claim file, started from the administrative verification officer to the file entry, takes time of 18:39:03 per file. Due to the completion standard on the claim files, there are 35% incomplete files that must be returned to the treatment room. The return of these claim files to the treatment room potentially causes the delay in filling the claims. Considering the number of human resources and the competency of management officers, those two issues are also potential to cause the delay in filing the claims. Furthermore, there are some of management officers still not participating in an appropriate training needed for their positions.

Keywords: BPJS Health Insurance, the Submission Delay in Claims, the In-patients

Process Redesign for Health Care Using Lean Thinking

A Guide for Improving Patient Flow and
the Quality and Safety of Care

David I. Ben-Tovim



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A PRODUCTIVITY PRESS BOOK

Why Is Lean Thinking Important for Health Care?

Not because it is a better way to make motor cars. It's because it is a good way to manage, coordinate, and schedule work practices in any industry, including Health Care. Lean Thinking needs some modification before it is "fit for purpose" in Health Care. But the basics of Lean Thinking are relevant and important. There is no better place to understand them than the writings of Taiichi Ohno himself.

Toyota and Taiichi Ohno

The Toyoda family firm started life as a manufacturer of ingenious automatic looms. As the Toyota Motor Company, it started building light trucks before the Second World War. Toyota entered the passenger vehicle market after the Second World War. When it started making passenger cars, it did not have the resources to compete against large American manufacturers, but it had a period of protection from imports, and a workforce on lifetime contracts that needed to be seen as assets, rather than as costs to be minimized. And, its production manager was an extraordinary man.

Taiichi Ohno (1998, 13) was a great admirer of Henry Ford in his Highland Park period and a great critic of mass production as it had evolved. He describes the outcomes of American style mass production using high-performance, high-speed machines in these terms: "... an earlier process forwards products to the later process continuously regardless of the production requirements of that process. Mountains of parts, therefore, might pile up at the later process. At that point, workers spend their time looking for storage space and hunting for parts instead of making progress in the most important part of their jobs, production...."

Waste and Flow

Over and again, Ohno stated that his goal was to eliminate waste. By "waste," he did not mean cutting a sheet of metal in such a way that, when a car body part was pressed out, the minimum amount of metal was wasted as scrap. Ohno emphasized that in conventional mass production, the cost of making a car includes the cost of wasted time and effort looking for things, the cost of making and storing parts before they could be used, and the cost of making good any faulty parts. Those and all the other accumulated costs of doing anything other than designing and producing components and assembling them into a finished vehicle were the wastes that were part and parcel of conventional mass production. Ohno's insight was that if he could minimize the costs associated with such wastes, he could produce cars at a competitive price.

For Ohno, waste and flow were two sides of the same coin. He could just as easily have said that his goal was to maximize flow rather than eliminate waste. Ohno (1998, 4) wrote:

[T]he basis of the Toyota Production System is the absolute elimination of waste. The two pillars needed to support the system are just-in-time and autonomation. What is just-in-time? Just that in a flow process the right parts are needed in assembly to reach the assembly line at the time they are needed and only in the amount needed. A company establishing this flow throughput can approach zero inventory.

Inventory is the term used in industry to include all the parts, held in stock by a company, that are needed to make the finished product. It does not matter whether the parts are in boxes waiting to be unpacked after delivery by a supplier, or already assembled into components, and stored somewhere in the factory waiting to be used (the latter is commonly known as work-in-progress).

Inventory absorbs time, money, and effort, none of which can be recouped until the final product is delivered to the customer and payment received.

Ohno's goal was to achieve a flow process with minimum inventory. It did not happen overnight. He experimented for many years to develop the innovative production techniques that form the basis of Lean Thinking.

Work and Waste

The heart of this experimentation was working out what was work and what was waste. Ohno defined waste in human terms. For him, waste was needless, repetitious movement that must be eliminated immediately—for example, waiting for or stacking subassemblies, and unnecessary transportation. Work was not one thing. Ohno separated work into nonvalue-adding (but necessary) work and value-adding work. Nonvalue-adding (but necessary) work is work that must be done "under present work conditions," such as removing wrappers from parts purchased from subcontractors, removing parts in small quantities from a pallet full of parts, or walking over to another location to receive parts. For Ohno (1998, 57), value-adding work involves "some kind of processing—changing the shape or character of a product or assembly. The higher this ratio [of value added to necessary but non-value-added work] the greater the working efficiency."

Kanban

How did Ohno set about reaching the seemingly unachievable goal of 100% value-added work with no inventory? Ohno (1998, 33) wrote that "Toyota Production System is the method [of reaching such goals]. Kanban is the way it is managed."

Conventional mass production relies on layer on layer of managers to schedule and supervise production. In the making your-numbers-based systems Sloan pioneered at General Motors, factory managers were judged on their capacity to meet two targets: yield and quality. Yield is the percentage of cars actually produced in relation to the scheduled volumes set by the head office. Quality is the quality of the finished goods at the point they leave the factory. "Moving metal" was all-important because the head office only assessed quality at the final check before the car left the factory. If defects occurred, they were made good at a rework area at the end of the production line.

In conventional mass production, the whole production system revolves around complex scheduling processes devised by humans and computers. Schedules instruct each group on the shop floor what to make and when. Because things never quite go to plan, the schedules have to be constantly rewritten. To make sure that the line never stops, large stocks of components are kept on hand to cover any eventuality.

In a truly inspired change of logic, Ohno realized that all this scheduling by managers was a source of waste in others. Ohno (1998, 28) approached the problem of production coordination in an entirely different way: "Generally, in a business, *what*, *when*, and *how many* are generated by the work planning section in the form of a work start plan, transfer plan, production order or delivery order passed through the plant ... 'when' is set arbitrarily and people think it will be all right whether parts arrive on time or early ... the word 'just' in 'just-in-time' means exactly that.... If parts arrive any time prior to their need ... waste cannot be eliminated."

How to get things just-in-time, at the moment they are needed and in the quantity required? A car (or other kinds of complex goods or services made step-by-step) is produced in a series of defined steps. Let us say a company generally sells around 20 cars per day of a particular model.

The particular actions, or means, required to complete the intermediate function will vary between differing end-to-end processes (a cardiac patient arriving with a possible heart attack will require a very different sequence of procedures from a 4-year-old child with an asthma attack), but the process ends are the same—moving the transformation of the abnormal or at-risk physical or mental state, along its transformative path.

Process Redesign can work at any level, from the improvement of a specific process, through to improving a large or small chunk of processes, up to end-to-end sequences, and groups of sequences. The improvement methodology is the same and is discussed in some detail. However, the focus of *Process Redesign for Health Care* as a text is mainly at the level of chunks of processes, and end-to-end processes.

Lean Thinking is a process-improvement methodology, and Ohno (1998) and Holweg (2007) provided the basic concepts that Womack and Jones (2003) articulated as Lean Thinking principles which were developed in the context of elaborately transformed goods such as motor cars. It would be easy to reformulate those principles in a language more familiar to Health Care. But language helps shape the way we see the world. A different language helps us see things in a different way, and Health Care Process Redesign is all about seeing Health Care in a different way. So, the Lean Thinking principles are put forward here in the kinds of terms that are in use in manufacturing and service industries.

The Lean Principles

The Lean principles can be stated as follows:

1. Specify value from the viewpoint of the end-customer
2. Identify the value stream for each product family
3. Eliminate waste and make the product flow
4. So that the customer can pull
5. As you manage toward perfection

Principle 1: Specify Value from the Viewpoint of the End-Customer

As it is, it is hard enough for Health Care practitioners to think in terms of customers, let alone end-customers. The late John Long was a Lean Thinking Health Care pioneer who was also a friend and mentor to our group in its early years. John taught us that the customer is the person who uses what you make (Long 2003). John separated out the patient, the Health Care end-customer, from intermediate customers who took possession of the product of one particular process, did a piece of transformative work, and moved the product on to the next process in its step-by-step transformation.

The end-product of Health Care is good-quality patient care. Many people working in Health Care do not interact directly with patients, yet still play an important role in the delivery of care. In a system where value is delivered by a series of processes, each intermediate process has a direct, or immediate, customer who uses what the previous process has made and passes on the product to a customer who uses what has just been made. A pathology laboratory is the customer of a phlebotomist (blood-taking technician). The laboratory subjects the blood sample to a series of procedures and produces an output in the form of a set of readings, printed on paper or delivered

7. BPJS Kesehatan (2017) ‘Peraturan Badan Penyelenggara Jaminan Sosial Kesehatan Nomor 3 Tahun 2017 Tentang Pengelolaan Administrasi Klaim Fasilitas Kesehatan Dalam Penyelenggaraan Jaminan Kesehatan Nasional’. BPJS Kesehatan.

PERATURAN BADAN PENYELENGGARA JAMINAN SOSIAL KESEHATAN
NOMOR 3 TAHUN 2017
TENTANG
PENGELOLAAN ADMINISTRASI KLAIM FASILITAS KESEHATAN
DALAM PENYELENGGARAAN JAMINAN KESEHATAN NASIONAL

DENGAN RAHMAT TUHAN YANG MAHA ESA

DIREKTUR UTAMA
BADAN PENYELENGGARA JAMINAN SOSIAL KESEHATAN,

- Menimbang :
- a. bahwa untuk menjalankan tugas BPJS Kesehatan dalam membayarkan manfaat dan/atau membiayai pelayanan kesehatan serta menerapkan kendali mutu dan kendali biaya, diperlukan pengaturan mengenai pengelolaan pengajuan dokumen klaim dan pembayaran pelayanan kesehatan ke fasilitas kesehatan tingkat pertama dan fasilitas kesehatan rujukan tingkat lanjutan;
 - b. bahwa berdasarkan pertimbangan sebagaimana dimaksud dalam huruf a, perlu menetapkan Peraturan Badan Penyelenggara Jaminan Sosial Kesehatan tentang Pengelolaan Administrasi Klaim Fasilitas Kesehatan dalam Penyelenggaraan Jaminan Kesehatan Nasional;

A

Bagian Kedua
Pengajuan Administrasi Klaim Manfaat di Fasilitas
Kesehatan Rujukan Tingkat Lanjutan

Pasal 15

- (1) Klaim manfaat Pelayanan Kesehatan Rujukan Tingkat Lanjutan terdiri atas:
 - a. Rawat Jalan Tingkat Lanjutan (RJTL);
 - b. Rawat Inap Tingkat Lanjutan (RITL);
 - c. obat untuk penyakit kronis dan obat kemoterapi;
 - d. alat bantu kesehatan yang meliputi:
 1. kacamata;
 2. alat bantu dengar;
 3. protesa alat gerak
 4. protesa gigi;
 5. korset tulang belakang;
 6. *collar neck*; dan
 7. kruk;
 - e. pelayanan ambulan;
 - f. *Continuous Ambulatory Peritoneal Dialysis* (CAPD); dan
 - g. pelayanan gawat darurat.
- (2) Persyaratan pengajuan klaim manfaat pelayanan kesehatan di FKRTL adalah sebagai berikut:
 - a. kelengkapan administrasi umum yang terdiri atas:
 1. formulir pengajuan klaim (FPK) rangkap 3 (tiga) yang ditandatangani oleh Pimpinan FKRTL atau pejabat lain yang berwenang, paling rendah adalah yang menjabat sebagai Kepala Instansi;
 2. *softcopy* luaran aplikasi BPJS Kesehatan;
 3. kuitansi asli bermaterai cukup; dan
 4. Surat Tanggung Jawab Mutlak bermaterai cukup yang ditandatangani oleh Pimpinan atau Direktur

4

8. BPJS Kesehatan (2018) ‘Peraturan Badan Penyelenggara Jaminan Sosial Kesehatan Nomor 7 Tahun 2018 Tentang Pengelolaan Administrasi Klaim Fasilitas Kesehatan Dalam Penyelenggaraan Jaminan Kesehatan’. BPJS Kesehatan.

PERATURAN BADAN PENYELENGGARA JAMINAN SOSIAL KESEHATAN
NOMOR 7 TAHUN 2018
TENTANG
PENGELOLAAN ADMINISTRASI KLAIM FASILITAS KESEHATAN
DALAM PENYELENGGARAAN JAMINAN KESEHATAN

DENGAN RAHMAT TUHAN YANG MAHA ESA

DIREKTUR UTAMA
BADAN PENYELENGGARA JAMINAN SOSIAL KESEHATAN,

- Menimbang :
- a. bahwa dalam rangka kepastian, kecepatan dan ketepatan proses administrasi klaim, telah ditetapkan Peraturan Badan Penyelenggara Jaminan Sosial Kesehatan Nomor 3 Tahun 2017 tentang Pengelolaan Administrasi Klaim Fasilitas Kesehatan Dalam Penyelenggaraan Jaminan Kesehatan Nasional;
 - b. bahwa Peraturan Badan Penyelenggara Jaminan Sosial Kesehatan Nomor 3 Tahun 2017 tentang Pengelolaan Administrasi Klaim Fasilitas Kesehatan Dalam Penyelenggaraan Jaminan Kesehatan Nasional perlu disempurnakan sesuai dengan ketentuan dalam Peraturan Presiden Nomor 82 Tahun 2018 tentang Jaminan Kesehatan;

Bagian Kedua
Sistem Pembayaran di FKRTL

Pasal 4

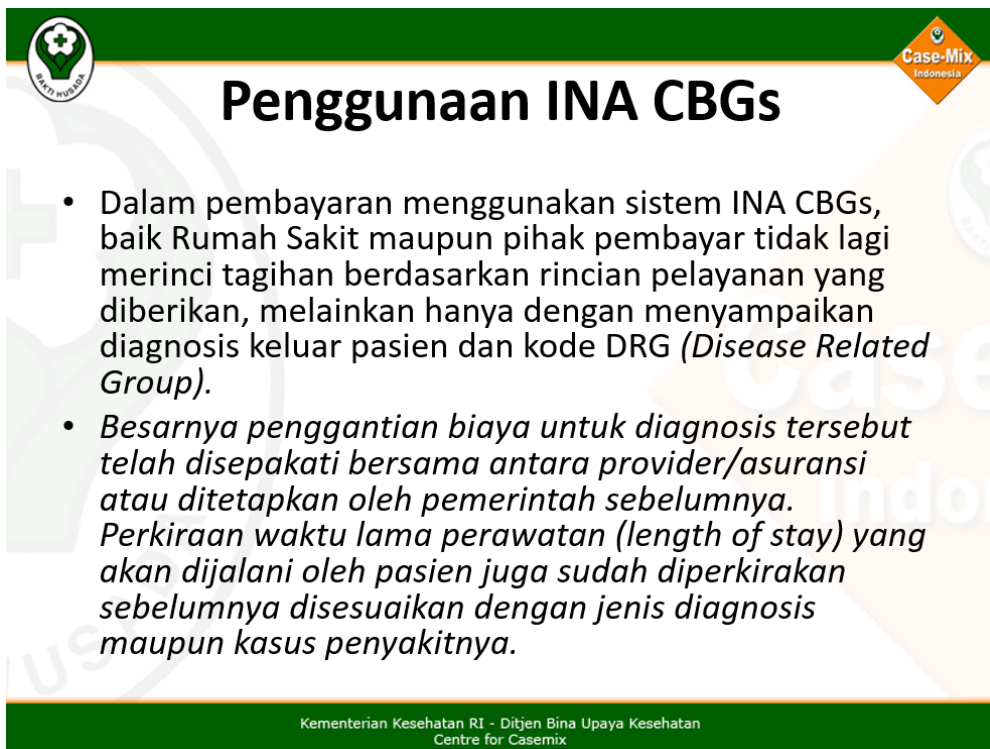
- (1) BPJS Kesehatan melakukan pembayaran kepada FKRTL secara *Indonesian Case Based Groups (INA CBG)*.
- (2) Tarif INA-CBG sebagaimana dimaksud pada ayat (1) diberlakukan pada FKRTL yang memberikan pelayanan:
 - a. RJTL; atau

6

-7-

- b. RITL.
- (3) Selain tarif INA-CBG, BPJS Kesehatan dapat melakukan pembayaran kepada FKRTL yang memberikan pelayanan:
 - a. obat untuk penyakit kronis dan obat kemoterapi;
 - b. alat bantu kesehatan yang meliputi:
 1. kacamata;
 2. alat bantu dengar;
 3. protesa alat gerak;
 4. protesa gigi;
 5. korset tulang belakang;
 6. *collar neck*; atau
 7. kruk;
 - c. pelayanan Ambulans yang diberikan antar FKRTL; dan
 - d. *Continuous Ambulatory Peritoneal Dialysis (CAPD)*.
- (4) Ketentuan pembayaran sebagaimana dimaksud pada ayat (1) dan ayat (3) mengacu kepada Peraturan

9. Ditjen Bina Upaya kesehatan Centre For Casemix (2013) ‘Pengenalan INA-CBGs (Indonesian Case Based Groups)’. Kementerian Kesehatan Republik Indonesia.



FAKTOR PENYEBAB KETERLAMBATAN WAKTU PENGEMBALIAN BERKAS REKAM MEDIS RAWAT INAP DI RS ESTOMIHI MEDAN TAHUN 2019

Erlindai

Dosen Prodi D-III Perekam Dan Infokes Imelda, Jalan Bilal Nomor 52 Medan

E-mail: erlindaipurba@gmail.com

ABSTRAK

Aspek ketepatan waktu pengembalian berkas rekam medis rawat inap harus sesuai dengan SPO yang ditetapkan oleh rumah sakit Estomihi yaitu 2x24 jam setelah pasien pulang dan sudah dalam keadaan lengkap. Oleh karena itu perlu adanya evaluasi faktor penyebab keterlambatan waktu pengembalian berkas rekam medis rawat inap untuk meningkatkan mutu pelayanan rumah sakit. Penelitian ini bertujuan untuk mengetahui penyebab ketidaktepatan waktu pengembalian berkas rekam medis rawat inap, jenis penelitian ini yaitu deskriptif, teknik pengumpulan data menggunakan observasi, kuisioner dan wawancara. Dari hasil penelitian yang dilakukan diketahui bahwa jumlah ketidaktepatan waktu pengembalian berkas rekam medis sebesar 63 atau 72,41% berkas rekam medis rawat inap dan jumlah berkas yang tepat waktu sebesar 24 atau 27,59%. Faktor penyebab keterlambatan waktu pengembalian berkas rekam medis rawat inap yaitu disebabkan oleh dokter yang terlambat mengisi kelengkapan berkas rekam medis, belum adanya petugas khusus pengembalian berkas rekam medis rawat inap, serta jarak Instalasi rawat inap ke Instalasi rekam medis yang cukup jauh sehingga mengakibatkan keterlambatan pengembalian berkas rekam medis rawat inap ke Instalasi rekam medis. Saran sebaiknya pihak rumah sakit melakukan sosialisasi dan mengingatkan kembali dokter dan profesi medis yang lain saat rapat tentang ketepatan pengembalian berkas rekam medis agar lebih disiplin dalam melengkapi berkas rekam medis sesuai dengan kebijakan SPO sehingga pengembalian berkas rekam medis tidak mengalami keterlambatan.

Kata Kunci: Pengembalian Berkas, Rekam Medis Rawat Inap.

ABSTRACT

The timeliness aspect of returning the inpatient medical record file must be in accordance with the SPO determined by the Estomihi hospital, which is 2x24 hours after the patient has returned and is in complete condition. Therefore it is necessary to evaluate the factors causing the delay in returning the inpatient medical record file to improve the quality of hospital services. This study aims to determine the cause of inaccurate return of inpatient medical record files, this type of research is descriptive, data collection techniques using observation, questionnaires and interviews. From the results of the research conducted, it is known that the number of inaccuracies in returning the medical record file is 63 or 72.41%, the inpatient medical record file and the number of timely files is 24 or 27.59%. Factors causing delays in returning the inpatient medical record file are caused by doctors who are late filling in the completeness of medical record files, the absence of special officers returning inpatient medical record files, as well as the distance of inpatient installations to medical record installations that are far enough to cause delay in returning record files medical hospitalization to medical record installation. Suggestions should the hospital do socialization and remind doctors and other medical professions during the meeting about the accuracy of returning medical record files to be more disciplined in completing the medical record file in accordance with the SPO policy so that the return of the medical record file is not delayed.

Keywords: File Returns, Inpatient Medical Records.

11. Farfar, I.O., Rahardjo, T.B. and Hutapea, F. (2022)

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**Analisis Jabatan Tim Casemix Dalam Upaya Peningkatan Klaim BPJS Di Rumah Sakit
Karya Medika II Tambun Bekasi Tahun 2019**

Inggrid Osa Far Far, Tri Budi W Rahardjo, Fresley Hutapea

Program Studi Administrasi Rumah Sakit Universitas Respati Indonesia

princesshapukh@gmail.com

ABSTRAK

Kurang optimalnya kinerja dari tim casemix yang mengakibatkan banyak klaim yang dipending oleh BPJS sehingga bila tidak disegera diperbaiki dapat mengganggu kinerja dari Rumah Sakit Karya Medika II Tambun Bekasi. Hal ini dapat dilihat dari pengajuan klaim BPJS dari bulan November 2018 sampai dengan bulan Februari 2019 yang angka pending klaim BPJS nya cukup tinggi. Hal ini yang ingin diteliti lebih lanjut oleh peneliti. Tujuan penelitian yaitu, mengetahui pembuatan uraian tugas anggota tim casemix, mengetahui kompetensi jabatan anggota tim casemix dan menetapkan indikator kinerja anggota tim casemix berdasarkan uraian tugas dan kompetensi. Metode penelitian ini adalah penelitian deskriptif dengan pendekatan kualitatif melalui wawancara, observasi dan melihat catatan karyawan atau Analisa data sekunder. Anggota tim casemix ini sudah paham mengenai apa yang menjadi tugas mereka walaupun secara kompetensi mereka kurang sesuai sehingga perlu ditetapkan indikator kinerja yang lebih sesuai dengan keadaan di Rumah Sakit Karya Medika II Tambun Bekasi.

Kata kunci : tim casemix, uraian tugas, kompetensi dan indikator kinerja.

casemix ini masih belum sesuai dengan kenyataan di lapangan.

SARAN

Dari hasil pengamatan, peneliti dapat memberikan beberapa saran, yaitu:

1. SDM:

- Untuk menambah petugas runnernya dengan petugas yang masih berusia muda sehingga mampu bertindak cepat untuk proses kelengkapan berkas klaim.
- Membuat uraian tugas, wewenang dan tanggungjawab yang lebih spesifik lagi untuk masing-masing petugas tim unit casemix Rumah Sakit Karya Medika II Tambun Bekasi.

2. Kompetensi:

- Diharapkan untuk kedepannya dilakukan perekrutan yang sesuai dengan jabatannya sehingga dapat memaksimalkan kinerja agar memperoleh hasil yang maksimal.
- Untuk yang ada sekarang harus secara kontinyu dilakukan pelatihan baik secara internal maupun eksternal yang sesuai dengan tugas dan tanggungjawabnya masing-masing.
- Agar unit casemix ini membuat rancangan strategik dalam menyusun program kerjanya.

3. Sarana dan Prasarana :

- Agar dibuatkan ruangan khusus kepala unit casemix serta ruang tamu agar lebih nyaman dalam melakukan pekerjaan.
- Menata ulang ruang casemix yang ada sekarang seperti posisi meja dan kursi yang sesuai aturan yang berlaku, sehingga tidak ada lagi dispenser yang letaknya persis dibelakang kursi petugas, membuat jendela sebagai ventilasi udara.
- Menambah kecepatan dari jaringan internetnya agar kinerja unit tim

casemix ini bisa terlaksana dengan baik.

- Komputernya dipasang filter buat radiasi, karena mereka bekerja dengan menggunakan computer dalam jangka waktu yang lama sehingga berakibat tidak baik bagi kesehatan mata mereka, dimana semua petugas tim casemix menggunakan kacamata yang minusnya bertambah terus. Sebaiknya pihak Rumah Sakit mengadakan pemeriksaan kesehatan mata bagi petugas yang baru masuk ke tim casemix atau yang sudah bekerja di tim casemix sehingga bila bertambah minusnya, maka mereka bisa mendapatkan kompensasi kacamata baru dari Rumah Sakit.

4. Indikator Kinerja: Rumah Sakit Karya Medika II Tambun Bekasi perlu membuat indikator kerja unit berdasarkan uraian tugas dan kompetensi yang sesuai kebutuhan bobot pekerjaan, seperti :

- Berapa jumlah berkas klaim yang dikirimkan Rumah Sakit Karya Medika II Tambun Bekasi oleh BPJS dalam 1 (satu) bulan?...100%
- Berapa jumlah berkas pending yang dikembalikan oleh BPJS dalam 1 (satu) bulan?... 0% dan sebagainya.

DAFTAR PUSTAKA

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LEAN HOSPITALS

Improving Quality, Patient Safety, and Employee Engagement

Third Edition

MARK GRABAN

Foreword by John Toussaint, MD



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Continuous Improvement

While many associate Lean with projects or weeklong events, the greatest potential comes when every person in the organization is engaged in improving processes every day. The Japanese word *kaizen* is often used to describe continuous improvement, sometimes translated as small changes or change for the good.²⁴ These improvement efforts regularly focus on reducing waste that exists in the patient's care or in people's work. Masaaki Imai defines *kaizen* simply as "everyday everyone, everywhere improvement." Contrast that to organizations where improvement is only the responsibility of experts, consultants, or managers, or where improvement only happens through sporadic projects or committees.

The term *waste* (also described using the Japanese word *muda*) has its own unique definition when used in association with Lean. In healthcare settings, waste can be defined as any activity that does not help patients or does not move them toward being diagnosed, treated, or discharged. One example of waste is time spent waiting—waiting for an appointment or waiting for the next step in the patient's treatment. Another example of waste would be activities or errors that harm a patient. We take a deeper look at waste in Chapter 3.

Dr. Donald Berwick, former president and CEO of the Institute for Healthcare Improvement and former administrator of the Centers for Medicare and Medicaid Services, argued that hospitals are full of waste, but the actual extent is unknown. Berwick claimed that 20% to 30% of the total expenditure of healthcare in the United States—about half a trillion dollars—is waste.²⁵ David Sharbaugh, director of quality improvement at Shadyside Hospital (Pittsburgh, Pennsylvania), said, "It's not unrealistic at all to consider 40% and 50% waste in the healthcare system."²⁶ Waste, to some extent, is present in every hospital process and organization. That is not an indictment of our people; it is just recognizing the system in which we work.

Continuous improvement methodologies have often been used in systems that are already stable and relatively free of waste. Leading hospitals are using Lean principles to completely redesign or radically overhaul their processes and space, working to create this stability. Beyond this redesign, or before it, Lean healthcare organizations create an environment for continuous improvement through their management mindsets and their mechanisms for engaging staff members, as covered in more detail in Chapter 11.

Respect for People

A display in the visitor center of a Toyota plant in Japan highlights "respect for people" and says, "There is no limit to how far human wisdom can be developed. Within the company, we continually aim to achieve mutual understanding, fulfill mutual responsibilities, and combine the power of our individual employees. Respect for people is the attitude that regards people's ability to think most."

When leaders at Toyota talk about having respect for people (or, originally, "respect for humanity"²⁷), this might have a different meaning than what traditional organizations might mean by respect—after all, what leader would say they do not respect their people? Respect does not mean that managers give employees latitude to do their jobs however they please, out of a sense of trust, as long as the results are good.²⁸ In a hospital that uses Lean principles, managers and leaders frequently verify the details of how work has been done. This is done out of respect for the patient (to ensure proper outcomes and quality) and can be done in a way that still shows respect for the employees.

Chapter 3

Value and Waste

Waste: A Global Problem with Local Solutions

A 2012 report from the Institute of Medicine (IOM) estimated that about one-third of healthcare spending in the United States—a total of about \$765 billion a year—is “waste.” Some of that waste is driven by broader societal issues, such as fraud or a lack of health insurance, but many of the categories of waste identified by the IOM can be addressed through Lean, including “inefficiently delivered services” (\$130 billion) and “unnecessary services” (\$210 billion).

While the United States and other countries try to address systemic waste through payment reform and other national initiatives, health systems can take action locally to reduce large amounts of waste. In 2011, when Dr. Don Berwick was the administrator of the Centers for Medicare and Medicaid Services (CMS), he said healthcare transformation “won’t yield to a massive top-down national project.” Instead, he proposed, “Successful redesign of health care is a community by community task.”¹ Let’s start by identifying and reducing or eliminating waste that we can affect locally.

Reducing Waste Is a Better Goal Than Reducing Cost

Healthcare organizations have focused on trying to reduce costs for a long time, but costs keep rising. Lean provides a different way to look at cost by not directly focusing on it. As author John Kay writes, “Strange as it may seem ... winning decisive battles or meeting global business targets are the type of goals often best achieved when pursued indirectly,” an idea he calls “obliquity.”² As an example of this, Patrick Hagan, former chief operating officer of Seattle Children’s Hospital, said, “We rarely talk about cost. We talk about waste, quality, and safety and we find our costs go down.”³

Lean hospitals focus on reducing waste, not cutting costs. Reducing waste leads to lower costs and better performance across the board, but without causing side effects or dysfunction. Lean organizations also focus on the customers (the patients) and the value that is being delivered to them. In this way, Lean is focused not on doing less but rather on delivering the right amount of value. If we are reducing waste, we can often provide more value while expending less effort and less cost. As the Lean Enterprise Institute teaches, “The core idea is to maximize customer

value while minimizing waste. Simply, Lean means creating more value for customers with fewer resources.³⁴

Cost is important, of course, to Hagan and all hospital leaders; however, Lean thinkers see cost as the end result of all of our systems and processes. Improving quality and patient safety leads to lower costs. Increasing patient flow and patient satisfaction can positively affect the bottom line.

Viewed as an end result, cost is not something that can be directly impacted, at least not without causing other things to get worse. Health systems have typically focused on direct “cost-cutting,” which means layoffs and the scaling back of services provided to our communities. Focusing only on cutting costs can also hurt safety and quality, patient satisfaction, and employee morale. As Dr. Berwick commented, “Costs should not be reduced by eliminating any helpful care or by harming a hair on any patient’s head.”³⁵ Lean helps us accomplish that goal.

Traditional healthcare cost-cutting also often doesn’t reduce costs in a sustainable way. For example, Gary J. Passama, chief executive officer (CEO) of NorthBay Healthcare (Fairfield, California), recognized that their system had three cycles of layoffs over a decade that were driven by financial pressures. However, Passama realized, “After a year or so, the employee count [was] back up and the savings evaporated.”³⁶ Passama concluded, “There has to be a better, longer lasting and less traumatic way to deal with such fiscal situations.” In 2012, Passama and NorthBay started a Lean program as a “better, longer lasting, and less traumatic” way of reducing costs.

What Is Waste?

What are the problems and annoyances that constantly appear, interfering with our work and the best patient care? In Lean, we call this *waste*. Dr. Berwick describes waste as “needless hassle” and “what does not make sense in our health care system.”³⁷

Hospital workdays are full of interruptions, miscommunications, wasted motion, and workarounds. Employees and leaders often think their job, or the value they bring to an organization, is their ability to put up with problems or to fight fires. When supplies are missing, we run to find them. When our workspaces are badly designed and workloads are high, we walk faster and try harder. When orders do not arrive from a physician’s office, we make multiple phone calls to track them down. It’s good, in a way, that people make this effort. But, they shouldn’t have to. These extra efforts do not prevent the same problem from reoccurring. Instead of pointing at workarounds and heroic measures as “our job,” we might do better by viewing waste as something to reduce or eliminate, so we can spend more time doing our real work—caring for patients.

Learning to separate motion (the things we do) from value (the things we do that help the patient) is a critical step in the Lean journey. Instead of defining our jobs in terms of “this is what we do” or “this is how we’ve always done it,” Lean gives us a framework for determining what we *should* be doing and how we should be doing it. Hospitals can learn how to free up time in ways that do not cut corners on quality or care that is needed by the patient.

Hospital employees typically spend a high percentage of their time on wasteful activities. For example, medical/surgical nurses in hospitals around the world typically spend only about 30% of their time on direct patient care, including

- Nursing procedures
- Hygiene and toileting

How Does Lean Define “Value?”

Within the context of these big picture questions, the Lean methodology gives us some specific rules to use in determining what activities are value-added (VA) or non-value-added (NVA). The three general rules that must be met for an activity to be considered value-added are²⁰

1. The customer must be willing to pay for the activity.
2. The activity must transform the product or service in some way.
3. The activity must be done correctly the first time.

All three of these rules must be met or the activity is non-value-added, or waste.

Rule 1: The Customer Must Be Willing to Pay for the Activity

Thinkers with diverse backgrounds such as Porter and Womack agree that value must be defined from the customer's perspective.^{21,22} This idea is less complicated in manufacturing. Think of buying a car. If you don't want a sunroof, you can choose to not get a sunroof, thereby not paying for a sunroof. If you don't value a car at all, you can often avoid buying a car. You might instead choose to pay to use a bus, taxi, or ride-sharing service, since what you really value, in terms of an outcome, is getting from point A to point B, safely and conveniently.

In healthcare, this question of willingness to pay quickly gets complicated, as patients often have no choice but to receive care. Additionally, the person receiving the care is most often not the person who is paying. Given the potential for different definitions of value from different customers, how can we agree on value? Often, the providers of a service assume what is valued or not valued by customers. One method for determining what customers value is to ask them. Some hospitals are beginning to formally involve patients and their families in improvement efforts, including asking patients to help define value for their care and the overall services provided by the hospital.²³

With the first rule, we can start with the patient as customer. A medical professional might think, “Our customers do not always know enough to answer that question! They do not appreciate everything we have to do for them.” That might be true; sometimes, customers or patients have to be educated. Hospital employees, caregivers, or leaders cannot assume that any activity that we do is automatically value-added because of our job title or because a certain activity has always been done or done a particular way.

A patient who comes in with a suspected hip fracture would value the steps directly required for comfort, diagnosis, and treatment. Time spent directly with caregivers, such as nurses and surgeons, would be valued. The patient having to give the same triage information to three different people would be waste the second and third times. Having X-rays reviewed would be valued, but time spent waiting because the radiologist is too busy would be considered waste. Education about how to reduce future falls at home might be valued, as well.

Rule 2: The Activity Must Transform the Product or Service in Some Way

The original manufacturing definition for the second rule described changing the “form, fit, or function of the product,”²⁴ meaning there was a physical change that brought the product closer to its final state. For example, installing a car door changes the product in a value-added way as customers are willing to pay for doors, and the product changes from a doorless chassis to one with

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UNIT COST RUMAH SAKIT DAN TARIF INA-CBGs: SUDAHKAH PEMBIAYAAN PELAYANAN KESEHATAN RUMAH SAKIT DIBAYAR DENGAN LAYAK?

Hospital Unit cost and INA-CBGs Tariff: Is The Hospital Health Services Paid Fair?

Lestari Handayani, Suharmiati, Niniek Lely Pratiwi

Puslitbang Humaniora dan Manajemen Kesehatan - Balitbangkes - Kemenkes RI

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ABSTRAK

Berbagai komentar baik dukungan ataupun penolakan dilontarkan pihak rumah sakit (RS) sejak diberlakukan tarif INA-CBGs pada tahun 2014 dalam Jaminan Kesehatan Nasional (JKN). Sebagian RS mengeluhkan ketidakadilan besaran tarif yang dianggap tidak sesuai dengan biaya riil pelayanan kesehatan. Tarif INA-CBGs sesuai peraturan, ditinjau minimal setiap dua tahun. Pemerintah melakukan evaluasi dan revisi terhadap Tarif yang ditetapkan berdasar atas perhitungan *Unit cost* (UC) serta memperhitungkan berbagai aspek terkait. Hasil penelitian menunjukkan bahwa secara umum hasil perhitungan UC dengan metode *step down* untuk pelayanan rawat inap, dan rawat jalan di 84 RS Umum BLU/BLUD lebih rendah dari Tarif INA-CBGs. Dapat disimpulkan bahwa pemberlakuan tarif INA-CBG masih memenuhi rasa keadilan dan dapat diterapkan. Direkomendasikan agar peninjauan tarif disamping memperhitungkan perubahan UC juga kondisi ekonomi global/regional/nasional sehingga dapat dilakukan sesuai kebutuhan dan tidak harus dilakukan setiap dua tahun. Di pihak lain, RS perlu mengelola pembiayaan INA-CBGs untuk pelayanan kesehatan secara efisien agar dapat menjaga mutu pelayanan sesuai harapan masyarakat.

Kata kunci: *Unit cost*, Tarif, Rumah sakit, Jaminan Kesehatan Nasional

ABSTRACT

Various comments either support or rejection made by the hospital since the introduction of INA-CBGs tariff of the National Health Insurance (JKN) in January of 2014. Some hospitals complained about the unfairness of tariffs that are considered inconsistent with the real cost of health services. INA-CBGs tariffs are subject to regulations, reviewed at least every two years. The Government evaluates and revises the tariffs determined based on Unit cost (UC) calculations and takes into account various aspects. The results showed that in general UC calculation result with step down method for inpatient and outpatient service at 84 Public Hospital BLU / BLUD is lower than INA-CBGs Tariff. It can be concluded that the implementation of INA-CBG tariffs still meet the sense of justice and can be applied. It is recommended that the tariff review also takes into account the UC change and global / regional / national economic conditions so it should not be done every two years. On the other hand, hospitals need to manage INA-CBGs health services financing efficiently in order to maintain the quality of service and to meet the patients demand.

Keywords: *Unit cost*, Tariff, Hospital, National Health Insurance

PENDAHULUAN

Indonesia menargetkan pencapaian Cakupan Kesehatan Semesta (*Universal Health Coverage*) pada tahun 2019, artinya pada tahun tersebut

rakyat Indonesia terjamin kesehatannya secara keseluruhan. Pelayanan kesehatan diperoleh dari Fasilitas Kesehatan Tingkat Pertama (FKTP) maupun Fasilitas Kesehatan Rujukan Tingkat Lanjut (FKRTL)

Korespondensi:

Lestari Handayani

Puslitbang Humaniora dan Manajemen Kesehatan - Badan litbangkes - Kemenkes RI

E-mail: lestarimail@yahoo.com.sg

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Tanya Jawab METODOLOGI PENELITIAN KESEHATAN

**Referensi Praktis Mahasiswa S1, S2, S3,
PPDS dan Peneliti Pemula**

dr. Hardisman, MHID, PhD

Dosen Fakultas Kedokteran Universitas Andalas
(FK-Unand) Padang, Sumatera Barat

Tabel 6.1. Jumlah sampel minimal pada penelitian populasi tunggal dengan data proporsi

Proporsi Kasus	Derajat Kepercayaan			
	99%, $\alpha:1\%$		95%, $\alpha:5\%$	
	d:5%	d:10%	d:5%	d:10%
10%	240	60	138	35
15%	339	85	196	49
20%	426	107	246	61
25%	499	125	288	72
30%	559	140	323	81
35%	606	151	349	87
40%	639	160	369	92
45%	659	165	380	95
50%	666	166	384	96

Bila penelitian dilakukan pada populasi terbatas (finite), maka rumus sampelnya dimodifikasi dengan memasukkan jumlah populasi (N). Misalnya penelitian pada sekolah dasar atau penelitian pada peserta Posyandu Lansia di suatu kelurahan.

$$n = \frac{Z^2_{1-\alpha/2} P(1-P) N}{d^2 (N-1) + Z^2_{1-\alpha/2} P(1-P)}$$

(Rumus 6.2)

15. Herawati, Franzone, R. and Chrisnahutama, A. (2020) *Universal Health Coverage: Tracking Indonesia's Progress*. Jakarta: Perkumpulan PRAKARSA.

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Authors:

Herawati, Robert Franzone, Adrian Chrisnahutama

Reviewers:

Eka Afrina Djamhari, Cut Nurul Aidha, Herni Ramdhaningrum

Managing Director:

Ah Maftuchan

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EXECUTIVE SUMMARY

Indonesia's health system is transitioning to universal health coverage (UHC) with the aim of providing access to health for the entire population. The National Health Insurance (Jaminan Kesehatan Nasional-JKN), is the national health program dedicated to achieving UHC as mandated under Law No.40/2004. UHC has generally only been explored in terms of participation levels of JKN. However, UHC has broader dimensions, namely service coverage, service quality, and financial protection for health. Therefore, a more comprehensive analysis is required to assess UHC progress in Indonesia.

The World Health Organization (WHO) in 2017 published a global progress report of UHC titled 'Universal Health Coverage Tracking: 2017 Global Monitoring Report'. The framework adopted in that report to measure UHC progress is based on Sustainable

Development Goal (SDG) 3, target 3.8 and indicators 3.8.1 (service coverage) and 3.8.2 (financial protection). Applying this framework, PRAKARSA conducted a study on UHC progress in Indonesia based on 2018 data. This study aims to measure progress made toward service coverage and measure the financial difficulties experienced by the community due to out-of-pocket spending on health expenditure.

There are four dimensions and 14 indicators used to track UHC service coverage in Indonesia. The index is obtained from the average value of the index of the four dimensions where the index value of each dimension is obtained from the average index value of a set of indicators. Service coverage index presents a numerical value based on a scale of one to one hundred, with the higher the index the better the service coverage. Meanwhile,

1 INTRODUCTION

“Indonesia’s health system is transitioning into universal health coverage (UHC), with the current system aiming to provide universal health care by the end of 2019” – TNP2K, 2015

As we enter 2020, analysis is required to review the extent to which National Health Insurance (Jaminan Kesehatan Nasional - JKN) is on the path to achieving UHC. This report will seek to illustrate Indonesia’s current position in achieving UHC using frameworks established by the World Health Organization (WHO).

Adopting the WHO’s definition of UHC “that all people have access to the health services they need, when and where they need them, without financial hardship” (The World Health Organization, 2019). Indonesia requires a system that adequately caters for nearly 270 million people (The World Bank, 2019). The current system, JKN, which was launched on 1 January 2014 (Maharani et al., 2019), is the consolidation of multiple previous health schemes

that will become the most extensive single-payer social health insurance program in the world (Erlangga et al., 2019).

Progress toward achieving UHC in Indonesia, is hindered by, amongst others, the triple burden of diseases as discussed by Moeloek (2017); noncommunicable diseases (NCDs), communicable diseases, and the neglected tropical diseases. Diseases, such as tuberculosis (TB), have seen greater spread due to high rates of urbanisation and population growth (Moeloek, 2017). Common NCDs, such as stroke, heart disease, and diabetes mellitus, have been the leading cause of morbidity and mortality in Indonesia since 2010 and has led to NCDs affecting all socioeconomic classes, affecting younger and older people (Moeloek, 2017). High rates of

16. Hikmah, F., Wijayantin, R.A. and Rahmadtullah, Y.P. (2019)

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Penentu Prioritas dan Perbaikan Masalah Keterlambatan Pengembalian Berkas Rekam Medis Rawat Inap di Rumah Sakit Daerah Kalisat

Faiqatul Hikmah¹, Rossalina Adi W², Yonica Putra Rahmadtullah³

Prodi Rekam Medik Jurusan Kesehatan, Politeknik Negeri Jember

email : faiqatul@polije.ac.id

ABSTRACT

The return of medical records file of inpatient patient has standard of payback time 2x24 hours after patient returns in accordance with SOP applicable in hospital. However, the delay in returning medical record files in RSD Kalisat is still common. The purpose of this research is to determine the priority and improvement of the problem of delay in return of medical records file of inpatient in RSD Kalisat. This type of research is descriptive qualitative research with interview data collection method, documentation, and brainstorming. The result of identification of factors causing the delay of medical record file stated that the delay of return of medical record file is caused by several things one of them is the incompleteness of the filing of medical record file. Planning done in this research is improvement of Standard Operational Evaluation Procedure of Filing File Record Medical File which aims to support the quality of file in completeness of filling of medical record file and to facilitate administration of return of file. From the results of this study the researchers suggested that there is training on the return of file files to inpatients. It is also necessary to apply standard operational procedures to speed up the timing of completing the medical record file and can be carried out continuous review of this purpose as a reminder that the medical record file can be completed immediately and can be returned within the specified time limit.

Keywords: Hospital, Inpatients, Medical Record

ABSTRAK

Kegiatan pengembalian berkas rekam medis pasien rawat inap memiliki standar waktu pengembalian 2x24 jam setelah pasien pulang sesuai dengan SOP yang berlaku di rumah sakit. Namun keterlambatan pengembalian berkas rekam medis di RSD Kalisat masih sering terjadi. Tujuan dari penelitian ini adalah melakukan penentuan prioritas dan perbaikan masalah keterlambatan pengembalian berkas rekam medis rawat inap di RSD Kalisat. Jenis penelitian ini adalah penelitian kualitatif deskriptif dengan metode pengumpulan data wawancara, dokumentasi, dan *brainstorming*. Hasil identifikasi faktor-faktor penyebab keterlambatan berkas rekam medis menyatakan bahwa keterlambatan pengembalian berkas rekam medis disebabkan oleh beberapa hal salah satunya yaitu ketidaklengkapan pengisian berkas rekam medis. Perencanaan yang dilakukan pada penelitian ini adalah perbaikan Standart Oprasional Prosedur Evaluasi Kelengkapan Pengisian Berkas Rekam Medis yang bertujuan untuk menunjang kualitas berkas dalam kelengkapan pengisian berkas rekam medis dan untuk mempermudah administrasi pengembalian berkas. Dari hasil penelitian ini peneliti menyarankan agar adanya pelatihan tentang pengembalian berkas terhadap petugas rawat inap. Perlu juga adanya penerapan standart oprasional prosedur untuk mempercepat waktu melengkapi pengisian berkas rekam medis dan dapat dilakukan peninjauan terus menerus hal ini bertujuan sebagai pengingat agar berkas rekam medis bisa segera dilengkapi dan bisa kembali sesuai dengan batas waktu yang telah ditentukan.

Kata Kunci: Rawat Inap, Rekam Medis, Rumah Sakit

PENDAHULUAN

Rekam medis adalah kumpulan fakta tentang kehidupan seseorang dan riwayat penyakitnya, termasuk keadaan sakit, pengobatan saat ini dan saat lampau yang ditulis oleh para praktisi kesehatan dalam upaya mereka memberikan pelayanan

kesehatan kepada pasien. Ketepatan dan kelengkapan berkas rekam medis merupakan salah satu mutu yang dimiliki oleh rekam medik dalam meningkatkan mutu pelayanan rumah sakit (Hatta,2008).

Menurut RSD Kalisat (2017), ketidaktepatan waktu pengembalian berkas rekam medis rawat inap di RSD Kalisat ke Unit Rekam Medis lebih dari 2x24 jam.

KAJIAN LITERATURE: EVALUASI PELAKSANAAN PROGRAM JAMINAN KESEHATAN NASIONAL DI INDONESIA

A LITERATURE REVIEW: EVALUATION OF THE NATIONAL HEALTH INSURANCE IN INDONESIA

Irwandy

Bagian Manajemen Rumah Sakit, Fakultas Kesehatan Masyarakat, Universitas Hasanuddin

ABSTRACT

Background: The National Health Insurance (JKN) in Indonesia, which started on January 1, 2014 has contributed greatly to reform health care systems and financing in Indonesia. As mandated by law, is expected to gradually JKN can become the backbone for achieving Universal Health Coverage in 2019. Until now, there are various studies aimed to evaluate the JKN program that has been expected to provide recommendations for this program.

Purposes: The purpose of this research was to conduct the literature review about the implementation of the National Health Insurance program in Indonesia and formulate the recommendations to improve it.

Methods: The research was conducted in March 2015 by reviewing the literature on various journals research those have been published during the period January 2014 to March 2015 on the UNHAS website repository. There were 8 Journals found and reviewed in this research.

Results: The results showed that at the beginning of JKN program, there are several problems found in the implementation such as the lack of regulations and guidelines related to the implementation of JKN, low coverage of socialization programs to health centers and hospitals, hospital was unprepared to meet the specific requirements for BPJS credentials, the hospital was unsatisfied with the tariffs of INA CBG, and hospital claims is often too late. However, another journal showed that as for the level of patient satisfaction at hospital, 87.7% of respondents are satisfied.

Conclusions: During the implementation of JKN Program in Indonesia, there are several problems and challenges. Therefore we need to learn and improve the program based on this experience and research findings. To achieve Universal Health Coverage in 2019 we need to improve the quantity and quality of research in evaluating the implementation of JKN in Indonesia.

Keywords: National Health Insurance, Evaluation, Literature Review

ABSTRAK

Latar belakang: Jaminan Kesehatan Nasional (JKN) di Indonesia yang dimulai sejak 1 Januari Tahun 2014 telah memberikan andil yang besar terhadap reformasi sistem pelayanan dan pembiayaan kesehatan di Indonesia. Sebagaimana diamanatkan Undang-Undang, JKN diharapkan secara bertahap dapat menjadi tulang punggung untuk mencapai *Universal Health Coverage* di Tahun 2019. Hingga saat ini telah banyak dilakukan berbagai penelitian yang bertujuan mengevaluasi program JKN yang diharapkan dapat memberi masukan dalam upaya perbaikan kedepan.

Tujuan: Penelitian ini bertujuan untuk melakukan kajian literature untuk memperoleh masukan dalam perbaikan implementasi program Jaminan Kesehatan Nasional di Indonesia.

Metode: Penelitian ini dilaksanakan pada Maret 2015 dengan melakukan kajian literature terhadap berbagai hasil penelitian yang telah dipublish selama periode Januari 2014 hingga Maret 2015 pada *website repository* Universitas Hasanuddin, Makassar yakni sebanyak 8 jurnal penelitian.

Hasil: Hasil kajian terhadap beberapa penelitian yang dilakukan menunjukkan bahwa selama penerapan JKN ditemui beberapa kendala yang dihadapi yakni pada awal pelaksanaan masih terkendala dengan belum tersedianya beberapa regulasi dan juknis terkait implementasi JKN, sosialisasi teknis program ke fasilitas pelayanan kesehatan baik Puskesmas dan RS masih rendah, disamping itu masih kurang siapnya beberapa RS dalam memenuhi persyaratan kredensial yang ditetapkan BPJS, besaran tarif INA CBG yang dirasa kurang tepat bagi RS serta klaim RS yang terlambat. Hasil penelitian lain juga memperlihatkan untuk tingkat kepuasan pasien BPJS di salah satu RS telah berada pada kategori baik yakni 87,7%.

Kesimpulan: Selama penerapan Program JKN di Indonesia telah ditemukan beberapa faktor pendukung dan penghambat pelaksanaan program JKN. Oleh karena itu diperlukan perbaikan secara terus menerus terhadap pelaksanaan program JKN demi pencapaian *Universal Health Coverage* pada Tahun 2019 dengan meningkatkan kuantitas dan kualitas pelaksanaan penelitian dalam mengevaluasi pelaksanaan JKN di Indonesia.

Kata Kunci: Jaminan Kesehatan Nasional, Evaluasi, Kajian Literature

PENGANTAR

Dalam beberapa Tahun terakhir ini, negara berusaha untuk mewujudkan jaminan kesehatan bagi seluruh penduduk Indonesia atau biasa disebut dengan jaminan kesehatan semesta (*Universal Health Coverage*). Upaya tersebut dimaksudkan untuk meningkatkan akses masyarakat pada pelayanan kesehatan yang komprehensif, bermutu, dan merata bagi seluruh rakyat Indonesia melalui pembentukan sistem jaminan sosial nasional bagi seluruh rakyat Indonesia. Jaminan Sosial adalah bentuk perlindungan sosial untuk menjamin seluruh rakyat agar dapat memenuhi kebutuhan dasar hidupnya yang layak termasuk kebutuhan akan kesehatan. Undang-Undang No. 40/2004 mengamatkan bahwa jaminan sosial wajib bagi seluruh penduduk termasuk

Chapter

Lean and Kaizen: The Past and the Future of the Methodologies

Vasileios Ismyrlis

Abstract

Lean and Kaizen improvement methodologies have been in the entrepreneurship spotlight for a long time. They can be adopted by any kind of enterprise, and they succeed in producing better long-term results, improving their performance, but most important, influencing the philosophy of the organizations implemented. In this research, many case studies and success stories of companies implementing Kaizen or/and Lean methodologies, or even the new Lean Kaizen methodology, will be introduced. We attempt to evaluate the performance of Lean and Kaizen implemented companies and distinguish the elements that made the difference. Maybe, it is some specific tool, or an aspect in the culture that was enhanced, since the implementation of these business process improvement methodologies. Finally, thoughts and estimations will be presented, regarding the future of these methodologies, in the unstable and rapidly changing economic environment.

Keywords: Lean, Kaizen, Lean Kaizen, performance, process improvement

1. Introduction

This chapter presents the methodologies of Lean and Kaizen, their contribution in the enterprises' field and their future potential contribution to the field of management.

1.1 Lean (production, manufacturing or management)

First of all, lean manufacturing, will be referred, as it seems to be a methodology, that was keenly embraced and wields a great acceptance in the management (theoretical and practical) world. It started with the efforts of Toyota automobile company, while some believe that Ford motor company, was also a great influence in creating its concept.

Its main scope and its achievement is the elimination of waste and this can lead in an increase in productivity.

There are many proven cases of continuous improvement with the implementation of lean thinking methods and tools. However, it is not a concept that impose specific rules or tools to be implemented, but rather it is a philosophy that encourages efforts in order to achieve its main goal, which is to eliminate waste.

1.2 Kaizen

Kaizen is more of a philosophy than specific technique or methodology, yet it has also affected and changed seriously the minds of the managers. It utilizes

19. Iswanto, A.H. (2019) *Lean Implementation in Hospital Departments: How To Move From Good To Great Services*. New York: Taylor & Francis.

Lean Implementation in Hospital Departments

How to Move from Good
to Great Services

By
A. Heri Iswanto



A PRODUCTIVITY PRESS BOOK

Chapter 12

Lean Implementation in the Medical Record Unit

Medical Record Unit Issues

As well as the radiology department, the medical record unit is an endangered unit due to the development of information technology, which allows each core unit to have access to electronic medical records and no longer requires the medical record unit. It is a traditional unit that stores the patient data from the entire history of the hospital in offline form. This traditional method is actually not good for the financial health of the hospital. Medical records that build up too fast can overpower the human resources available so that hospitals can lose income because most medical records could not be converted into a bill for the patients. In other words, manual labor is too big; electronic work may also be too big if the electronic design is still too rough and the speed of data entry is slower than the speed of manual writing.¹

Of all hospital parts, the medical record unit is the most antique unit in the sense of having medical records of patients that span from the time the hospital was first established. This information can be valuable, and many other units also consider

it important for particular patients' medical record information. Problems related to the seizing of medical record documents often occur between the medical record unit and other units, fighting over particular patients' medical record documents because of the high value, especially in terms of finance. The unit may favor the patient, so it does not want to hand over the documents to the medical record unit and therefore reduce the function of such a unit for those who do not understand the existence of this internal conflict. In addition, at very old hospitals, a number of medical record documents become extremely valuable because of their age and association with famous figures who have got treatment at the hospital. The documents are often guarded and are not included in the computer system.¹

The most common waste for the medical record unit is the waiting time associated with processing time at the unit. In the very traditional system, an officer must examine piles of data for obtaining the patient data. When the data is not accurate, for example, because a patient has the same name as another patient, there will be difficulties in access that lengthen the waiting time. Usually, when patients order a place in the hospital, the medical records officer will check the patient's medical records and hand it to the physician to review and, based on their advice, the patients are given the right place at the hospital. This process can take from five minutes up to 36 days.²

Lean implementation in this unit can be illustrated with the following examples from National Health Service (NHS) hospitals in the United Kingdom.² An NHS hospital has a problem of delay and cancellation due to the inefficient flow of patients' medical records. A Lean implementation technique is run involving three units at once: the medical record unit, the inpatient unit, and medical secretaries. The Lean team formed consists of a group of managers, secretaries, employees, and nurses. The team is trained in the Lean principles.

The first step taken by the Lean team is to build an information flow map. This map illustrates from when the patients pose a health problem to when they are released. The

mapping results are quite surprising. A patient, on average, has to pass more than 150 procedures and 50 replacement handling responsibilities. There being so many steps is one reason for the inefficiency of the medical record services. In addition to excessive steps, a problem found is poor communication between the units. The Lean team focuses on efforts to remove procedures that do not add value and which, in fact, add to the cost and the time to respond to the patient.

Steps taken by the Lean team in the context of medical records are to create standard letters and forms, redesign the layout, mark files in the library so that they can be easier and faster to find, and shorten the distance between employee desks and the printer. Empty space is created in which to store predicted patients' medical records the day before their arrival. This step generates savings of 57 hours per week. Standard letters and forms are submitted to the secretaries and they hire one additional officer for help. The additional officer enables the unit to handle the previously piling work. Standard letters and forms prevent new work from accumulating because it can be resolved quickly. This effect brings a saving of 8 working hours a week. The Lean step in the medical record unit also has an effect on the inpatient unit. The redesign of the layout, better marking of files, and reduction of personnel distance with the printer, as well as the provision of space for patients, allow the nurses to move efficiently in the medical record room. This acceleration generates a reduction in patient walking distance of up to 30% and a reduction of 4% in treatment cancellation.

This step can be more efficient if the standard form is planned carefully so that it covers the entire value required by the patients. This matter can be achieved by mapping the patient value. With the value map, it can be seen where the patients move, beginning from admission to the hospital. These units have the information needed from the patient and provided by the medical record unit. If the unit cannot provide the required information, then the patient has to provide

20. Jimmerson, C.L. (2010) *Value stream mapping for healthcare made easy*. Boca Raton: CRC Press.

Value Stream Mapping for Healthcare Made Easy

Cindy Jimmerson

Illustrated by Amy Jimmerson and Herman Ranpurnia



CRC Press

Taylor & Francis Group

Boca Raton London New York

CRC Press is an imprint of the
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Chapter 1

Identifying Waste in Healthcare

Taiichi Ohno, the man credited with the development of the Toyota Production System (TPS) in the early 1950s, identified the seven *mudas* (sources of waste) in manufacturing, which include the following:

- Conveyance
- Motion
- Waiting
- Overprocessing
- Inventory
- Defects
- Overproduction

While there are likely many more sources of *muda* that are unique to every industry, in this chapter I have adapted Ohno's list, with only minor modification to the first *muda*, to make it more pertinent to healthcare. The term seven *mudas* is well recognized by advocates of TPS, but in a slightly converted list for this industry, I have combined "conveyance" and "motion" (my apologies to Toyota purists!) and included "confusion." This was not an arbitrary decision, but one based on thousands of hours of direct observation in which highly skilled and educated caregivers spent many hours of their day asking questions like "Where does this go?", "What do I do with this (thing/person/information)?", "I can't read this writing, what does this say?", "What happens next?", and so on. Since 2000 I have received many suggestions for adding to the list of sources of waste—all good ones! But I had to stop somewhere. So I encourage you not to be stuck on these seven wastes as an exact prescription, but to recognize that there are basic systemic failures that occur regularly in every industry, and identifying the ones specific to our own work is incredibly valuable. It is amazing how easy it is to see elements of waste in daily work once you review and understand them. Here is my rendition of the seven *mudas* for healthcare:

- Confusion
- Motion/conveyance
- Waiting
- Overprocessing
- Inventory
- Defects
- Overproduction

Waste 1: Confusion

Patient safety is now and always has been at the forefront of every caregiver's mind. The medical errors that have been reported in recent academic and media exposés have alarmed and infuriated the general population and devastated the morale of healthcare workers. Failure of processes to support healthcare workers in doing their good work is very often rooted in confusion.

A casual observer in a hospital anywhere in the world would likely be alarmed if they focused only on the questions of clarification that are asked every day. In one study conducted by Anita Tucker and Steven Spear (2006), nurses on a busy medical unit experienced 8.4 work system failures per shift. Working with scores of hospitals of all sizes and levels of sophistication in the past 9 years, my colleagues and I have recorded very similar results, with nurses spending as much as 65% of their time looking for things they could not find, clarifying information and instructions that were unclear, and doing redundant paperwork (Jimmerson et al. 2005). Confusion included questions like the following:

- "What do I do with this requisition?"
- "What does this order mean?"
- "Does anyone know what I'm supposed to do with this?"
- "Where do we store the...?"
- "Where are the reports for...?"

Similar questions are asked thousands of times in the daily course of caring for patients.

Although resolution of the confusion was necessary for caregivers to get their jobs done or meet regulatory requirements, most of their activities did not add value to the patient. And to no one's surprise, these confusion-laden activities were recognized by the hardworking and motivated staff as being a waste of their time and a source of great frustration.

Imagine if the work process were so intuitive that answers were built into the process and the current time spent and frustration experienced could be eliminated. In reducing the confusion *muda* alone lies the potential to capture a great deal of worker capacity, decrease worker frustration, and reduce the opportunity for errors in patient care.

Penelitian Kombinasi (*Mixed Methods*)

Rahmat Justan¹, Margiono², Abdul Aziz³, Sumiati⁴

^{1,2,3,4}Universitas Muhammadiyah Makassar

E-mail: rahmatjustanadi@gmail.com¹, margionoislamiah@gmail.com², Abuhijazil4@gmail.com³,
hjsumiati.unismuh@gmail.com⁴

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Abstract: Penelitian menjadi kegiatan yang penting dilakukan. Penelitian dapat dilakukan dengan metodologi kuantitatif, kualitatif dan campuran (*mixed method*). Tujuan pada penulisan makalah ini adalah untuk membahas penelitian campuran (*mixed method*) dari aspek definisi, karakteristik, perkembangan, jenis dan prosedur penelitian. Definisi penelitian campuran (*mixed method*) adalah prosedur untuk mengumpulkan, menganalisis, dan mengkombinasi metode kuantitatif dan kualitatif dalam satu penelitian. Karakteristik Penelitian campuran (*mixed method*) terletak pada aspek rasionalitas, prioritas, sekuens/waktu, dan penggabungan data. Rasionalitas penggunaan penelitian campuran (*mixed method*) didasarkan pada aspek kredibilitas, konteks, ilustrasi, utilitas, mengkonfirmasi temuan, dan keragaman pandangan. Penelitian campuran (*mixed method*) berkembang lebih dari abad ke-20 sebagai bentuk solusi dari permasalahan para peneliti yang merasa memerlukan dukungan dari metode kuantitatif atau kualitatif terhadap penelitiannya. Perkembangan terus berlanjut hingga menghasilkan beberapa jenis penelitian campuran (*mixed method*) yaitu: 1) eksplanasi berurutan (*sequential explanatory strategy*), 2) eksplorasi berurutan (*sequential exploratory strategy*), 3) transformasi berurutan (*sequential transformative strategy*), 4) triangulasi bersamaan (*concurrent triangulation strategy*), 5) terpadu bersama-sama (*concurrent embedded strategy*), dan 6) transformatif bersamaan (*concurrent transformative strategy*). Prosedur penelitian campuran (*mixed method*) secara umum sama dengan penelitian pada umumnya yang meliputi 1) menentukan masalah dan tujuan penelitian, 2) mengidentifikasi rasionalitas penelitian, 3) menentukan desain/jenis penelitian campuran dan mengungkapkan alasan yang mendasarinya, 4) mengumpulkan data 5) menganalisa data, dan 6) menulis laporan.

22. Katao, I. and Smalley, A. (2011) *Toyota Kaizen Methods Six steps to Improvement*. Taylor and Francis Group.

Toyota
Kaizen
Methods

Six Steps to Improvement

Isao Kato and Art Smalley



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Chapter 2

Background of Kaizen in Toyota

2.1 History of Kaizen Methods in Toyota

In this chapter, we briefly review the different influences on the concept of Kaizen inside Toyota and clarify some of its origins. As you will see, there is no simple or single beginning for Kaizen inside Toyota Motor Corporation. Kaizen is not a new word in Japanese, and the notion of improvement was always central to Toyota from the time of the founder Sakichi Toyoda and his son Kiichiro in their initial endeavors related to creating better looms in the early 1900s. In this background section, we briefly highlight some of the influences in Toyota's Kaizen methodology. For those interested just in the actual process and methodology, you can skip ahead directly to the chapters covering the six steps of Kaizen.

The word *Kaizen* in Japanese is written 改善 with two kanji characters meaning “to change” and “for the better.” Unfortunately, the origins of the term are not exactly clear in terms of etymology. The word *Kaizen* is Chinese in origin

Marija Kovacevic
Milos Jovicic
Marko Djapan¹
Ivana Zivanovic-
Macuzic

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LEAN THINKING IN HEALTHCARE: REVIEW OF IMPLEMENTATION RESULTS

Abstract: For over decade, automotive industry originated lean concept has been successfully implemented in healthcare systems as a management method and philosophy with main focus on elimination of all types of wastes and losses in all tasks and processes so that time, materials, resources and medical procedures could be realized as effectively as it is possible. As main result lean concept implementation ensured to healthcare organizations to focus on their main core function and dedicate more time and efforts to patients without additional costs for them or healthcare system. However, lean implementation in healthcare could be much more difficult than in standard industrial environment and there are significant number of examples of lean in healthcare projects that failed to gain any measurable results and sustainable benefits from it. This paper presents review of some of the most successful implementations of lean tools and principles in healthcare organizations.

Keywords: lean, healthcare, kaizen

1. Introduction

Healthcare systems and units, worldwide, focusing continuous pressure to reduce all types of costs for its services from one side, but also, on the other side, to increase quality, reduce response, waiting and lead time, improve patient safety, constantly introduce advance and costly methods and equipment in everyday practice. Those demands represents joint framework for healthcare management in developed and developing countries in their search for solutions, methods and techniques which will ensure satisfaction of all requirements and achieving of defined targets.

One of most promising resource for further improvement of healthcare management

for all healthcare service providers, especially hospitals and clinics, is recognized in industrial management strategies accepted and implemented by largest multinational corporations and huge number of other large to small and mid-sized companies around the globe. Although there is number of different names for those strategies (Lean production/philosophy, Toyota Production System, Lean/Six Sigma, World Class Manufacturing, Kaizen, etc.) in scientific literature, books and papers term "lean" as concept for management of production and business systems is generally accepted and used.

2. Lean Concept and Philosophy

Originally developed in 50's and 60's of 20th century, in Toyota automotive

¹ Corresponding author: Marko Djapan
email: djapan@kg.ac.rs



**IMPLEMENTASI LEAN HOSPITAL DALAM MENINGKATKAN PELAYANAN RAWAT JALAN
POLIKLINIK PENYAKIT DALAM
(Studi Kasus di Rumah Sakit "X" Indonesia)**

Dewi Kurniasih^{1*}, Nuryakin¹, Firman Pribadi¹

Universitas Muhammadiyah Yogyakarta, Indonesia

^{*}Email corresponding author: nias.kursi@gmail.com

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Abstrak

Permasalahan yang umum terjadi dalam pelayanan rawat jalan di rumah sakit adalah lamanya waktu tunggu, proses administrasi, ketersediaan informasi, dan yang lainnya. Salah satu pendekatan perbaikan kualitas yang digunakan dalam penelitian ini adalah lean hospital dengan tujuan untuk mencapai efektivitas dan efisiensi penggunaan waktu, tenaga kerja, ruang, dan sumber daya lainnya. Tujuan dari penelitian ini adalah untuk mengetahui gambaran value stream mapping (VSM), menganalisa hal yang menjadi waste, dan usulan perbaikan menggunakan pendekatan lean hospital pada pelayanan rawat jalan poliklinik penyakit dalam RS "X" di Indonesia. Penelitian dilakukan dengan pendekatan kualitatif melalui observasi langsung, wawancara mendalam dan telaah dokumen. Hasil penelitian yang didapatkan menunjukkan nilai Non Value Added (NVA) tertinggi adalah pada unit poliklinik yaitu sebesar (97,09%) dengan Value Added (VA) sebesar (2,91%) dan waiting time (107,22 menit) pada pelayanan pasien non-asuransi dengan pemeriksaan penunjang. Waste yang terjadi berupa waste of waiting, motion, transportation, human potential, overproduction, defect, inventory dan overprocessing. Dari hasil fishbone diagram diketahui bahwa akar penyebab masalah yang terjadi di unit poliklinik adalah dalam hal manajemen, peralatan, layout, petugas dan sistem informasi. Usulan perbaikan yang dapat diberikan berupa usulan jangka pendek, jangka menengah dan jangka panjang.

Kata kunci: Rawat Jalan, Lean Hospital, Waste, VA, NVA, VSM

Abstract

Some problems commonly occur in outpatient services, such as long waiting time, administration, lack of information, and others. Lean hospital is one of the quality improvements that used in this study to achieve the use of time, space, labor, and other resources become more effective and efficient. This study aimed to determine the VSM (Value Stream Mapping), analyzed the waste that occurs, and suggested the improvement using lean hospital approach in outpatient services "X" Hospital in Indonesia. A qualitative approach in this research was used through direct observation, document review, and in-depth interviews. The results obtained showed that the highest non-value-added (NVA) value was in the polyclinic unit for 97.09% with a Value Added (VA) for 2.91% and waiting time for 107.22 minutes in non-insurance patient with additional examinations. The waste that occurs was waste of waiting, motion, transportation, human potential, overproduction, defects, inventory, and overprocessing. It is known that the root causes of problems from the fishbone diagram was in terms of management, equipment, layout, staff, and information systems. Some recommendations that can be given were short-term improvement, medium-term improvement, and long-term improvement.

Key Words: Outpatient Care, Lean Hospital, Waste, VA, NVA, VSM

ANALISIS PENYEBAB KETERLAMBATAN PENGEMBALIAN BERKAS REKAM MEDIS RAWAT JALAN DI RUMAH SAKIT TINGKAT III BALADHIKA HUSADA JEMBER

Mila Imamatul Lutfiah*, Efri Tri Ardianto, Atma Deharja, Selvia Juwitaswari

Jurusan Kesehatan, Politeknik Negeri Jember, Indonesia

*e-mail: milalutfiah0401@gmail.com

Abstract

The return of outpatient medical records at Baladhika Husada Hospital Level III Jember is still had delays. In the first quarter of 2019, the total number of late outpatient medical records was 25.32%. Delay in returning the medical record file can affect the medical record service and hamper further activities, such as assembling, coding, analysis, and indexing activities. This study aimed to analyze the causes of late return of outpatient medical record files at Baladhika Husada Hospital Level III Jember. This qualitative research obtained data by interviewing, observing, documenting and brainstorming. Research results showed there were a lack of knowledge and attitudes, inadequate infrastructure or facilities. The head of the medical record gave no motivation, and there had never been SOP socialization about the return of outpatient medical record files. Efforts were made as follows, informs about expedition books and their usefulness and officers must also attend training or seminars to increase the knowledge and skills about management of medical records, the head of the medical record gives a warning to officers who are late in returning medical record files, conducts expedition book design, provide motivation work and conduct SOP socialization related to returning outpatient medical records.

Keywords: Delay, Return, Medical Record Files.

Abstrak

Pengembalian berkas rekam medis rawat jalan di Rumah Sakit Tingkat III Baladhika Husada Jember masih mengalami keterlambatan. Pada triwulan pertama tahun 2019 total berkas rekam medis rawat jalan yang terlambat sebanyak 25,32% berkas. Keterlambatan pengembalian berkas rekam medis dapat mempengaruhi pelayanan rekam medis dan akan menghambat kegiatan selanjutnya, seperti kegiatan assembling, koding, analisis, indeks. Penelitian ini bertujuan untuk menganalisis penyebab keterlambatan pengembalian berkas rekam medis rawat jalan di Rumah Sakit Tingkat III Baladhika Husada Jember. Jenis penelitian ini menggunakan kualitatif dan pengumpulan data dengan wawancara, observasi, dokumentasi dan brainstorming. Hasil penelitian yang didapatkan oleh peneliti pengetahuan dan sikap yang masih kurang baik, prasarana atau fasilitas yang kurang memadai. Tidak ada motivasi yang diberikan oleh kepala rekam medis, serta belum pernah dilakukannya sosialisasi SOP tentang pengembalian berkas rekam medis rawat jalan. Upaya yang dilakukan adalah, Menginformasikan tentang buku ekspedisi dan kegunaannya dan petugas juga harus mengikuti pelatihan atau seminar agar pengetahuan dan keterampilan petugas mengenai pengelolaan rekam medis meningkat, kepala rekam medis memberi teguran kepada petugas yang terlambat mengembalikan berkas rekam medis, Melakukan perancangan buku ekspedisi, memberikan motivasi kerja dan melakukan sosialisasi SOP terkait pengembalian berkas rekam medis rawat jalan.

Kata kunci : Keterlambatan, Pengembalian, Berkas Rekam Medis.

1. Pendahuluan

Rumah Sakit adalah institusi pelayanan kesehatan yang menyelenggarakan pelayanan kesehatan perorangan secara paripurna yang menyediakan pelayanan rawat inap, rawat jalan, dan gawat darurat (Menkes RI, 2018). Rumah sakit merupakan pelayanan kesehatan, sehingga perlu menjaga kepuasan pasien dengan meningkatkan mutu pelayanan dan menjaga kepuasan pemakai jasa. Rumah sakit harus meningkatkan mutu pelayanan sesuai dengan peraturan yang sudah ditentukan dan harapan pemakai jasa yang dapat dilakukan melalui kualitas kerja, salah satunya adalah kinerja petugas rekam medis. Perekam medis adalah seorang yang telah melaksanakan pendidikan rekam medis dan informasi kesehatan yang sesuai dengan ketentuan peraturan perundang-undangan (Kemenkes, 2013).

Penyelenggaraan rekam medis merupakan proses kegiatan yang dimulai pada saat pasien datang di rumah sakit untuk melakukan pemeriksaan, diteruskan kegiatan pencatatan identitas pasien, data medis pasien selama pasien itu mendapatkan pelayanan medis di rumah sakit sampai pasien sembuh dan keluarpelayanan yang harus berkualitas dan sesuai dengan standar pelayanan yang ada. Pelayanan dapat dikatakan baik jika memiliki mutu yang baik yaitu dapat ditandai

26. Menteri Hukum dan Hak Asasi Manusia Republik Indonesia (2009) ‘Undang-Undang Republik Indonesia Nomor 44 Tahun 2009 Tentang Rumah Sakit’.
Republik Indonesia.

UNDANG-UNDANG REPUBLIK INDONESIA
NOMOR 44 TAHUN 2009
TENTANG
RUMAH SAKIT

DENGAN RAHMAT TUHAN YANG MAHA ESA

PRESIDEN REPUBLIK INDONESIA,

- Menimbang : a. bahwa pelayanan kesehatan merupakan hak setiap orang yang dijamin dalam Undang-Undang Dasar Negara Republik Indonesia Tahun 1945 yang harus diwujudkan dengan upaya peningkatan derajat kesehatan masyarakat yang setinggi-tingginya;
- b. bahwa Rumah Sakit adalah institusi pelayanan kesehatan bagi masyarakat dengan karakteristik tersendiri yang dipengaruhi oleh perkembangan ilmu pengetahuan kesehatan, kemajuan teknologi, dan kehidupan sosial ekonomi masyarakat yang harus tetap mampu meningkatkan pelayanan yang lebih bermutu dan terjangkau oleh masyarakat agar terwujud derajat kesehatan yang setinggi-tingginya;
- c. bahwa dalam rangka peningkatan mutu dan jangkauan pelayanan Rumah Sakit serta pengaturan hak dan kewajiban masyarakat dalam memperoleh pelayanan kesehatan, perlu mengatur Rumah Sakit dengan Undang-Undang;
- d. bahwa pengaturan mengenai rumah sakit belum cukup memadai untuk dijadikan landasan hukum dalam penyelenggaraan rumah sakit sebagai institusi pelayanan kesehatan bagi masyarakat;
- e. bahwa . . .

27. Menteri Kesehatan Republik Indonesia (2008) 'Peraturan Menteri Kesehatan Nomor 269 Tahun 2008 Tentang Rekam Medis'. Kementrian Kesehatan Republik Indonesia.



**PERATURAN MENTERI KESEHATAN REPUBLIK INDONESIA
NOMOR 269/MENKES/PER/III/2008**

TENTANG

REKAM MEDIS

MENTERI KESEHATAN REPUBLIK INDONESIA,

- Menimbang** : bahwa sebagai pelaksanaan Pasal 47 ayat (3) Undang-Undang Nomor 29 Tahun 2004 tentang Praktik Kedokteran, perlu mengatur kembali penyelenggaraan Rekam Medis dengan Peraturan Menteri Kesehatan;
- Mengingat** :
1. Undang-Undang Nomor 23 Tahun 1992 tentang Kesehatan (Lembaran Negara Republik Indonesia Tahun 1992 Nomor 100, Tambahan Lembaran Negara Republik Indonesia Nomor 3495);
 2. Undang-Undang Nomor 29 Tahun 2004 tentang Praktik Kedokteran (Lembaran Negara Republik Indonesia Tahun 2004 Nomor 116, Tambahan Lembaran Negara Republik Indonesia Nomor 4431);
 3. Undang-Undang Nomor 32 Tahun 2004 tentang Pemerintahan Daerah (Lembaran Negara Republik Indonesia Tahun 2004 Nomor 125, Tambahan Lembaran Negara Republik Indonesia Nomor 4437) sebagaimana telah diubah dengan Undang-Undang Nomor 8 Tahun 2005 tentang Penetapan Peraturan Pemerintah Pengganti Undang-Undang Nomor 3 Tahun 2005 tentang Perubahan atas Undang-Undang Nomor 32 Tahun 2004 tentang Pemerintahan Daerah (Lembaran Negara Republik Indonesia Tahun 2005 Nomor 108, Tambahan Lembaran Negara Republik Indonesia Nomor 4548);
 4. Peraturan Pemerintah Nomor 10 Tahun 1966 tentang Wajib Simpan Rahasia Kedokteran (Lembaran Negara Republik Indonesia Tahun 1966 Nomor 21, Tambahan Lembaran Negara Republik Indonesia Nomor 2803);
 5. Peraturan Pemerintah Nomor 32 Tahun 1996 tentang Tenaga Kesehatan (Lembaran Negara Republik Indonesia Tahun 1996 Nomor 39, Tambahan Lembaran Negara Republik Indonesia Nomor 3637);
 6. Peraturan Pemerintah Nomor 38 Tahun 2007 tentang Pembagian Urusan Pemerintahan Antara Pemerintah, Pemerintah Daerah Provinsi dan Pemerintah Daerah Kabupaten/Kota (Lembaran Negara Republik Indonesia Tahun 2007 Nomor 82, Tambahan Lembaran Negara Republik Indonesia Nomor 4737);
 7. Peraturan Menteri Kesehatan Nomor 920/Menkes/Per/XII/1988 tentang Upaya Pelayanan Kesehatan Swasta Di Bidang Medik;
 8. Peraturan Menteri Kesehatan Nomor 159b/Menkes/Per/III/1988 tentang Rumah Sakit;
 9. Peraturan Menteri Kesehatan Nomor 1575/Menkes/Per/XII/2005 tentang Organisasi dan Tata Kerja Departemen Kesehatan;

28. Menteri Kesehatan Republik Indonesia (2014) ‘Peraturan Menteri Kesehatan Republik Indonesia Nomor 59 Tahun 2014 Tentang Standar Tarif Pelayanan Kesehatan Dalam Penyelenggaraan Program Jaminan Kesehatan’. Kementerian Kesehatan Republik Indonesia.



PERATURAN MENTERI KESEHATAN REPUBLIK INDONESIA
NOMOR 59 TAHUN 2014

TENTANG

STANDAR TARIF PELAYANAN KESEHATAN DALAM PENYELENGGARAAN
PROGRAM JAMINAN KESEHATAN

DENGAN RAHMAT TUHAN YANG MAHA ESA

MENTERI KESEHATAN REPUBLIK INDONESIA,

- Menimbang : a. bahwa untuk melaksanakan ketentuan Pasal 37 ayat (1) Peraturan Presiden Nomor 12 Tahun 2013 tentang Jaminan Kesehatan sebagaimana telah diubah dengan Peraturan Presiden Nomor 111 tahun 2013, telah ditetapkan Peraturan Menteri Kesehatan Nomor 69 tahun 2013 tentang Standar Tarif Pelayanan Kesehatan bagi Fasilitas Kesehatan Tingkat Pertama dan Fasilitas Kesehatan Tingkat Lanjutan Dalam Penyelenggaraan Program Jaminan Kesehatan;
- b. bahwa Peraturan Menteri Kesehatan Nomor 69 tahun 2013 tentang Standar Tarif Pelayanan Kesehatan Pada Fasilitas Kesehatan Tingkat Pertama Dan Fasilitas Kesehatan Tingkat Lanjutan Dalam Penyelenggaraan Program Jaminan Kesehatan perlu disesuaikan dengan perkembangan dan kebutuhan pelayanan kesehatan di fasilitas Kesehatan, sehingga perlu disempurnakan.
- c. berdasarkan pertimbangan sebagaimana dimaksud huruf a dan huruf b perlu menetapkan Peraturan Menteri tentang Standar Tarif Pelayanan Kesehatan Dalam Penyelenggaraan Program Jaminan Kesehatan;
- Mengingat : 1. Undang-Undang Nomor 40 Tahun 2004 tentang Sistem Jaminan Sosial Nasional (Lembaran Negara Republik Indonesia Tahun 2004 Nomor 150, Tambahan Lembaran Negara Republik Indonesia Nomor 4456);
2. Undang-Undang Nomor 36 Tahun 2009 tentang Kesehatan (Lembaran Negara Republik Indonesia Tahun 2009 Nomor 144, Tambahan Lembaran Negara Republik Indonesia Nomor 5063);
3. Undang-Undang ...

29. Menteri Kesehatan Republik Indonesia (2016) ‘Peraturan Menteri Kesehatan Republik Indonesia Nomor 76 Tahun 2016 Tentang Pedoman Indonesian Case Base Groups (INA CBGs) Dalam Pelaksanaan Jaminan Kesehatan Nasional’. Kementrian Kesehatan Republik Indonesia.



MENTERI KESEHATAN
REPUBLIK INDONESIA

PERATURAN MENTERI KESEHATAN REPUBLIK INDONESIA
NOMOR 76 TAHUN 2016
TENTANG
PEDOMAN *INDONESIAN CASE BASE GROUPS* (INA-CBG)
DALAM PELAKSANAAN JAMINAN KESEHATAN NASIONAL

DENGAN RAHMAT TUHAN YANG MAHA ESA

MENTERI KESEHATAN REPUBLIK INDONESIA,

- Menimbang : a. bahwa dalam rangka pelaksanaan Jaminan Kesehatan dalam Sistem Jaminan Sosial Nasional telah ditetapkan tarif pelayanan kesehatan pada fasilitas kesehatan tingkat pertama dan fasilitas kesehatan tingkat lanjutan;
- b. bahwa Peraturan Menteri Kesehatan Nomor 27 Tahun 2014 tentang Petunjuk Teknis Sistem *Indonesian Case Base Groups* (INA-BG's) perlu disesuaikan dengan perkembangan dan kebutuhan pelayanan kesehatan di Fasilitas Kesehatan Tingkat Lanjutan, sehingga perlu disempurnakan;
- c. bahwa berdasarkan pertimbangan sebagaimana dimaksud dalam huruf a dan huruf b, perlu menetapkan Peraturan Menteri Kesehatan tentang Pedoman *Indonesian Case Base Groups* (INA-CBG) dalam Pelaksanaan Jaminan Kesehatan Nasional;

30. Menteri Kesehatan Republik Indonesia (2020) ‘Peraturan Menteri Kesehatan Republik Indonesia Nomor 3 Tahun 2020 Tentang Klasifikasi Dan Perizinan Rumah Sakit’. Kementrian Kesehatan Republik Indonesia.



PERATURAN MENTERI KESEHATAN REPUBLIK INDONESIA
NOMOR 3 TAHUN 2020
TENTANG
KLASIFIKASI DAN PERIZINAN RUMAH SAKIT

DENGAN RAHMAT TUHAN YANG MAHA ESA

MENTERI KESEHATAN REPUBLIK INDONESIA,

- Menimbang : a. bahwa penyelenggaraan pelayanan di rumah sakit yang profesional dan bertanggung jawab dibutuhkan dalam mendukung upaya kesehatan dalam rangkaian pembangunan kesehatan secara menyeluruh dan terpadu;
- b. bahwa Peraturan Menteri Kesehatan Nomor 30 Tahun 2019 tentang Klasifikasi dan Perizinan Rumah Sakit perlu disesuaikan dengan perkembangan dan kebutuhan hukum;
- c. bahwa berdasarkan pertimbangan sebagaimana dimaksud dalam huruf a dan huruf b, serta untuk melaksanakan ketentuan Pasal 24 ayat (4) dan Pasal 28 Undang-Undang Nomor 44 Tahun 2009 tentang Rumah Sakit, perlu menetapkan Peraturan Menteri Kesehatan tentang Klasifikasi dan Perizinan Rumah Sakit;
- Mengingat : 1. Pasal 17 ayat (3) Undang-Undang Dasar Negara Republik Indonesia Tahun 1945;
2. Undang-Undang Nomor 29 Tahun 2004 tentang Praktik Kedokteran (Lembaran Negara Republik Indonesia Tahun

31. Mirfat, S., Andadari, N. and Nusaria Nawa Indah, Y. (2017)

JMMR (Jurnal Medicoeticolegal dan Manajemen Rumah Sakit), 6 (2): 174-186, Juli 2017

Website: <http://journal.umy.ac.id/index.php/mrms>

DOI: 10.18196/jmmr.6140

Faktor Penyebab Keterlambatan Pengembalian Dokumen Rekam Medis di RS X Kabupaten Kediri

Sayyidah Mirfat*, Nurwulan Andadari, Yetty Nusaria Nawa Indah

* Penulis Korespondensi: sayyidah.mirfat11@gmail.com

* Rumah Sakit Umum Islam Madinah Kasembon Malang, Jawa Timur

INDEXING

Keywords:

Medical record;
delays return;
factors;

ABSTRACT

The purpose of this study was to determine the root problem of any late return of inpatient medical records documents in X Hospital. This research was conducted with a qualitative descriptive approach with the method of observation, in-depth interviews and time motion study. Determining root of the problem is done by brainstorming with the hospitals staff with USG method (urgency, seriousness, growth). Root problem that contribute to delay return of inpatient medical records are indiscipline doctor in filling out medical records especially medical resumes; some doctor are not making patient visit every day, so the order was given by phone; and sometime nurses forgot to remind the doctor to fill out a medical resume and signature. Other factors affecting the delay are method, money, material dan machine factors.

Kata kunci:

Rekam medis;
keterlambatan
pengembalian;
faktor-faktor;

Tujuan dari penelitian ini adalah untuk mengetahui akar masalah keterlambatan pengembalian dokumen rekam medis rawat inap di RS X. Penelitian ini dilakukan dengan pendekatan deskriptif kualitatif dengan metode observasi, wawancara mendalam, serta time motion study. Pencarian akar masalah dilakukan dengan cara brainstorming dengan pihak rumah sakit dengan metode USG (urgency, seriousness, growth). Faktor utama penyebab keterlambatan pengembalian DRM rawat inap adalah faktor SDM (sumber daya manusia) yaitu ketidakdisiplinan DPJP (dokter penanggungjawab pelayanan) dalam pengisian rekam medis terutama resume medis, beberapa DPJP tidak visite setiap hari sehingga advis pulang per telepon dan perawat lupa mengingatkan dokter untuk mengisi resume medis dan tanda tangan. Faktor lain yang mempengaruhi keterlambatan antara lain faktor method, money, material dan machine

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PENDAHULUAN

Rekam medik yang lengkap adalah rekam medik yang telah diisi lengkap oleh dokter dalam waktu kurang dari 24 jam setelah selesai pelayanan rawat jalan atau setelah pasien rawat inap diputuskan untuk pulang. Pengembalian dokumen rekam medis dinyatakan terlambat apabila melebihi batas waktu pengembalian yaitu maksimal 2x24 jam setelah pasien keluar dari rumah sakit. Keterlambatan ini akan menghambat pelaksanaan tugas bagian assembling rekam medis yang dapat berdampak pada terhambatnya pelayanan pasien. Bagian assembling memiliki tugas

untuk merakit dokumen rekam medis, meneliti isi rekam medis termasuk kelengkapan penulisannya, mengendalikan dokumen rekam medis yang tidak lengkap serta mengendalikan penggunaan formulir rekam medis.¹

Penelitian yang dilakukan oleh Rachmani menunjukkan bahwa keterlambatan pengembalian dokumen rekam medis ke bagian assembling di RS Tentara dan POLRI Semarang sebesar 95,10%. Data yang didapat yaitu rata-rata kembalinya dokumen rekam medis (DRM) adalah 5 hari, paling cepat 3 hari dan paling lama 159 hari. Penyebab keterlambatan terbesar yaitu anggapan

32. Nash, M.A. and Poling, S.R. (2008) *Mapping the total value stream: a comprehensive guide for production and transactional processes*. Boca Raton: CRC Press.

MAPPING THE TOTAL VALUE STREAM

A Comprehensive Guide for
Production and Transactional Processes

MARK A. NASH AND SHEILA R. POLING

 **CRC Press**
Taylor & Francis Group
Boca Raton London New York

CRC Press is an imprint of the
Taylor & Francis Group, an informa business
A PRODUCTIVITY PRESS BOOK

Chapter 2

Identifying the Value Stream

Before everything else, getting ready is the secret of success.

Henry Ford

Introduction

One of the greatest challenges for anyone involved with continuous improvement (regardless of the discipline or methodology used) is knowing what to focus on when starting on an improvement project. To provide some guidance to this dilemma, subject-matter experts began creating process maps of the current state as a way to demonstrate what the project team was facing and perhaps even as a way to create a starting point. Showing what the process currently looks like and being able to identify the things that need improving is the starting point for process improvement. But what do you map? Where does it start, and where does it end?

When using Value Stream Mapping (VSM), you can solve this problem, to some extent, by using a product or process matrix. However, not everyone using VSM subscribes to the use of a product matrix. Instead, some organizations prefer to identify the target area and quickly start mapping. Both approaches have advantages and disadvantages:

- The matrix approach's advantages are that it provides great definition to the value stream that is going to be mapped, and it provides the mapping team with insight into how big the map may be. However, one of its disadvantages is that it can take longer to physically get out into the process for the actual mapping exercise. Another disadvantage is that it can bias the mapping team's attitudes and perceptions of what is actually occurring once they begin mapping.
- Organizations that use the fast-hitting approach of identifying the target area and starting the mapping exercise immediately will almost always benefit from staying in step with Taiichi Ohno's "just do it" philosophy. This approach can still be aligned with what James Womack and Daniel Jones explained (in Step 4

of Chapter 11 of *Lean Thinking*), where they emphasized the utility of mapping the entire value stream for all of your product families.

Many companies believe that instead of spending time systematically identifying your value stream, the best approach is to get a team started mapping what they consider to be a value stream, and then rolling out multiple teams to attack remaining value streams not covered in the first exercise. Whichever approach you subscribe to can work, as long as you achieve the ultimate goal: map all of your value streams.

Option 1: The Matrix Approach

Being able to logically capture the starting and end point of the value stream greatly simplifies VSM work. This concept may not capture every known process task within the current state, but it will provide a valuable framework from which to base your map. In the manufacturing world, a product matrix can give clarity to a product family. Many companies have been surprised to see that items that they had considered as part of the same product family can actually have *very few process steps in common*. Likewise, you often find that items categorized in *different* product families should have been grouped in the *same* family, based on the commonality in how they are produced.

Trying to explain how this matrix concept works can be challenging enough when focused on product alone, but to try and explain how to use the methodology for transactional processes at the same time can confuse even the most seasoned process improvement specialist. To simplify the explanation of this pre-mapping work, definitions of production and transactional process matrix, explanations, and examples are presented in the two subsections that follow. Although there is not a significant difference in the two situations, by separating them, it is much easier to understand both the power of the matrix concept and the common mistakes made in both situations.

Production Process Matrix

On the manufacturing floor, this matrix shows a list of all products manufactured by the company, or a subset of these products that the mapper, project team, or Executive Council believes may be a part of the value stream. (The Executive Council is the management team responsible for the overall coordination and success of the continuous improvement initiative.) The simplest way to start this product listing for many people is to list each item that is a part of the product family manufactured on the line, or in the cell, that is targeted for improvement. This list of products is contained in a column down the left side of the matrix. Figure 2.1 shows the start of a product matrix, with the product listing down the left-hand column.

Across the top row of the matrix, you list each process step, or task, that is used in making the product or in performing the service, as shown in Figure 2.2.

Product Matrix								
Task Product	Task #1	Task #2	Task #3	Task #4	Task #5	Task #6	Task #7	Task #8
AB-13402								
AB-15300								
HF-10110								
HC-99955								
HC-88776								
MP-20000								
MP-30001								

Figure 2.1 A product matrix template (ready to be populated) for products sold by a manufacturing company.

Getting the steps or tasks documented can create confusion for many people. This is not a list of *parts*, but of *process steps*. The work performed here can also help you draw the map as you go through the Current State Mapping exercise. This list of tasks will rarely be complete enough to draw a map, and you should never attempt to draw a Current State Map directly from this list, because critical pieces of data will not be accessible to you while sitting in a vacuum.

The challenge comes in how you create this list of tasks for the matrix. A quick and effective way to capture this information is to assemble a team of operators and management that work within the target area. Have this team look at each product listed in the left-hand column individually and think about the basic steps involved in the process. After a quick review of all products, have the team participate in a mental exercise to identify process steps. For the first product listed, give the team 30 sec. to recite the basic steps. Record these tasks on a whiteboard, flipchart, or other medium that is visible to all team members. When the team stops listing tasks, or the 30 sec. has expired, write these tasks in process-step order across the top row of the matrix. Put an "X" in the cell on the row of this first product underneath each process step listed.

Repeat this 30-sec. exercise for the second product listed on the matrix. As new process steps are identified, add the step to the row across the top. Once again, place an "X" in the cells on the second product's row for all process steps that are used in the manufacture of this second product. Repeat this exercise for each product listed in the left-hand column, adding as many additional process steps across the top row as necessary to document the process tasks involved.

Product Matrix												
Task Product	Motor Seal	Shaft Insertion	Spacer Placement	Cord Hang	Case Close	Seal	LED	Test	Package	Band Insertion	Cable Insertion	Switch Connect
AB-13402												
AB-15300												
HF-10110												
HC-99955												
HC-88776												
MP-20000												
MP-30001												

Figure 2.2 A product matrix with tasks assigned, ready to be populated with product information.

33. National Casemix Center (2014) ‘Konsep dan Peran INA-CBG Dalam Standardisasi Pelayanan’. Persatuan Rumah Sakit Seluruh Indonesia (PERSI).

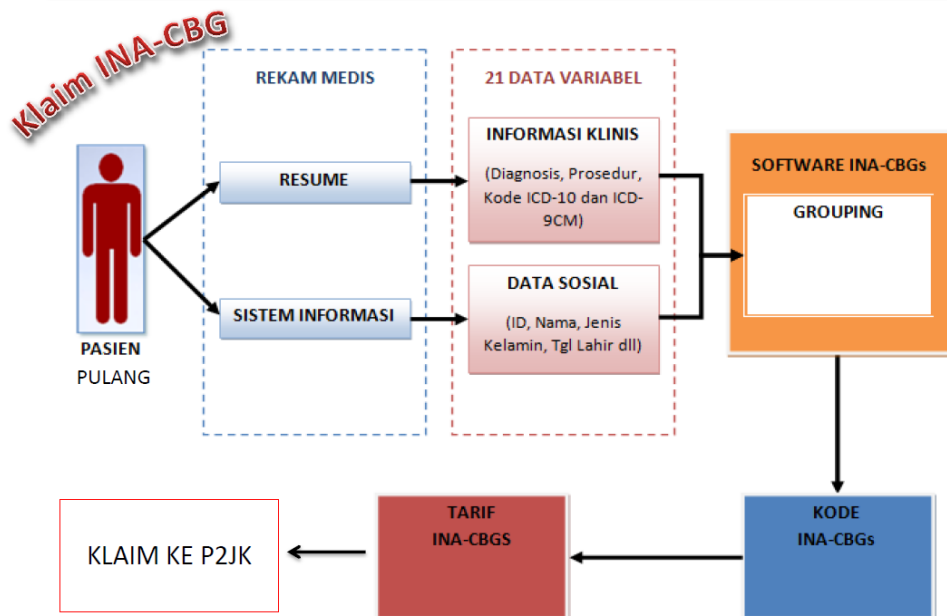
KONSEP DAN PERAN INA-CBG DALAM STANDARISASI PELAYANAN



Bambang Wibowo
National Casemix Center Kemenkes

JAKARTA_CP_KOMDIK_PERSI_8 Februari 2014

ALUR KLAIM INA-CBG DI RUMAH SAKIT BERBASIS PADA *OUTPUT*

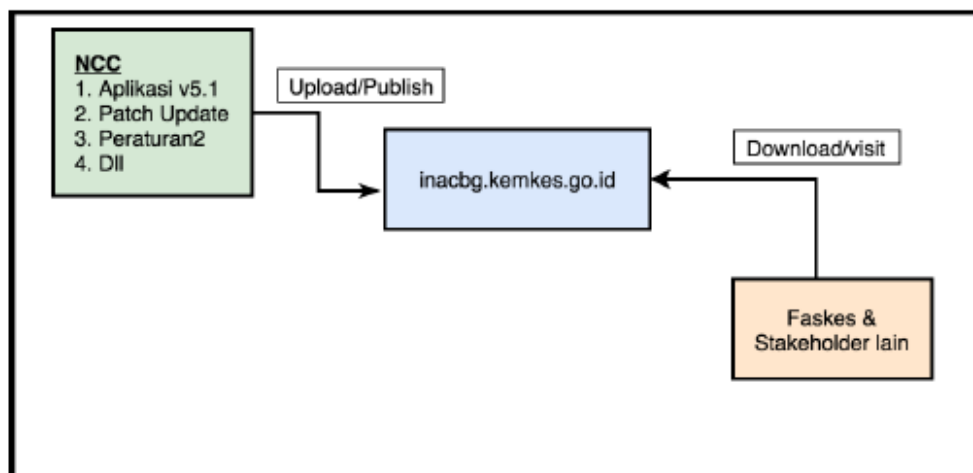


34. National Casemix Center (2016) 'Petunjuk Teknis Aplikasi INA-CBGv5 Build 5.1.0.201703170645'. Kementerian Kesehatan Republik Indonesia.

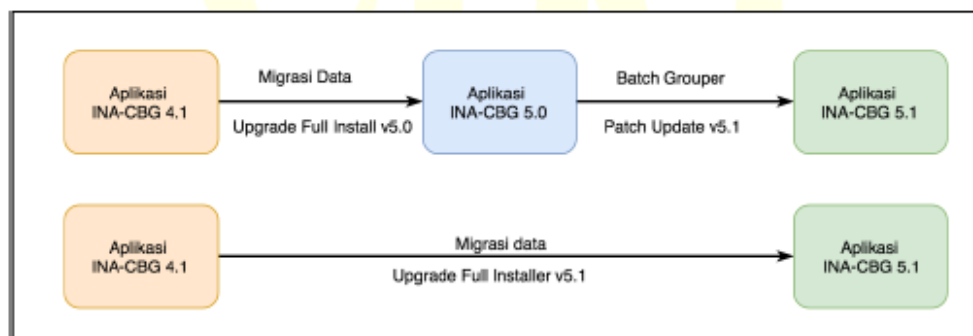


SUMMARY

UPDATE INFORMASI SISTEM INA-CBG



ALUR MIGRASI DATA DARI 4.1 KE 5.1



**Penerapan Lean Manajemen pada Pelayanan Rawat Jalan Pasien BPJS
Rumah Sakit Hermina Depok Tahun 2017**

*The Application of Lean Management Method on Outpatient BPJS Services at Hermina
Depok Hospital in 2017*

Elisabeth Dyah Noviani

Program Pasca Sarjana Kajian Administrasi Rumah Sakit Indonesia
Departemen Administrasi dan Kebijakan Kesehatan
Fakultas Kesehatan Masyarakat, Universitas Indonesia

*Email : novianidyah@yahoo.com

ABSTRAK

Lamanya waktu tunggu dalam proses pelayanan rawat jalan akan menghambat pelayanan, yang berdampak pada antrian yang menumpuk dan mengakibatkan pelayanan tidak efisien. Penelitian ini bertujuan untuk menganalisis penerapan metode lean pada pelayanan rawat jalan pasien BPJS di rumah sakit Hermina Depok tahun 2017. Penelitian dengan metode kualitatif ini mengobservasi waktu yang digunakan oleh pasien rawat jalan BPJS selama berada di rumah sakit Hermina Depok dengan menggunakan penerapan metode lean untuk melihat dan memotret kondisi alur pelayanan pasien rawat jalan BPJS. Hasil penelitian menunjukkan 90 % waktu pelayanan merupakan kegiatan non value added dan hanya 10 % kegiatan yang value added. Setelah melakukan analisis future state dengan usulan perbaikan dengan metode lean secara simulatif yaitu 5S, Kanban Inventory, visual management menghasilkan kegiatan non value added menjadi 78,30 % dan kegiatan value added menjadi 21,70 %.

Kata kunci: Metode lean, rawat jalan, waktu tunggu, kegiatan value added, kegiatan non value added.

ABSTRACT

The length of waiting time in the hospital outpatient service is important for efficient hospital service. Long waiting time leads to accumulating queue and inefficient service. This study was aimed to analyze the application of lean method on outpatient BPJS services at Hermina Depok Hospital in 2017. This qualitative research method investigated the time spent by BPJS outpatient patient by applying lean method and observing the outpatient service flow condition. The results showed that 90% service time was a non-value added activities and only 10% of value-added activities. After conducting future state analysis with the proposed improvement with simulative lean method (5S, Kanban Inventory, visual management), it was found that non value added activity became 78,30% and value added activity became 21,70%.

Keywords: lean method, outpatient waiting time, value added activity, non-value added activity.

PENDAHULUAN

Upaya meningkatkan mutu layanan kesehatan, khususnya pelayanan pasien rawat jalan BPJS, dilandasi adanya peningkatan kesadaran masyarakat tentang informasi kesehatan, adanya tuntutan pasien dan masyarakat akan mutu pelayanan kesehatan. RS Hermina Depok merupakan rumah sakit kelas B yang merupakan salah satu pusat rujukan rawat jalan maupun rawat inap di

wilayah Depok dan sekitarnya, baik untuk pasien umum maupun BPJS. Berbagai upaya dilakukan untuk membenarkan pelayanan yang bermutu khususnya di unit rawat jalan, namun masih adanya permasalahan-permasalahan terhadap lamanya waktu tunggu, sistem dan prosedur pelayanan yang masih panjang (tidak efisien) dalam alur proses terutama di pelayanan rawat jalan BPJS.

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Analisis Faktor Penyebab Keterlambatan Pengajuan Klaim Rawat Inap ke Verifikator BPJS Kesehatan di RSUD Genteng Banyuwangi

Novita Nuraini¹, Puput Puji Lestari²

Jurusan Kesehatan, Politeknik Negeri Jember, Indonesia^{1,2}

Email: novita_nuraini@polije.ac.id

Abstract

Badan Penyelenggara Jaminan Sosial (BPJS) claims process for inpatient admissions starts from registration until the patient file is entered into the INA-CBGs application. Claim submission under the claims verification technique instructions is limited to the 10th of the following month. RSUD Genteng in filing a claim exceeds the 10th of the following month. In the data of the delay in the medical record file, there is still a delay in submitting the claim file by 55%. The purpose of this research is to analyze the factors causing the delay in submitting BPJS claims for hospitalization to the BPJS verifier in RSUD Genteng, determining the priority of the problem and the improvement effort to the problem. The type of this research is qualitative using a systematic approach based on 7M factors (Man, Method, Materials, Machine, Money, Market and Minute). Methods of data collection using observation, interview, and documentation. Based on the result of NGT that has been done, the priority of problem causing delay is RM refund more than 2x24 hours, internet network is less stable, less discipline officer, no claim submission SOP, DPJD main diagnosis placement and BPJS verification of different perception. Improvement efforts that can be done are to make SOP return of medical records of inpatient and SOP related to claims of inpatient BPJS, repair internet network, conduct coordination meeting among officer related to office discipline and make a special form for correction from BPJS verifier.

Keywords: *delay, claim BPJS, hospital, inpatients*

Jurnal Kesehatan

Author(s) : Novita Nuraini, Puput Puji Lestari

1. Pendahuluan

Rumah Sakit adalah institusi pelayanan kesehatan yang menyelenggarakan pelayanan kesehatan perorangan secara paripurna yang menyediakan pelayanan rawat inap, rawat jalan, dan gawat darurat. Rumah sakit selalu identik dengan pelayanan pasien. Pasien adalah setiap orang yang melakukan konsultasi masalah kesehatannya untuk memperoleh pelayanan kesehatan yang diperlukan, baik secara langsung maupun tidak langsung di Rumah Sakit (Kemenkes RI, 2009)

Pasien dibedakan menjadi dua yaitu pasien umum dan pasien asuransi. Salah satu asuransi yang dipakai oleh masyarakat Indonesia adalah asuransi milik pemerintah yaitu BPJS (Badan Penyelenggara Jaminan Sosial) Kesehatan. Berdasarkan UU No. 24 tahun 2011, BPJS Kesehatan adalah perusahaan asuransi yang menyelenggarakan program jaminan kesehatan. Dalam melakukan pengajuan pembayaran pelayanan kesehatan, rumah sakit perlu melakukan proses klaim ke pihak provider yaitu BPJS dengan melengkapi persyaratan administrasi.

Dokumen yang diperlukan berupa (Kartu Tanda Penduduk) KTP atau Kartu Identitas Pasien, Kartu Keluarga (KK), surat rujukan, Surat Eligibilitas Pasien (SEP), resume medis dan rincian biaya. Jika pasien memerlukan pemeriksaan penunjang maka disertakan pula formulir pemeriksaan penunjang. Dalam proses klaim, rumah sakit harus memperhatikan kelengkapan dan kebenaran pengisian formulir berkas rekam medis yang berhubungan dengan administrasi klaim. Hal ini berkaitan dengan cepat lambatnya rumah sakit mendapatkan hasil klaim, besarnya nilai tarif klaim yang akan diterima nantinya, serta untuk pelaporan rumah sakit (Indrawaraswanti, 2017).

Pada studi pendahuluan di RSUD Genteng Banyuwangi, analisis faktor penyebab keterlambatan pengajuan klaim belum pernah dilakukan penelitian sebelumnya. Dalam buku petunjuk teknis verifikasi klaim disebutkan bahwa tanggal maksimum pengajuan berkas klaim ke pihak verifikasi yaitu tanggal 10 pada bulan berikutnya. Berdasarkan hasil wawancara dengan kepala rekam medik tanggal 25 Maret 2017 yang dilaksanakan peneliti di Rumah

Sakit Umum Daerah (RSUD) Genteng, yang berkaitan dengan pengajuan klaim pihak Rumah Sakit Umum Daerah (RSUD) Genteng ke pihak verifikasi BPJS terjadi keterlambatan pengumpulan berkas, untuk pengajuan klaim melebihi tanggal 10 pada bulan berikutnya. Data tanggal pengajuan klaim dapat dilihat pada tabel 1.

Tabel 1 Tanggal Pengajuan Berkas Klaim Rawat Inap Bulan Januari- Maret 2017

Bulan	Berkas Yang Diajukan	Tanggal Pengajuan	Jumlah Berkas Klaim yang Terlambat	Persentase Berkas Klaim yang Terlambat	Keterangan
Januari	-	-	-	-	-
Februari	Januari 2017	27 Februari 2017	1.308	52 %	Terlambat 17 hari
Maret	Februari 2017	22 Maret 2017	1.223	55 %	Terlambat 12 hari
April	Maret 2017	17 April 2017	1.126	53 %	Terlambat 7 hari

Sumber: Buku Kendali Pengajuan Berkas Klaim BPJS Rawat Inap RSUD Genteng 2017

Tabel tanggal pengajuan berkas klaim diatas menunjukkan pengajuan klaim bulan Januari diajukan tanggal 27 Februari 2017 yang artinya pengajuan terlambat 17 hari dari tanggal ditetapkannya pengajuan maksimal klaim BPJS ke pihak verifikasi. Untuk klaim bulan Februari diajukan pada tanggal 22 Maret 2017, ini menunjukkan pengajuan klaim melebihi dari batas ketentuan yaitu tanggal 10 pada bulan berikutnya. Untuk klaim bulan Maret diajukan pada tanggal 17 April 2017. Pada tabel tersebut juga menunjukkan bahwa masih ditemukan keterlambatan penyerahan berkas klaim sebesar 55% sedangkan ketentuan BPJS Kesehatan, berkas dikatakan terlambat apabila pihak rumah sakit belum mampu menyerahkan 75% berkas klaim ke BPJS Kesehatan (BPJS Kesehatan, 2018)

Dampak dari keterlambatan pengajuan berkas klaim rawat inap yaitu pelaporan klaim akan tertunda yang nantinya proses pencairan dana yang diajukan rumah sakit ke BPJS mengalami penundaan. Jika dibiarkan secara terus-menerus, hal ini akan menyebabkan kerugian pada pihak rumah sakit dan menghambat proses pelayanan pasien. Berkaitan dengan permasalahan tersebut,

Sistem Pembayaran *Mixed Method* INA-CBGs dan *Global Budget* di Rumah Sakit: Tahap 1 Uji Coba *Mixed Method* INA-CBGs-*Global Budget* di Indonesia

Health Service Payment System in Hospital Mixed INA-CBGs and Global Budget

**Fachmi Idris¹, Atik Nurwahyuni², Mundiharno¹, Benjamin Saut¹, Citra Jaya¹, Wan Aisyiah Baros¹,
Ayunda Oktavia¹, Dedy Revelino¹, Erzan Dhanalvin¹, Rasinta Ria Ginting¹**

¹BPJS Kesehatan

²Departemen Administrasi dan Kebijakan Kesehatan, Fakultas Kesehatan Masyarakat, Universitas Indonesia

Korespondensi: Wan Aisyiah Baros
E-mail: wan.aisyiah@bpjs-kesehatan.go.id

Abstrak

Tidak ada sistem pembayaran pelayanan kesehatan yang sempurna dalam penerapannya termasuk sistem pembayaran DRG (*Diagnosis-Related Groups*) yang lebih dikenal dengan nama INA-CBGs (*Indonesia Case-Based Groups*) di Indonesia. Beberapa negara yang mengadopsi DRG telah menerapkan kebijakan pembayaran *mixed method* DRG-*Global Budget* dengan variasi implementasinya demi menjaga kesinambungan sistem jaminan kesehatan nasional di negaranya. BPJS Kesehatan menginisiasi studi operasional penerapan sistem pembayaran rumah sakit *mixed-method* INA-CBGs dan *Global Budget* mulai tahun 2018. Terdapat tiga tahapan dalam uji coba sistem pembayaran rumah sakit *mixed-method* INA-CBGs dan *Global Budget* ini. Tahap pertama adalah *Global Budget* Tanpa Resiko yang bertujuan untuk menguji metode penghitungan *global budget* dan mengidentifikasi tantangan yang dihadapi bila kebijakan *mixed method* INA-CBGs dan *Global Budget* ini diberlakukan. Studi dilakukan di 5 (lima) kabupaten/kota di 30 rumah sakit (RS). Hasil studi menunjukkan bahwa metodologi penghitungan *global budget* yang diterapkan cukup akurat untuk memprediksi realisasi klaim di RS. Penghitungan *global budget* di tingkat kabupaten/kota lebih akurat hasilnya dibandingkan dengan menghitung *global budget* di tingkat RS karena mengakomodir *shifting* pasien dari RS yang satu ke RS yang lainnya akibat perubahan kapasitas RS. Perubahan kapasitas RS di tahun berjalan dan adanya pandemi COVID-19 menyebabkan adanya selisih antara penghitungan *global budget* dan realisasi klaim.

Kata kunci: Sistem Pembayaran, INA-CBGs, *Global Budget*

Abstract

When it comes to provider payment system, no one shoe fits all including DRG payment system which in Indonesia are known as INA-CBGs. In some countries that used DRG have mixed it with Global Budget in various mechanisms to maintain the sustainability of the national health insurance system in their countries. BPJS Kesehatan initiated a three-stage pilot study on the implementation of the mixed-method hospital payment system INA-CBGs and Global Budget starting in 2018. The first stage is the Non-Risk stage which aims to test the accuracy of the global budget calculation and prediction and to identify the challenges faced when the mixed-method payment is implemented. The pilot was conducted in 5 districts in 30 hospitals. Initial results show that the calculation and prediction method is accurate to predict the actual hospital claims in the following year. The calculation of the global budget at the district level is more accurate than the hospital level because it accommodates patient transfer from one hospital to another due to changes in hospital capacity. Changes in hospital capacity in the current year and the COVID-19 pandemic requires some adjustments to the budget calculation.

Keywords: Provider Payment System, INA-CBGs, *Global Budget*

Kinerja Rumah Sakit Swasta dengan Pembayaran INA-CBGs di Era Jaminan Kesehatan Nasional: *Casemix*, *Casemix Index*, *Hospital Base Rate*

Performance of Private Hospitals with INA-CBGs Payments in the Era of National Health Insurance: Casemix, Casemix Index, Basic Hospital Rates

Atik Nurwahyuni,¹ Ery Setiawan,²

¹Departemen Administrasi dan Kebijakan Kesehatan, Fakultas Kesehatan Masyarakat, Universitas Indonesia

²Pusat Kajian Ekonomi dan Kebijakan Kesehatan, Fakultas Kesehatan Masyarakat, Universitas Indonesia

Korespondensi: Atik Nurwahyuni
e-mail: atikn.akk@gmail.com

Abstrak

Pembayaran ke rumah sakit yang sebelumnya *fee for service*, pada era JKN diselenggarakan melalui pola DRG atau INA-CBGs. Rumah sakit swasta harus memonitor kinerjanya menggunakan indikator yang lazim digunakan dalam sistem pembayaran DRG yaitu *casemix*, *casemix index* dan *Hospital base rate*. Kajian ini bertujuan untuk menganalisis kinerja rumah sakit swasta meliputi *casemix*, *casemix index* dan *hospital base rate*. Studi *cross sectional* ini dilakukan dengan sampel 7 RS yang dipilih secara purposif mewakili RS swasta kelas B, C, dan D yang tersebar di 6 provinsi. *Casemix* dan CMI RS sangat dipengaruhi oleh kapasitas RS sehingga RS kelas B memiliki *casemix* dan CMI lebih tinggi dari RS kelas C dan D. Terdapat fenomena CMI di RS kelas C lebih kecil dari kelas D yang kemungkinan disebabkan oleh akurasi koding. Kelengkapan dan ketepatan pengkodean diagnosis dan prosedur sangat berdampak pada besaran *casemix* dan CMI RS. Hampir semua RS memiliki HBR di atas HBR Nasional kecuali RSC3. Dapat dipastikan RSC3 mendapatkan profit dari implementasi INA-CBGs. Rumah sakit sebaiknya memonitor *casemix*, CMI dan HBR secara berkala. Kementerian Kesehatan diharapkan mempublikasikan *cost weight* dan HBR Nasional INA-CBGs serta besaran rata-rata *casemix* dan CMI menurut kelas RS agar dapat digunakan sebagai benchmark oleh RS.

Kata kunci: INA-CBGs, *casemix*, *casemix index*, *hospital base rate*

Abstract

Private hospitals must monitor their performance using indicators commonly used in DRG payment systems: *casemix*, *casemix index* and *hospital base rate*. This study aims to analyze the performance of private hospitals including *casemix*, *casemix index* and *hospital base rate*. This cross sectional study was conducted with a sample of 7 hospitals selected purposively representing private hospital type B, C, and D in 6 provinces. *Casemix* and CMI RS are strongly influenced by the hospital capacity, which the hospitals class B have higher *casemix* and CMI than class C and D hospitals. There is a phenomenon, CMI in class C hospitals smaller than class D which is probably caused by coding accuracy. The completeness and accuracy of diagnosis and procedures coding predominating affect the *casemix* and CMI. Almost all hospitals have HBR which are higher than National HBR except RSC3. It definitely will trigger profit from the implementation of INA-CBGs. Hospitals should monitor *casemix*, CMI and HBR regularly. The Ministry of Health is expected to publish the Cost Weight and National HBR as well as the average of *casemix* and CMI according to class of hospital, for a benchmark by hospitals.

Keywords: INA-CBGs, *casemix*, *casemix index*, *Hospital base rate*

Pendahuluan

Diselenggarakannya program JKN membawa perubahan yang cukup signifikan khususnya

pada pembayaran fasilitas kesehatan terutama rumah sakit. Pola pembayaran ke rumah sakit yang sebelumnya berbasis *fee for service*, pada era JKN diselenggarakan melalui pola

39. Peraturan Pemerintah (2022) ‘Peraturan Pemerintah Pengganti Undang-Undang (Perpu) Nomor 2 Tahun 2022 tentang Cipta Kerja’. Indonesia.



PRESIDEN
REPUBLIK INDONESIA

SALINAN

PERATURAN PEMERINTAH
PENGGANTI UNDANG-UNDANG REPUBLIK INDONESIA
NOMOR 2 TAHUN 2022
TENTANG
CIPTA KERJA

DENGAN RAHMAT TUHAN YANG MAHA ESA

PRESIDEN REPUBLIK INDONESIA,

- Menimbang : a. bahwa untuk mewujudkan tujuan pembentukan Pemerintah Negara Indonesia dan mewujudkan masyarakat Indonesia yang sejahtera, adil, dan makmur berdasarkan Pancasila dan Undang-Undang Dasar Negara Republik Indonesia Tahun 1945, Negara perlu melakukan berbagai upaya untuk memenuhi hak warga negara atas pekerjaan dan penghidupan yang layak bagi kemanusiaan melalui cipta kerja;
- b. bahwa dengan cipta kerja diharapkan mampu menyerap tenaga kerja Indonesia yang seluas-luasnya di tengah persaingan yang semakin kompetitif dan tuntutan globalisasi ekonomi serta adanya tantangan dan krisis ekonomi global yang dapat menyebabkan terganggunya perekonomian nasional;
- c. bahwa untuk mendukung cipta kerja diperlukan penyesuaian berbagai aspek pengaturan yang berkaitan dengan kemudahan, perlindungan, dan pemberdayaan koperasi dan usaha mikro, kecil, dan menengah, peningkatan ekosistem investasi, dan percepatan proyek strategis nasional, termasuk peningkatan perlindungan dan kesejahteraan pekerja;
- d. bahwa pengaturan yang berkaitan dengan kemudahan, perlindungan, dan pemberdayaan koperasi dan usaha mikro, kecil, dan menengah, peningkatan ekosistem investasi, dan percepatan proyek strategis nasional, termasuk peningkatan perlindungan dan kesejahteraan pekerja yang tersebar di berbagai Undang-Undang sektor saat ini belum dapat memenuhi kebutuhan hukum untuk percepatan cipta kerja sehingga perlu dilakukan perubahan;

e. bahwa . . .

PENERAPAN LEAN PADA REDESAIN PROSES PELAYANAN RAWAT JALAN RUMAH SAKIT MATA

Rastri Paramita

Program Studi Magister Manajemen Rumah Sakit Pascasarjana Universitas Muhammadiyah
Yogyakarta
Email: rastriparamita@gmail.com

ABSTRAK

Tujuan Penelitian: Tujuan penelitian ini yaitu untuk mengetahui lama waktu tunggu pasien di rawat jalan, mengidentifikasi Value Added Activities dan Non-Value Added Activities, menemukan penyebab serta membuat redesign untuk perbaikan lanjutan dengan menggunakan metode Lean Kaizen.

Data atau Objek Penelitian: Penelitian awal merupakan penelitian kuantitatif berupa pengambilan waktu lama pelayanan yang dijalani 362 pasien rawat jalan bukan peserta asuransi pemerintah yang datang ke rumah sakit. Penelitian dilanjutkan studi kualitatif berupa Focus Group Discussion (FGD) yang diikuti kepala beserta 1 orang staf dari instalasi pendaftaran, rawat jalan dan farmasi

Metode: Analisa Value Added Activity (VA) dan Non-Value Added Activity (NVA) dengan menggunakan Visual Stream Mapping. Hasil yang didapatkan ditindaklanjuti dengan Focus Group Discussion dengan mencari akar masalah menggunakan metode 5 Why, Fish-bone Analysis untuk pemetaan masalah, diakhiri dengan tahapan Analisa spaghetti diagram untuk analisa redesign

Hasil: Hasil penelitian menunjukkan bahwa perbandingan VA dengan NVA tiap unit yaitu di pendaftaran VA (57,63%)>NVA (42,37%), RJ VA (35,97%)<NVA (64,03%), Farmasi VA (9,92%)<NVA (90,08%), Kassa VA (27,57%)<NVA (72,43%). Komponen utama penyebab lama waktu tunggu pelayanan rawat jalan di rumah sakit tersebut adalah lingkungan, tenaga kerja dan sistem.

Simpulan: Penggunaan rekam medik elektronik dan input data pasien melalui mobile-tab sebagai redesign terbukti berhasil mengurangi waste berupa motion, merampingkan proses pelayanan dan menjadi solusi bagi rumah sakit untuk meningkatkan mutu pelayanan tanpa mengubah bangunan cagar budaya

Kata Kunci: Lean; Waktu Tunggu; Rawat Jalan; Redesain; Bangunan Cagar Budaya

ABSTRACT

Purpose: The study aimed to examine the waiting time in outpatient, identify Value Added Activity and Non-Value Added Activity, finding the causes and create redesign for improvements using Lean Kaizen method.

Data and Research Objects: The initial study was a quantitative study consisting of taking long time service data from 362 outpatients not government insurance participants who came to the hospital. The study was continued with a qualitative study with a Focus Group Discussion (FGD) which was followed by a leader with 1 staff member from each registration, outpatient and pharmacy unit

Methods: Value Added Activity (VA) and Non-Value Added Activity (NVA) analysis that using Visual Stream Mapping. The results obtained are actionable with Focus Group Discussion, 5 Why method analysis, Fish-Bone analysis is used to simplify problems mapping and last stage is analysis of spaghetti diagram result.

Results: The results of the study shows that the comparison between VA and NVA in each departments that is at registration VA (57,63%)>NVA (42,37%), Outpatients VA (35,97%)<NVA (64,03%), Pharmacy VA (9,92%)<NVA (90,08%), Cashier VA



**EFEKTIVITAS PENGEMBALIAN BERKAS REKAM MEDIS RAWAT INAP DALAM
MENUNJANG KUALITAS LAPORAN DI RUMAH SAKIT BHAYANGKARA SARTIKA
ASIH BANDUNG**

Oleh

Alif Kurnia Putri¹⁾ & Dina Sonia²⁾

^{1,2}Program Studi Rekam Medis dan Informasi Kesehatan, Politeknik Piksi Ganesha,
Indonesia

Email: ¹alifkurniaputri55@gmail.com & ²nasoniaonva.ds@gmail.com

Abstract

The medical record file in a hospital is one that affect the quality of reports in the medical record unit. The return of medical record files that are not timely calculated from the time the patient returns home results in delays in data processing, reporting, insurance claims and delays in service to patients. The purpose of this study was to determine the return of medical record files in supporting the quality of reports and the level of delay in medical record files. The method used is descriptive method. Method of data collection is done by observation, interviews and documentation studies. The result of the study show that there are still frequent delays in returning inpatient medical record files. The delay is caused by the doctor's indiscipline in filling out the form which causes data processing and report quality to be ineffective.

Keywords: Return Effectivity, Medical Record & Hospital.

PENDAHULUAN

Rumah sakit sebagai sarana pelayanan kesehatan merupakan tempat yang digunakan untuk menyelenggarakan upaya kesehatan dan memelihara, serta meningkatkan derajat kesehatan. Oleh karena itu, rumah sakit diharapkan mampu memberikan pelayanan yang efektif dan efisien kepada masyarakat pengguna jasa layanan kesehatan. Rumah sakit adalah lembaga pelayanan kesehatan yang menyediakan pelayanan rawat inap, rawat jalan, dan gawat darurat.

Seperti yang tercantum dalam PERMENKES No 269/MENKES/PER/III/2008, disebutkan bahwa rekam medis adalah berkas yang berisikan catatan dan dokumen tentang identitas pasien, pemeriksaan, pengobatan, tindakan dan pelayanan lain yang telah diberikan kepada pasien. Hal ini sebagai landasan hukum bagi semua pengelola rumah sakit untuk menyelenggarakan rekam medis rumah sakit. Hal tersebut dijelaskan lebih lanjut dalam surat keputusan Dirjen Yanmed No.78

tahun 1991 tentang petunjuk penyelenggaraan rekam medis di rumah sakit.

Unit Rawat inap (URI) merupakan salah satu bagian pelayanan klinis yang melayani pasien karena keadaannya harus dirawat selama satu hari atau lebih. Tugas pokok URI adalah mencatat hasil semua pelayanan yang diberikan kepada pasien kedalam formulir rekam medis yang sesuai, kemudian diserahkan kepada Unit Rekam Medis. Mengingat pentingnya kegunaan berkas rekam medis dan dampak keterlambatan waktu pengembalian berkas rekam medis maka akan mempersulit pelaksanaan petugas assembling. Oleh karena itu berkas rekam medis pasien harus segera dikembalikan ke instalasi rekam medis paling lambat 2x24 jam setelah pasien pulang secara lengkap dan benar (Depkes RI, 2006).

Dalam pengembalian rekam medis, rekam medis harus dikembalikan sesudah pasien pulang atau setelah pasien selesai mendapatkan pengobatan. Pengembalian yang tepat waktu akan memudahkan pelayanan terhadap pasien yang datang ke poliklinik untuk kontrol kembali setelah rawat inap. Waktu

Health Insurance (BPJS-Kesehatan) late payment for hospital inpatient claims - a case study in West Sumatra

Novia Putri¹, Rima Semiarty¹, Nur Afrainin Syah^{2*}

Abstract

Purpose: Claim pending is a major problem faced by Hospitals in the universal coverage (JKN) era in Indonesia. The delay is believed due to incomplete claim requirements submitted by the hospital. This study aims to explore contributing factors of late payment of inpatient BPJS claims at the Government hospitals in terms of input and process. **Method:** This was qualitative research. Data was collected through semi-structured interviews, observation, and document review. Content analysis was applied in data analysis. **Results:** Component input contributing to claim pending were case-mix team, human resources, and standard operational procedures. Component processes were medical resume filling, the accuracy of coding, and internal verification process. **Conclusion:** Many factors contributed to the hospital claim pending at the level of input and process. All the factors together influenced the accuracy of the inpatient service claim. Any effort to improve the factors could prevent the claim delay.

Keywords: BPJS Health; claim; late payments; claims hospital; claims pending

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¹ Faculty of Public Health,
Universitas Andalas

² Department of Medical
Education, Universitas
Andalas

*Correspondence:
nur@med.unand.ac.id

INTRODUCTION

The Law No. 40 of 2004 states that the National Health Insurance System (JKN) is part of the National Social Security System, which is a compulsory social health insurance for meeting primary health needs of its member, managing by the Health Social Security Administering Body (BPJS Kesehatan). BPJS Kesehatan is a legal entity responsible for providing national health insurance for all Indonesians in all levels of health care services, from primary to tertiary care [1]. Hospitals are health care facilities that provide secondary and tertiary services to BPJS Kesehatan members, via a tiered referral system from primary care facilities. Services provided by the hospitals are paid using the INA-CBGs payment method [2,3].

Technical Guidelines (Juknis) of BPJS Kesehatan states that hospitals have to submit service claims to BPJS Kesehatan for the payment of services that they provided. The submitted claim must meet the requirements for being processed and paid. If there is an incomplete or unsuitable file, it will return to the hospital or health facilities [4]. Studies identified some factors that contributed to claim pending were incomplete medical resumes, inaccuracies in coding, misplaced diagnoses, and input errors [5-7].

Delay in claim payment affects hospital cash flow and impacts the quality of service, especially on the dimensions of safety and comfort of services for BPJS Kesehatan participants. BPJS patients' dissatisfaction with health services, which in turn affect the number of visits [8]. Five indicators have the lowest Average

43. Sayer, N.J. and Williams, B. (2012) *Lean for Dummies*. 2nd edn. New Jersey: John Willey & Sons, Inc.

Chapter 6

Seeing Value through the Eyes of the Customer

In This Chapter

- ▶ Understanding the concept of value
 - ▶ Identifying what customers value
 - ▶ Differentiating customers and consumers
-

You may think the concept of value is pretty straightforward, but the reality is that everyone has their own perception of what constitutes value. What people value and how they value it changes with circumstance and time. But, as mutable as the criteria for defining value may be, Lean provides a framework for understanding what customers and consumers value, and then helping us understand how to provide that value in the most effective way. As you define what your customers value, you also define the very nature of your activities and actions: what you should be doing, how you should be doing it, and even *if* you should be doing it.

Consider this: When the coffee-shop barista writes your name on the cup for your double latte, is he “adding value” to your

What Is Value?

Simply stated, *value* is the worth placed upon something. That something can be goods, services, or both. The worth can be expressed in terms of money, an exchange, a utility, a merit, or even a principle or standard.

Who determines the value? *Customers determine value.* And there are billions of them — individuals, businesses, social groups, and other organizations.

Although Lean provides us a standard definition of value, what is more difficult to understand is what these customers deem worthy and then how to create, apply, measure, and translate

their definition of value. What are the actions and activities that actually create value? How does a person or organization come to value a particular product or service? What determines how much a person is willing to “pay” for it — with their time, money, or other resources? In addition, how do they exchange value?

Value isn’t absolute — it doesn’t occur in isolation. Value is relative to such factors as location, place, time, timing, form, fit, function, integration, interactions, resources, markets, demand, and economics. But in all cases, *value is defined by the customer.*

The process of *value creation* — the act of developing and delivering a product or service that the customer desires and is willing to invest in having it — is usually lengthy and complicated.

Defining value-added

In Lean, always define value from the customer's viewpoint. The customer is the one — and only one — who defines the value of the output of a process. For an activity to be *value added*, you must meet *all* three precise criteria:

- ✓ The customer must be willing to pay for the activity.
- ✓ The activity must transform the product or service in some way.
- ✓ The activity must be done correctly the first time.

This strict definition applies to everything. To add value in a process, all actions, activities, processes, persons, organizations, systems, pieces of equipment, and any other resources committed to the process must meet all three criteria.

You can easily spot value-added activity:

- ✓ At the carwash, it's when someone actually washes the car.
- ✓ At the hospital, it is when the patient receives treatment.
- ✓ On the assembly floor, it's when someone is actually putting parts together.

In each of these cases, it's clearly what the customer is paying for; it's transforming the product or providing the primary service; and as long as it's being done correctly the first time, it is by-definition contributing directly to customer value (that is, it's *value-added*).

44. Sugiyono (2013) *Metode Penelitian Kuantitatif, Kualitatif dan R&D*. 19th edn.
Bandung: Alfabeta.

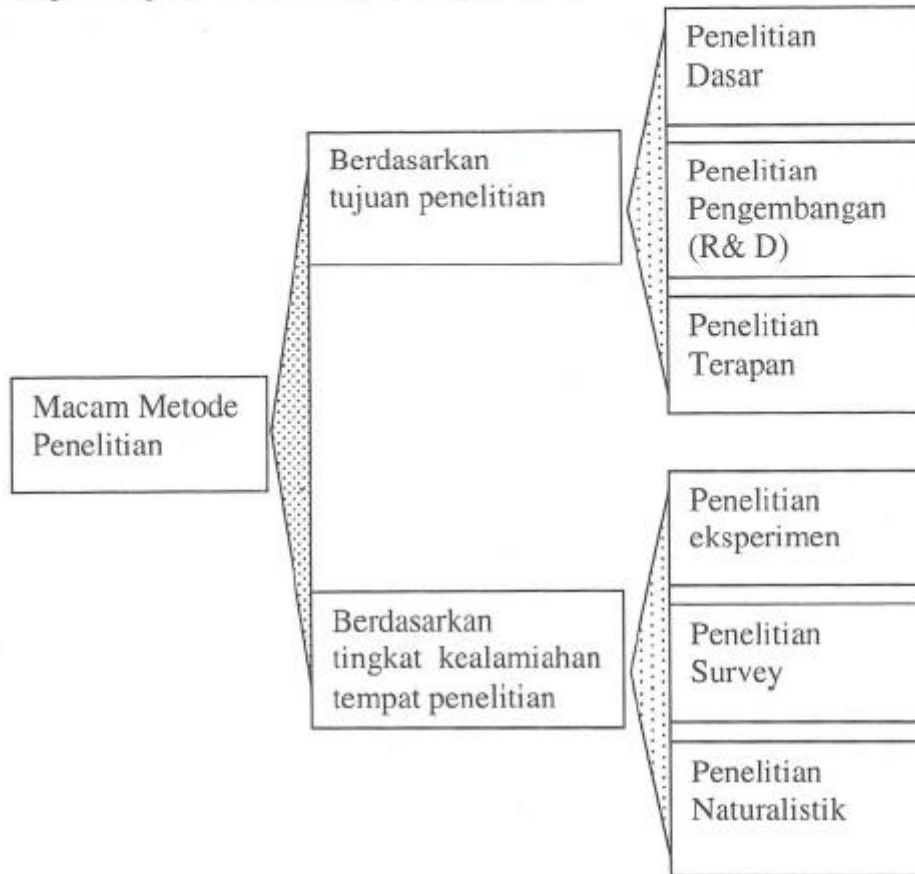
METODE PENELITIAN KUANTITATIF, KUALITATIF DAN R & D

Prof. Dr. Sugiyono



PENERBIT ALFABETA BANDUNG

Walaupun ada kalanya penelitian terapan juga untuk mengembangkan produk. Penelitian dan pengembangan bertujuan untuk menemukan, mengembangkan dan memvalidasi suatu produk.



Gambar 1.1. Macam-macam metode penelitian berdasarkan tujuan dan tingkat kealamiah tempat penelitian

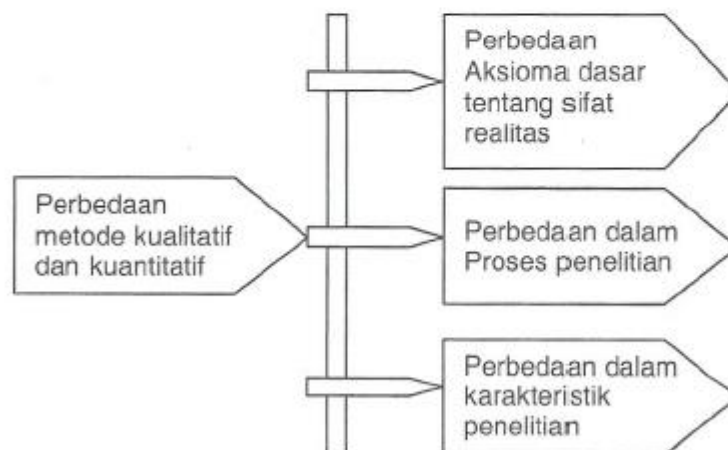
Selanjutnya Borg and Gall (1989) menyatakan: *One way to bridge the gap between research and practice in education is to Research & Developmet*. Pada umumnya penelitian R&D bersifat *longitudinal* (beberapa tahap). Untuk penelitian analisis kebutuhan sehingga mampu dihasilkan produk yang bersifat hipotetik sering digunakan metode penelitian dasar. Selanjutnya untuk menguji produk yang masih bersifat hipotetik tersebut, digunakan eksperimen. Setelah produk teruji, maka dapat diaplikasikan. Proses pengujian produk dengan eksperimen tersebut, dinamakan penelitian terapan (*applied research*). Hubungan antara penelitian dasar, penelitian pengembangan (R&D) dan penelitian terapan ditunjukkan pada gambar 1.2.

berdasarkan fakta-fakta yang ditemukan di lapangan dan kemudian dikonstruksikan menjadi hipotesis atau teori. Metode kualitatif digunakan untuk mendapatkan data yang mendalam, suatu data yang mengandung makna. Makna adalah data yang sebenarnya, data yang pasti yang merupakan suatu nilai di balik data yang tampak. Oleh karena itu dalam penelitian kualitatif tidak menekankan pada generalisasi, tetapi lebih menekankan pada makna. Generalisasi dalam penelitian kualitatif dinamakan *transferability*,

Metode penelitian kualitatif adalah metode penelitian yang berlandaskan pada filsafat postpositivisme, digunakan untuk meneliti pada kondisi obyek yang alamiah, (sebagai lawannya adalah eksperimen) dimana peneliti adalah sebagai instrumen kunci, teknik pengumpulan data dilakukan secara triangulasi (gabungan), analisis data bersifat induktif/kualitatif, dan hasil penelitian kualitatif lebih menekankan *makna* dari pada *generalisasi*.

D. Perbedaan penelitian kualitatif dan kuantitatif

Untuk memahami metode penelitian kuantitatif dan kualitatif secara lebih mendalam, maka harus diketahui perbedaannya. Perbedaan antara metode kualitatif dengan kuantitatif meliputi tiga hal, yaitu perbedaan tentang *aksioma*, *proses penelitian*, dan *karakteristik penelitian* itu sendiri. Hal ini ditunjukkan pada gambar 1.4 berikut.



Gambar 1.4 Perbedaan penelitian kualitatif dan kuantitatif

1. Perbedaan Aksioma

Aksioma adalah pandangan dasar. Aksioma penelitian kuantitatif dan kualitatif meliputi aksioma tentang realitas, hubungan peneliti dengan yang diteliti, hubungan variabel, kemungkinan generalisasi, dan peranan nilai.

b. Proses Penelitian Kualitatif

Rancangan penelitian kualitatif diibaratkan oleh Bogdan, seperti orang mau piknik, sehingga ia baru tahu tempat yang akan dituju, tetapi tentu belum tahu pasti apa yang di tempat itu. Ia akan tahu setelah memasuki obyek, dengan cara membaca berbagai informasi tertulis, gambar-gambar, berfikir dan melihat obyek dan aktivitas orang yang ada di sekelilingnya, melakukan wawancara dan sebagainya. Proses penelitian kualitatif juga dapat diibaratkan seperti orang asing yang mau melihat pertunjukkan wayang kulit atau kesenian, atau peristiwa lain. Ia belum tahu apa, mengapa, bagaimana wayang kulit itu. Ia akan tahu setelah ia melihat, mengamati dan menganalisis dengan serius.

Berdasarkan ilustrasi tersebut di atas, dapat dikemukakan bahwa walaupun peneliti kualitatif belum memiliki masalah, atau keinginan yang jelas, tetapi dapat langsung memasuki obyek/lapangan. Pada waktu memasuki obyek, peneliti tentu masih merasa asing terhadap obyek tersebut, seperti halnya orang asing yang masih asing terhadap pertunjukkan wayang kulit. Setelah memasuki obyek, peneliti kualitatif akan melihat segala sesuatu yang ada di tempat itu, yang masih bersifat umum. Misalnya dalam pertunjukan wayang pada tahap awal, ia akan melihat penontonnya, panggungnya, gamelannya, penabuhnya (pemain gamelannya), wayangnya, dalangnya, pesindennya (penyanyi) aktivitas penyelenggaranya. Pada tahap ini disebut tahap orientasi atau deskripsi, dengan *grand tour question*. Pada tahap ini peneliti mendeskripsikan apa yang dilihat, didengar, dirasakan dan ditanyakan. Mereka baru mengenal serba sepintas terhadap informasi yang diperolehnya. Dalam gambar 1.7 (tahap deskripsi) data yang diperoleh cukup banyak, bervariasi dan belum tersusun secara jelas. Di sana ada huruf besar, kecil, angka, dan simbol-simbol yang berserakan.

Proses penelitian kualitatif pada tahap ke 2 disebut *tahap reduksi/fokus*. Pada tahap ini peneliti mereduksi segala informasi yang telah diperoleh pada tahap pertama. Pada proses reduksi ini, peneliti mereduksi data yang ditemukan pada tahap I untuk memfokuskan pada masalah tertentu. Pada tahap reduksi ini peneliti menyortir data dengan cara memilih mana data yang menarik, penting, berguna, dan baru. Data yang dirasa tidak dipakai disingkirkan. Berdasarkan pertimbangan tersebut, maka data-data tersebut selanjutnya dikelompok menjadi berbagai kategori yang ditetapkan sebagai fokus penelitian. Dalam gambar 1.7 (tahap reduksi/fokus) kategori itu ditunjukkan dalam bentuk huruf besar, huruf kecil, dan angka.

Bila dikaitkan dengan melihat contoh pertunjukkan wayang, maka peneliti telah memfokuskan pada masalah tertentu, misalnya masalah wayang dan dalangnya saja.

Proses penelitian kualitatif, pada tahap ke 3, adalah tahap *selection*. Pada tahap ini peneliti menguraikan fokus yang telah ditetapkan menjadi

**Klaim Rumah Sakit Kepada BPJS Kesehatan Berkaitan
Dengan Rawat Inap Dengan Sistem INA- CBGs**

Suhartoyo
Fakultas Hukum, Universitas Diponegoro
Jl.Prof.Soedarto, SH Tembalang Semarang
suhartoyo@undip.ac.id

Abstract

This study aims to find out the hospital problem for the body organizing the health service (BPJS) with INA-GBGs system. The research method used in this research is normative law research, using a written approach (legal approach), and conceptual approach (conceptual approach), then after that analysis using site analysis. The database analysis base uses primary data and secondary data that allows the author of the data needed directly through the literature and the literature. The results showed that the compilation of the Ministerial Regulation no. 27 of 2014 concerning the basics of the Indonesian case base system and Permenkes No. 28 of 2014 concerning Guidelines for the Implementation of the National Health Insurance Program. This is due to the availability of equipment for the payment of Hospital to BPJS which berorientasi on the frequency of health professions in the Hospital, through the sorting and classification of the hospital.

Keywords: *hospital claims, BPJS, inpatient With INA-GBGs system*

Abstrak

Penelitian ini bertujuan untuk mengetahui pengaturan klaim rumah sakit kepada badan penyelenggaraan jaminan sosial (BPJS) kesehatan berkaitan dengan rawat inap dengan sistem INA-GBGs. Metode penelitian yang digunakan dalam penelitian ini adalah penelitian hukum normatif, yang menggunakan pendekatan perundang-undangan (statutory approach), dan pendekatan konseptual (conceptual approach), kemudian setelah itu dianalisis menggunakan analisis sitesis. Basis analisa data menggunakan data primer dan data sekunder yang artinya penulis mencari data-data yang diperlukan secara langsung melalui data kepustakaan dan literatur-literatur. Hasil penelitian menunjukkan bahwa pengaturan Permenkes No. 27 Tahun 2014 tentang petunjuk teknis sistem Indonesian Case Base Groups dan Permenkes No. 28 Tahun 2014 tentang Pedoman Pelaksanaan Program Jaminan Kesehatan Nasional telah berjalan sebagaimana mestinya. Hal tersebut diakibatkan oleh telah tersediannya instrumen teknis petunjuk pelaksanaan pembayaran klaim Rumah Sakit Kepada BPJS yang berorientasi pada perlindungan profesi kesehatan di Rumah sakit, melalui penjenisan dan penggolongan rumah sakit.

Kata Kunci: *Klaim rumah sakit, BPJS Kesehatan, Rawat Inap Dengan Sistem INA-GBGs*

A. Pendahuluan

Pembiayaan kesehatan merupakan bagian yang penting dalam implementasi Jaminan Kesehatan Nasional (JKN). Menurut Miller (2007) tujuan



Analisis Pengajuan Klaim BPJS Kesehatan Rawat Inap di Bangsal Sadewa RSUD Saptosari Gunungkidul, Yogyakarta

Suliantoro

*Manajemen, suliantoro@amavogogyakarta.ac.id, Akademi Manajemen Administrasi Yogyakarta

Abstract

One of the subsystems contained in the health system is the health financing subsystem. Therefore, in order to understand clearly and completely the health system, it is necessary to understand the subsystem of health financing. However, in reality this is still not fully understood and understood where there are still problems between the health services received and the demands for submitting claims from the hospital, namely the submission of claims is not in accordance with the procedures and rates in the Cooperation Agreement (PKS), causing problems for hospitals, without exception, RSUD Saptosari Gunungkidul, Yogyakarta.

So that researchers are interested in conducting an analysis related to the submission of BPJS Health claims at the Saptosari Gunungkidul Hospital, Yogyakarta, especially in the Sadewa inpatient ward in January 2022. This study uses a qualitative descriptive research methodology by obtaining data through observations, interviews and libraries. In this study it was found that there were several obstacles related to BPJS Health claims

Keyword : BPJS, BPJS Health claims, health system.

Abstrak

Salah satu subsistem yang terdapat dalam sistem kesehatan ialah subsistem pembiayaan kesehatan. Untuk itu, dalam rangka memahami dengan jelas dan lengkap sistem kesehatan maka perlulah dipahami pula tentang subsistem pembiayaan kesehatan. Namun dalam kenyataan hal ini masih kurang dimengerti dan dipahami sepenuhnya dimana masih terdapat permasalahan antara pelayanan kesehatan yang diterima dengan tuntutan pengajuan klaim dan rumah sakit, yaitu pengajuan klaim tidak sesuai dengan prosedur dan tarif dalam Perjanjian Kerjasama (PKS) sehingga menimbulkan masalah bagi rumah sakit, tanpa terkecuali dengan RSUD Saptosari Gunungkidul, Yogyakarta.

Sehingga peneliti tertarik untuk melakukan analisis terkait pengajuan klaim BPJS Kesehatan di RSUD Saptosari Gunungkidul, Yogyakarta khususnya pada bangsal rawat inap Sadewa pada bulan Januari 2022. Penelitian ini menggunakan metodologi penelitian deskriptif kualitatif dengan cara mendapatkan data melalui observasi, wawancara dan Pustaka. Dalam penelitian ini ditemukan bahwa ada beberapa kendala terkait Klaim BPJS Kesehatan.

Kata Kunci : BPJS, Klaim BPJS, Sistem Kesehatan

1. PENDAHULUAN

Jaminan Sosial wajib bagi seluruh penduduk Indonesia yang disebut Jaminan Kesehatan Nasional (JKN), diselenggarakan melalui suatu Badan Penyelenggara Jaminan Sosial (BPJS). Pemerintah bertanggungjawab atas pelaksanaan jaminan kesehatan masyarakat melalui Jaminan Kesehatan Nasional (JKN).

Salah satu subsistem yang terdapat dalam sistem kesehatan ialah subsistem pembiayaan kesehatan. Untuk itu, dalam rangka memahami dengan jelas dan lengkap sistem kesehatan maka perlulah dipahami pula tentang subsistem pembiayaan kesehatan. Namun dalam kenyataan hal ini masih kurang dimengerti dan dipahami sepenuhnya dimana masih terdapat permasalahan antara pelayanan kesehatan yang diterima dengan tuntutan pengajuan klaim dan rumah sakit, yaitu pengajuan klaim tidak sesuai dengan prosedur dan

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ANALISIS KETERLAMBATAN PENGEMBALIAN BERKAS REKAM MEDIS RAWAT JALAN DI RSUP Dr. HASAN SADIKIN

Ridwan Cahya Sunardi¹, Fahrul Rizal Pahlepi^{2*}, Meira Hidayati³

¹Politeknik Piksi Ganesha, Indonesia^{1,2,3}

cahyaaalam94@gmail.com¹, piksi.fahrul.18303136@gmail.com^{2*},

meirahidayati58@gmail.com³

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Abstrak

Latar Belakang: Keterlambatan pengembalian berkas Rekam Medis Pasien Rawat Jalan dapat menghambat proses pengelolaan Rekam Medis dan Pelayanan Rawat Jalan Di RSUP Dr. Hasan Sadikin Bandung. Standar Pengembalian berkas rekam medis rawat jalan di Rumah Sakit Dr. Hasan Sadikin Bandung adalah segera setelah selesai pelayanan atau 1 x24 jam.

Tujuan: Tujuan penelitian ini adalah ingin mengetahui lebih dalam tentang pengembalian rekam medis rawat jalan apakah sudah sesuai standar operasional prosedur yang berlaku di RSUP Dr. Hasan Sadikin

Metode: Metode penelitian menggunakan metode kuantitatif dengan pendekatan deskriptif. Teknik sampel yang di gunakan adalah teknik *simple random sampling* dengan jumlah sample 100 berkas rekam medis rawat jalan dari total kunjungan pasien rawat jalan sebanyak 12461 pada bulan juni 2021.

Hasil: Dari hasil penelitian penulis terjadi ketidaksesuaian standar operasional prosedur yang berlaku di RSUP Dr. Hasan Sadikin, dimana terjadi keterlambatan pengembalian rekam medis yang seharusnya dikembalikan 1x24jam ternyata penelitian menunjukan bahwa keterlambatan pengembalian rekam medis terendah pada tgl 2 s/d 14 Juni 2021 sebanyak 30 berkas rekam medis (60%) dan keterlambatan pengembalian berkas rekam medis tertinggi pada tgl 15 s/d 30 Juni 2021 sebanyak 36 berkas rekam medis (72%).

Kesimpulan: Ketidaksesuaiannya prosedur yang ada dengan pelaksanaan di lapangan masih terjadi keterlambatan pengembalian total dari keseluruhan sampel yang di ambil terjadi keterlambatan sebesar 72% dan yang terendah sebesar 60% yang dikarenakan tidak ada pengecekan terhadap rekam medis yang di pinjam dengan yang dikembalikan oleh perawat dan petugas poliklinik.

Kata kunci: keterlambatan pengembalian berkas rekam medis, kualitas pelayanan, rawat jalan.

Abstract



**ANALISIS PENGEMBALIAN BERKAS KLAIM BPJS TERHADAP KETENTUAN
PENGKLAIMAN BIAYA PELAYANAN PASIEN COVID-19**

Oleh

Salwa Rizkiani Syah¹, Sali Setiatin²

^{1,2}Fakultas Kesehatan, Jurusan Rekam Medis dan Informasi Kesehatan, Politeknik Piksi
Ganesha, Bandung

e-mail: ¹salwariani2015@gmail.com, ²salisetiatin@gmail.com

Abstrak

Covid-19 merupakan wabah penyakit yang menyerang sistem pernafasan manusia. Saat ini hampir seluruh rumah sakit di Indonesia melayani pasien Covid-19. BPJS Kesehatan menjadi salah satu penjamin pelayanan kesehatan pasien Covid-19. Pengajuan klaim dari rumah sakit kepada BPJS Kesehatan melalui beberapa tahap verifikasi, berkas klaim yang tidak lengkap menyebabkan pengembalian berkas oleh BPJS Kesehatan dan memicu terjadinya penundaan biaya klaim. Tujuan dari penelitian ini dilakukan untuk menganalisis ketidaksesuaian berkas klaim, mengetahui penyebab dikembalikannya berkas klaim, mengetahui jumlah keterlambatan pembayaran biaya klaim dan cara mengurangi terjadinya dispute klaim. Metode penelitian ini menggunakan metode penelitian Kualitatif dengan pendekatan Deskriptif. Hasil dari penelitian yang dilakukan pada periode triwulan 1 tahun 2021 terdapat 120 berkas klaim Covid-19 yang diajukan kepada BPJS Kesehatan, sebanyak 21 berkas (17.5%) masuk kedalam kategori dispute klaim dan 99 berkas (82.5%) terverifikasi dalam pengklaiman BPJS Kesehatan. Dari 21 berkas sebanyak 17 berkas (80.95%) diantaranya termasuk pada kriteria berkas yang tidak lengkap dan 4 berkas (19.5%) lainnya termasuk pada kriteria berkas yang tidak sesuai dengan ketentuan penjamin pasien Covid-19. Pengembalian berkas berpengaruh pada penundaan pembayaran biaya klaim, pada Triwulan 1 tahun 2021 terdapat Rp.1.278.524.000 biaya penundaan klaim Covid-19. Untuk mengurangi terjadinya pengembalian berkas dapat dilakukan 8 upaya untuk mengurangi terjadinya dispute klaim.

Kata Kunci: Covid-19, BPJS Kesehatan, Pengembalian Berkas, Klaim Covid-19

PENDAHULUAN

Pada akhir tahun 2019 sebuah kota di China yaitu Wuhan di gemparkan dengan adanya penyakit kasus pernapasan yang menyebabkan peningkatan pada angka kesakitan di wilayah tersebut. Kasus tersebut ternyata merupakan kasus coronavirus jenis baru. Pada awalnya penyakit ini dinamakan 2019 novel coronavirus (2019-nCov) kemudian pada awal 2020 WHO mengumumkan nama penyakit tersebut yaitu Coronavirus Disease 2019 (COVID-19) penyakit tersebut disebabkan oleh virus *Severe Acute Respiratory Syndrome Coronavirus-2* (Yuliana, 2020)^[1]

Covid-19 pertama kali muncul di Indonesia pada awal bulan maret tahun 2020 dan pada pertengahan bulan maret Covid-19 ditetapkan sebagai pandemi oleh organisasi kesehatan dunia (WHO). Penyakit tersebut menular dari manusia ke manusia melalui droplet saat batuk atau bersin dan melalui kontak erat dengan penderita penyakit Covid-19. Tenaga medis sangat beresiko terinfeksi virus Covid-19 karena virus tersebut dapat menempel pada benda mati yang ada di sekitar rumah sakit termasuk dokumen rekam medis. (Susilo et al., 2020)^[2]

Lean Six Sigma Concept in The Health Service Process in The Universal Health Coverage of BPJS Healthcare (Healthcare and Social Security Agency)

Tantri Yanuar Rahmat Syah*, Achmad Nurohim, Dominicus Sutrisno Hadi

Magister Management of Economic and Business, Esa Unggul Universities

Corresponding author: tantri.yanuar@esaunggul.ac.id

Abstract

Since the beginning of 2014 BPJS Kesehatan has been operating as a "single payer" by introducing a health service referral system is the provision of health services that regulate the delegation of duties and responsibilities of health services reciprocally both vertically and horizontally. With the adoption of new systems and quality improvement demands, hospitals are one of the providers of health care facilities, so all hospitals in Indonesia seem to be required to improve and make improvements in their service systems. To implement improvements, methods are needed so that improvements can be realized. One method that is currently developing in system improvement and process efficiency is the Lean Six Sigma method. By looking at the successful implementation of Lean Six Sigma in the health service sector (Lean Hospital) in several health service organizations in various countries, one of the hospitals in Indonesia that is currently improving health service governance is Rumah Sakit Ibu dan Anak Harapan Mulia also has the same potential in implementing Lean Hospital. Based on the results of Lean Six Sigma research, it was able to be applied with LCM tools on improving the BPJS tiered referral patient service process at RSIA Harapan Mulia by reducing the total time of service completion both from service users 351 minutes to 122 minutes or 65.2% and from the service provider 481 to 153 minutes or 68.2%. Activities with Added value also increased from 25.6% to 43.4% from the service user side and from 16.2% to 39.9% from the service provider side. While non-added value was reduced both from the service user side from 74.4% to 56.6% and service provider side from 83.8% to 60.1%.

Introduction

The Indonesian government continues to make various efforts to implement the national social security system in the health sector with the aim of covering the entire population, guaranteeing the majority of diseases, by reducing the portion of health costs borne by the population. In accordance with the mandate of the 1945 Constitution, every citizen without exception the poor and vulnerable has the right to receive adequate and quality health services. To realize health insurance for the entire population or universal health insurance in accordance with the mandate of the 1945 Constitution and Law no. 40 of 2004 concerning the National Social Security System (SJSN)), the government launched the National Health Insurance (JKN) program in early 2014 with the target that universal participation would be achieved within five years. That is, each individual must be a participant and be protected in the national social health insurance program. This universal health insurance aims to increase public access to comprehensive, quality and equitable health services for the entire population.

Since the beginning of 2014 BPJS Kesehatan has operated as a "single payer" by integrating membership from the former PT. Askes, ex Jamsostek, ex-TNI, ex-National Police and ex-Jamkesmas in one organizing body to achieve JKN. In addition to introducing the INA-CBG's (Indonesia Case Base Groups) payment system, the BPJS, which is a prospective health service system that only pays the cost of care and treatment according to standard rates by the government, also regulates the concept of health service providers through tiered referral systems.

The health service referral system is the implementation of health services that regulate the delegation of duties and responsibilities for reciprocal health care both vertically and horizontally that must be carried out by health insurance participants or social health insurance,

A comparison of electronic records to paper records in mental health centers

JACK TSAI AND GARY BOND

Department of Psychology, Indiana University-Purdue University Indianapolis (IUPUI)

Abstract

Objective. Medication documentation is a critical aspect of quality patient care. The current study examined whether electronic medical records provide medication documentation that is more complete and faster to retrieve than traditional paper records.

Method. This study involves a comparison of archived paper medical records to recent electronic medical records through chart review. A convenient sample of three large community mental health centers in Indiana was used. Medical charts for 180 patients with schizophrenia were rated on a checklist composed of 16 items that was adapted from a national project. Documentation that existed before implementation of the electronic medical record system was compared with that after implementation at each of the three centers. The main outcome measures were completeness and retrieval time of medication documentation.

Results. Electronic medical records provided medication documentation that was more complete and faster to retrieve than paper records across all centers and within each center. On average, electronic medical records were 40% more complete and 20% faster to retrieve.

Conclusion. Electronic records have potential to improve medication management for patients in mental health centers over traditional records. However, medication documentation for patients diagnosed with schizophrenia was found to be deficient in many areas, regardless of documentation format.

Keywords: community mental health centers, documentation, electronic medical records, medication management, schizophrenia

Medical records contain treatment history and relevant experiences pertaining to the care of the individual. As medical records are continually updated, they provide written proof of the medical life of a patient over time which can aid future courses of treatments and provide decision support. Traditionally, clinical documentation has been handwritten on forms and filed into paper medical records. However, the shortcomings of paper records are well known [1]. Handwritten medical records can be illegible, incomplete and poorly organized, making it difficult to ensure quality of care [2].

The advent of computer technology has introduced enormous possibilities for electronic documentation and usage of electronic medical records. Electronic medical records are defined as medical records located on a shared computer network that are both read and written electronically on a relational database through a graphic user interface. Dudman [3] describes six levels of sophistication in electronic medical record systems, which were used to characterize electronic medical records in this study. (i) Level 1 is the most basic level supporting administrative functions of an organization

through patient administration with independent departmental systems. (ii) Level 2 is Level 1 plus integration via master patient index. (iii) At Level 3, true clinical support is available with many practical uses, such as electronic clinical orders, results reporting, prescribing and multi-professional integrated care pathways. (iv) Level 4 has Level 3 plus electronic access to knowledge bases, embedded guidelines, electronic alerts and expert system support. (v) Level 5 has Level 4 plus specific clinical models and document imaging. (vi) The most advanced level is Level 6. It has telemedicine and other multi-media applications such as picture archiving and communication systems.

The potential benefits of electronic records in healthcare, such as increased communication between users, reduced paperwork, fewer medical errors and cost savings have been widely discussed [4–9]. Electronic records allow for ‘just in time’ access and have led to faster data searches and increased physician efficiency [10]. Surprisingly, the direct evidence of the advantages of electronic medical records over paper records is meager. Although there is an extensive literature on

Address reprint requests to: Jack Tsai, Department of Psychology, Indiana University-Purdue University Indianapolis (IUPUI), Tel: +317 274-6760; Fax: +317 988-2719; E-mail: jatsai@iupui.edu

Strategi Implementasi Jaminan Kesehatan Nasional dengan Metode *Balanced Scorecard*: Studi Kasus di Rumah Sakit X Tangerang Tahun 2018

Strategy Implementation of National Health Insurance Using Balanced Scorecard Method: A Case Study in X Hospital in Tangerang

Luh Putu Sinthya Ulandari¹, Yaslis Ilyas², Putu Ayu Indrayathi³

^{1,3}Divisi Administrasi dan Kebijakan Kesehatan, Fakultas Kedokteran, Universitas Udayana, Gedung PSKM Lantai 2, Universitas Udayana Sudirman 80234, Indonesia

²Departemen Administrasi dan Kebijakan Kesehatan, Fakultas Kesehatan Masyarakat, Universitas Indonesia, Gedung F Lantai 1 Kampus Baru UI Depok 16424, Indonesia

Korespondensi: Luh Putu Sinthya Ulandari
E-mail: sinthyaulandari@unud.ac.id

Abstrak

RS X merupakan salah satu rumah sakit swasta di Tangerang yang berhasil mengimplementasikan JKN (Jaminan Kesehatan Nasional) dengan efisiensi biaya tanpa mengabaikan mutu layanan. Penelitian ini bertujuan untuk mengetahui strategi RS X dalam pelaksanaan Program JKN dengan metode *Balanced Scorecard*. Penelitian dilakukan pada Mei 2018 dengan pendekatan kualitatif. Data dikumpulkan melalui wawancara mendalam kepada 7 informan pihak RS dan 2 informan dari BPJS Kesehatan. Subjek dipilih berdasarkan *purposive sampling* dan dianalisis dengan analisis tematik. Hasil penelitian menunjukkan ada beberapa strategi yang telah dikembangkan dan diterapkan yaitu dari (1) Perspektif keuangan (menambah jenis layanan, meningkatkan kapasitas pada rawat inap dan poliklinik, menerapkan prinsip *low cost* dan meningkatkan modal kerja, menambah slot dokter, melengkapi perawatan medis menerapkan prinsip *low cost*, dan meningkatkan modal kerja); (2) Perspektif pelanggan (menentukan target market, mengembangkan 5 nilai tambah, dan manajemen keluhan); (3) Perspektif proses bisnis internal (pembuatan standar operasional prosedur, menyusun formulir dan *clinical pathway*, melakukan pengendalian dan audit operasional, menetapkan bisnis model, pembentukan tim *casemix*, serta manajemen klaim); (4) Perspektif pembelajaran dan pertumbuhan (reward dan gaji bagi karyawan, lingkungan kerja kompetitif serta memperhatikan jenjang karir karyawan). Melalui strategi tersebut, RS X mampu mengimplementasikan Program JKN dengan baik dan tetap membukukan surplus tanpa mengorbankan kualitas pelayanan.

Kata kunci: *Balanced scorecard*, strategi rumah sakit, implementasi jaminan kesehatan nasional

Abstract

One of the private hospital successful implementation the National Health Insurance with cost efficiency without neglecting the quality of service is X Hospital. This study aimed to finding out the strategy of X Hospital in the implementation of the National Health Insurance with *Balanced Scorecard*. The research was conducted in May 2018 using qualitative approach. Data was collected through in-depth interview to 7 informants from hospital and 2 informants from BPJS Kesehatan. The subjects were selected purposively and the data was analyzed using thematic analysis. The results show that there are several strategies that have been developed and implemented, including: (1) financial perspective (adding types of services, increasing the capacity of inpatients and polyclinics, increasing doctor practice slots, completing medical equipment, applying the principle of low cost and increasing working capital); (2) customer perspective (choosing target market, develop 5 values propotion, complaint management); (3) internal business processes perspective (develop standard operating procedures, develop drug formulary and clinical pathways, carry out operational and audit controls, build business models, form case mix teams and claim management);

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Indikator	Tahun 2021	Tahun 2022	Referensi
Jumlah Tempat Tidur	28	25 (Desember 2022)	
Bed Occupation Rate (BOR)	74%	76,3%	60-85%
AVLOS	2.69	2.45	6-9 hari
TOI	1.44	1.08	1-3 hari
BTO	66	66.05	40-50 kali

** data yang digunakan dalam laporan ini adalah Januari –November 2022

Angka Kematian Ibu dan Bayi:

Terdapat 3 angka kematian pasien Ibu selama tahun 2022, dengan rincian:

- 1 kematian ibu di IGD dengan diagnose syok perdarahan ec rupture uteri (pasien rujukan dari bidan)
- 1 kematian ibu 2 hari setelah dirujuk ke RSUP Dr.Diamil dengan diagnosa Eklampsia
- 1 kematian ibu 2 hari pasca pulang rawatan dengan diagnosa PIA0 post SC hari ke 5 dengan susp Pulmonary edema

Terdapat 6 angka kematian Bayi selama tahun 2022 dengan rincian:

- 1 kasus kelainan kongenital (usia hidup 20 menit)
- 2 kasus APGAR rendah dengan perburukan kondisi
- 2 kasus bayi cpap perburukan → tidak dapat RS rujukan
- 1 kasus BBLSR

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Faktor yang Memengaruhi Keterlambatan Pengembalian Rekam Medis Pasien Rawat Inap di Rumah Sakit: Kajian Literatur

Made Karma Maha Wirajaya¹ dan Vitalia Fina Carla Rettobjaan²

¹Program Studi Manajemen Informasi Kesehatan, Fakultas Ilmu Ilmu Kesehatan, Universitas Bali Internasional

²Program Studi Bisnis Digital, Fakultas Bisnis, Sosial, Teknologi dan Humaniora, Universitas Bali Internasional

mdkarma.wirajaya@gmail.com¹ dan vitaliacarlarettobjaan@gmail.com²

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ABSTRAK

Latar Belakang: Rekam medis adalah dokumen penting dalam sebuah layanan kesehatan. Indikator kunci penyelenggaraan rekam medis yang bermutu adalah pengembalian rekam medis secara tepat waktu. Kenyataannya masih terdapat pengembalian rekam medis yang terlambat di rumah sakit.

Tujuan: Mengetahui faktor yang berpengaruh terhadap keterlambatan pengembalian rekam medis pasien di rumah sakit.

Metode: Studi literatur ini yang disajikan secara deskriptif menggunakan kata kunci “faktor keterlambatan pengembalian rekam medis” yang ditelusuri pada *google scholar*. Database jurnal yang digunakan adalah semua jurnal yang terindeks oleh *google scholar*.

Hasil: Terdapat 11 variabel yang dikelompokkan dalam 5 faktor, yang berpengaruh terhadap keterlambatan pengembalian rekam medis pasien, beberapa di antaranya belum terisi dengan lengkap berkas rekam medis oleh dokter, tidak adanya petugas yang khusus menangani kelengkapan rekam medis, serta tingginya beban kerja dokter dan perawat.

Kesimpulan: Terdapat 11 variabel yang memengaruhi keterlambatan rekam medis pasien, yang dikelompokkan dalam 5 faktor, yakni faktor SDM, keuangan, material, dan metode. Rumah sakit diharapkan dapat memperhatikan hal tersebut untuk menjaga kualitas layanan rumah sakit.

Kata Kunci: Keterlambatan; Rekam Medis; Rawat Inap; Rumah Sakit

ABSTRACT

Background: Medical records are important documents in a health service. The key indicator of the implementation of quality medical records is the timely return of medical records. In fact, there are still delays in medical record returns at the hospital.

Objective: To determine the factors that influence the delay in returning the patient's medical records at the hospital.

Method: This literature study presented descriptively used the keyword “factor of delay in returning medical records” searched on *google scholar*. The journal database used all journals indexed by *google scholar*.

Results: There were eleven variables, that grouped in 5 factors, that affected the delay in returning the patient's medical records that included, among others, the incomplete medical record file by the doctor, the absence of an officer who specifically handled the completeness of the medical record, and the high workload of doctors and nurses.

Conclusion: There are eleven variable that affect the delay in patient medical records classified in 5 factors, i.e., human resources, finance, materials, and methods. Hospitals are expected to pay attention to this to maintain the quality of hospital services.

Keywords: Delay; Medical Records; Hospitalization; Hospital

INTRODUCTION

Lean Thinking versus *Muda*

Muda. It's the one word of Japanese you really must know. It sounds awful as it rolls off your tongue and it should, because *muda* means "waste," specifically any human activity which absorbs resources but creates no *value*: mistakes which require rectification, production of items no one wants so that inventories and remaindered goods pile up, processing steps which aren't actually needed, movement of employees and transport of goods from one place to another without any purpose, groups of people in a downstream activity standing around waiting because an upstream activity has not delivered on time, and goods and services which don't meet the needs of the customer.

Taiichi Ohno (1912–1990), the Toyota executive who was the most ferocious foe of waste human history has produced, identified the first seven types of *muda* described above and we've added the final one.¹ Perhaps there are even more. But however many varieties of *muda* there may be, it's hard to dispute—from even the most casual observation of what gets done in an average day in the average organization—that *muda* is everywhere. What's more, as you learn to see *muda* in the pages ahead, you will discover that there is even more around than you ever dreamed.

Fortunately, there is a powerful antidote to *muda*: *lean thinking*. It provides a way to specify value, line up value-creating actions in the best sequence, conduct these activities without interruption whenever someone requests them, and perform them more and more effectively. In short, lean thinking is *lean* because it provides a way to do more and more with less and less—less human effort, less equipment, less time, and less space—while coming closer and closer to providing customers with exactly what they want.

Lean thinking also provides a way to make work more satisfying by providing immediate feedback on efforts to convert *muda* into value. And, in striking contrast with the recent craze for process reengineering, it provides a way to create new work rather than simply destroying jobs in the name of efficiency.

Specify Value

The critical starting point for lean thinking is *value*. Value can only be defined by the ultimate customer. And it's only meaningful when expressed in terms of a specific product (a good or a service, and often both at once) which meets the customer's needs at a specific price at a specific time.

Value is created by the producer. From the customer's standpoint, this is why producers exist. Yet for a host of reasons value is very hard for producers to accurately define. Business school-trained senior executives of American firms routinely greet us when we visit with a slick presentation about their organization, their technology, their core competencies, and their strategic intentions. Then, over lunch, they tell us about their short-term competitive problems (specifically their need to garner adequate profits in the next quarter) and the consequent cost-cutting initiatives. These often involve clever ways to eliminate jobs, divert revenues from their downstream customers, and extract profits from their upstream suppliers. (Because we are associated with the concept of lean production, they are usually eager to label these programs "lean," although often they are only "mean.") By dessert, we may be hearing about their personal career issues in the current age of "downsizing."

What only comes up when we push it to the foreground is the specific products the firm expects specific customers to purchase at a specific price to keep the company in business and how the performance and delivered quality of these products can be improved while their fundamental costs are pushed steadily down. In raising this issue it's often revealing to ask these executives a simple question: Can you put yourself in the position of a design as it progresses from concept to launch, an order as information flows from initial request to delivered product, and the physical product as it progresses from raw material to the customer, and describe what will happen to you at each step along the way? Usually there is an awkward silence, and then, if we aren't persistent, these issues quickly slip out of sight to be replaced once more by aggregated financial considerations. In short, the immediate needs of the shareholder and the financial mind-set of the senior managers have taken precedence over the day-to-day realities of specifying and creating value for the customer.

When we've gone to Germany, until very recently, we've found a reverse distortion of value specification. For much of the post-World War II era, executives of private or bank-controlled companies could ignore the need for short-term financial performance and were eager to tell us all about their products and process technologies. Even the most senior executives could go into great detail about product features and new processing methods

But who specified their value? The engineers running the companies! Designs with more complexity produced with ever more complex machinery were asserted to be just what the customer wanted and just what the production process needed. But where was the evidence?

In pressing this point, it often became apparent that the strong technical functions and highly trained technical experts leading German firms obtained their sense of worth—their conviction that they were doing a first-rate job—by pushing ahead with refinements and complexities that were of little interest to anyone but the experts themselves. Our doubts about proposed products were often countered with claims that “the customer will want it once we explain it,” while recent product failures were often explained away as instances where “the customers weren’t sophisticated enough to grasp the merits of the product.”

A central feature of the crisis of German industry in the period since the end of the cold war has been the dawning perception that the complex, customized designs and sophisticated processing technologies favored by German engineers are too expensive for customers to afford and often irrelevant to their real desires.

When we have traveled to Japan, also until very recently, we have encountered yet a third distortion. What’s been really important for Japanese firms as they have defined value is *where* value is created. Most executives, even at firms like Toyota which pioneered lean thinking, have begun their value definition process by asking how they can design and make their product at home—to satisfy societal expectations about long-term employment and stable supplier relations. Yet most customers across the world like products designed with an eye to local needs, which is hard to do from a distant home office. And they like products made to their precise order to be delivered immediately, which ocean shipping from a Japanese production base makes impossible. They certainly do not define the value of a product primarily in terms of where it was designed or made.

What’s more, the stay-at-home-at-all-costs thinking of Japanese senior managers, even as the yen steadily strengthened, depleted the financial resources these firms needed to do new things in the future. The immediate needs of employees and suppliers took precedence over the needs of the customer, which must sustain any firm in the long term.

Moving beyond these national distortions in the world’s three most important industrial systems (and every country probably has its own unique set),² we are repeatedly struck how the definition of value is skewed everywhere by the power of preexisting organizations, technologies, and undepreciated assets, along with outdated thinking about economies of scale. Managers around the world tend to say, “This product is what we know how to produce using assets we’ve already bought, so if customers don’t

Pendekatan *Lean Hospital* untuk Meminimalkan Waste di Instalasi Farmasi Rawat Jalan di Rumah Sakit Umum Daerah Pandan Arang Boyolali

Tria Yuganingsih

Fakultas Farmasi, Universitas Setia Budi; yuganingsih@gmail.com (koresponden)

Gunawan P. Widodo

Fakultas Farmasi, Universitas Setia Budi; Gunawanpanudji@yahoo.com

Opstaria Saptarini

Fakultas Farmasi, Universitas Setia Budi; opstaria.saptarini79@gmail.com

ABSTRACT

Lean Hospital is needed so that in the hospital can fulfill patient's need optimally to give healthy service as much as possible by reducing waste which finally will create added value for the hospital. The purpose of this research is to identify waste and the cause of waste that happen in Outcare Pharmaceutical Installation Regional Public Hospital Pandan Arang, Boyolali. The method of this research is case study research with qualitative approach. The sequence of the research are Chart observation of service process in the form of value stream mapping. The distribution of Value Patient questionnaire and waste, doing interview by 5 Why Method to know the cause and critical waste. The results showed that the critical waste in the form of overproduction waste was 63.33%, waste waiting was 23.07% and waste inventory was 39.35%. The root cause of waste overproduction is inefficient information related to prescription service flow, the root cause of waste waiting is limited human resources, the root cause of waste inventory is doctor's practice hours that are not in accordance with the predetermined hours causing buildup. The proposed improvement for waste overproduction is to add acrylic information from service providers who are more effective at registration counters, queue collection counters. The proposed waste waiting improvement is done by leveling employees to create a middle system by requiring additional human resources. The proposed improvement in waste inventory is to arrange a doctor's practice schedule or a shift system.

Keywords: critical waste; lean hospital; pharmaceutical installation; service improvement

ABSTRAK

Pendekatan *lean* adalah untuk meningkatkan efisiensi dan efektivitas organisasi dengan meningkatkan nilai, mempercepat waktu pelayanan dan meningkatkan kualitas dengan menghapus pemborosan dalam semua proses pelayanan di suatu instalasi. Tujuan penelitian ini untuk mengidentifikasi waste dan akar penyebab waste yang terjadi di dalam Instalasi Farmasi Rawat Jalan RSUD Pandan Arang Boyolali. Metode penelitian ini adalah penelitian studi kasus dengan pendekatan kualitatif. Tahapan penelitian yaitu observasi alir proses pelayanan yang dibuat dalam bentuk *value stream mapping*, penyebaran kuesioner *value* pasien dan waste, melakukan wawancara dengan metode 5 why untuk mengetahui akar penyebab dan waste kritis. Hasil penelitian menunjukkan bahwa waste kritis berupa waste *overproduction* sebesar 63,33%, waste *waiting* sebesar 23,07% dan waste *inventory* sebesar 39,35%. Akar penyebab dari waste *overproduction* adalah informasi yang kurang efisien terkait alir pelayanan resep, akar penyebab dari waste *waiting* adalah keterbatasan sumber daya manusia, akar penyebab dari waste *inventory* adalah jam praktek dokter yang tidak sesuai dengan jam yang telah ditentukan sehingga menyebabkan penumpukan. Usulan perbaikan untuk waste *overproduction* adalah menambahkan akrilik keterangan petugas pemberi pelayanan yang lebih efektif pada loket pendaftaran, loket pengambilan nomor antrian. Usulan perbaikan waste *waiting* adalah dilakukan leveling pegawai membuat sistem *middle* dengan memerlukan tambahan sumber daya manusia. Usulan perbaikan waste *inventory* adalah mengatur jadwal praktik dokter atau dibuat sistem shift.

Kata kunci: waste kritis; lean hospital; instalasi farmasi; perbaikan pelayanan

PENDAHULUAN

Rumah sakit merupakan institusi pelayanan kesehatan bagi masyarakat dengan karakteristik tersendiri yang dipengaruhi oleh perkembangan ilmu pengetahuan kesehatan, kemajuan teknologi, dan kehidupan sosial ekonomi masyarakat. Rumah sakit harus tetap mampu meningkatkan pelayanan kesehatan yang lebih bermutu dan terjangkau bagi masyarakat agar terwujud derajat kesehatan masyarakat yang setinggi-tingginya dengan menyelenggarakan pelayanan kesehatan perorangan secara paripurna, menyediakan pelayanan rawat inap, rawat jalan, dan gawat darurat, melakukan upaya kesehatan yang dilaksanakan secara serasi, terpadu, menyeluruh, dan berkesinambungan dengan tujuan untuk mewujudkan derajat kesehatan yang optimal bagi masyarakat.⁽¹⁾

Pelayanan instalasi farmasi yang bermutu adalah pelayanan kesehatan yang mana dapat memberikan kepuasan setiap pemakaian jasa pelayanan sesuai dengan kode etik dan standar pelayanan yang telah ditetapkan. Diharapkan bahwa kesembuhan pasien mencapai angka 25% didapat dari pelayanan dan kenyamanan yang baik, sedangkan angka 75% didapat dari obat yang digunakan oleh pasien.⁽²⁾ Adanya masalah mutu dalam sebuah instalasi yang dapat menyebabkan tidak terpenuhinya kepuasan pasien di rumah sakit dan keluhan yang sering terdengar dari pihak pemakai pelayanan kesehatan yang salah satunya sering menjadi sasaran di pelayanan farmasi rawat jalan. Instalasi farmasi rawat jalan merupakan salah satu diantara instalasi di rumah sakit yang menjadi perbincangan karena masalah mutu pelayanan sehingga menyebabkan ketidakpuasan pasien. Masalah yang sering terjadi diantaranya pelayanan tugas farmasi terlambat, prosedur yang berbelit dan menyulitkan pasien, informasi yang disampaikan oleh petugas farmasi yang kurang jelas.⁽³⁾ Selain itu, waste kritis di satelit farmasi rawat jalan adalah waste *motion* (19,26%) dan waste kritis di satelit farmasi rawat inap adalah waste *waiting* (15,23%).⁽⁴⁾ Penelitian lain menemukan 2 waste kritis yang terdapat di instalasi farmasi yaitu waste *overprocessing* dengan persentase sebesar 23% dan waste *waiting* dengan persentase sebesar 19%.⁽⁵⁾ Hal serupa ditemukan oleh Triyani dalam penelitiannya menemukan waste *waiting* dan *overprocessing*.⁽⁶⁾ Waste *waiting* disebabkan SIM mengalami error, banyak

