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ANALYSIS IMPLEMENTATION OF BACK REFERRAL PROGRAM DIABETES MELLITUS AND HYPERTENSION IN HOSPITAL X, JAKARTA

Riza Ambari ^{1,*}, Mieke Savitri ²

¹ Master's Program of Hospital Administration, Faculty of Public Health, Universitas Indonesia

² Faculty of Public Health, Universitas Indonesia

*Corresponding authors's email : riza_ambari23@yahoo.com

ABSTRACT

Background: Since morbidity rate of Diabetes Mellitus and Hypertension in Indonesia increased, the number of referral in hospital automatically high. National Health Insurance and hospital burden also increase if the Back-Referral Program (BRP) has not been implemented yet. The impact of the ineffectiveness of Back-Referral Program also felt by Hospital "X" in Jakarta. This study aims to analyze the effectiveness implementation of Back-Referral Program (BRP) Diabetes Mellitus and Hypertension in Hospital "X".

Methods: This research was conducted in Hospital "X" of East Jakarta by using Qualitative Method. The informant are considered influential with Back-Referral Program (BRP) in Hospital "X", consisting of Head of Medical Service Section, Internist Doctors, Nurses in internist station, Diabetes mellitus and Hypertension patients in Hospital "X", Doctor's in first health facility (FKTP), BPJS pharmacy partner and Head of Health Services Primary Management Unit (MPKP) BPJS East Jakarta.

Results: This study found an indication of medicine shortage in first health facility (FKTP). Lack of communication and coordination between BPJS, Hospitals, FKTP and BPJS pharmacy partner, and also less of monitoring and evaluation of Back-Referral Program (BRP) in hospital.

Conclusions: Since Back-Referral Program (BRP) has not been implemented yet in Hospital "X" will induce long queue in internist station and caused the internist cannot examine and verify patients with properly.

Keywords: Back-Referral Program, Diabetes Mellitus, Hypertension, Implementation

INTRODUCTION

Health is the most basic human right and an important factor to be considered in policy making in Indonesia. Its underline in the national goals of the Indonesian Nation in accordance with the Preamble of the 1945 Constitution of the State of Indonesia, the development of health is directed to increase the awareness, the willingness, and the ability to live healthy for every person in order to improve the highest degree of public health can be realized [1].

Therefore, the Indonesian government provides health protection through the JKN (National Health Insurance), implemented by BPJS (Social Security Administering) as a legal entity formed to organize the health insurance program. The JKN's program is an implementation of National Social

Security System Act [2,3]. The scope of the health service provided promotive, preventive, curative and rehabilitative services including medicines and medical consumables services in accordance with the necessary medical needs [4]. These services must be qualified, equitable and affordable by the community and implemented by health facilities with high quality standards, and also implement efficient service systems [5,6]. In the implementation of health services, the JKN program is given in stages, effectively and efficiently by applying the principles of quality control and cost control. One program that represents the concept is the Back- Referral Program (BRP) [7].

Back Referral Program is health services provided to chronically disease patients with stable conditions and still require long-term treatment or nursing care carried out at a first-rate health facility (FKTP) on recommendation / referral from a specialist / sub-treating physician [8]. The types of BRP are: Diabetes Mellitus, Hypertension, Heart, Asthma, Chronic Obstructive Pulmonary Disease (COPD), Epilepsy, Schizophrenia, and Stroke. The BRP procedure begins in the first health facility (FKTP). The doctor in FKTP refers a Diabetes mellitus and hypertension patient to hospital. After examination by internist doctor, patient with stable diagnostic should return to FKTP to receive another treatment by recommendation from internist doctor, ex: blood check, medicine, therapy, etc.

Epidemiologically, it is estimated that in 2030 the prevalence of Diabetes Mellitus (DM) in Indonesia reaches 21.3 million people [9]. And one of the complications of Diabetes Mellitus type 2 is Hypertension. Studies have shown that diabetics with odds of 6.85 times are at greater risk of hypertension, and hypertension patients have 1.5 times more risk of developing diabetes than non-hypertensive individuals [10]. Meanwhile, hypertension in Indonesia is very high and is the third main cause of death after stroke and tuberculosis; reaching 6.7% of death population at all age in Indonesia. Hypertension is a disorder of the circulatory system that causes a rise in blood pressure above normal, 140/90 mmHg. Results of Basic Health Research (Riskesdas) Balitbangkes in 2007 showed the prevalence of hypertension nationally reached 31.7% (Ministry of Health of the Republic of Indonesia). From these data shows that Diabetes Mellitus and Hypertension are chronic disease with most priorities in BRP.

In Hospital "X" there were 616 Diabetes Mellitus and Hypertension patients with potential to get BRP, but only 92 patients were actually returned to FKTP, which represents the lack of BRP coverage in Hospital "X" [13]. This study aims to analyze the effectiveness implementation of Back-Referral Program (BRP) Diabetes Mellitus and Hypertension in Hospital "X".

METHOD

A qualitative approach is conducted by investigating and collecting data through face-to-face and direct interaction with relevant people at the research site [11]. The findings are not through statistical procedures or other forms of calculation [12]. The Informants come from internal and external hospital side who directly involves with the implementation of BRP program in hospital. Primary data obtained from the results of in-depth interviews with 25 informants and observations in the field while the secondary data is obtained from the document review. The internal informants as a main implementer in hospital, are consisting of one Head of Medical Service Section (I1), four Internist Doctors (ID1-ID4), and four nurse in internist station (N1-N4). The external informants who have benefit by this program are consisting of ten Diabetes mellitus and Hypertension patient at hospital "X" (P1-P10), three Doctors at FKTP (D1-D3), two BPJS Pharmacy Partner (PP1-PP2) and one Head of Management Unit Primary Health Care (MPKP) BPJS East Jakarta (H1). Data analysis is done by collecting the data used as transcripts, the data is categorized and included in a matrix and then used to identify the relationship between variables so that it can analyze each phrase, words and sentences precisely to describe data and analysis result from this research.

RESULTS

Standard Operating Procedure (SOP)

Standard Operating Procedure (SOP) is created as a guideline and reference for running the tasks. Should be containing the duties, authority and responsibility.

“The BRP is created by BPJS for quality and cost control, we should implement in hospital, we knew it. We have run the program. The implementer in the hospital is the internist doctor, nurses and BPJS officer. There is no official appointment but I think they already know their respective portions because it has been explained through the BPJS meeting.” (I1)

The continuation of the SOP is that there should be a clear organizational structure and division of tasks

“There is no organizational structure, as my thought only the internist doctor can decide whether the patient can be join the BRP or not, the rest is the duty of nurses and BPJS officer.” (D11, D12)

In FKTP as a gate keeper, the SOP and organizational structure to maintain the BRP are running well for its inclusion in the assessment of KBK (Competency Based Performance). FKTP also provide PROLANIS (Chronic disease control program) once in a month as a tool to gather Diabetes Mellitus and Hypertension patients. The PROLANIS patients received teachings from FKTP doctors, diagnostic support, and medicine from BPJS Partners' pharmacy. The doctor in FKTP refer the Diabetes Mellitus and Hypertension patient but do not return by internist doctors in Hospital "X".

“Indeed, we make a priority for this program since it include on our assessment of KBK, SPO and organizational structure also exist” (D1, D2)

“Diabetes and hypertension patient who need further treatment we must refer. But sometimes the internist doctor does not give back referrals. Another patient do not want to be returned to us because our examination is not complete as hospital.” (D3, D4)

The cholesterol diagnostic support for hypertension patient and HbA1c for Diabetes Mellitus patient are not covered in FKTP as they are not claimable to BPJS.

Monitoring and evaluation the BRP

In order to identify and review whether the program implemented is in accordance with the plan, monitoring and evaluation are also needed. Monitoring can be manual or automatically by system. Unfortunately, monitoring both by manual and by system for BRP participants in the hospital is not yet exist. Hospital System information to maintain BRP is only based on hospital visit data and P-care System from BPJS, which do not specifically analyze the potential number of Diabetes and Hypertension patients in referral.

Another current problem is imbalance between patient and doctor quantity. Hospital "X" has four internist doctors to treat approximately 250 patients per day. The practice of an internist doctor is four hours per day, means a doctor received 63 patient in four hours. The imbalance caused fatigue and ineffective examination. Internist doctors did not have more time educating BRP to Diabetes mellitus and Hypertension patient.

“By long queue in internist station, honestly we tired. Moreover our internist doctors.. Diabetes and hypertension patient are the most quantity but we have no incentive by maintain them” (N1, N2)

“The internist doctor not examine properly, they only they just give a prescription. The internist doctor said they give the medicine is for one month. And suggest us to control on next month” (P1, P2, P3)

Medicine Shortage

BPJS hired a pharmacy partner to fulfill the medicine procurement to BRP patient once in a month in FKTP.

“Most of Diabetes and hypertension patient comes with severe and complication condition. We are worried, FKTP cannot provide the medicine and the therapy will be discontinued. ” (D11-D13)

“We have been being BRP participants in FKTP but the medicine is not complete as hospital. The pharmacy said that the medicine is not available and they didn't know they do not know when it's available. Though our treatment should not be interrupted, then we usually buy the medicine by ourselves.” (P4, P5, P6)

A BPJS Pharmacy partner agree that sometimes there is medicine shortage due to the medicine also not available in their distributors. Another problem is FKTP or Hospital as a provider does not report a medicine demand so they found difficulty in predicting the medicine needs. Some patients are also reluctant to take the medicine if the brand is different with doctor prescription, albeit the medicine content is same only different manufacturers.

Socialized and promotion the BRP Program

Diabetes Mellitus and Hypertension patients know the BRP. They got the information from first health facility (FKTP). Patients are interested in BRP to avoid long queue in hospital and the distance of Hospital “X” is too far from their location. The obstacle came from the internist doctors who do not allowed them return to FKTP. The patient didn't know the reason due to the examination time is very short. However, some of patients are not pleased with BRP since they are more confident to consult with internist doctor than with a doctor in first facility (FKTP). The patients are also complaining about the shortage of medicine and other diagnostic support which not coverable in FKTP; for instance: cholesterol check for hypertension patient and HbA1c for Diabetes Mellitus patient.

According to the Head of Primary Health Care Management Unit (MPKP) BPJS East Jakarta, the purpose of BRP is to avoid double claim between INA CBG's in hospital with capitation in FKTP. The socialization of BRP has been implemented through coordination meeting between FKTP and FKTL but only limited in monthly meeting attended by both representatives but not routine. Not knowing whether the outcome was well socialized in FKTP and FKTL.

“Currently BPJS has not implemented a punishment system against hospitals that have not been maximally applying BRP... we provided Promotion media or education about referrals facilitated by BPJS is only brochures” (H1)

From the interview result, it can be concluded that Implementation of BRP Diabetes Mellitus and Hypertension in Hospital "X" has not run effectively. The visit number of hypertension and diabetes patients still high and causing a long queue in internist station.

DISCUSSION

The results of interview techniques found that the implementation of BRP in Hospital “X” is ineffective. The BRP contribute to reduce patient queue and waiting time in internist station in hospital, improving the quality of internist services in hospitals and improve internist doctor function as disease management coordinator and consultant. The obstacle come from hospital in managing the program. The structure organization and standard operating procedure for this program has not been created which cause unclear task and indifferent behavior from implementer. Incentives for running the program such as free seminar or training to improve their knowledge should be allocated in order to motivate implementing agencies to work with more vigor.

Hospitals data collecting system are still weak - such a system does not specify the origin of the referring hospital and the history behind the BRP. So, the attention for medical record is particularly needed either through manual or online data collection System. The Hospital should create a system with controlling BRP patient that is linked to FKTP and P-Care BPJS. The result of the system contain an information the number of diabetes and hypertension patient and monitoring whether the patient who has been given a referral has actually returned to the FKTP or even returned to the hospital. Information system for medicinal usage is also recommended since the prescribing is done by internist doctors at the hospital. Should the disposal of medicine be predicted earlier by BPJS pharmacy partner, it could reduce the risk of shortage of medicine in FKTP.

To avoid internists and doctors' fatigue and inefficient examination to diabetes mellitus and hypertension patients, hospital should evaluate the resources and number of patients. Hospital "X" should lengthen hours of practice or hire more internist doctors.

Another critical problem is shortage of medicine. BPJS and their pharmacy partners should find any solution to manage the shortage. BPJS Health should give a warning to provider who do not report the medicine demand to prevent the incidence of drugs being unavailable. BPJS also had to evaluate their pharmacy partners in addition to fulfill the medicine demand. There are still patients refer participants turning back outpatients because the drugs patients receive from different pharmacies are not the same as the medications doctors give at the hospital. There is a need for rules enforcement for prescribing; trade names should be used, and patients should receive education about their prescriptions.

BPJS, Hospital "X", FKTP and BPJS pharmacy partners should create a regular meeting in order to make BRP running well and avoid lack of coordination as several problems are ignored by both hospital and BPJS stakeholders, which leads to another problem such as patient data and the division of labor became less strict documented.

CONCLUSION

Based on the results of research at the Hospital "X", researchers can remark that the main obstacles for BRP is the lack of supervision by Hospital "X" to maintain the resource and maintain the program. Lack of effective coordination between BPJS, Hospital, FKTP and BPJS pharmacy partners caused shortage of medicine. However the BRP can be implemented if there is a synergistic cooperation between BPJS, Hospital, FKTP and BPJS Pharmacy Partner.

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