



Mentoring for Identifying Operational Waste at PKU Sekapuk Hospital

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Abstract

The intense competition in the healthcare industry in Lamongan Regency demands that private hospitals abandon traditional governance models that trigger high levels of wasteful spending. The Pembina Kesejahteraan Umat Hospital (RS PKU) in Sekapuk faces managerial challenges where 80% of its staff have purely clinical backgrounds without modern governance skills, leading to service inefficiencies and revenue leakage. The Community Empowerment Program (CEP) aims to detect, measure, and map existing operational inefficiency nodes in the hospital's healthcare facilities. The implementation method is carried out through technical mentoring and collaborative Focus Group Discussions (FGDs) with 25 core hospital managers, adopting the curriculum of the Asian Tiger Healthcare Camp and the Ikatan Konsultan Kesehatan Indonesia (Ikkesindo). The results of the CEP indicate a simultaneous accumulation of high-level waste across all parameters of the Seven Biggest Sources of Wasteful Spending instrument. The main root causes are detected in outpatient queues (operational inefficiencies), uncertainty in the conventional pharmaceutical supply chain, and delayed claim files (revenue leakage). This comprehensive audit successfully formulated a new governance roadmap that serves as a scientific basis for the board of directors in determining priorities for sustainable quality interventions.

Keywords: Hospital Management; Operational Audit; Revenue Leakage; Wasteful Spending.

INTRODUCTION

Healthcare industry at the regional level faces an increasingly high-stakes competitive landscape. Accelerated growth of modern healthcare facilities in Lamongan Regency, including the expansion of religious-based hospital networks and private clinics, has triggered a fierce competition for market share among non-governmental healthcare facilities. The dominance of purely clinical backgrounds in management without any balanced advanced governance training has resulted in bias in daily decision-making. Tactical policies often override corporate operational cost efficiency.¹

These dynamics place religious-based private hospitals in a vulnerable position if they fail to adapt to changes in operational governance. Medical inflation triggers a significant annual surge in operational costs for drug procurement, medical equipment, and facility maintenance. Restrictions on service package rates and tightening national accreditation regulations limit the flexibility of healthcare facilities'



financial profit margins.² Regional hospitals are required to expand service capacity without allowing internal cost inflation to occur.

Inability to control inefficiencies in modern hospital operational management studies is considered the largest source of wasteful spending. Direct cost-cutting measures often ignore latent revenue leakage.³ Operational inefficiencies in healthcare generally manifest themselves in the form of duplicate bureaucratic workflows, slow, multi-tiered approval processes, and patient bottlenecks at registration counters and pharmacy depots. These non-value-added activities trigger inflated administrative costs, long waiting times (wasted waiting), and reduced service asset utilization.⁴ Operational inefficiencies act as hidden costs, simultaneously eroding patient satisfaction, triggering workforce burnout among staff, and reducing hospital's financial resilience.

PKU Sekapuk Hospital is a private healthcare facility that plays a strategic role in serving the community in Lamongan. Hospital is still managed using a conventional, traditional managerial approach. Root of internal problems stems from weak human resource capacity, with 80% of workers and healthcare personnel having degrees in nursing, midwifery, health, economics, and hospital administration who empirically lack strong managerial competencies. The dominance of purely clinical backgrounds without advanced governance training leads to bias in daily decision-making. Staff tend to be trapped in daily tactical problem-solving (firefighting mode) rather than long-term systemic improvements. This situation has direct implications for poor patient flow management, slow administrative bureaucracy, and inaccurate cross-unit coordination, which simultaneously reduces the annual volume of patient visits.

Given the complexity of the hospital's problems, this CEP intervention presents an urgent academic and practical need for implementation. Improving hospital performance cannot be done haphazardly without objective data and evidence-based decision-making. This mentoring program adopts the modules and curriculum of the Asian Tiger Healthcare Camp and a special program from the *Ikatan Konsultan Kesehatan Indonesia* (Ikkesindo) as its primary analytical tool. Based on the Seven Biggest Sources of Wasteful Spending Framework, the CEP team assists hospital management in conducting a comprehensive audit to detect, measure, and map leaks and inefficiencies in the existing operational system.⁵ Initial identification through this standardized instrument serves as an essential foundation for continuous quality improvement, repositioning PKU Sekapuk Hospital's competitiveness within the regional healthcare landscape.

MENTORING IMPLEMENTATION METHODS

Mentoring Design and Partner Characteristics

CEP is designed in the form of problem-based mentoring and structured workshops. The activities will be carried out for three months, starting from February to April 2025, at the Meeting Hall of PKU Sekapuk Hospital, Lamongan Regency. The

main or strategic target of the hospital in this program is the core management elements of the hospital, consisting of the Board of Directors, Head of Medical Affairs, Head of Nursing Affairs, Head of Finance, Head of General Administration, and all Heads of Implementing Service Units (Outpatient Clinic, Emergency Room, and Pharmacy Installation) with a total of 25 active participants. The selection of components is based on their vital role as daily operational policy makers of health facilities that directly interact with the object of systemic inefficiency.⁶

Stages of Implementing CEP Interventions

In accordance with the organizational governance blueprint, the implementation stages of this activity are divided into three systematic chronological phases adopted from the change management modification cycle to unravel internal staff resistance.⁷

Phase 1, pre-mentoring (Pre-Intervention Assessment). The CEP team carried out initial field observations without intervention regarding the bureaucratic flow of submitting registration documents, waiting times for outpatient clinics, and the drug preparation process at the pharmacy. In-depth interviews are also conducted randomly with frontline staff to validate early indications of operational waste.⁸

Phase 2, main implementation (Mentoring and workshops). The implementation of the core program is carried out through collaborative classical work. The CEP team held a session on the application material Building An Efficient & Scalable Healthcare System. After the presentation of the material, participants were divided into cross-divisional working groups to conduct FGDs. Participants were guided to detect inefficiencies in their respective units using a standardized self-assessment form.

Phase 3, post-mentoring (impact analysis) with activities of tabulating and weighting waste instrument scores, and mapping the priority scale matrix of tactical interventions (impact analysis). The findings from the instrument forms were collected, cross-validated between divisions, then tabulated to calculate the significance weight of the waste that occurred. The final stage of this method produced a document mapping the priority scale of internal hospital problems.

Data Collection Instruments

Primary instrument used as an analytical tool in collecting objective data in the field is an audit questionnaire form adopted from the healthcare quality and cost control framework. Accelerating public accountability requires healthcare institutions to shift their internal governance paradigm from a conventional model to a data-driven performance measurement system. Amidst the intense competition in healthcare facilities in Lamongan Regency, hospital management can no longer rely on subjective assessments to measure the productivity of its human resources, but must instead base it on an analysis of actual workloads.⁹ Instrument dissects the real conditions of hospital governance into seven waste parameters assessed using a Likert

scale (1 = Very Low to 5 = Very High).¹⁰ Operational indicators assessed in the structured questionnaire.

Operational inefficiencies, measuring the duration of patient waiting times, the complexity of the medical record circulation bureaucracy, and the existence of duplication in recording administrative documents.¹¹

Revenue leakage, identifying the potential for unbilled medical consumables, failed action input, and delays in insurance claim files due to coding errors; Poor manpower productivity, assessing the workload of administrative staff compared to daily work output and the level of employee idle time due to the absence of a clear Standard Operating Procedure (SOP) for assignment flow; Procurement and supply chain inefficiency, detecting the accumulation of expired drugs in the pharmacy warehouse (overstock) or the occurrence of shortages of essential drugs due to traditional ordering patterns; Low value spending expenses, evaluating non-medical routine operational expenditure items that do not have a direct impact on improving the quality of patient care; Technology spending without measurable impact, assessing the effectiveness and utilization of the existing *Sistem Informasi Manajemen Rumah Sakit* (SIMRS), whether it functions optimally or is merely a passive recording device, and; Poor asset utilization, measuring the level of room occupancy (bed occupancy rate), the use of medical support equipment (laboratory and radiology), and the efficiency of operational vehicle utilities.

RESULTS AND DISCUSSION

Overview of Operational Waste Audit Results

The FGD, combined with a standardized self-assessment form, yielded a comprehensive mapping of waste levels at PKU Sekapuk Hospital. Based on a recapitulation of scores from The Seven Biggest Sources of Wasteful Spending instrument, internal management confirmed that all seven areas of waste fall within the "High" to "Very High" categories. This phenomenon demonstrates the simultaneous accumulation of inefficiencies across all levels of hospital governance, from resource inputs and service processes to financial outputs.

Analysis of the 7 Largest Sources of Wasted Expenditures

The first source of waste, operational inefficiencies (patient flow dilemmas and outdated bureaucracy), was found in the first cluster, indicating massive bottlenecks in patient flow management, particularly in outpatient settings. The conventional registration bureaucracy leads to long queues during peak hours (8:00–11:00 a.m. WIB). This inefficiency is exacerbated by manual wait times for medical record document preparation and complicated guarantee approval mechanisms. From a healthcare facility's operational perspective, long wait times constitute a form of waste of time (waste of waiting), which psychologically imposes a non-financial cost on patients, directly contributing to declining customer satisfaction.¹²

The second source of waste is revenue leakage (billing and claims). Revenue leakage at PKU Sekapuk Hospital was detected at two main points: pre-billing for general patient services and post-billing for patients covered by *Badan Penyelenggara Jaminan Sosial* (BPJS). In general patient services, the lack of an integrated procedure recording system resulted in unbilled consumables not being included in the final patient bill. Meanwhile, in the covered patient cluster, leakage occurred due to the high frequency of pending claims or disputes by verifiers.¹³ These latent leaks act as hidden costs that aggressively erode cash flow and disrupt the financial liquidity of private hospitals facing intense competition in Lamongan.

The third source of waste is poor manpower productivity (limited competency of 80% of clinical staff). Field evidence shows that 80% of workers and healthcare workers with nursing, midwifery, health, economics, and hospital administration degrees lack strong managerial capacity, a key driver of low workforce productivity. The lack of governance expertise leads to an uneven and unstructured workload. Unit administrative staff often experience idle time due to unclear daily job descriptions (SOPs), while certain staff are overworked during patient surges. The clinician-to-manager dilemma without the intervention of cutting-edge governance training has been shown to reduce the efficiency of cross-functional coordination and slow down the organization's bureaucratic response.¹⁴

The fourth source of waste is procurement and supply chain inefficiency (traditional supply chain mechanisms). The pharmaceutical inventory and logistics management system at PKU Sekapuk Hospital still relies on traditional (intuitive) estimates, not evidence-based forecasting. The impact of this conventional governance system triggers two simultaneous losses: overstocking of non-fast-moving drugs, which increases the risk of expiration, and conversely, periodic shortages in essential drug depots. Supply chain uncertainty forces patients to queue for long periods at the pharmacy depot to await procurement or to purchase drugs outside the hospital, which is theoretically identified as wasteful healthcare logistics.¹⁵

The fifth source of waste is low-value spending expenses (non-strategic routine expenses). Budget audit results revealed allocations of routine operational expenses that do not directly correlate with improvements in the quality of healthcare services or patient safety. Low-value spending includes inflated administrative document printing costs due to manual form duplication, inefficient use of office utilities, and high costs of reactive coordination meetings to resolve repetitive daily operational issues. Budgets that could have been reallocated for staff managerial training programs are instead absorbed by non-strategic operational items.

The sixth source of waste is technology spending without measurable impact (passive SIMRS). PKU Sekapuk Hospital has adopted SIMRS. However, its use has not yet yielded a measurable operational impact. The existing SIMRS is only used as a tool for recording financial transactions at the cashier and inputting patient demographic data at the front desk. The system has not been modularly integrated with the

laboratory, radiology, electronic medical records (EME), or pharmacy units. Limited integration makes information technology investments seem wasteful because staff still have to manually perform paper-based verification, prolonging the internal bureaucracy of healthcare facilities.

The seventh source of waste is poor asset utilization (low utilization of rooms and medical equipment). The final area of waste relates to the optimization of hospital fixed assets. Due to the general decline in patient visit volume, there have been sharp fluctuations in the bed occupancy rate (BOR). Some inpatient wards often fall below national efficiency standards. Furthermore, utilization of advanced medical support equipment in the laboratory and radiology has not reached daily operational break-even because the internal referral flow from outpatient clinics to supporting units is not managed in an integrated and systematic manner.

Simultaneous Causality Between Waste

Through a CEP mentoring discussion forum, the team, along with the management of PKU Sekapuk Hospital, successfully formulated a common thread of causality from the findings above. These seven wastes do not exist in isolation, but rather operate like a mutually reinforcing vicious cycle. The root of the problem is Human Resources (HR) competency. 80% of staff have clinical backgrounds and lack managerial skills (the first source of waste).

HR competency results in traditional and manual operational processes. A passive SIMRS (Sixth source of waste). A passive SIMRS leads to a guesswork-based supply chain (fourth source of waste). A guesswork-based supply chain leads to long bureaucracy and duplication (fifth source of waste).

A passive SIMRS; a guesswork-based supply chain; and; long bureaucracy and duplication manifest in the field in the form of bloated registration and pharmacy queues (the first source of waste). Registration queues cause a decline in BOR/Asset utilization (the seventh source of waste).

Registration queues and BOR utilization have financial and competitive impacts. Revenue leakage occurred (the second source of waste), ultimately leading to the hospital's competitiveness in Lamongan.

The simultaneous combination of these seven aspects provides a scientific explanation for why PKU Sekapuk Hospital, Lamongan, experienced slowing visit growth amidst intense competition among regional healthcare facilities. The problem identification provided a clear roadmap for the CEP team and the hospital to prioritize tactical interventions for subsequent CEP projects.

CONCLUSION

The implementation of the CEP through a governance audit using the Seven Biggest Sources of Wasteful Spending Framework successfully uncovered latent inefficiencies at PKU Sekapuk Hospital, Lamongan. This action research concluded

that the hospital experienced high and interconnected operational waste accumulation simultaneously.

The root of the problem stems from limited managerial competency among 80% of the staff, who have purely clinical educational backgrounds (nurses/midwives) and non-management backgrounds. Weaknesses in human resource input have triggered massive operational inefficiencies, ranging from patient flow management that leads to long outpatient queues, to traditional pharmaceutical supply chain mechanisms that lead to overstocking and drug shortages, to the failure to utilize the integrated SIMRS technology module. The downstream impact of traditional governance leads to revenue leakage in the form of high rates of pending/disputed BPJS claims and uncollected medical supplies. This combined chain of inefficiencies has massively lowered the patient satisfaction index, reduced visit volume, and weakened PKU Sekapuk Hospital's competitiveness amidst the intense competition for healthcare services in Lamongan Regency.

PROGRAM SUSTAINABILITY RECOMMENDATION

Identifying waste is not the end of the program, but rather an initial roadmap for prioritizing tactical interventions in the next series of CEP. To ensure the sustainability of social and managerial impacts, the CEP team formulated recommendations for phased interventions that must be implemented by the management of PKU Sekapuk Hospital, along with the CEP team, in subsequent phases:

First, immediately implement a restructuring of work accountability through assistance in the development of S.M.A.R.T.-based Key Performance Indicators (KPIs) at the unit head level. This step is crucial for shifting the work paradigm of 80% of clinical staff toward evidence-based decision-making.

Second, redesign the outpatient registration and pharmacy flow using the Lean Healthcare approach and the PDSA (Plan-Do-Study-Act) cycle. The primary target is to eliminate waiting times for non-prescription patients to a safe limit (a maximum of 15 minutes) to boost patient retention.

Third, develop standardized Clinical Practice Guidelines (PPK) and Clinical Pathways for the top 10 disease diagnoses. This strategic step must be collaborated between the medical committee and the healthcare facility's coding team to minimize dispute claims from Indonesia Case Based Groups (INA-CBGs) and secure the hospital's long-term cash flow stability.

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