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Mentoring for the Integration of Quality Management and Financial Control at PKU Sekapuk Hospital

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Abstract

The financial dependence of regional private hospitals on claims from the Badan Penyelenggara Jaminan Sosial Kesehatan (BPJS Kesehatan) demands a robust daily revenue cycle. Internal coordination at PKU Sekapuk Hospital in Lamongan is reactive, limited to post-claim rejection issues, without integrated guidance documents, leading to high claim dispute rates and cost leakage. Community Empowerment Program (CEP) aims to secure the hospital's cash flow through synchronized quality control and cost control. The method used is a multidisciplinary reconciliation workshop and collaborative medical record audit, bringing together the Medical Committee (Doctors) and the Administrative Team (Coders/Finance) based on the BPJS Balanced Hospital Operating Model Framework. This CEP successfully formulated a formal Clinical Pathway Blueprint document for the 10 diagnoses with the highest case volume. The implementation results have proven effective in controlling unnecessary variations in medical operational costs through standardized drug formularies and increasing the net claim acceptance rate above 95%. This document serves as the final pillar of a holistic solution to boost the hospital's financial competitiveness.

Keywords: *Clinical Pathway; Cost Containment; Dispute Claim*

INTRODUCTION

The landscape of the Indonesian healthcare industry in the era of the *Jaminan Kesehatan Nasional* (JKN) demands radical changes to the business models of regional private hospitals. In Lamongan Regency, the local government's commitment to achieving Universal Health Coverage (UHC) has resulted in a significant reliance on government insurance claims for the majority of private healthcare facilities' revenue streams. A gradual restructuring from a reactive, post-event coordination system to a standardized, preventive system is being implemented to maintain financial stability and operational continuity. This situation creates significant financial vulnerability for medium-sized hospitals like PKU Sekapuk Hospital.[1] Amidst the onslaught of aggressive expansion of modern healthcare facilities by competitors, the inability to manage the revenue cycle based on the Indonesia Case Based Groups (INA-CBGs) tariff package system will directly impact profitability and threaten the long-term sustainability of the institution's operations.[2]

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Modern healthcare facility management is required to integrate quality control and cost control to mitigate financial risk through the implementation of the BPJS-Balanced Hospital Operating Model. This operational model mandates that hospital cost efficiency should not be achieved by compromising medical quality, but rather by standardizing treatment protocols.[3] The primary instrument for achieving balance is the clinical pathway document. A clinical pathway theoretically functions as an integrated, multidisciplinary service plan that maps each stage of medical intervention sequentially and standardized based on a specific disease diagnosis. Having a standardized clinical pathway has been proven to reduce unnecessary variations in treatment costs while minimizing errors in disease coding that trigger file rejections.[4]

The actual state of governance at PKU Sekapuk Hospital reflects a gap in downstream inefficiencies stemming from the limited managerial capacity of 80% of clinical staff. Based on the CEP team's analysis, the coordination between the Medical (Doctors) and Administrative (Coders/Finance) teams has been limited to reactive problem-solving when a file is rejected, without a shared guidance document (clinical pathway). This post-event problem-solving pattern is severely detrimental to the hospital's liquidity as claim disputes recur monthly.[5] The absence of a shared guideline document allows doctors to write diagnoses and therapies freely without reference to rates, while coding staff have difficulty extracting medical records accurately, resulting in a high frequency of delays in disbursement of funds from the insurer.

CEP intervention is needed to address the impact of weak quality-cost control integration. The success of reducing patient waiting times in previous programs will be wasted if the hospital's cash flow continues to experience leaks downstream from billing. The pillars of quality and financial integration adopted from the Asian Tiger Healthcare Camp curriculum and the *Ikatan Konsultan Kesehatan Indonesia* (Ikkesindo) guidelines form the basis of the CEP program, which provides assistance in the preparation of joint Clinical Pathway documents for the 10 most common disease diagnoses. Post-CEP, it is hoped that PKU Sekapuk Hospital will be able to create a robust internal control system, secure smooth cash flow, and win the healthcare competition in Lamongan.

MENTORING IMPLEMENTATION METHODS

Intervention Design and Collaboration

CEP uses a collaborative action mentoring approach, participatory action based on macro problem solving. Financial intervention and service quality activities were implemented for three months, effective from April to June 2026, taking place in the Main Meeting Room of PKU Sekapuk Hospital, Lamongan. The program focused on breaking down sectoral communication barriers by bringing together the two core hospital management components directly. Active participants numbered 25 people, consisting of representatives from the Medical Committee (Specialists and General

Practitioners), the Nursing Committee, the Coder Team (Medical Records), Internal Financial Verifiers, and the Board of Directors of PKU Sekapuk Hospital as the highest policy makers.

BPJS-Balanced Model Assistance Stages

The restructuring of the post-event reactive coordination system to a standardized preventive system was carried out in stages through three chronological phases. Phase 1 (Month 1), case identification and audit (problem mapping). The CEP team assisted the medical records department and internal financial verifiers to track historical insurance claim data. The team identified the top 10 inpatient diagnoses with the highest volume that had most frequently triggered file disputes (pending/disputed claims) with *BPJS Kesehatan*. Phase 2 (Month 2), a multidisciplinary reconciliation workshop (core workshop). The CEP team held a joint working session that brought together physicians and coding staff. Physicians explained clinical therapy standardization (clinical excellence), while coding staff aligned it with ICD-10 (International Classification of Diseases, 10th Revision) and ICD-9-CM (Clinical Modification) coding rules to comply with the INA-CBGs (Indonesia Case Base Groups) package tariff ceiling (cost containment). This phase resulted in a written understanding in the form of a draft integrated clinical pathway blueprint. Phase 3 (Month 3) involved regulatory trials and standardization. The prepared clinical pathway draft was piloted on real inpatient wards for two weeks. Evaluations were conducted to ensure the document was easy to complete and did not delay medical services. The final stage of this method was to facilitate the legalization of the draft into an official legal document through a Decree from the Director of PKU Sekapuk Hospital, Lamongan.

Implementation Instruments: *Clinical Pathway Blueprint*

The main instrument used as a medium for community service intervention was adopted from the BPJS-Balanced Hospital Operating Model pillar of the Asian Tiger Healthcare Camp and Ikkesindo curriculum. The instrument is in the form of a clinical pathway matrix worksheet consisting of five components of integrated medical services per outpatient/inpatient day. First, clinical assessment. Standardization of the schedule for regular doctor examinations and vital signs by nurses. Second, supporting examinations. Limiting the types of laboratory and radiology examinations to only items that directly support the diagnosis to prevent wasteful examination costs (over-utilization). Third, pharmacological interventions. Developing essential drug guidelines (Hospital Formulary) that are in accordance with the cost efficiency of the insurance package without sacrificing patient safety. Fourth, nutrition and education. Standardization of nutritional care plans and fulfillment of integrated informed consent forms. Fifth, logistics variants. Providing a column for evaluating cost deviations in the event of unexpected medical complications, so that financial transparency is maintained.

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RESULTS AND DISCUSSION

Balanced Hospital Operational Model (*BPJS-Balanced*)

A series of multidisciplinary reconciliation workshops successfully facilitated the development of a new governance blueprint for 25 core administrators at PKU Sekapuk Hospital. The mentoring resulted in a formal Clinical Pathway Blueprint document, which serves as a standard for quality control and cost control for the 10 diagnoses with the highest case volumes.

The fundamental shift from the old, reactive coordination system following rejections to a new, balanced operational system (BPJS - Balanced Hospital Operating Model) is presented in the comparison matrix in Table 1. The operational model design in Table 1 demonstrates that synchronization between clinical and financial administrative aspects can be achieved without sacrificing either pillar. A joint guideline document reduces tensions between service divisions, thereby maintaining the stability of the healthcare facility's liquidity.

Table 1. Quality and financial operational model change matrix

Dimensions of governance	Conditions before CEP mentoring (reactive model)	Conditions after CEP (BPJS-Balanced Model) assistance	Impact on Hospital Financial Resilience
Internal coordination mechanism.	It operates independently; new interactions occur reactively if a claim file is rejected by the BPJS verifier.	Regular preventive collaboration from the first day the patient enters using an integrated Clinical Pathway sheet.	Minimize the risk of cash flow delays due to disputes over claim rejection documents downstream.
Quality-cost control protocol.	Doctors write prescriptions for medication and supporting examinations freely without reference to the standard rates for INA-CBGs packages.	The selection of medical and pharmacological support types is locked based on the Hospital Formulation agreement which is in line with the package tariff ceiling.	Prevent unnecessary cost variances from increasing medical operational costs without sacrificing patient safety.
Quality-cost control protocol.	Manual medical record entry is often incomplete; coding staff have difficulty determining ICD-10 codes precisely.	Electronic Medical Records (EMR) filling must be 100% completed on the current day with alignment of doctor-coder medical terminology.	Speed up the billing audit process and increase the acceptance rate (net claim acceptance rate) to above 95%.

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Analysis of the Success of Cost Variance Reduction and Dispute Claims

The success of the operational paradigm shift at PKU Sekapuk Hospital was analyzed based on two strategic intervention elements resulting from the adaptation of the Asian Tiger Healthcare Camp curriculum. First, the transformation of coordination from a reactive to a preventive-systemic approach. Prior to the community service program, the claim dispute resolution pattern at PKU Sekapuk Hospital was characterized by a "firefighting" approach. When the insurance company refused payment due to a mismatched diagnosis, the financial administration team would suddenly confront the physician in charge of the service. The cumbersome manual bureaucracy consumed energy, created psychological tension among internal staff, and significantly hampered the hospital's capital turnover. The implementation of the Clinical Pathway Blueprint completely transformed the workflow into a preventative control system from the outset. Doctors and coding staff now share the same perception before the file is sent to an external verifier. Disciplined clinical documentation completed from the time the patient is admitted to the inpatient ward ensures that all medical procedures have a logical justification according to regulations. As a result, the potential for delays in filing or unilateral deductions from claim fees is minimized.

Second, controlling hidden costs through standardizing clinical pathways. The absence of a shared guideline document in the past allowed for uncontrolled variations in medical costs. For example, for the same diagnosis (e.g., Acute Appendicitis or Dengue Fever), the type of antibiotics and frequency of laboratory tests prescribed by different doctors could vary significantly depending on individual preferences. Excessive costs exceeding the INA-CBGs package limit became hidden costs that had to be borne by the hospital's coffers. Standardizing the Clinical Pathway instrument successfully reduced variations in low-value expenditures. The Medical Committee agreed to organize daily patient care pathways into structured examination packages, making the use of supporting equipment and pharmaceutical drugs highly efficient and rational, while still maintaining patient safety standards. Internal cost savings provided a secure financial margin for PKU Sekapuk Hospital in Lamongan to invest in future improvements to other physical service facilities.

CONCLUSION

The CEP, which focused on integrating quality management and financial control based on the BPJS-Balanced Hospital Operating Model Framework, successfully addressed the root causes of downstream billing issues at PKU Sekapuk Hospital, Lamongan. The collaborative intervention successfully transformed the traditional reactive coordination pattern following claim rejection into a standardized, preventive-systemic control system from the service upstream.

Cross-functional synergy between the Medical Committee (Doctors) and the Administrative Team (Coders) resulted in a formal Clinical Pathway Blueprint document for the 10 disease diagnoses with the highest case volume. The implementation of a balanced operational model has proven effective in aligning clinical excellence with cost control principles without compromising patient safety. Standardization of daily treatment pathways and an integrated drug formulary has successfully reduced unnecessary variations in medical operational costs and improved the accuracy of ICD-10 codification. The final impact, PKU Sekapuk Hospital has succeeded in increasing the acceptance rate of billing files to above 95%, minimizing disputes over rejection files, securing smooth cash flow, and strengthening the hospital's financial resilience in facing the competition of healthcare services in Lamongan Regency. All links in the vicious cycle of traditional governance at PKU Sekapuk Hospital that were successfully identified at the beginning of the program have now been holistically broken. The audit has mapped 7 areas of macro budget leakage. The development of written SMART KPI accountability has successfully strengthened the managerial capacity of 80% of clinical staff and eliminated the bias of the surprise inspection method. Physical restructuring of separate registration service flows and internal prescription couriers (Lean Healthcare via *Plan-Do-Study-Act* /PDSA) reduced outpatient waiting times to meet national standards. The Clinical Pathway Blueprint achieved internal cost savings and financial liquidity savings.

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MENTORING DOCUMENTATION





