Original Article

Root Cause Analysis Of Quality Control And Cost Control Of Implementing The Referback Program In First Level Health Facilities

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ABSTRACT

Background: *The incidence of chronic diseases in Jambi City is still high from year to year. The Referback Program (PRB) is one of the government's efforts through BPJS Health in collaboration with health facilities to ensure chronic disease sufferers have easier access to obtain the medicines they need at an efficient cost. This research aims to analyze the main problems of quality control and cost control of PRB implementation in terms of man, material-machine, method, market, money and time elements at FKTP in Jambi City.*
Methods: *The research was conducted using qualitative methods using the perspective of Root Cause Analysis (RCA) theory to form research procedures. The informants consisted of the person in charge of PRB, the head of the community health center and PRB participants at FKTP in Jambi City. The research instrument is a structured interview sheet. Data analysis uses thematic analysis techniques according to the RCA flow*
Results: *The research results found that the main cause of the problem was weak coordination between PRB officers and BPJS Health in implementing PRB at FKTP.*
Conclusion: *It is recommended that BPJS Health be more active in providing outreach and special training to PRB officers as well as setting up a clear monitoring and evaluation system regarding the implementation of PRB in FKTP*

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Introduction

Indonesia experiences significant health problems related to chronic diseases. Some chronic diseases that are common in Indonesia include diabetes mellitus, hypertension, heart disease, cancer and stroke. According to data from the Indonesian Ministry of Health, in 2019 the number of diabetes mellitus sufferers in Indonesia reached 10.7 million people or around 6.9% of the total population. Meanwhile, the prevalence of hypertension in Indonesia reaches 34.1%, and heart disease is the second highest cause of death in Indonesia after stroke. Data from the World Health Assembly in 2021, as many as 73% of deaths in Indonesia are caused by

NCDs such as hypertension, heart disease, diabetes, stroke and cancer (Kemenkes, 2021).

There will be a negative impact and huge burden on the Indonesian health system if the number of chronic disease sufferers continues to increase and is not handled properly. Research by the Health Research and Development Agency of the Indonesian Ministry of Health shows that chronic diseases can cause lost productivity and high expenses in the sufferer's family (Kemenkes, 2021). Research conducted by the Puslitbang-BPPT in 2018 showed that a lack of attention to chronic disease prevention could lead to increased death rates due to chronic diseases and high health costs (Ministry of Health, 2019). The prevalence of diabetes, hypertension and stroke in Indonesia is increasing and affecting the quality of life and productivity of sufferers (Balgis et al., 2022). Chronic diseases such as hypertension, diabetes and obesity can affect quality of life and reduce work productivity (Manik & Ronoatmodjo, 2019).

One of the government's efforts to overcome the problem of chronic disease is by launching the Referral Program (PRB) through BPJS Health. The Refer Back Program is part of the implementation of National Health Insurance (JKN-KIS) by BPJS Health since 2014 based on BPJS Health Regulation number 1 of 2014 and Circular Letter HK/Menkes/32/I/2014 concerning the Implementation of Health Services for BPJS Health participants in primary health facilities and advanced health facilities in administering health insurance. This program ensures that participants who suffer from chronic diseases with a stable condition and have a diagnosis without complications have access to obtain the medicines they need more easily and cost efficiently by strengthening the role of First Level Health Facilities (FKTP) as centers for chronic disease services and management. In this case, the community health center or clinic becomes the center for chronic disease management for BPJS Health patients.

The Refer Back Program is one of the government's efforts to reduce the state budget for health costs. In this program, patients with chronic diseases who receive health services at hospitals or community health centers will be referred back to First Level Health Facilities (FKTP) to receive continuous health services such as medication management, counseling and education about chronic disease management. BPJS Health has determined nine types of diseases that must be referred and monitored further, namely, diabetes mellitus, hypertension, heart disease, stroke, chronic obstructive pulmonary disease, asthma, schizophrenia, epilepsy and lupus erythematosus syndrome.

In implementing PRB, legal regulations mandate that Quality Control and Cost Control (KMKB) must be carried out. Quality control and cost control are the result of collaboration between the Ministry of Health, BPJS Health and Health Facilities regarding health services in the National Health Insurance, the implementation of which is regulated in Minister of Health Regulation Number 71 of 2013. This system must be implemented comprehensively in the implementation of PRB, including compliance with health facility quality standards, ensuring that the PRB service process complies with established standards, as well as monitoring participant health outcomes.

The quality control and cost control mechanisms for implementing the Refer Back Program are carried out through several collaborative processes between health facilities and BPJS Health. Health facilities include First Level Health Facilities (FKTP), Advanced Level Referral Health

Facilities (FKRTL) and pharmacies. First, health facilities regulate the authority of health workers in carrying out PRB practices according to competency, monitoring clinical practice guidelines and service operational standards. Second, health facilities conduct PRB utilization reviews and medical audits. Third, health facilities provide professional ethics and discipline training to health workers. Fourth, monitoring and evaluating the use of medicines, medical devices and consumables regularly through the health information system.

The aim of quality control and cost control in the implementation of PRB at FKTP is to improve the function of FKTP as a gatekeeper for comprehensive services but with rational financing, increasing medical competence and the function of monitoring treatment. This means that quality control and PRB costs at FKTP mean that the Puskesmas continues to maintain and provide quality services according to standards but at an efficient cost.

In practice, there are still many deficiencies and obstacles in controlling the quality and costs of PRB, both in first-level health facilities, follow-up referrals and drug-supplying pharmacies. On a national scale, several regions in Indonesia are experiencing quality control and cost control problems in implementing PRB, including a shortage of Human Resources (HR) and contributions from organizations in meeting health human resource needs, especially in FKTP. Several Community Health Centers experienced difficulty in employing sufficient medical and pharmaceutical personnel to meet the needs of PRB participants (Wahidin et al., 2023). As a result of the lack of human resources, many community health centers do not have special staff for implementing PRB (Paramita et al., 2019). This problem is related to quality control and the costs of implementing PRB which can cause delays in providing quality and efficient health services for participants.

In some cases, PRB network community health centers and pharmacies experience problems in obtaining sufficient financial resources to ensure that the required stock of medicines is continuously available. This may cause delays in providing quality and efficient health services to participants (Lestari, 2021). This is related to the management of funds from BPJS Health, that 80% of health expenditures are focused on hospitals for inpatient treatment of high-cost or catastrophic diseases, meanwhile cost control and quality control are not only oriented towards treatment funds, but also include the quality and efficiency of services. others that must be considered (Dianingsih et al., 2022). The lack of infrastructure and facilities results in inadequate service delivery, such as the absence of a PRB corner as a registration facility for PRB, which results in complex administrative obstacles and causes PRB participants to be reluctant to continue the service process. (Pertiwi et al., 2017).

The lack of information and education causes some PRB participants to lack understanding about the Reconciliation Program and how to use it, resulting in ignorance and reluctance of PRB participants to carry out reconciliation (Sulung, 2022). This problem has the impact of not achieving the coverage of PRB services that should be met so that the provision of quality and efficient PRB services is still not experienced optimally by participants. BPJS Health data in 2021 shows that the increase in membership was 7.05 million people or 3.16% compared to the previous year due to the tendency of chronic disease patients to choose to go to hospital for treatment rather than refer back to FKTP because FKTP is not yet able

to provide pharmaceutical medicine services.

In Jambi Province, the area with the highest prevalence of chronic disease is Jambi City. Jambi City has always been at the top as the area with the highest incidence of hypertension, diabetes mellitus and heart disease in Jambi Province in the last 3 years. In 2019, it was recorded that 21,092 residents of Jambi City aged ≥ 20 years suffered from hypertension. In 2020, there were 60,188 hypertension sufferers ≥ 15 years old in Jambi City. The incidence of hypertension has always been in the top position from 2016 to 2020 with a percentage range of 13.69% to 23.63% of the 10 most diseases recorded in all health centers in Jambi Province based on the 2020 Jambi Provincial Health Service report. Diabetes mellitus was recorded as 11,447 DM sufferers in Jambi City in 2020.

Jambi City has 20 Community Health Centers which are First Level Health Facilities (FKTP) implementing the Refer-Back Program with Jambi City BPJS Health in dealing with chronic disease problems in Jambi City. Based on Jambi City BPJS Health data regarding the coverage of active participants in the Jambi City Health Center Refer-Back Program from 2020 to 2022, the coverage of active PRB participants is still low. The average active PRB coverage was only around 50% in 2020, dropping to 40% in 2021 and to 44% in 2022. The average active participant coverage in 2022 ranged from the lowest 28% to the highest 56% from 20 Community Health Centers in Jambi City. This means that only some chronic disease sufferers registered as PRB participants have actively referred back in the last three years in Jambi City.

The low coverage of active PRB participants in the FKTP in Jambi City indicates that there are quality control and cost control problems in implementing PRB. The results of the initial interview survey with the Community Health Center as the PRB implementer at FKTP stated that there was a problem of double workload, and a shortage of special PRB personnel. Several approaches used in reviewing PRB problems include the systems approach and Root Cause Analysis (RCA)(Kusumawardhani & Ripha, 2020).

Methods

The research was conducted using qualitative methods using the perspective of Root Cause Analysis (RCA) theory to form research procedures. The research was conducted in three working areas of the Jambi City Health Center which were selected based on active PRB coverage data from BPJS Health. There were 9 informants consisting of the person in charge of PRB, the head of the community health center and PRB participants at FKTP in Jambi City. The research instrument is a structured interview sheet. Data analysis uses thematic analysis techniques according to the RCA flow by analyzing the causes of the main problems in terms of the elements of man, money, method, material-machine, market and time.

Results

The implementation of PRB in the FKTP studied in Jambi City had obstacles that were largely similar. In general, community health centers have limitations in terms of the number of human resources, which results in a double burden on staff. In the funding component, the main source of funding for PRB is from the BOK community health center, no funding at all comes from BPJS Health, there is no opportunity to get additional funding. In general, the Community Health Center has sufficient medical equipment for the Refer-Back Program, but there are several obstacles related to the availability and maintenance

of medical equipment and infrastructure such as computers and electricity.

In the method element, the procedures used by each community health center have several differences even though basically they are equipped with SOPs for implementing PRB at FKTP. This happens because there is an opinion that the implementation of PRB is not the main activity of the community health center which is engaged in preventive and promotive matters, the community health center considers that PRB is part of curative activities. So generally community health centers do not have a special and routine schedule to discuss the achievements of the PRB program. This was also triggered by the absence of specific monitoring and evaluation regarding the implementation of PRB in FKTP by BPJS Health. In terms of program target elements, community health centers have the same obstacles, namely low motivation and level of compliance among communities undergoing PRB. Meanwhile, regarding the timeliness element, the implementation of reverse reconciliation will depend greatly on the level of compliance of PRB participants in carrying out reverse reconciliation.

Table 1. Matrix for Identification of PRB Implementation Problems in FKTP Jambi City

Elemen	FKTP1	FKTP2	FKTP3
Man	-Limited number of human resources -Irregular training	-Limited number of human resources -Training is not yet specific	-Limited number of human resources -Double burden on officers -Dependence on other officers -The gap between the needs of available human resources and the patients being faced -Requires training to increase officers' abilities in implementing the program
Money	-There is no special funding source for PRB from BPJS Health -Puskesmas does not budget a special allocation for PRB activities	-There is no additional funding or optimization of PRB funds	-Lack of funds in PRB activities is overcome through internal cash funds -There is no additional funding for PRB
Material-Machine	-Examination tools for diabetes mellitus patients are limited -No medical equipment	-Availability of equipment depends on obtaining equipment from the Health Service	-Availability of sticks for examining diabetes patients is limited -The condition of the computer is damaged which slows down the

Elemen	FKTP1	FKTP2	FKTP3
	assistance is needed from BPJS Health		process of implementing the Referback Program
Method	-Not yet optimal socialization of the referral procedure to patients -The standards set by BPJS for calculating PRB achievements are not explained in the FKTP -There is no monitoring and evaluation between FKTP and BPJS -Periodic evaluation monitoring at FKTP regarding PRB is not yet optimal	-Determination of program achievement standards that are unclear and not understood by PRB officers -There is no monitoring and evaluation between FKTP and BPJS	-The level of patient compliance in following the PRB pathway on time is still low -Kontrolled patient reporting is not always appropriate -The criteria for calculating the percentage of program achievements per puskesmas calculated by BPJS Health are not yet understood by officers -Evaluation monitoring between FKTP and BPJS does not exist -Periodic evaluation monitoring at FKTP regarding PRB is not yet optimal because it is assumed that PRB is not the main activity of the Community Health Center
Market	-Motivation for chronic disease sufferers to participate in PRB is still low -Compliance with PRB according to the provisions is still low	-Motivation for PRB is still low -Treatment during PRB is not followed by a healthy lifestyle -Reasons include difficulty in access, limited transportation or lack of family support for participating in PRB	-Motivation to participate in PRB is low -Reasons for difficulty in access, limited transportation or lack of family support for participating in PRB
Time	-Timeliness of referral depends on patient compliance	-Timeliness in the referral process according to patient compliance.	-In general there are no problems with punctuality

Based on the identification of problems in the implementation of the Refer-Back Program in the three FKTPs in Jambi City studied, which were reviewed

from the elements of man (human resources), money (finance), material-machine (facilities and infrastructure), method (method), market (target) , and time, the following root cause analysis is carried out which is visualized in the form of a fishbone diagram.

The results of the Root Cause Analysis related to the implementation of the Refer-Back Program at FKTP Jambi City provide information that the root of the problem identified lies in three main elements, namely human resources (man), methods (method), and target market (market). In the context of the human resources element, it was found that there were still FKTPs that experienced a shortage of PRB officers in numbers, resulting in a double workload for these officers. Apart from that, there were problems related to the delegation of duties to officers who were not initially responsible for the PRB, but due to external services or training which took a relatively long time, this delegation had to be carried out as a result of the PRB officers only consisting of 1 person in each FKTP.

In the method element, there is a lack of uniformity in the implementation of PRB procedures in FKTP. This happens because BPJS Health has not carried out special monitoring of the PRB performance carried out by each FKTP. FKTP does not have an understanding of the standard indicators from BPJS Health that can be used to evaluate whether the PRB they implement has reached the set standards or not. In addition, there are several FKTPs who do not know how to ensure that the patient's condition remains stable because there are no standard guidelines available. BPJS Health has not carried out adequate outreach and activities to update the implementation of PRB in each FKTP. As a result, FKTP carries out PRB procedures without carrying out routine evaluations, because there is an opinion that PRB is more curative in nature and is not the main focus of FKTP activities.

In the context of program targets, the majority of PRB participants did not show a high level of enthusiasm in implementing the Refer-Back Program because they felt that their health condition was stable and did not require further treatment. Many participants, especially the elderly, experience difficulties in accessing FKTP because there is no one to take them, transportation problems, and lack of knowledge about the program. Most of the informants interviewed admitted that they did not understand the referral program well.

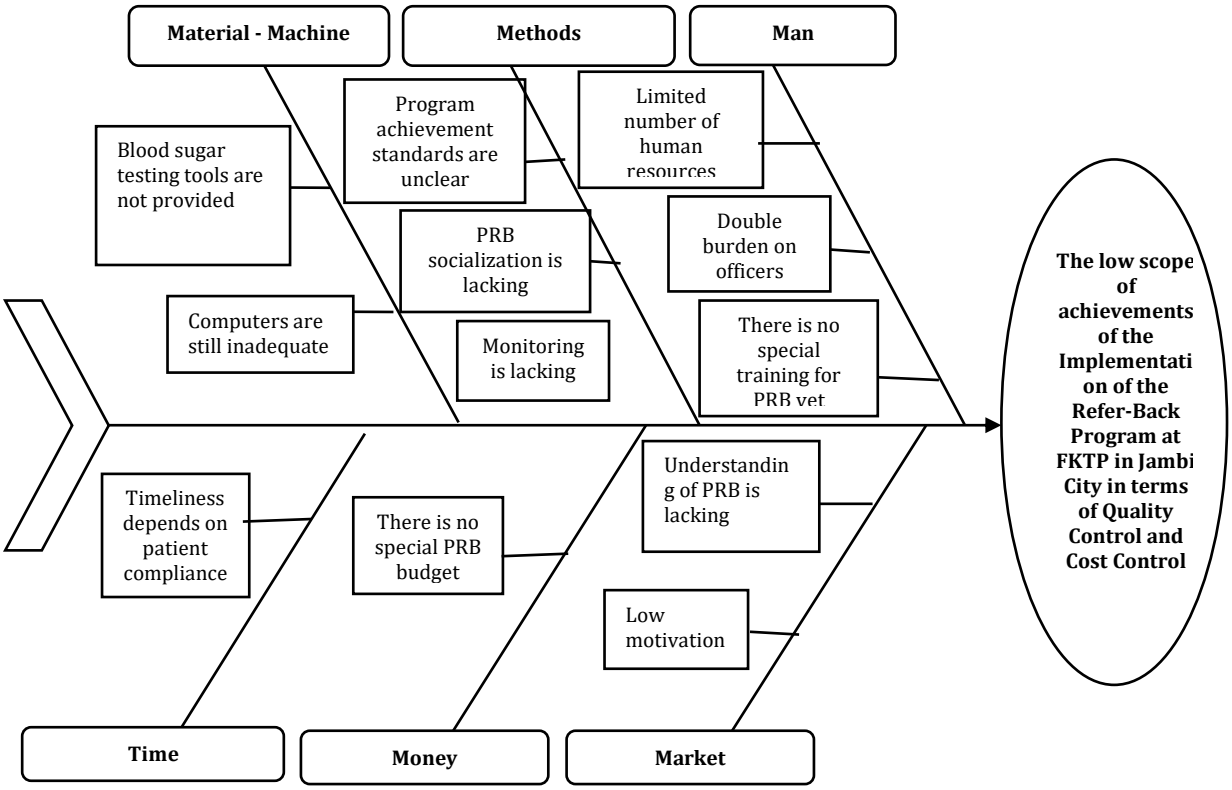

Figure 1. Root Cause Analysis of PRB Implementation in FKTP Jambi City

Meanwhile, in the other three elements, namely money, material-machines, and time, there are obstacles that FKTP can still overcome. In the financial element, there is no special funding for PRB from BPJS Health, so FKTP allocates the BOK budget for PRB needs. Meanwhile, regarding the facilities and infrastructure element, the majority of FKTP stated that they did not find any significant obstacles interfering with the implementation of the reconciliation process. In the context of time, FKTP found no obstacles other than the timing of the referral process which really depends on the patient's compliance in undergoing the referral.

Discussion

The main problem with human resources in the implementation of FKTP in Jambi City is the lack of PRB officers in several FKTPs and the double workload on these officers. This condition can occur due to several factors, including an unbalanced ratio between staff and the number of patients they face. Limited human resources in terms of numbers can be caused by limited budgets or difficulties in recruiting additional officers. This has the impact of delegating duties to officers who were not initially responsible for PRB, which may occur due to policy or urgent needs. For example, when the PRB officer is the only one available at FKTP and has to deal with additional duties from external services or training. To overcome this problem and prevent a shortage of PRB officers in FKTP, can take steps to evaluate the need for PRB officers in FKTP, while BPJS Health must

evaluate the need for the number of PRB officers in accordance with the number of patients and the volume of services provided. This is important to ensure there are sufficient officers to handle requests for PRB services.

Several previous studies have shown that human resource elements are an important factor in the success of program implementation. The problem of high rates of chronic disease in Indonesia in the era of National Health Insurance (JKN) can be overcome through the implementation of the Referral Program (PRB) by increasing easier access to health services (Pertiwi et al., 2017). Apart from that, improving the quality of health services which includes promotive, preventive, curative and rehabilitative aspects, as well as strengthening relationships between doctors and patients within a comprehensive service framework. (Liansyah et al., 2021).

In Jambi City, the implementation of PRB went smoothly from a financial perspective even though BPJS Health did not allocate special funds for the PRB program. Other things such as providing reference books or blood sugar testing tools for diabetes mellitus patients can be handled by FKTP, and they consider that these things can be ignored, which should be the responsibility of BPJS Health to provide these facilities. Even though the implementation of PRB in Jambi City looks smooth from a financial perspective, BPJS Health and FKTP should still take certain actions to ensure the sustainability and effectiveness of the PRB program through regular monitoring and evaluation as well as better coordination (Solida et al., 2022). The study of the financial elements for program implementation was discussed in previous research that the implementation of funding that is not in accordance with the mechanism procedures and targets set will have an impact on the output aspects of PRB participant visit achievements which do not meet targets (Sulung, 2022).

It is acknowledged that the availability of medical equipment and materials needed to carry out the Tiered Referral Program (PRB) at FKTP is without significant obstacles, even though all the equipment and materials come from themselves. BPJS Health does not provide the equipment and materials needed to implement PRB. FKTP relies on medical equipment already in the puskesmas warehouse, all of which is funded by the health service budget. Even though FKTP admits that there are no problems, BPJS Health should be able to facilitate the provision of all types of equipment and materials needed for implementing PRB, such as blood sugar sticks for examining diabetes mellitus patients. To overcome this problem, it is important for both parties to communicate openly, identify mutual needs, and work together to improve the system of providing medical equipment and materials. This will help improve the quality of health services at FKTP and ensure that patients get the care they need without unnecessary obstacles.

Previous research explains that the impact of not having clear standard procedures or technical instructions for PRB services means that the services and equipment received by PRB participants are the same as other patients. (Kusumawardhani & Ripha, 2020). Therefore, good coordination is very necessary in implementing PRB, including in the use of medical equipment and other equipment that should only be used for PRB services.

PRB implementation procedures have varying levels of understanding and different interpretations of how to carry out PRB at FKTP in Jambi City, which can lead to inconsistent implementation. Analysis of

the interview results revealed that the cause of this problem was a lack of understanding of standard indicators. FKTP may not have sufficient understanding of the standard indicators set by BPJS Health. This makes it difficult for them to evaluate whether the PRB they carry out reaches the predetermined standards or not. In response to this, several things can be recommended to BPJS Health to be more active in socializing PRB standards to FKTP and providing regular training. BPJS Health needs to improve monitoring and supervision of the implementation of PRB at FKTP. This can be done through regular audits and inspections.

In line with previous research, facts were found in the field that many technical aspects were the source of complaints, such as lack of effort in informing the program, lack of clarity in rewards for good results and sanctions related to performance in carrying out PRB, methods for determining stable and unstable status of patients, and procedures. administration related to PRB, and lack of scheduled monitoring and evaluation activities (Paramita et al., 2019). Apart from that, clear operational standards are needed in carrying out the program so that implementation runs uniformly (Rinata et al., 2019)

Regarding the program targets, the majority of PRB participants showed a lack of enthusiasm in undergoing the Referral Program because they felt that their health condition was stable and did not require further treatment. In addition, many participants, especially the elderly, face difficulties accessing FKTP because no one can help them get there, there are obstacles in transportation, and they have limited knowledge about the program. This also triggers a reduction in their motivation to participate in the referral program.

Puskesmas as FKTPs that run PRB need to provide clear information and a better understanding of the benefits of the program. Provide clear and structured education to PRB participants about the benefits of the referral program and the importance of follow-up care. Increase participants' understanding of the procedures and processes involved in the referral program. Provide educational material that is easy to understand, perhaps using simple language and clear illustrations. Similar research shows that participant motivation factors have a major influence on the successful implementation of the referral program (Liansyah et al., 2021). One strategy for optimizing the implementation of the reconciliation program is to increase the participation of people with diabetes mellitus to be active in reconciliation activities (Dianingsih et al., 2022).

Regarding the time element, there are no significant problems in implementing PRB in the Jambi City FKTP. This is based on information from officers that the referral process carried out at community health centers and hospitals is running well in terms of timeliness for compliant patients. However, problems occur in patients who are disobedient or unmotivated. Whether or not the patient complies with the referral process greatly influences the timeliness of the referral. Previous research explains that from the patient's perspective, the existence of a PRB program will provide benefits by reducing waiting and travel times, as well as providing faster access to health facilities (Paramita et al., 2019). Compliance with PRB participants determines the timeliness of referrals (Sandi, 2022).

Conclusion

In the implementation of the Refer-Back Program at the Jambi City FKTP, there are several problems that still arise, such as the limited number of PRB officers at the Community Health Center who also face

double burdens, lack of socialization about PRB, low motivation, and lack of compliance in implementing PRB. Apart from that, socialization, training and monitoring related to PRB are still inadequate. After analyzing the causes of the main problems, it was found that weak coordination between PRB officers and BPJS Health in implementing PRB at FKTP was the main cause of the low achievement of PRB coverage in Jambi City.

The Refer Back Program is actually an effort to reduce the incidence of chronic disease. However, the perception needs to be corrected that PRB is only related to curative care and is not the main focus of services at Community Health Centers. Therefore, BPJS Health must be more active in providing outreach and special training to PRB officers as well as setting up a clear monitoring and evaluation system regarding the implementation of PRB in FKTP. This aims to ensure that quality control and cost control of the Refer Back Program can run more optimally.

Authors Contributions

The author contributed to the analysis and discussion of this manuscript

Conflicts of Interest

The authors declare there is no conflict of interest

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References

Balgis, B., Sumardiyono, S., & Handayani, S. (2022). Hubungan Antara Prevalensi Hipertensi, Prevalensi DM dengan Prevalensi Stroke di Indonesia (Analisis Data Riskesdas Dan Profil Kesehatan 2018). *Jurnal Kesehatan Masyarakat (Undip)*, *10*(3), 379–384.

Dianingsih, T. M., Utarini, A., & Bismantara, H. (2022). STRATEGI OPTIMALISASI PELAKSANAAN PROGRAM RUJUK BALIK PASIEN DIABETES MELITUS PESERTA BPJS KESEHATAN DI PUSKESMAS KECAMATAN PANCORAN. *Jurnal Manajemen Pelayanan Kesehatan (The Indonesian Journal of Health Service Management)*, *25*(4).

Kemenkes, R. I. (2021). Profil Kesehatan Indonesia 2020. *Kementrian Kesehatan Republik Indonesia*, *139*.

Kusumawardhani, O. B., & Ripha, R. W. (2020). Systematic Review: Kendali Mutu Dan Biaya Program Rujuk Balik (PRB) BPJS Kesehatan. *Prosiding University Research Colloquium*, 149–164.

Lestari, D. A. (2021). *Gambaran Ketersediaan Obat Program Rujuk Balik (PRB) di Indonesia*.

Liansyah, T. M., Yani, M., & Hidayaturrahmi, H. (2021). A PELAKSANAAN PROGRAM RUJUK BALIK DALAM PENANGANAN MASALAH PENYAKIT KRONIS PADA FASILITAS PELAYANAN KESEHATAN TINGKAT PRIMER:-. *Medicus Darussalam*, *1*(1), 1–15.

Manik, C. M., & Ronoatmodjo, S. (2019). Hubungan Diabetes Melitus Dengan Hipertensi Pada Populasi Obes Di Indonesia (Analisis Data IFLS-5 Tahun 2014)(Relationship Between Diabetes Mellitus And Hypertension In Obesity Populations In Indonesia (Data Analysis Of IFLS-5 In 2014)). *Jurnal Epidemiologi Kesehatan Indonesia*,

3(1).

Paramita, A., Andarwati, P., & Kristiana, L. (2019). Upaya Kendali Mutu dan Biaya Program Rujuk Balik Menggunakan Pendekatan Root Cause Analysis. *Journal of Health Science and Prevention*, *3*(2), 68–78.

Pertiwi, D., Wigati, P. A., & Fatmasari, E. Y. (2017). Analisis Implementasi Program Rujuk Balik Peserta Jaminan Kesehatan Nasional Di Rumah Sakit Umum Daerah Tidar Kota Magelang. *Jurnal Kesehatan Masyarakat (Undip)*, *5*(3), 1–11.

Rinata, F., Arsyati, A. M., & Maryati, H. (2019). Gambaran Implementasi Program Rujuk Balik (PRB) BPJS Kesehatan di Puskesmas Wilayah Kerja Kecamatan Tanah Sareal Kota Bogor Tahun 2018. *PROMOTOR*, *2*(1), 20–26.

Sandi, F. D. (2022). Upaya Peningkatan Capaian Kepatuhan Program Rujuk Balik di RS X dengan Menggunakan Problem Solving Cycle. *Jurnal Keperawatan Silampari*, *5*(2), 1207–1218.

Solida, A., Noerjoedianto, D., Mekarisce, A. A., & Subandi, A. (2022). Costs and Impacts of Utilizing National Health Insurance Reducing the Economic Burden of Hypertension Patients. *Jurnal Aisyah: Jurnal Ilmu Kesehatan*, *8*(1), 143–150.

Sulung, N. (2022). ANALISIS PELAKSANAAN PROGRAM RUJUK BALIK DI PUSKESMAS KOTA BUKITTINGGI TAHUN 2021. *Human Care Journal*, *7*(1), 104–114.

Wahidin, M., Agustiya, R. I., & Putro, G. (2023). Beban Penyakit dan Program Pencegahan dan Pengendalian Penyakit Tidak Menular di Indonesia. *Jurnal Epidemiologi Kesehatan Indonesia*, *6*(2).