

DOI:  
10.22301/IJHMCR.2528-3189.358

Article can be accessed online on:  
<http://www.ijhmcr.com>

-----  
**ORIGINAL ARTICLE**  
-----

**INTERNATIONAL JOURNAL  
OF HEALTH MEDICINE AND  
CURRENT RESEARCH**

**ANALYSIS OF PATIENTS REFERENCE SYSTEM IMPLEMENTATION IN  
REGIONAL GENERAL HOSPITAL DR. SAMRATULANGI  
TONDANO OF MINAHASA REGENCY**

**Gabby Doaly<sup>1</sup>, Grace D. Kando<sup>1</sup>, Tubagus D. E. Abeng<sup>1</sup>**

<sup>1</sup> Faculty Of Medicine, Postgraduate IKM UNSRAT Manado

---

## ARTICLE INFO

### *Article History:*

Received 06th April, 2017  
Received in revised form  
07th May, 2017  
Accepted 12th June, 2017  
Published online 30th June, 2017

---

### *Key words:*

Presepsin, C-Reactive Protein,  
Procalcitonin, Late-Onset Neonatal  
Sepsis (LONS).

---

### *\*Correspondence to Author:*

**Gabby Doaly**  
Faculty Of Medicine, Postgraduate  
IKM UNSRAT Manado

### **E-mail:**

tewigado1@gmail.com

---

## ABSTRACT

The referral system is a set of health services that delegation of tasks and responsibilities of health services on a reciprocal basis both vertically and horizontally. In the era of National Health Insurance (JKN), based of the Presidential Regulation No. 12 Year 2013 on Health Insurance, health services implemented by the Social Security Agency (BPJS) Health adheres to the referral system. Health care facilities that work with BPJS Health required to implement a referral system. The Dr. Sam Ratulangi hospital is advanced referral health facilities that have established close cooperation with the BPJS Health beginning in 2013. Through an initial interview with the hospital doctor and the first-level health facilities (FKTP) doctor found problems such as: follow up letter from Dr. Sam Ratulangi Hospital was not filled by doctors, not returned to the FKTP doctors, the writing in the follow up letter unreadable by the FKTP doctor, and there was no communication between healthcare facilities in the process of referring and receiving patients. The purpose of this study was to analyze the implementation of the referral system of patient seen from administrative and operational procedures in the Dr. Sam Ratulangi Tondano hospital.

This qualitative descriptive research was carried out at the Dr. Sam Ratulangi Tondano hospital for 3 months (October – December 2016). Primary data concerning the implementation of the referral system of patient seen from

*Copyright © 2017, Gabby Doaly. This is an open access article distributed under the creative commons attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.*

**Citation: Gabby Doaly<sup>1</sup>, Grace D. Kando<sup>2</sup>, Tubagus D. E. Abeng<sup>2</sup>, 2017 “Analysis Of Patients Reference System Implementation In Regional General Hospital Dr. Samratulangi Tondano Of Minahasa Regency”, International Journal of Health Medicine and Current Research, 2, (02), 358-374.**

administrative and operational procedures in Dr. Sam Ratulangi hospital obtained through in-depth interviews to 8 informants i.e., Director, Head of Section, FKTP doctor, emergency room nurse, inpatient nurse, outpatient nurse, Chief Medical Record Unit and Admission Officer -and supported by direct observation and research documents.

The results showed that that the administrative procedure for the receipt and delivery of patient referrals in the Dr. Sam Ratulangi Tondano hospital has been implemented according to the standard. Operational procedures refer patients in Dr. Sam Ratulangi Tondano hospital, has not performed according to the standard namely the Dr. Sam Ratulangi hospital did not contact the intended health facilities. The operational procedure of referring back to the faskes 1 has been implemented according to the standard operating procedures while the follow-up over the reference from faskes level 3 has not been carried out according to the standard where there is no communication between faskes level 3 with the Dr. Sam Ratulangi hospital.

From the result it can be concluded that the implementation of the system of referral patients in Dr. Sam Ratulangi Tondano Hospital seen from administrative procedures, has implemented appropriate standard, contrarily from operational procedures, the implementation of the system of referral patients in Dr. Sam Ratulangi Tondano Hospital has not yet implemented appropriate standard. RSUD Dr. Sam Ratulangi Tondano require a qualified human resources in medical record section and whole employees need to be socialized about the operational procedure of the reference system.

## INTRODUCTION

### 1. Development Principle of Reference System

There were some principles in developing and implementing the reference system. Those basics or principles were patients' safety that also included service quality, efficiency, orderliness, global rivalry, justice, and implementation of National Health System. A good reference system must be set out and give priority to patients' safety above other things. All decisions related to reference must be made by the patients' safety. Patients' safety was integral part of all steps of quality health service. Reference system was held with the purpose to give quality health service, so that the service goal was achieved without using expensive cost. This was called effective and efficient. Efficient meant less of waiting time in the process of reference and less of unnecessary reference because the problem, in fact,

could be solved in the origin health service facility (Fasyankes), either with sophisticated technology or low cost technology, that could be accountable.

Health service system as stated would be running well if there was orderliness in that implementation. It meant, all things must obedient the manual determined. Therefore, it needed to arrange a manual which could be used in all around Indonesia, and could be revised from time to time.

Global rivalry also became one of rationale in developing reference system, because Indonesia is wide archipelago state, within bound with some states whether in the land directly or indirectly in the outer small islands. There are Indonesian citizens who stayed in the boundaries of neighbor states, geographically was nearer and easier to access health service and or reference in the neighbor states than in Fasyankes of reference destination in Indonesia. Without mentioning, the consideration of service quality in other state was often assumed better than Fasyankes service in Indonesia.

National Health System 2009 that hereafter revised became National Health System 2012, was arranged by the ideal based of Pancasila, constitutional based of the 1945 Constitution, and operational based of Law Number 36 Year 2009 about Health. Hereafter, the National Health System 2012 as the document of health management policy would be the reference in conducting health development in order to fulfill human right. National health System arranged also paid attention to the innovation or penetration for health conducting widely included for the reinforcement of reference system (Anonym, 2012b).

### 2. Organization of reference System

#### a. Organization and Management in Implementing the Reference System

In order that this reference system could be implemented effectively and efficiently, so it needed to pay attention the organization and management. The chain of authority and responsibility from each service units must be belonged clearly, included the rule of implementation and coordination. Reference system would be run well and could give benefit, not only for the institution that gave reference but also for the institution that received the reference by giving the priority of benefit for the patients referred. There must be sanction agreed by all sides related to the rule in making reference.

#### 1) Organization or institution in concerned in the reference system

Other than health service facility which gave

direct service to the patients, there was organization or institution in this reference system. Organization in concerned in the implementation of reference system were:

- a) Owner and executor of health service facility with it's caretaker.
- b) Health Department of Regency/Municipality and Province Health Department.
- c) Health Ministry, by the General Directorate of Health Effort Building.
- d) BPJS of health and it's network.
- e) Organization of profession of health personnel who concerned in the individual health service.
- f) Education institutions of medicine, nursing, pharmacy, and other health education institutions that related with individual health service.

2) Fasyankes from all level of reference system as knot of reference system.

In the decentralization era, the involvement of local especially regency/municipality, became very important in order to function the reference system that built by its rule. The first point of an individual health reference process, except for the emergency case, was Fasyankes that functioned as gate keeper, they were:

- a) Puskesmas and clinics of government and private,
- b) Private practice of doctor/dentist and practice of primary service doctors, which were in the administration area of local government of regency/municipality. (Anonym, 2012b).

b. Build the Reference System for Individual and Its Supervision

**Table 1.** Classifications of health service facility in the reference system

	Description	Facility of Health Service	Monitoring and Evaluation by
Fasyankes First Level (Clause 2, Section 2 dan 3)	Able to give Individual Health Service/Medical First level was done by doctor/dentist and special for service of maternal & neonatal physiology and special condition were helped by midwife	1. Clinic Puskes (in Puskesmas & Pusk.TT) 2. First Clinic (Government & private) 3. Individual Practice Dr/Drg 4. Firstly Hospital	1. Head of Health Department of Regency/municipality 2. Profession Organization branch of Regency/municipality
Fasyankes Second Level (Clause 2, Section 4)	Able to give specialist individual health service	Hospital Class D or Class C RS Hospital Class B Non Education (Owned by Government/ABRI/POLRI/BUMN, Private)	1. Head of Province Health Department 2. Profession Organization branch of province
Fasyankes Third level (Clause 2, Section 5)	Able to give sub specialist individual health service	Hospital class education/A, in Province, Hospital A Main Reference, General/Specific National, in central	Dir BUKR Dirjen BUK, 3. Profession Organization 4. Education Institution

3. Rule of Reference System at Second Level of Fasyankes

Reference process in reference system in the second level Fasyankes consisted of process of receiving the reference from first level Fasyankes, service the patients, did the horizontal reference to the same level, vertical reference to the third level Fasyankes, and

receive the horizontal and vertical return reference, and return the reference to the first level Fasyankes.

a. Clinical Procedure

- 1) Received the reference patient from first level fasyankes and gave follow up Communication by available communication technology among the referrer fasyankes and

reference fasyankes made it possible to know the patients' condition. Reference fasyankes would prepare well to receive the patients and then serve referred to the patients' condition at coming. Patients who came to the reference fasyankes would be immediately served refer to standard operational procedure (SOP) occurred in the related fasyankes. Non emergency patients would be served in clinic of reference fasyankes according to the purpose after passing through the administration procedures of clinic service while the emergency patients were served in IGD that must be ready to serve 24 hours/day.

- 2) Send the patients to the third level fasyankes  
The referred patients in clinic or IGD, after being examined and observed, actually needed sub specialist service and or needed more complete supporting examination, so that the patients needed to be sent to third level of fasyankes. .

b. Administration Procedure

- 1) Process of receiving the referred patients :

- a) Administration staffs had job to complete the patients' administration procedure, both out patients and in patients, and made receipt of patients referred to each tools' rules.
- b) The staffs completed patients' ID form referred to provisions before giving service for referred patients of non emergency while the administration of emergency patients completed after stabilization process of patients' condition had been done.
- c) Received, examined, and signed the agreement of receiving the patients in referred fasyankes, based on the patients' letter reference from the referred fasyankes to be pasted on the patients' status card, that furthermore would be served in the pertinent reference fasyankes.
- d) For the patients of insurance participant, the administration staffs must give explanation about:

- (1) Rights and duty of insurance participants, in using service in fasyankes, based on their sick status/condition,
- (2) Fulfillment of condition to get insurance service,
- (3) Enclosed the examination result and therapy/medical treatment and caring at the patients' note/medical record card to be continued

to the caring place or following service referred to the provider direction that gave service and patients' condition, included Health Department for the patients who needed follow up of epidemiology surveillance.

- 2) Process of sending the referred patients.  
Administration staffs had duty of:
  - a) Prepared and completed all letter that had been made by the provider of service giver. Patients' reference letter was made in duplicate 2 (two), one for being sent and one for archive.
  - b) Wrote clear address at the reference letter and gave explanation to the patients/their family about all things related to their needs of service.
  - c) Kept the patients' medical record with all completeness in the right place.
  - d) Fulfilled monthly and quarterly reports.

c. Operational Procedure

- 1) Reference the patients  
If the patients were referred to the other part in the same fasyankes so the request of reference was written in patients' document/medical record and the reference answer also written at the same file. If the patients were referred to the other fasyankes level 2 so the preferred provider would write the reference with resume of examination results and service/action that had been done, if it was needed, completed with x-ray photo, EKG, and other information. The referred fasyankes must give answer, suggestion, and others based on its consideration. If the patients were referred to the fasyankes level 3, so the operational procedures that must be fulfilled were as follow:

- a) Prepared transportation for reference and it was better if completed with IT (Information Technology) equipments that could connected preferred fasyankes with referred fasyankes included ambulance that brought the patients to the fasyankes destination.
- b) If it was decided that the patients would be cared in the preferred fasyankes so co-reference, formally, would transfer the responsibility of caring the patients to the authoritative provider in the preferred fasyankes.
- c) At the condition that referred patients after getting the examination and action/service in the preferred fasyankes actually did not need to be cared, so co-provider would return the patients by bringing letter of return reference with suggestions and or medicine and others.
- d) If the patients wanted to be cared in the fasyankes of second level, so they were still there and

fasyankes tried to ask suggestion/consult with the referred fasyankes by telecommunication tools available or IT tools if it had been developed in the reference system in that area.

- 2) Referred back to the first level of fasyankes : :
  - a) Facilitated the patients/family to return to the beginning place (referred fasyankes or house) based on the note from preferred fasyankes.
  - b) Suggested patients' transportation and needs of assistant from the official if it needed.
  - c) Completed information/explanation about:
    - a. Recent health condition
    - b. Medicines that must be used
    - c. Things that were commanded and prohibited
    - d. Follow up of service needed
  - d) Patients' return reference that contained of answer of reference, resume of examination result and service/treatment, and suggestions of follow up treatment in the first fasyankes and or repeatedly reference at the time decided.
- 3) Follow up of return reference from third fasyankes :
  - a) Re-accepted the return reference in the second fasyankes from third fasyankes, were done as follow:
    - (1) Second fasyankes should accept information about planning of return reference of the patients from preferred fasyankes by the communication tools available.
    - (2) Second fasyankes arranged planning of follow up based on the suggestion in the answer letter of return reference.
    - (3) Did the treatment to the patients based on the palling
    - (4) Following up the suggestion from preferred fasyankes that related with disease/patients' health problem.
    - (5) Doctor and nurse/other health staffs in the second fasyankes and first fasyankes where the patients lived would be collaborated in giving follow up treatment for the patients around them.
    - (6) For the patients who must be repeatedly referred, the second fasyankes collaborated with first fasyankes to prepare the patients in order to be re-referred to the preferred fasyankes.
  - b) The patients who claimed not appropriate to be referred and had been treated in the third fasyankes, before being re-referred, tried to:
    - (1) Evaluating self of carefulness in doing the examination and giving diagnose
    - (2) Knowing the rule determined for the treatment in second level and rule to make reference
    - (3) Reporting and consulting with Health Department

of Regency/Municipality and Province if it was needed

- c) Patients who forced home and had been reported by the third
    - (1) Health *provider* of second level cooperated with first fasyankes needed to investigate/trace the patients' condition and knew the reason why the patients/family choose to be forced home.
    - (2) Tried to help patients/family to get the best solution of the problem faced related to the incident of forced home. This case needed to be discussion topic in the coordination meeting.
  - d) Patients who died :
    - (1) Did problem tracing/identification for certain cases that needed to be known the problem background in the effort of promote and preventive in the family or community.
    - (2) For certain condition, it could be followed up by giving health treatment at the family, group, and society at their environment.
    - (3) Death caused by infect disease need to be reported and explained to the family.
    - (4) Cases of death became discussion topic in the monthly meeting of referred fasyankes, preferred fasyankes, or coordination meeting and became discussion topic cross by sector if it was needed.
    - (5) Death of referred patients with infect disease needed to be informed by second and third fasyankes to the first fasyankes.
  - e) Patients "who lost" based on the report from preferred fasyankes, needed to do investigating by the caretaker of development area in the first level.
3. Reference system in Minahasa Regency

In order to implement Health Minister Regulation Number 001 Year 2012 about Reference of Individual health Service so the Government of Minahasa Regency published Regulation of Minahasa Regent Number 22 Year 2013 about Reference System of Health Service in Minahasa Regency. This regulation contained of: reference system, level of medical reference, area of reference, channel and condition of reference. In the section 9 clause (3) managed RSUD Dr. Sam Ratulangi Tondano as the facility of reference from 21 (twenty one) Puskesmas in Minahasa Regency (Anonym, 2013c).

#### **A. Health Service at the National health Assurance**

##### **1. Health Assurance**

Health assurance was assurance of health guard in order that the participants got benefit of health

care and guarding in fulfilling the basic needed oh health which was given for each person who had paid contribution or his contribution had paid by government. Program of health assurance was held by National Health Care Security (BPJS *Kesehatan*) (Anonymous, 2013a).

## 2. Social Care Security (BPJS)

Social Care Security (BPJS) was body corporate formed in order to held social assurance program. BPJS was formed based on Laws Number 40 Year 2004 about National Social Security System that compelled to form a body of social security organized. Next, government published Laws Number 24 Year 2011 about Social Care Security (BPJS). There were 2 (two) BPJS, Health BPJS and Labour BPJS. Health BPJS held health care program and Labour BPJS held work accident care, old age benefits, pension, and death (Anonymous, 2011).

## 3. Caretaker of Health Service

The caretaker of health service included all health facilities which cooperated with Health BPJS in the form of health service of first level and health service of advance level. Health services of first level were: puskesmas or on an equal, practice of doctor and dentist. Health facilities of advance level were: main clinic or on an equal, general hospital and special hospital (Anonymous, 2013d).

## 4. Procedures of Health Service

Health service for participants was done gradually accord with medical needs started from Health Service of First level (FKTP). Health service of first level was held by FKTP of the participants registered. If the participants needed health service at advance level based on medical indication, FKTP must refer to the nearest Health Facility of Advance Level (FKRTL) appropriate with the reference system that regulated at laws. Health service of level 2 only could be given based on reference from health service of first level. Health service of level only could be given based on reference from health service of level 2 or first level. This provision was excepted at for emergency situation, disaster, speciality patients' health problem, geography consideration, and consideration of facility availability (Anonym, 2013d).

## B. Hospital

### 1. Definition and Function

Definition of hospital in Laws of Republic Indonesia Number 44 Year 2009 was institution of health service that held individual health service completely which provided in-patients, out-patients, and emergency. Function of hospital was as place for getting health service needed in the process of healing or health treatment. Hospital had social and economy function. In broad outline, functions of hospital were:

- a. Function of extramural service was activity that was done out of the Hospital such as nutrients service, social activity service, and environment health program.
- b. Function of intramural service was all activities that were done in the Hospital itself such as medical treatment and healing service, in-patients and out-patients service, administration service, and education organization.

### 2. Types of Hospital

- a. Based on the service given, hospital was categorized into General Hospital and Special Hospital.
- b. Based on its management, hospital was divided into Public Hospital and Private Hospital.
- c. Based on the ownership, hospital was divided into Hospital owned by government, Hospital owned by military, Hospital owned by private, Hospital owned by BUMN.

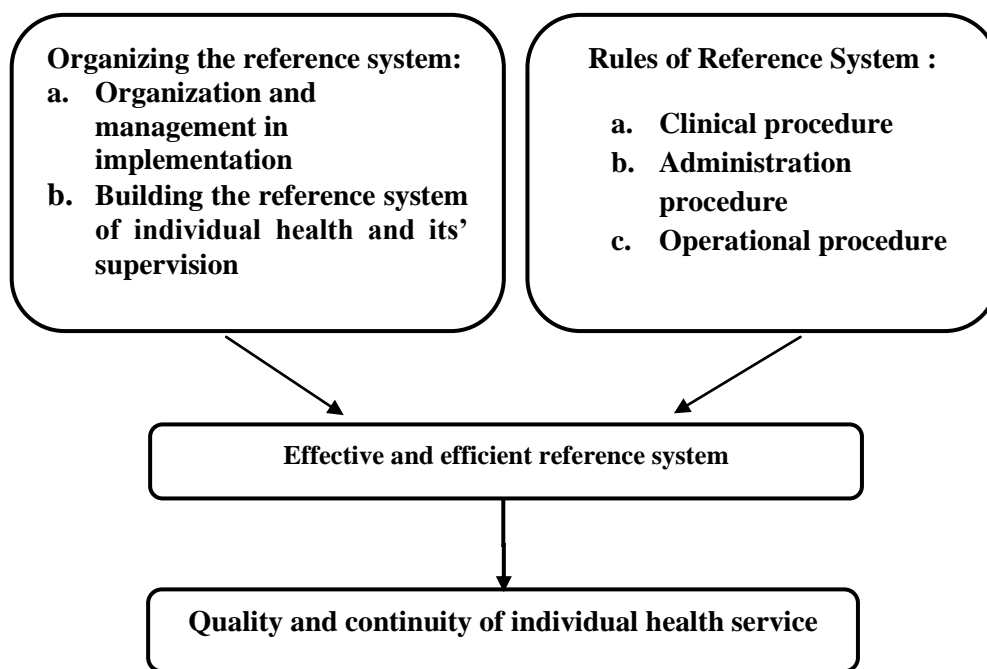
### 3. Classification of Hospital

In the implementation of health service gradually and function of reference, general hospital and specific hospital were classified based on the hospital's facility and ability of service. Classification of hospital consisted of:

- a. Hospital Class A
- b. Hospital Class B
- c. Hospital Class C
- d. Hospital Class D (Anonym, 2009b)

**C. Theoretical Framework**

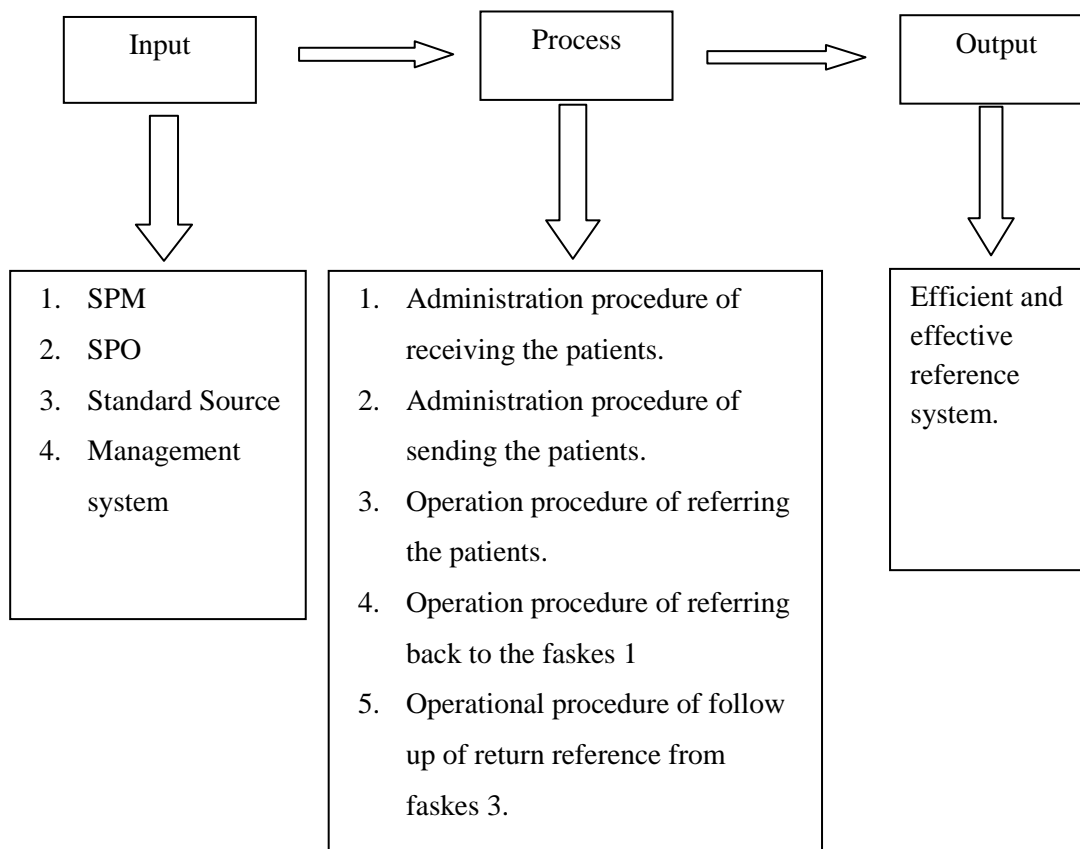
Based on the theoretical review, it arranged theoretical framework as follow:



**Figure 2.** Theoretical Framework

**D. Conceptual Framework**

Based on the theoretical framework, it was made the research conceptual framework as follow:



**Figure 3.** Conceptual Framework of the Research

## METHODS

Selection of informant in this research was based on (*appropriateness*) and (*adequacy*) principles. Appropriateness principle was that the informant selected based on knowledge owned related to research topic. Adequacy principle was that number of informant did not become main determinant factor but completeness of the data. Based on both principles, so the informants taken were 8 personals, they were 1 director, 1 head of section, 1 doctor FKTP, 1 nurse IGD, 1 nurse of in-patient, 1 nurse of out-patients, 1 head of medical record unit, and 1 admission staff.

### Definition of Technical Term

1. SPM (Minimum Service Standard) was provision about types and quality of basic service that was the obligatory affair of local government which could be got by each citizen minimally.
2. SPO (Standard operational Procedure) was a tool of instructions/steps standard in order to finish the process of certain routine work.
3. Standard Sources were tools, infrastructures, device and materials, energy, and fund.
4. Management Information System was a system that used computer as basic in order to get information needed by manager.
5. Clinical procedure was procedure that contained rules of reference system seen from clinical aspect.
6. Administration procedure was procedure that contained rules of implementation of reference system seen from administration aspect.
7. Operational procedure was procedure that contained rules of implementation of reference system seen from operational system.
8. Reference system of health service was system of implementation of health service that managed transfer of duty and responsibility of health service mutually both vertically and horizontally.

### Organization of Data Analysis

Data was collected by in depth interview and direct observation. Data of interview was recorded and copied in the form of transcript then merger with secondary data obtained from observation result. Data analysis in this research was using *content analysis* from Miles and Huberman that quoted by Putra (2011) with the steps as follow:

#### Data Collecting

Data was collected by in depth interview that was recorded and then copied in the transcript form.

#### Data Reduction

Data reduction was done by making code and category. Data reduction was analysis form of sharpening, classifying, directing, throwing unessential data and organizing the data.

#### Data Display

Data was displayed in the form of narration.

Examination of data validity was using triangulation of source and triangulation of method.

#### Analyzing the Component of Research Result

Analyzing the component of research result was done by analyzing the content (*content analysis*) that comparing the result with theories in the library.

### Data Validity

Data validity of the research was done by triangulation technique as follow:

#### 1. Triangulation of source

It was done by doing interview with different informants, they were director, head of section, doctor of FKTP, nurse of IGD, nurse of in patients, nurse of out patients, head of medical record unit, and administration unit.

#### 2. Triangulation of method

It was done by using in depth interview method and document observation.

## RESULTS

### 1. General Description of RSUD Dr. Sam Ratulangi Tondano

RSUD Dr. Sam Ratulangi Tondano was hospital type C owned by government of Minahasa regency, today it has 118 beds with the services available were: Emergency Installation, out-patients service (Clinic Interna, Children, Surgical Operation, Obstetrician, Ophthalmologist, Skin, Hearth, Neuron, Physiotherapy & Rehabilitation, Dentist, Growth & Immunization), in-patients service (Interna, Children, Su rgical Operation, Obstetrician, ICU, VIP), and service of medical supporting (Pharmacy, Laboratory, Radiology) (Profile RS, 2016).

RSUD Dr. Sam Ratulangi Tondano had passed accreditation assessment version 2012 of special program on 17 June 2016. There were 4 standards that were assessed in the accreditation of special program, such as Rights of Patients and Family (HPK), Tackling the infection Disease (PPI), Qualification of Education and Staff (KPS), and target of Patients' Safety (SKP).



Vision and Mission of Sam Ratulangi Tondano in doing the service were:

Vision : Realization of first-rate, achievable, and powered health service in RSUD Dr. Sam Ratulangi Tondano.

Mission : 1. Increasing health service through improvement the medical and non medical service, service of medical supporting, service of education nursing, dan service of reference.

2. Increasing the quality of human resources in RSUD Dr. Sam Ratulangi Tondano in order to improve the health service.

### 2. Characteristic of the Informant

Informants taken were 8 personals, they were 1 director, 1 head of section, 1 FKTP doctor, 1 IGD nurse, 1 nurse of in-patient room, 1 nurse of outpatients room, 1 head of medical record unit, and 1 administration staff. Characteristic of informant could be seen on the Table 2.

**Table 2.** Informant Characteristics

Informant Code	Age	Position	Education
I1	51	Direktur	S2
I2	37	Head of Section	S1
I3	44	Doctor FKTP	S1
I4	31	Nurse IGD	S1
I5	46	Nurse of inpatient	D4
I6	37	Nurse of Outpatient	D3
I7	38	Head of Medical record unit	SMA
I8	45	Administration Staff	SPK

### 3. Result of In Depth Interview

Below were interview result that written based on the aims, in order to analyze the implementation of reference system in RSUD Dr. Sam Ratulangi Tondano.

#### a. Administration procedures of receiving the patients

Based on the result of in depth interview with the informant about how the implementation of administration procedures of receiving the reference patients in RSUD Dr. Sam Ratulangi Tondano, all informants stated that its implementation had been appropriate with the standard although there was problem there. Statements given by the researcher, according to the interview results were as follow:

Answer 11 : “.... Administration procedure of receiving the patients had run well appropriate with the standard ....”

Answer 12 :“...It had run well. There was staff on duty 24 hours in the Hospital...”

Answer 14 :“... It had run well. Administration staff was always there ...”

Answer 16 :“...It had run doc; but the medical record card for old patients a bit long to be prepared. The doctor was too long in the poly, but the card was not there yet ...”

Answer 17 :”...It had run doc, there was administration staff who was ready 24 hours. Receiving of patients in IGD or clinic had run well. But, there was a bit difficulty in looking for the medical record document of old patients. We got difficulty in finding the leis, it was about a half hour. There were many leis which were not ordered because there was lack of shelf/filling cabinet and file folder. And also, the room of medical record was small...”

Answer 18 :”...It had run, but little bit slow in preparing leis for old patients. We got difficulty in finding the documents because the keeping place was not ordered yet. There were many leis piled up on the table, unordered yet.”

Based on the result of in depth interview with the informants about factors which became problems in implementing administration procedure of receiving the referred patients, informants’ answer stated that the problem was limited of human resources and infrastructure (room), and tools (file folder, shelf/filling cabinet). Statements given by the researcher were appropriate with the quotation of interview result as follow:

Answer 11 :“...I think there was problem in implementing the receiving patients that related with human resources. There were many personals in the medical record but the D3 of medical record was not there ... He continued his study. There was only 1 personal who had got training of medical record, our room and tools were also limited.”

Answer 12 :“...The problem was that patients and doctor in polyclinic and IGD often too long wait the leis. It was commonly occurred for old patients, not new patients. It was

because the management in medical record unwell yet....”

Answer I7 :“....The problem here that the room of document was small, lack of filling cabinet, lack of file folder. There were many patients’ status not recorded in the file folder and not kept in the shelf yet. This made the staff got difficulty in finding the leis ...”

Answer I8 :“...The problem was when found the status of old patients .... It was difficult because many leis that were not ordered yet or there were no record because the leis was still in the room, was not returned to the medical record....”

When it was asked about the time of returning the medical record from the inpatient room to the medical room, some informants answered that it was some days after the patient check out.

Answer I5 : “... commonly some days I brought to the medical record. It was because the doctor had not finished yet to make the resume....”

Answer I7 : “... there were some days the leis was in the room. It made me took long time to work.

When it was asked about the cause of the doctor took long time to write the medical resume, some informants answered as follow:

Answer I5 :“...there were many patients of specialist doctor both in the poly and clinic. Commonly they didn’t have time to write the resume...”

Answer I2 :“... the specialist doctors was in hurry ... must cexamine other patients so they delayed to make the resume ...”

#### b. Administration procedure of sending the patients

Based on the in depth interview with the informants about the implementation of administration procedure of sending the reference patients in RSUD Dr. Sam Ratulangi Tondano, all informants stated that it was done standard. Statement given by the researcher were appropriate with the quotation of interview result as follow:

Answer I1 : “... it was same with the receiving patients, the administration procedure of sending the patients was done standard ...”

Answer I2 : “... it had run well, appropriate with the standard ...”

Answer I4 : “... administration standard of sending the patients was done according to the standard ...”

Answer I6 : “... it had run well according to standard ...”

Answer I7 : “... it was done according to standard ...”

When it was asked about the problem of implementing administration procedure of sending the reference patients, the informants answered at the steps of keeping the medical record file. The file of medical record had not kept well and in order yet as the quotation of informants’ answer as follow:

Answer I1 : “...the problem was at the point of keeping the medical record file. We didn’t have wide room so the medical record wasn’t kept well and in order yet ...”

Answer I2 : “...the problem was at the keeping of medical record file... not in order yet ... many leis piled up on the table because lack of filling cabinet. The filling cabinet couldn’t enter the room because the room was too small ...”

Answer I7 : “...medical record file weren’t ordered well yet because thsmall room and lack od shelf/filling cabinet ...”

#### c. Operational procedure of sending patients

Based on the in depth interview result with the informants about how the implementation of operational procedure to send the patients, some informants stated that the procedures had run well, as the following quotations:

Answer I1 : “... operational procedure of sending the patients had run well ...”

Answer I2 : “... it had run well...” Some other informants stated that the operational procedure of sending the patients wasn’t run well yet as the following informants’ answers:

Answer I4 : “...operational procedure of sending the patients had been implemented but it wasn’t appropriate with the standard, where before giving reference the doctor should contact the preferred faskes. But, doctor IGD never contacted the preferred faskes.

Answer I5 : “...it wasn’t done with standard. We in the inpatient room never contacted the preferred faskes before sending the reference ....”

Answer I6 : "...it had run wasn't appropriate with standard because we in the clinic never contacted the preferred faskes before doing the reference ..."

When it was asked about the problem in implementing the operational procedure of sending the patients, the informants answered that there was no communication with the preferred faskes, and the problem was at the driver and ambulance, as the following quotations:

Answer I4 : "...the problem was instead I never contacted the preferred faskes, the other problem was related with driver and ambulance .. sometimes the driver didn't stay so he must be contacted. Sometimes the ambulance didn't have diesel fuel so it wasn't ready to send the patients ..."

Answer I5 : "...commonly had problem in preparing ambulance, the driver must be contacted instead problem in contacting the preferred hospital..."

Answer I6 : "...instead the problems we mentioned, sometimed there was problem with ambulance and driver..they weren't ready ..."

#### d. Operational procedure of return referred to the faskes 1

Based on the in depth interview with informants when they wer asked about implementation of operational procedure to make return reference to the faskes 1, so all informants stated that it had been implemented with standard, as seen from the following quotations:

Answer I1 : "... operational procedure to make return reference to the faskes 1 had been done appropriate with the standard..."

Answer I5 : "... it had run appropriate with standard ..."

Answer I6 : "...to make return reference, it was appropriate with standard ..."

When it was asked about the problems faced in implementing operational standard to make return reference to the faskes 1, the informants answered that there was problem at the letter of return reference where commonly that letter wasn't fulfilled by the doctor or wasn't returned to the doctor in the FKTP or the notes in the return reference wasn't readable by the doctor in FKTP, as the following quotations:

Answer I6 : "...sometimes the doctor forgot to write in the letter of return reference and the note wasn't readable..."

Answer I3 : "...letter of return reference from the hospital sometime, wasn't readable , sometimes blanks, or sometimes the letter wasn't given to us. The patients said that they forgot or the letter was lost."

e. Operational procedure of follow up of return reference from faskes

From the result of in depth interview with informants about implementation of operational procedure of follow up of return reference from faskes 3 whether it had been implemented or not yet, so all informants answered that it wasn't done yet with standard, as seen from the following quotations:

Answer I1 : "... operational procedure of follow up of return reference from faskes 3 wasn't appropriate with standard, where we never got information by the communication tools about the planning of return back the patients ..."

Answer I5 : "...it wasn't implemented yet... because we never got information by communication tools about planning of return reference the patients to the Tondano Hospital..."

Answer I6 : "...it wasn't run standard ..."

When it was asked about the problem faced in implementing the operational procedure of follow up of return reference from faskes 3, the informants answered that the problem was that there no coordination and less of monitoring, evaluation, development, and supervision in implementing the reference system. Those all could be seen in the following quotations:

Answer I1 : "...The problem was that there was no coordination among the faskes, we also lack of socialization about reference system ..."

Answer I2 : "...there was no relation/communication among faskes. I think that the problem was about lack of monitoring, evaluation, development, and supervision from the hospital itself or from the Health Department toward the reference system ..."

Answer I5 : "...we were lack of socialization about procedure and reference system. There

was also no supervision/warning when we didn't implement the system as standard ...”

Answer I6 : “...the problem was unclear operational procedure. There was no development/explanation from the head of installation.”

#### 4. Observation Result

##### a. Administration procedure of receiving the patients

Based on the document of observation result in the medical record room, emergency installation, and outpatient installation for the implementation of administration procedure of receiving the patients, it got the result with good criteria.

##### b. Administration procedure of sending the patients

Based on the document of observation result in the medical record room, emergency installation, and outpatient installation for the implementation of administration procedure of sending the patients, it found that the result had good criteria.

##### c. Operational procedure of referring the patients

Based on the document of observation result in the medical record room, emergency installation, and outpatient installation for the implementation of operational procedure of sending the patients, it found that the result had enough criteria.

##### d. Operational procedure to make return reference to the faskes 1

Based on the document of observation result in the medical record room, emergency installation, and outpatient installation for the implementation of operational procedure of sending the patients, it found that the result had good criteria.

##### e. Operational procedure of follow up of return reference from faskes 3

Based on the document of observation result in the inpatients room, and outpatient installation for the implementation of operational procedure of return the patients from faskes 3, it found that the result had poor criteria.

## DISCUSSION

### 1. Administration procedure of receiving referred patient

From the result of interview, it found that administration procedure of receiving the referred patients in RSUD Dr. Sam Ratulangi Tondano had been done as standard. This was appropriate with the result of direct observation with document investigation it found the implementation of patients' administration, filling the patients' personal identity, and giving explanation about patients' rights and duties. This research result was different with the research of Rukmini and Ristrini (2015) about Implementation of Maternal Reference System in Clinic Tambakrejo and Tanah Kali Kedinding Surabaya City, where it reported that for clinical procedure, it was done, whereas for the administration procedure, there were some that not done yet about the standard procedure of receiving the reference, it was registration in the register book of patients' reference.

Although the administration procedure of receiving the referred patients had been implemented appropriate with standard in RSUD Dr. Sam Ratulangi Tondano, but there some problems in the implementation, that was the preparation of medical record document for old patients that needed more than 15 minutes. Whereas, the standard of preparation the medical record document of out patient service was starting from the patients' registration until the medical record found by the staff, it's average  $\leq 10$  minutes. While the standard of preparation of medical record document for the inpatients service was started from when the patients decided to be hospitalized by the doctor until the document of medical record prepared in the patients' shed, its average  $\leq 15$  minutes (Anonym, 2008).

The preparation of medical record document that needed long time in RSUD Dr. Sam Ratulangi Tondano was caused by its poor ordering so that the staff got difficulty in finding the medical record document. This was caused by the limited room, facility, and tool, they were small/narrow medical record room, lack of shelves and file folder. This was appropriate with the report by Primasari (2015) in the research with the title “Analysis of Reference System of National Health Care Reference of RSUD Dr. Adjudarmo Lebak Regency”, the readiness of Clinic and RSUD Karimus as center of reference was not optimal yet, because the limited of source at the basic service in the form of facilities and tools, although it was not too significant influenced the reference system.

According to the book of Guidance of Organization of Hospital Service, complete facilities and tools must be prepared in order to support efficient service. Medical record unit must have sufficient

location so the taking and distribution of medical record run well. Work room must be sufficient for the staff interest, keeping of medical record, and placing the tools (Anonym, 2012).

Organization of medical record that was not optimal yet in RSUD Dr. Sam Ratulangi Tondano caused by the limited quality human resources in the medical record unit. From the interview and data result, it known that personal that had duty in the medical record unit was 12 personals. Most of them were honorary. From 12 personals, 1 staff had education background of D3 medical record but at the time or research he was joining advance study, 1 staff had ever joined training of medical record but at the time of research he wasn't on duty, while the other 10 staffs never joining the medical record training at all. At the time of research, head of medical record unit didn't have medical record education background and never joining medical record training at all. This wasn't appropriate with the Guidance of Organization of Hospital Service where it mentioned that medical record unit lead by a head with minimum educational background of D3 medical record and had appropriate experience, and the qualification of staffs must be appropriate with the job description (Health Ministry, 2012).

Based on the research of Yella, related with analysis and discussion of head's knowledge, attitude, behavior and commitment toward completeness of medical record document filling in RSUP Dr. M. Djamil Padang in 2011 it stated that more than a half of staffs' filling were not complete, a half of staffs had low knowledge about filling the medical record document, more than a half of staffs had negative attitude in filling the medical record document, more than a half of staffs had good step and a half of them had poor step in filling the medical record document and there was meaningful correlation between knowledge and organization result of filling the medical record document. The result of this research was almost similar with the research of Nasution H. A. with the title Knowledge Level of Medical Record Staffs in Filling the Medical Record Bundle in General Hospital of Sipirok Year 2014 where there were 6 persons (60%) with average knowledge and there were 174 bundles (87,2%) of incomplete medical record of new outpatients.

Other cause of time taken in preparing the medical record in RSUD Dr. Sam Ratulangi Tondano was the slow of returning the medical record in the inpatients room, more than one day. The standard of returning the medical record of inpatients and outpatients according to Health Minister Regulation Number 129 year 2008 about Minimum Service

Standard was maximum 24 hours (Health Minister 2008). This research result was still similar with research of Malonda (2015) with title Analysis of Proposing Claim of Social and Health Care Security in RSUD Dr. Sam Ratulangi where it stated that majority of returning the medical record in RSUD Dr. Sam Ratulangi Tondano was not on time. Likewise the research of Winarti (2014) about Completeness Analysis of Filling and Returning Medical Record of Inpatients in RSUD Dr. Soetomo Surabaya showed that from 195 bundles, the returning on time was 29% while the late returning was 71%.

From the interview with some informants, it found that the late of returning the medical record documents because the documents weren't complete yet, where the resume wasn't completed yet by the specialist. According to interview it found the data that the specialists who sent home the patients didn't have enough time to write the resume because there were many other patients who must be examined, both in the inpatient and outpatient rooms. Whereas, according to health Minister Regulation Number 269 year 2006 about medical record, it mentioned that medical record must be made immediately and completed after the patients got the treatments. Each doctor or dentist, in doing the practice, must make medical record. Except being complete, medical record must be made clearly (Anonym, 2006).

## 2. Administration procedure of sending the referred patients

From the interview result, it found that administration procedure of sending the referred patient in RSUD Dr. Sam Ratulangi Tondano had been implemented with standard. This was appropriate with result of direct observation of investigation of the documents, it found 2 double (two) letters of reference of return patients and medial record keeping.

Although the administration standard of sending the referred patients had been implemented with standard, there was problem in its implementation. The problem was at the making of double 2 (two) letters of reference. In RSUD Dr. Sam Ratulangi Tondano, the letter of reference made double 2 (two), one letter was sent to referred health facility and the other one was kept as claim document to the Health BPJS. While according to standard written in Guidance Book of National reference, the letter of reference was made double 2 (two), one was sent to referred health facility and the other one was archive (Health Ministry, 2012). By the sending of reference letter as claim document to Health BPJS, so there was no archive in RSUD Dr. Sam Ratulangi Tondano.

Other problem was making of patients' return reference letter. From the interview with informants, it found that there was patients' return reference letter which wasn't filled by the doctors in the hospital, the form of return reference wasn't returned to the doctor in FKTP, and the doctors' note in the form of return reference wasn't readable by the doctors in FKTP. This was appropriate with result of direct observation of document of investigation where the form of return reference was available but incompletely filled and the written wasn't clear.

There were forms of return reference that not returned to the doctor in FKTP, similar with research result of Zuhrawardi 2007 about Analysis of Implementation of Outpatients Reference of First Level of Obligatory Participants of PT Askes at Third Level of Clinic in Banda Aceh City Year 2007 where they who get outpatient reference, generally only 25-30% returned the reference to Clinic.

It was different with the research of Ali 2015 in Clinic City, Clinic Kalumata and Clinic Jambula, found that doctor in those Clinic never received letter of return reference from hospital. Likewise at the report of cases in Namibia, stated that most of cases about the reference that wasn't returned to the referred facility (Rumita, 2013).

Primasari said in his research that rules of return reference wasn't well implemented in RSUD Dr. Adjidarmo. According to her, this was caused by misunderstanding of some doctors about return reference and constraints of medicine in primary facility so the patients who ever been referred, returned to RSUD in order to get medicine needed. The lack information from Health BPJS to the doctors about return reference system became the perception difference that caused the activity of return reference in RSUD Dr. Adjidarmo wasn't optimal. The problem of return reference system was also occurred because the way to get medicine was not effective enough when the patients returned referred to the PPK I.

This was in line with the research of Frenti about Analysis of Management System of Inpatient Medical Record in General Hospital of Semarang City that limited of staffs, medical record training which wasn't wholly yet caused some obstacles, they were uncompleted medical record, nonstandard abbreviation/unclear doctor's note, misfile/ misplacing of medical record document, the document wasn't placed in the keeping shelf yet and report that was late, manual and system weren't run optimum yet.

### 3. Operational procedure to refer the patients

From the result of interview, it was found that operational procedure to refer the patients in RSUD Dr. Sam Ratulangi Tondano wasn't implemented as standard yet, where RSUD Dr. Sam Ratulangi didn't contact the preferred health facility. This was appropriate with direct observation of investigation of document where there wasn't found the communication notes with health facility of reference receiver.

This was different with the research of Puspitaningtyas (2014) in the quantitative research with the title "Implementation of Reference RSUD Banyudono", found that based on the data collecting that was done in RSUD Banyudono on Juli of 2014 toward 59 nurses, it was concluded that most of the nurses in RSUD Banyudono had implemented the reference as the procedure of reference system well, mechanism or implementation of reference system there had been implemented well, the nurses preparation before doing the reference was appropriate with the operational standard, and the nurses' obstacle in referring the patients were varied; because of local culture conviction and belief, or expense problem. However, generally, there was no nurses' problems in referring the patients.

Communication between health facilities was much needed before doing reference of emergency patients. By the communication, it was hoped that the health facility of reference receiver had prepared to receive the reference patients. By the communication between referred health facility and preferred health facility would increase patients' safety and service quality. This was appropriate with the foundation in developing and implementing reference system, that was patients' safety which also included the service quality and efficiency (Anonym, 2012b). As informed by Ani dan Djoko (2012), the effective reference needed communication among the nurses. The purpose of communication was in order to know the patients' condition and able to prepare earlier the treatment needed by the patients immediately after the patients reached the hospital.

One way in order to improve effectiveness and efficiency at the reference process was building strong networking among the health service institution. This networking was important to guaranty the speed and exactness of treatment toward the patients that directly influence the health service quality. Ignasius in the research with the title policy of Local Government in Improving Health Reference System of Archipelago Area in Lingga reGENCY of Riau Province, found that networking process between clinic and hospital was available but wasn't run well yet. In order to make it more effective, it needed a written engagement whether

in the form of regent regulation or local regulation which clearly managed right and duty of staffs in clinic and hospital.

At the context of work networking forming in the reference process, communication aspect between institutions became most important. The failing of formal reference system caused by two things, that were lack of communication and lack of using the service of ambulance (Nakahara, 2010). In order to solve the problem, it needed organization of each component of every health facility to mobilize the available sources and cooperated in an integrated system. The research of Mwangome showed that organization of reference at the health system in some area in Africa was still weak. Theoretically, social health centre in remote places and hospital in the regency, must be connected one and each other and the reference system would guaranty the problem that couldn't be handled in the social health centre, it could be solved by the hospital of regency on time.

Beside the problem of communication, from the interview with informants it was also found that transportation of reference patients in RSUD Dr. Sam Ratulangi wasn't managed well yet, seen from the unready ambulance and driver. This was appropriate with the finding of Primasari (2015) in the research with the title "Analysis of Reference System of National health Care RSUD. Dr. Adjidarmo of Lebak regency", the readiness of Clinic and RSUD Karimun as the centre of reference wasn't optimal yet, one of the reason because the transportation of reference wasn't managed well in doing the cases of emergency reference. While, according to the research of Bunda dan S. Mulya (2008) about access in the reference system of Clinic in remote place in Majene regency of West Sulawesi, it was concluded that the available transportation had supported the reference system although still found the late of reference. Kelley L. M. In the journal with the title of *Developing Rural Communities Capacity for palliative Care* said that the existence of transportation in the reference process was very important thing. Good transportation facility in the implementation of reference was transportation that was appropriate with the geographical condition of certain area. The importance of transportation was also reported in the research of Macintyre K, Hotchkiss R.D. *Referral Revisited: Community Financing Schemes and Emergency Transport in Rural Africa* that transportation influenced the reference because the travelled time to the hospital would influence the quality of reference.

4. Operational procedure to make return reference toward health facility level 1

From the result of interview, it was found that operational procedure to make return reference the patients toward health facility level 1 in RSUD Dr. Sam Ratulangi Tondano had been done with standard. However, from the interview with some informants, it was found problems; there were some patients' letter of return reference that weren't filled by the doctor in the hospital, the return reference form weren't returned to the doctor in FKTP and doctor's note in the return reference form was unreadable by the doctor in FKTP. This was appropriate with the result of direct observation of investigation of document where there was return reference form but wasn't completely filled and the note was unclear.

There was return reference form which wasn't returned to the doctor in FKTP, similar with research result of Zuhrawardi 2007 Analysis of Implementation of Outpatient Reference at First Level of Obligatory Participants PT. Askes at Three Clinic in Banda Aceh City Year 2007 where patients who got reference of outpatient, mostly only 25-30% who brought the reference back to Clinic.

It was different with research of Ali 2015 in Clinic City, Clinic Kalumata and Clinic Jambula, it found that doctors in those Clinic never received the letter of return reference from hospital. Likewise at the report of cases in Namibia, it said that most of reference cases wasn't done the return reference to the referee facility (Rumita, 2013).

Primasari said in his research that rules of return reference wasn't well implemented in RSUD Dr. Adjidarmo. According to her, this was caused by misunderstanding of some doctors about return reference and constraints of medicine in primary facility so the patients who ever been referred, returned to RSUD in order to get medicine needed. The lack information from Health BPJS to the doctors about return reference system became the perception difference that caused the activity of return reference in RSUD Dr. Adjidarmo wasn't optimal. The problem of return reference system was also occurred because the way to get medicine was not effective enough when the patients returned referred to the PPK I.

5. Operational procedure of follow up of return reference from health service level 3

From the result of interview, it was found that operational procedure of follow up of return reference from health service level 3 in RSUD Dr. Sam Ratulangi Tondano wasn't implemented as standard yet where all informants answered that there was no information through communication tools to RSUD Dr. Sam Ratulangi about the planning of returning reference the

patients from the preferred health service. This was appropriate with the result of investigation of document where there was no evidence of notes about the patients' returning reference which was done by communication tools.

According to the book of Guidance of National Reference System, health service level 2 must receive information about the planning of patients' returning reference from referee health service through communication tools available. The existence of communication made the health service of reference receiver prepared itself. Communication between referee and preferred health service would improve the patients' safety and quality of service. This was appropriate with foundation in developing and implementing the reference system, that the patients' safety was also included the quality of service and efficiency (Anonym, 2012b). As stated by Ani dan Djoko (2012), an effective reference needed communication among the nurses. The purpose of communication was to know the patients' condition and could prepare earlier about the treatment needed by the patients immediately after the patients reached the hospital.

## CONCLUSION

1. Administration procedure of receiving the reference patients had been implemented with standard.
2. Administration procedure of sending the reference patients had been implemented with standard.
3. Operational procedure of referring the patients wasn't implemented with standard yet, RSUD Dr. Sam Ratulangi didn't contact the preferred health service.
4. Operational procedure of referring to the health service level 1 had been implemented with standard.
5. Operational procedure of follow up of returning reference from health service level 3 wasn't implemented with standard yet where there was no communication between health service level 3 and RSUD Dr. Sam Ratulangi.

## Suggestions

1. For Local Hospital of Dr. Sam Ratulangi Tondano:
  - a. Place human sources with education background minimum D3 of medical record as head of medical record unit and give training of medical record for all staffs who worked in the medical record unit.

- b. Prepare representative medical record room with its equipments, facilities, and tools with standard of medical record room.
  - c. Give socialization to doctors about roles and functions of doctors related with the medical record bundles and making of return reference letter.
  - d. Revise the policy of patients' reference letter into 3 copies (three).
  - e. Development and monitoring of reference service, that was before referring the patients must contact the preferred health facility.
  - f. Advocate the Health Department in order to build networking between the health service for the effectiveness and efficiency of reference system.
  - g. Manage the patients' transportation well for the effectiveness and efficiency of reference system.
2. Government of Minahasa Regency./health Department of Minahasa Regency:
    - a. Support the program of improving the Human Resources quality and adding the infrastructure, administration facilities in the hospital's medical record room of.
    - b. Monitoring, evaluating, development, and monitoring the implementation of reference system in hospital and other health facilities.
    - c. Develop integrated reference system based information technology.

## REFERENCES

1. Aditama, T. Y. Manajemen Administrasi Rumah Sakit Edisi Kedua. Jakarta: UI Press; 2015..
2. Ali. Analisis Pelaksanaan Rujukan Rawat Jalan Tingkat Pertama Peserta Program JKN di Puskesmas Kota, Puskesmas Kalumata dan Puskesmas Jambula Kota Ternate. Manado. IKM UNSRAT. 2015.
3. Anonim. UUD 1945; 1945.
4. \_\_\_\_\_. Standar Pelayanan Minimal. PMK Nomor 129; 2008.
5. \_\_\_\_\_. Undang-Undang Republik Indonesia Nomor 36 tahun 2009, Tentang Kesehatan. Jakarta: Presiden Republik Indonesia; 2009a.
6. \_\_\_\_\_. Undang-Undang Republik Indonesia Nomor 44 tahun 2009, Tentang Rumah Sakit. Jakarta: Presiden Republik Indonesia; 2009b.
7. \_\_\_\_\_. Undang-Undang Republik Indonesia Nomor 24 tahun 2011, Tentang Badan Penyelenggara Jaminan Sosial. Jakarta: Presiden Republik Indonesia; 2011.



8. \_\_\_\_\_ Peraturan Menteri Kesehatan Republik Indonesia nomor 001 Tahun 2012 tentang Sistem Rujukan Pelayanan Kesehatan Perorangan. 2012a.
9. \_\_\_\_\_ Buku Pedoman Sistem Rujukan Nasional. Kementerian Kesehatan RI. 2012b.
10. \_\_\_\_\_ Pedoman Penyelenggaraan Pelayanan Rumah Sakit. Kementerian Kesehatan RI. 2012c.
11. \_\_\_\_\_ Peraturan Presiden No. 12 Tahun 2013 tentang Jaminan Kesehatan; dan Peta Jalan JKN (Roadmap Jaminan Kesehatan Nasional). Jakarta: Peraturan Pemerintah. 2013a.
12. \_\_\_\_\_ Peraturan Gubernur Sulawesi Utara Nomor 17 Tahun 2013 tentang Rujukan Pelayanan Kesehatan di Provinsi Sulawesi Utara. 2013b.
13. \_\_\_\_\_ Peraturan Bupati Minahasa nomor 22 Tahun 2013 tentang Sistem Rujukan Pelayanan Kesehatan di Kabupaten Minahasa. 2013c.
14. \_\_\_\_\_ Peraturan Menteri Kesehatan Republik Indonesia nomor 71 Tahun 2013 tentang Pelayanan Kesehatan Pada JKN. 2013d.
15. \_\_\_\_\_ Peraturan Menteri Kesehatan Republik Indonesia nomor 82 Tahun 2013 tentang Sistem Informasi Manajemen Rumah Sakit. 2013e.
16. \_\_\_\_\_ Profil RSUD Dr. Sam Ratulangi Tondano. 2015a.
17. \_\_\_\_\_ Peraturan Direktur Pelayanan Badan Penyelenggara Jaminan Sosial Kesehatan nomor 01 Tahun 2015 tentang Pedoman Pelayanan Kesehatan Rujukan Badan Penyelenggara Jaminan Sosial Kesehatan. 2015b.
18. Bunda., S. Mulya. Akses dalam Sistem Rujukan Puskesmas Daerah terpencil di Kabupaten Majene Sulawesi Barat: S2 Ilmu Kesehatan Masyarakat UGM; 2008.
19. Eksasila., I. Wayan. Kajian Rujukan Pasien Gakin di RSUD Kabupaten Buleleng Singaraja Provinsi Bali: S2 Ilmu Kesehatan Masyarakat UGM; 2005.
20. Essing S. O. Analisis Pelaksanaan Rujukan Rawat Jalan Tingkat Lanjut (RJTL) Peserta Jaminan Kesehatan Nasional (JKN) di Poliklinik Jiwa RSJ Prof. dr. V. L. Ratumbusang Manado: Program Studi Ilmu Komputer Program Pascasarjana Universitas Gadjah Mada; 2014.
21. Hidayat R., A. Ashari. Penerapan Teknologi Berbasis Web Service Untuk Integrasi Layanan Puskesmas dan Rumah Sakit; 2013.
22. Kesumawati. Analisis Pelaksanaan Rujukan RJTP Peserta Askes Sosial PT Askes (Persero) Kantor Cabang Sukabumi di Puskesmas Nanggaleng dan Gedong Panjang Tahun 2012. Depok: FKM UI; 2012.
23. Kismoyo C. P. Evaluasi Pelayanan Kegawatdaruratan Maternal Neonatal pada Puskesmas Mampu Pelayanan Obstetri dan Neonatal Emergensi Dasar (PONED) di Kabupaten Bantul. Yogyakarta: S2 Kesehatan Masyarakat UGM; 2012.
24. Kurniawati R. Evaluasi Kualitas Rujukan dan Rujukan Balik Pasien Rawat Jalan Penyakit Jantung Koroner Peserta Jaminan Kesehatan Nasional (JKN) di Puskesmas Kecamatan Menteng: S2 Ilmu Kesehatan Masyarakat UGM; 2016.
25. Malonda, T. D. Analisis Pengajuan Klaim Badan Penyelenggara Jaminan Sosial Kesehatan Di RSUD Dr. Sam Ratulangi Tondano. 2015.
26. Nur, K. I. Analisis Pelaksana Rujukan RJTP Peserta ASKES (PERSERO) Kantor Cabang Sukabumi di Puskesmas Nanggaleng dan Gedong Panjang Tahun 2012: Skripsi Fakultas Kesehatan Masyarakat Universitas Indonesia; 2012.
27. Nasution H. A. Tingkat Pengetahuan Petugas Rekam Medis Dalam Pengisian Berkas Rekam Medis Di Rumah Sakit Umum Sipirok Tahun 2014.
28. Primasari K. L. Analisis Sistem Rujukan Jaminan Kesehatan Nasional RSUD Dr. Adjidarmo Kabupaten Lebak. 2015.
29. Puspitaningtyas A, Indarwati, Kartikasari D. Pelaksanaan Sistem Rujukan DI RSUD Banyudono Surakarta: 2014.
30. Putera N. Penelitian Kualitatif Proses dan Aplikasi. Indeks. Jakarta. 2011.
31. Rukmini dan Ristrini. Pelaksanaan Sistem Rujukan Maternal Di Puskesmas Tambakrejo Dan Tanah Kali Kedinding Kota Surabaya. 2015.
32. Sedana P. L. E. Pelaksanaan Pelayanan Rawat Jalan Peserta Badan Penyelenggara Jaminan Sosial (BPJS) Oleh Petugas Puskesmas Kakaskasen Tomohon. 2015.
33. Sugiyono. Memahami Penelitian Kualitatif. Alfabeta: Bandung; 2009.
34. Winarti. Analisis Kelengkapan Pengisian dan Pengembalian Berkas Rekam Medis Rawat Inap Di RSUD Dr. Soetomo Surabaya. 2014. <http://adln.lib.unair.ac.id/go.php?id=gdlhub-gdl-sl-20144-winarti>.
35. Yella. Analisis dan pembahasan yang menyangkut dengan hubungan pengetahuan, sikap, tindakan dan komitmen pimpinan terhadap kelengkapan pengisian dokumen rekam medis Di RSUP Dr. M. Djamil Padang Tahun 2011.
36. Zuhrawardi. Analisis Pelaksanaan Rujukan Rawat Jalan Tingkat Pertama Peserta Wajib PT Askes pada Puskesmas Mibo, Puskesmas Batoh, dan Puskesmas Baiturahman di Kota Banda Aceh Tahun 2007: Tesis Ilmu Kesehatan Masyarakat Universitas Sumatera Utara; 2007.