# Pengembangan model layanan terpadu di fasilitas kesehatan primer bagi orang dengan skizofrenia (ODS) disertai risiko kardiometabolik = Development of an integrated service model in primary health care for people with schizophrenia PWS and cardiometabolic risks

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Abstrak

Komorditas risiko kardiometabolik pada ODS lebih besar dibandingkan populasi umum dan menyebabkan mortalitas tinggi di usia produktif. Berbagai modalitas tata laksana untuk masalah kesehatan tersebut tersedia di fasilitas primer hingga tersier. Sayangnya, akses layanan yang terpadu dan bermutu belum ada di Indonesia. Penelitian ini bertujuan untuk mengembangkan model layanan terpadu tersebut di fasilitas kesehatan primer di Indonesia. Penelitian ini menggunakan model pengembangan sistem spiral yang mengikuti tiga tahap action research. Tahap pertama menggabungkan metode kuantitatif desain potong lintang studi komparatif dan kualitatif observasi, penelusuran kepustakaan, wawancara mendalam, dan lokakarya untuk mengidentifikasi masalah, gambaran pelayanan, dan potensi penyelesaian masalah sebagai dasar pengembangan model layanan terpadu. Subjek penelitian kuantitatif pada tahap ini adalah ODS usia 18-59 tahun yang menjalani pengobatan di 20 puskesmasprovinsi DKI Jakarta. Data kualitatif berasal dari ODS, keluarga, penyedia layanan, akademisi, dan pemangku kebijakan di daerah maupun pusat. Model awal dikembangkan berdasarkan modifikasi terhadap clinical pathway dari WHO-PEN Package of essential noncommunicable disease interventions . Kemamputerapan dan kebutuhan penyesuaian model dinilai berdasarkan hasil identifikasi solusi. Model layanan terpadu yang dikembangkan, kemudian diujicobakan dan dinilai secara kuantitatif dan kualitatif di tahap kedua untuk melihat kemampulaksanaan melalui ketersediaan layanan, kesesuaian penerapan, dan kesediaan tenaga kesehatan untuk melanjutkan layanan. Evaluasi dampak model layanan melalui desain eksperimental kuasi dinilai melalui efektivitas terhadap parameter klinis dan nonklinis. Proporsi ODS dengan risiko kardiometabolik adalah 88 dari 216 partisipan ODS , dan hanya 6,8 yang mendapatkan akses layanan komorbiditas. Data kuantitatif maupun kualitatif menunjukkan bahwa para pemangku kepentingan berharap akan model layanan terpadu dapat dikembangkan di puskesmas 63,7 , menggunakan berbagai sumber daya yang telah ada, melibatkan tim 61,1 , ditekankan pada upaya skrining dan pemantauan berkala 59,5 . Model layanan terpadu dalam bentuk clinical pathway maupun alur layanan ternyata tidak dapatditerapkan sepenuhnya di puskesmas karena masalah ketersediaan layanan, infrastruktur, keberadaan tenaga kesehatan, sistem komunikasi antar tenaga kesehatan, dan budaya kerja, serta faktor pasien dan keluarga. Namun demikian > 79 tenaga kesehatan yang terlibat bersedia untuk melanjutkan penerapan alur layanan. Model layanan efektif memperbaiki kadar kolesterol-HDL darah, tetapi untuk parameter tekanan darah, lingkar pinggang, kadar glukosa, trigliserida darah menunjukkan hasil tidak berbeda bermakna antara kelompok intervensi dan kelompok kontrol. Evaluasi parameter nonklinis yang menunjukkan hasil bermakna terbatas pada tingkat aktivitas fisik ODS, tetapi tidak untuk variabel pola diet, pengetahuan, dan kepuasan pasien. Model layanan luar gedung yang pengaturannya terpisah dari tata laksana kegiatan puskesmas dan model layanan dalam gedung yang terpisah antara layanan penyakit tidak menular PTM dan layanan jiwa, adalah sebab utama kurang mampu laksananya model yang diujikan. Proses skrining dan pemantauan berkala perlu dilakukan pada semua ODS

sebagai awal akses layanan. Peningkatan pengetahuan dan keterampilan ODS dan keluarga penting untuk meningkatkan kapasitas partisipatif, sedangkan bagi tenaga kesehatan diperlukan untuk manajemen risiko melalui skrining dan pemantauan berkala. Pengembangan tim terpadu PTM dan jiwa baik untuk kegiatan di dalam maupun luar gedung diharapkan dapat memudahkan kerja tim untuk mengatasi hambatan kesinambungan penyediaan layanan, infrastruktur, dan kesulitan akses ODS sehingga efektivitas layanan semakin baik.

.....Cardiometabolic comorbidity is higher in people with schizophrenia than in general population and this caused high mortality in productive age. A variety of management modalities for this specific health problem are available in primary to tertiary health facilities. Unfortunately, high quality and accessible comprehensive service did not exist in Indonesia. This research aimed to develop an integrated service in primary health facilities for PwS and cardiometabolic risks in public health centers in Indonesia.Using the spiral model of system development, this research followed the three phase of action research. The first phase combined quantitative comparative cross-sectional study and qualitative observation, literature review, in-depth interview, and workshop methods to identify problems, health service condition, and potential solutions as a basis for developing an integrated service model. Subjects for the quantitative research in this phase were PwS who were at the age of 18-59 years old who underwent treatment in 20 public health centers in Jakarta Special Capital Region. Qualitative data came from PwS, their families, academia, and policy makers at national and sub-national levels. Early model was developed based on modification to the WHO-PEN Package of essential noncommunicable disease interventions clinical pathway. Implementability and needs for model adjustments were evaluated from the result of solutions identification. The developed comprehensive service model was tested and evaluated quantitative and qualitatively in the second phase to see if it is feasible by means of availability of services, suitability of implementation, and availability of health workers to continue the service. Evaluation on the impact of the service model was done through quasi-experimental design to evaluate its efficacy using clinical and non-clinical parameters. Proportion of PwS with cardiometabolic risks was 88 from 216 PwS participants , from which only 6.8 had access to service for comorbidities. Quantitative and qualitative data showed that stake-holders would like to see that this integrated service model can be implemented in primary health care service PHCs 63.7 , using various existing resources, involving team approach 61.1 , and stressing on screening and periodic monitoring 59.5 . An integrated service model in the form of clinical pathway or service algorithm could not be fully implemented because of problems with service availability, infrastructures, availability of health workers, communication system among health workers, working culture, patient and family factors. In spite of that, more than 79 of health workers who were involved in the research are willing to continue implementing the service pathway. This service model was proven to be effective in controlling blood HDL-cholesterol level, but failed to show significant differences in blood pressure, waist circumference, blood glucose, and triglyceride between intervention and control groups. Evaluation on non-clinical parameters showed limited meaningful results on level of physical activities, but not on diet pattern, knowledge, and satisfaction. Extramural model, which separated arrangement from management activities in the PHC and disintegration intramural services between Non-communicable diseases NCDs and mental health services, was the main reason for the lack of efficacy in the tested model. Screening and periodic monitoring should be done for all PwS as initial access to service. Improvement of knowledge and skills of PwS and their families is important in increasing their participatory capacity and for health workers to be able to manage risks through screening and periodic monitoring. It is expected that the

development of an integrated non-communicable disease and psychiatric team, intra and extra-mural of PHCs, could overcome the barriers of continuous provision of service, infrastructure, and access of PwS.