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LAMPIRAN

Lampiran 1 JBI Critical appraisal checklist for RCT

JBI Critical Appraisal Checklist for Randomized Controlled Trials

Reviewer_____Date_____

Author _____Year_____Record Number_____

		Yes	No	Unclear	NA
1.	Was true randomization used for assignment of participants to treatment groups?	☐	☐	☐	☐
2.	Was allocation to treatment groups concealed?	☐	☐	☐	☐
3.	Were treatment groups similar at the baseline?	☐	☐	☐	☐
4.	Were participants blind to treatment assignment?	☐	☐	☐	☐
5.	Were those delivering treatment blind to treatment assignment?	☐	☐	☐	☐
6.	Were outcomes assessors blind to treatment assignment?	☐	☐	☐	☐
7.	Were treatment groups treated identically other than the intervention of interest?	☐	☐	☐	☐
8.	Was follow up complete and if not, were differences between groups in terms of their follow up adequately described and analyzed?	☐	☐	☐	☐
9.	Were participants analyzed in the groups to which they were randomized?	☐	☐	☐	☐
10.	Were outcomes measured in the same way for treatment groups?	☐	☐	☐	☐
11.	Were outcomes measured in a reliable way?	☐	☐	☐	☐
12.	Was appropriate statistical analysis used?	☐	☐	☐	☐
13.	Was the trial design appropriate, and any deviations from the standard RCT design (individual randomization, parallel groups) accounted for in the conduct and analysis of the trial?	☐	☐	☐	☐

Overall appraisal: Include ☐ Exclude ☐ Seek further info ☐

Comments (Including reason for exclusion)

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Lampiran 2 JBI Critical Appraisal for Quasi eksperimen

JBI Critical Appraisal Checklist for Quasi-Experimental Studies (non-randomized experimental studies)

Reviewer_____Date_____

Author _____Year_____Record Number_____

		Yes	No	Unclear	Not applicable
1.	Is it clear in the study what is the 'cause' and what is the 'effect' (i.e. there is no confusion about which variable comes first)?	☐	☐	☐	☐
2.	Were the participants included in any comparisons similar?	☐	☐	☐	☐
3.	Were the participants included in any comparisons receiving similar treatment/care, other than the exposure or intervention of interest?	☐	☐	☐	☐
4.	Was there a control group?	☐	☐	☐	☐
5.	Were there multiple measurements of the outcome both pre and post the intervention/exposure?	☐	☐	☐	☐
6.	Was follow up complete and if not, were differences between groups in terms of their follow up adequately described and analyzed?	☐	☐	☐	☐
7.	Were the outcomes of participants included in any comparisons measured in the same way?	☐	☐	☐	☐
8.	Were outcomes measured in a reliable way?	☐	☐	☐	☐
9.	Was appropriate statistical analysis used?	☐	☐	☐	☐

Overall appraisal: Include ☐ Exclude ☐ Seek further info ☐

Comments (Including reason for exclusion)

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Lampiran 3 Level evidance dan rekomendasi

Level	Therapy / Prevention, Aetiology / Harm	Prognosis	Diagnosis	Differential diagnosis / symptom prevalence study	Economic and decision analyses
1a	SR (with homogeneity*) of RCTs	SR (with homogeneity*) of inception cohort studies; CDR" validated in different populations	SR (with homogeneity*) of Level 1 diagnostic studies; CDR" with 1b studies from different clinical centres	SR (with homogeneity*) of prospective cohort studies	SR (with homogeneity*) of Level 1 economic studies
1b	Individual RCT (with narrow Confidence Interval"¡)	Individual inception cohort study with > 80% follow-up; CDR" validated in a single population	Validating** cohort study with good" " " reference standards; or CDR" tested within one clinical centre	Prospective cohort study with good follow-up****	Analysis based on clinically sensible costs or alternatives; systematic review(s) of the evidence; and including multi-way sensitivity analyses
1c	All or none§	All or none case-series	Absolute SpPins and SnNouts" "	All or none case-series	Absolute better-value or worse-value analyses " " " "
2a	SR (with homogeneity*) of cohort	SR (with homogeneity*) of either	SR (with homogeneity*) of Level >2	SR (with homogeneity*) of 2b and better	SR (with homogeneity*) of Level >2 economic

	studies	retrospective cohort studies or untreated control groups in RCTs	diagnostic studies	studies	studies
2b	Individual cohort study (including low quality RCT; e.g., <80% follow-up)	Retrospective cohort study or follow-up of untreated control patients in an RCT; Derivation of CDR" or validated on split-sample§§§ only	Exploratory** cohort study with good" " " reference standards; CDR" after derivation, or validated only on split-sample§§§ or databases	Retrospective cohort study, or poor follow-up	Analysis based on clinically sensible costs or alternatives; limited review(s) of the evidence, or single studies; and including multi-way sensitivity analyses
2c	"Outcomes" Research; Ecological studies	"Outcomes" Research		Ecological studies	Audit or outcomes research
3a	SR (with homogeneity*) of case-control studies		SR (with homogeneity*) of 3b and better studies	SR (with homogeneity*) of 3b and better studies	SR (with homogeneity*) of 3b and better studies
3b	Individual Case-Control Study		Non-consecutive study; or without consistently applied reference standards	Non-consecutive cohort study, or very limited population	Analysis based on limited alternatives or costs, poor quality estimates of data, but including sensitivity analyses incorporating clinically sensible variations.

4	Case-series (and poor quality cohort and case-control studies	Case-series (and poor quality prognostic cohort studies***)	Case-control study, poor or non-independent reference standard	Case-series or superseded reference standards	Analysis with no sensitivity analysis
5	Expert opinion without explicit critical appraisal, or based on physiology, bench research or "first principles"	Expert opinion without explicit critical appraisal, or based on physiology, bench research or "first principles"	Expert opinion without explicit critical appraisal, or based on physiology, bench research or "first principles"	Expert opinion without explicit critical appraisal, or based on physiology, bench research or "first principles"	Expert opinion without explicit critical appraisal, or based on economic theory or "first principles

Grades of Recommendation :

A	consistent level 1 studies
B	consistent level 2 or 3 studies ***or*** extrapolations from level 1 studies
C	level 4 studies ***or*** extrapolations from level 2 or 3 studies
D	level 5 evidence ***or*** troublingly inconsistent or inconclusive studies of any level

"Extrapolations" are where data is used in a situation that has potentially clinically important differences than the original study situation.

Lampiran 4 Risk of Bias Tools

Bias domain	Source of bias	Support for judgment	Review authors' judgment (assess as low, unclear or high risk of bias)
Selection bias	Random sequence generation	Describe the method used to generate the allocation sequence in sufficient detail to allow an assessment of whether it should produce comparable groups	Selection bias (biased allocation to interventions) due to inadequate generation of a randomised sequence
	Allocation concealment	Describe the method used to conceal the allocation sequence in sufficient detail to determine whether intervention allocations could have been foreseen before or during enrolment	Selection bias (biased allocation to interventions) due to inadequate concealment of allocations before assignment
Performance bias	Blinding of participants and personnel*	Describe all measures used, if any, to blind trial participants and researchers from knowledge of which intervention a participant received. Provide any information relating to whether the intended blinding was effective	Performance bias due to knowledge of the allocated interventions by participants and personnel during the study
Detection bias	Blinding of outcome assessment*	Describe all measures used, if any, to blind outcome assessment from knowledge of which intervention a participant received. Provide any information relating to whether the intended blinding was effective	Detection bias due to knowledge of the allocated interventions by outcome assessment
Attrition bias	Incomplete outcome data*	Describe the completeness of outcome data for each main outcome, including attrition and exclusions from the analysis. State whether attrition and exclusions were reported, the numbers in each intervention group (compared with total randomised participants), reasons for attrition or exclusions where reported, and any reinclusions in analyses for the review	Attrition bias due to amount, nature, or handling of incomplete outcome data
Reporting bias	Selective reporting	State how selective outcome reporting was examined and what was found	Reporting bias due to selective outcome reporting
Other bias	Anything else, ideally prespecified	State any important concerns about bias not covered in the other domains in the tool	Bias due to problems not covered elsewhere

*Assessments should be made for each main outcome or class of outcomes.

Lampiran 5 Checklist PRISMA

Section/topic	#	Checklist item	Reported on page #
TITLE			
Title	1	Identify the report as a systematic review, meta-analysis, or both.	cover Line 2
ABSTRACT			
Structured summary	2	Provide a structured summary including, as applicable: background; objectives; data sources; study eligibility criteria, participants, and interventions; study appraisal and synthesis methods; results; limitations; conclusions and implications of key findings; systematic review registration number.	Page xii
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known.	Page 1-3
Objectives	4	Provide an explicit statement of questions being addressed with reference to participants, interventions, comparisons, outcomes, and study design (PICOS).	Page 6
METHODS			
Protocol and registration	5	Indicate if a review protocol exists, if and where it can be accessed (e.g., Web address), and, if available, provide registration information including registration number.	Page 39
Eligibility criteria	6	Specify study characteristics (e.g., PICOS, length of follow-up) and report characteristics (e.g., years considered, language, publication status) used as criteria for eligibility, giving rationale.	Page 39
Information sources	7	Describe all information sources (e.g., databases with dates of coverage, contact with study authors to identify additional studies) in the search and date last searched.	Page 40

Search	8	Present full electronic search strategy for at least one database, including any limits used, such that it could be repeated.	Page 40
Study selection	9	State the process for selecting studies (i.e., screening, eligibility, included in systematic review, and, if applicable, included in the meta-analysis).	Page 45
Data collection process	10	Describe method of data extraction from reports (e.g., piloted forms, independently, in duplicate) and any processes for obtaining and confirming data from investigators.	Page 45
Data items	11	List and define all variables for which data were sought (e.g., PICOS, funding sources) and any assumptions and simplifications made.	Page 49
Risk of bias in individual studies	12	Describe methods used for assessing risk of bias of individual studies (including specification of whether this was done at the study or outcome level), and how this information is to be used in any data synthesis.	48
Summary measures	13	State the principal summary measures (e.g., risk ratio, difference in means).	-
Synthesis of results	14	Describe the methods of handling data and combining results of studies, if done, including measures of consistency (e.g., I^2) for each meta-analysis.	-

Section/topic	#	Checklist item	Reported on page #
Risk of bias across studies	15	Specify any assessment of risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within studies).	-
Additional analyses	16	Describe methods of additional analyses (e.g., sensitivity or subgroup analyses, meta-regression), if done, indicating which were pre-specified.	-
RESULTS			
Study selection	17	Give numbers of studies screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally with a flow diagram.	Page 51-52
Study characteristics	18	For each study, present characteristics for which data were extracted (e.g., study size, PICOS, follow-up period) and provide the citations.	Page 52

Risk of bias within studies	19	Present data on risk of bias of each study and, if available, any outcome level assessment (see item 12).	Page 66
Results of individual studies	20	For all outcomes considered (benefits or harms), present, for each study: (a) simple summary data for each intervention group (b) effect estimates and confidence intervals, ideally with a forest plot.	Page 63
Synthesis of results	21	Present results of each meta-analysis done, including confidence intervals and measures of consistency.	Page 58
Risk of bias across studies	22	Present results of any assessment of risk of bias across studies (see Item 15).	-
Additional analysis	23	Give results of additional analyses, if done (e.g., sensitivity or subgroup analyses, meta-regression [see Item 16]).	-
DISCUSSION			
Summary of evidence	24	Summarize the main findings including the strength of evidence for each main outcome; consider their relevance to key groups (e.g., healthcare providers, users, and policy makers).	Page 72
Limitations	25	Discuss limitations at study and outcome level (e.g., risk of bias), and at review-level (e.g., incomplete retrieval of identified research, reporting bias).	Page 79
Conclusions	26	Provide a general interpretation of the results in the context of other evidence, and implications for future research.	Page 80
FUNDING			
Funding	27	Describe sources of funding for the systematic review and other support (e.g., supply of data); role of funders for the systematic review.	-

From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. PLoS Med 6(7): e1000097. doi:10.1371/journal.pmed1000097

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Lampiran 6 SINTESIS GRID

NO	Author, Year, Country	Tittle	Population	Study Design	Study Aim	Intervention	Instrumen and Follow Up	Outcome
1.	(Clark et al., 2015) Amerika Serikat	Health Status and Self-care Outcomes After an Education-Support Intervention for People With Chronic Heart Failure	Jumlah partisipan 50 pasien berusia 60 tahun lebih menderita penyakit jantung kronik	Randomized control trial	Menguji efek dari dukungan pendidikan dengan menggunakan strategi untuk meningkatkan kesehatan dan perawatan diri pada orang dewasa / tua dengan penyakit jantung kronik grade 1-3.	Pendidikan dan pengembangan keterampilan dengan tindak lanjut telepon disampaikan secara individual oleh perawat spesialis **Fase pertama** disampaikan selama periode 3 bulan pertama, bertemu setiap 10 hingga 14 hari selama 1 hingga 1,5 jam **fase kedua**, 3 bulan kedua pendidikan melalui telepon	• Mini-Mental State Examination (MMSE) • Kansas City Cardiomyopathy Questionnaire (KCCQ) • Self- care ofHeart Failure Index (SCHFI)	Hasil positif terlihat dalam beberapa variabel yaitu status kesehatan pada 3 bulan pertama dilaporkan meningkat pada kelompok intervensi (p=.013) dan 3 bulan kedua (p=.034). Hasil perawatan diri : pengetahuan meningkat dari waktu kewaktu (p=.000) dibanding awal. Kemampuan perawatan diri

								termasuk pemeliharaan perawatan direplikasi dengan keyakinan diri (p=.001), manajemen perawatan diri (p=.03) dan kepercayaan diri (p=.006) meningkat dari waktu ke waktu
2.	(Moon et al., 2018), Korea	The Effect of a Telephone-Based Self-management Program Led by Nurses on Self-care Behavior,	Jumlah partisipan 38 orang, kelompok intervensi 18 kelompok kontrol 20, berusia 60-75 tahun Terdiagnosa HF 6 bulan sampai 10 tahun	Quasi eksperimen t	untuk menguji efek dari program dukungan manajemen diri berbasis telepon yang dipimpin oleh perawat pada perilaku	Kelompok eksperimen menerima program dukungan manajemen diri berbasis telepon, yang mencakup sesi pendidikan tatap muka selama 30 menit dan empat sesi konsultasi telepon dan pendidikan.	• Heart Failure Self-care Behavior 9-item (EHFScB-9) • Echocardiography and	Para peserta dalam kelompok eksperimen menunjukkan peningkatan skor perilaku perawatan diri yang signifikan (p <0,001), dan penurunan skor depresi (p =.001) dibandingkan

					perawatan diri, indeks biologis untuk fungsi jantung, dan depresi	Sesi pendidikan tatap muka dilakukan pada kunjungan pertama ke klinik rawat jalan. Setelah itu, konsultasi telepon mingguan dan sesi pendidikan dilakukan selama 4 minggu.		dengan kelompok kontrol.
3.	(Seraji & Rakhshani, 2018) Iran	Effect of education on practice and knowledge rate of hospitalized heart failure patients regarding their self-care behaviors and methods	Jumlah partisipan 140 pasien yang dirawat di Rumah sakit dengan HF, usia rata-rata 60 tahun	Quasi eksperimental	untuk menentukan efek pendidikan pada pengetahuan dan praktik pasien gagal jantung yang dirawat di rumah sakit mengenai perilaku perawatan diri mereka.	Pendidikan kesehatan diberikan melalui pidato menggunakan media buklet dan film. Kedua media diberikan kepada pasien	Kuesioner yang dibuat oleh para peneliti	skor pengetahuan kelompok intervensi (pre: 8.23±3.79, post: 21.93±2.32) p<0,001, kontrol (pre: 8.08±3.27, post: 10.10±2.03) p<0,0001. Praktik perawatan diri kelompok intervensi (pre:

								39.40±5.49, post: 66.04±3.44) p<0,001, kontrol (pre: 43.17±6.59, post: 45.33±3.64) p<0,001.
4.	(Wang et al., 2017) Cina	Effectiveness of a PRECEDE-based education intervention on quality of life in elderly patients with chronic heart failure	Partisipan berjumlah 62 pasien dengan CHF usia lebih dari 60 tahun	RCT	untuk menggunakan PRECEDE model untuk secara optimal menyesuaikan program promosi pendidikan kesehatan di antara pasien usia lanjut dengan CHF dan menyelidiki pengaruhnya terhadap	Kelompok intervensi dan kelompok kontrol sama-sama menerima perawatan konvensional namun pada Kelompok intervensi juga menerima 2 bulan intervensi pendidikan berdasarkan model PRECEDE selama 9 sesi dengan 60-90 menit setiap seminggu sekali, melalui	• Skala Perilaku Perawatan Diri Gagal Jantung Eropa (EHFScBS-9) pasien akan di follow up selama 3 bulan, selama follow up pasien disarankan melaporkan self-care setiap 2 minggu	Setelah intervensi, skor semua item kecuali item 9 (saya berolahraga secara teratur) dan skor total menurun secara signifikan pada kelompok intervensi dan secara signifikan berbeda dari yang di kelompok kontrol. Temuan ini

					depresi, perilaku perawatan diri, dan kualitas hidup	wawancara tatap muka, bahan tertulis, ceramah, tanya jawab sesi, diskusi, dan interaksi dengan pasien lain	• Kuisioner Kesehatan (PHQ-9) • Kuesioner Minnesota Living Heart Failure Questionnaire (MLHFQ)	menunjukkan bahwa intervensi pendidikan secara signifikan meningkatkan perilaku perawatan diri
5.	(Liou et al., 2015) Taiwan	The effects of a self-care program on patients with heart failure	Jumlah partisipan sebanyak 131 pasien dan terdiagnosa CHF Kelompok intervensi sebanyak 56 pasien dan kelompok kontrol 75 pasien. Pasien yang terdaftar telah melalui persetujuan tertulis	Quasi eksperimental	Menilai efektifitas program perawatan diri untuk meningkatkan pengetahuan terkait CHF dan evaluasi perubahan perawatan diri dibandingkan perawatan biasa	Tahap awal peneliti akan mengikuti pedoman praktik klinik yang dikembangkan oleh panel expert berdasarkan Riegel Self-Care Heart Failure Model. Kemudian dari program dan pengalaman tersebut mengembangkan booklet pengajaran dan rekaman video dalam bahasa mandarin dan	• Knowledge of the CHF questionnaire • self-care of HF index (SCHFI) telah ditranslasi kedalam bahasa mandarin dan telah ditinjau oleh ahli bahasa	Hasil 4 pengukuran perawatan diri menunjukkan perbedaan yang signifikan antara 2 kelompok. Efek program perawatan diri memiliki dampak yang positif pada kelompok intervensi namun tidak pada kelompok kontrol. Program perawatan diri

						Taiwan Kelompok intervensi akan menerima sesi pelatihan perawatan diri sendiri selama 1 hari setelah 1minggu masuk rumah sakit		juga memiliki efek yang signifikan pada perilaku perawatan diri selama 3 bulan, hasil ini terutama pada pemeliharaan perawatan diri, manajemen perawatan diri dan kepercayaan perawatan diri.
6.	(Siabani et al., 2015) Australia	Efficacy of a home-based educational strategy involving community health volunteers in improving self-	Jumlah partisipan 112 pasien CHF berada pada kelas II atau III NYHA	Randomized control trial	Mengevaluasi efektivitas strategi pendidikan berbasis rumah menggunakan CHV dalam meningkatkan perawatan diri pasien dengan CHF	Kelompok intervesi pertama (CHV) pendidikan secara individual diberikan oleh relawan kesehatan dirumah pasien termasuk kepatuhan pengobatan, manajemen perawatan diri	• Self-care of heart failure index (SCHFI)	Komponen perawatan diri meningkat secara signifikan pada dua kelompok intervensi untuk besaran efek termasuk maintenance (FHP: 29.5 (11.87), CHV 26.2 (12.69), managemen (FHP: 31.3 (11.80), CHV:

		care in patients with chronic heart failure in western Iran			dibandingkan dengan strategi pendidikan formal dengan kelompok kontrol yang menerima perawatan biasa di Iran barat	selama 2 jam Kelompok intervensi kedua (FHP) dikerjakan oleh seorang perawat dan dokter umum, kelas pendidikan selama 3 jam dengan istirahat 30 menit		29.4 (10.85) dan kepercayaan perawatan diri hanya megalami sedikit peningkatan (FHP: 18.1 (16.69), CHV: 9.5 (16.55) Kelompok FHP memiliki peningkatan lebih besar dibanding kelompok CHV.
7.	(Sun et al., 2019) Cina	Application of self-care based on full-course individualized health education in patients with chronic heart failure	100 partisipan terdiagnosis CHF oleh AHA dan termasuk kelas II atau lebih berdasarkan klasifikasi NYHA	Randomized control trial	Untuk menyelidiki penerapan perawatan diri berdasarkan pendidikan kesehatan individual kursus penuh (FCIHE) dan faktor-faktor yang mempengaruhinya pada	• Kelompok kontrol menerima perawatan rutin, bimbingan kesehatan rutin dan tindak lanjut melalui telepon 2 minggu setelah keluar dari RS • Kelompok intervensi menerima FCIHE.. selama 3 hari	• Self-care of heart failure index (SCHFI) • 36-item short form health survey (SF-36) berisi delapan sub-skala, termasuk fungsi fisik, keterbatasan peran karena masalah	skor perilaku perawatan diri tidak menunjukkan perbedaan yang signifikan saat masuk antara kedua kelompok (P> 0,05). Namun, pada 3 dan 6 bulan setelah pulang, skor total pemeliharaan perawatan diri,

		and its influencing factors			pasien dengan gagal jantung kronis (CHF).	rancangan dimodulasi dalam bentuk jadwal harian. Tindak lanjut dilakukan setelah pulang melalui platform medis berbasis internet.	fisik, sakit tubuh, persepsi kesehatan umum, vitalitas, fungsi sosial, pembatasan peran karena masalah emosional, dan kesehatan mental.	manajemen, kepercayaan diri, dan perilaku secara signifikan lebih tinggi pada kelompok intervensi daripada kelompok kontrol (P <0,05)
8.	(Y. Chen et al., 2018) Cina	Effectiveness of a multidisciplinary disease management program on outcomes in patients with heart failure in	62 partisipan dibagi dalam 2 kelompok dan terdiagnosis CHF dengan kelas NYHA II s/d IV	Randomized control trial	Menilai efektifitas MDMP pada kualitas hidup, kinerja fisik, gejala depresi, perilaku perawatan diri dan penerimaan kembali di rumah sakit	Pendidikan diawali oleh seorang ahli jantung termasuk pengenalan terkait penyakit jantung, pengendalian berat badan, pemantauan input dan output serta apa yang dilakukan jika kondisi memburuk, keterampilan perawatan diri, kepatuhan pengobatan dan rekomendasi diet disampaikan secara	• MLHFQ adalah kuesioner untuk menilai kualitas hidup • European Heart Failure Self-care Behavior Scale (EHFScBS) untuk mengukur	skor pada MLHFQ atau kualitas hidup sebagai hasil primer meningkat sebesar 37% pada kelompok kontrol dan. 66% pada kelompok MDMP (intervensi).Variasi dalam perilaku perawatan diri sebagai hasil

		China			pada pasien CHF	individual	perilaku perawatan diri	sekunder setelah intervensi keduanya signifikan pada hari 90 dan hari 180 -6.90 ± 1.00 P <0,001; -8.29 ± 0.88 P<0.001) masing-masing pada kelompok intervensi dibandingkan sebelum intervensi.