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L'éducation thérapeutique du patient

La place des médecins généralistes

Bibliographie thématique

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Sommaire

Problématique : l'éducation thérapeutique du patient, un atout dans la gestion des maladies chroniques

Face à la montée des maladies chroniques dans nos sociétés modernes, de nombreuses études ont démontré que l'éducation (thérapeutique) du patient (ETP) était un facteur important d'amélioration du parcours de soins des patients souffrant de telles pathologies. Génératrice à la fois d'une meilleure observance thérapeutique et d'une meilleure qualité de vie chez le patient, elle répond aussi à un changement plus général de pratique, incluant le patient dans la prise en charge de sa maladie avec les concepts « d'empowerment », d'« accompagnement » ou de « care »[1].

En France, l'éducation du patient s'est développée à partir des années 90, de manière non structurée et non coordonnée, alors qu'il n'existait pas d'encadrement juridique. Les premiers programmes d'éducation thérapeutique ont été conçus et mis en œuvre essentiellement en milieu hospitalier ou dans des réseaux de santé par des professionnels de santé. Le développement s'est ensuite poursuivi avec un accompagnement des pouvoirs publics à partir de l'année 2005, et, plus particulièrement, dans le cadre de la définition du plan pour l'amélioration de la qualité de vie des personnes atteintes de maladies chroniques 2007-2011. La loi portant réforme de l'hôpital et relative aux patients, à la santé et aux territoires (Loi HPST) du 21 juillet 2009 a introduit l'ETP par son article 84 dans le droit français. Enfin deux nouveaux textes publiés fin décembre 2020 au Journal officiel remplacent le régime d'autorisation des programmes d'éducation thérapeutique du patient par un régime de déclaration à compter du 1er janvier 2021 et fixent le cahier des charges d'un programme d'éducation thérapeutique du patient[2].

En matière d'éducation du patient (Patient education), il n'existe pas de modèle européen type. Chaque pays a développé sa propre approche, en fonction de l'organisation de son système de soins et des expérimentations qui ont été conduites. Le mode de financement est également très variable d'un pays à un autre en fonction de l'organisation du système de protection sociale. L'éducation du patient a tout d'abord été majoritairement mise en œuvre dans les établissements de santé, sous l'impulsion de professionnels de santé hospitalo-universitaires convaincus de l'intérêt de cette nouvelle approche. Les programmes se sont ensuite étendus au secteur ambulatoire en étant financés principalement par les systèmes de protection sociale ou les assureurs privés. Les ministères chargés de la santé ont accompagné la démarche sans toutefois que des cadres législatifs ou réglementaires soient définis, la France faisant exception dans ce domaine[3].

Cette bibliographie a été réalisée dans le cadre d'un projet de recherche en cours à l'Irdes sur la thématique de l'éducation thérapeutique du patient en médecine générale. Les recherches ont été effectuées sur les bases : Irdes, Banque de données en santé publique (Bdsp), Cairn, Cochrane, Medline, Sciencedirect, Santécom sur la période 2008-2020. Quelques documents de référence ont été sélectionnés sur la période antérieure. Le périmètre géographique retenu concerne les pays de l'OCDE. Les mots-clés croisés dans les différentes stratégies de recherche sont principalement les suivants : patient education, self management, self care, education – medical training, primary health care, family practice, general practice, general practitioners, physicians, patient centered care, qualitative study, qualitataive research.

Cette bibliographie constitue une première étape de recherche documentaire, que nous mettons à disposition de la communauté scientifique. Néanmoins, elle reste extensive et ne prétend pas à l'exhaustivité. Les documents identifiés sont accompagnés des résumés.

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[1] HCSP (2015). Avis relatif à la mise en oeuvre de l'éducation thérapeutique du patient depuis la loi n°2009-879 du 21 juillet 2009 portant réforme de l'hôpital et relative aux patients, à la santé et aux territoires (HPST).

[2] Décret du 31 décembre 2020 et Arrêté du 30 décembre 2020

[3] Jacquat, D. r. (2010). Éducation thérapeutique du patient : propositions pour une mise en oeuvre rapide et pérenne. Rapport au Premier ministre.

L'éducation thérapeutique du patient : concepts, théorie et politique

FOCUS : UN ESSAI DE DEFINITION

Le terme d'éducation thérapeutique du patient a été utilisé pour la première fois en Suisse, à la fin des années 90 – l'objectif étant le remboursement de ces pratiques par l'assurance maladie. Le terme a été ensuite repris en 1998 par l'Organisation mondiale de la santé (OMS) qui définit ainsi l'éducation thérapeutique du patient : « l'éducation thérapeutique du patient est un processus continu, intégré dans les soins et centré sur le patient. Il comprend des activités organisées de sensibilisation, d'information, d'apprentissage et d'accompagnement psychosocial concernant la maladie, le traitement prescrit, les soins, l'hospitalisation et les autres institutions de soins concernées, et les comportements de santé et de maladie du patient. Il vise à aider le patient et ses proches à comprendre la maladie et le traitement, coopérer avec les soignants, vivre le plus sainement possible et maintenir ou améliorer la qualité de vie. L'éducation devrait rendre le patient capable d'acquérir et maintenir les ressources nécessaires pour gérer de manière optimale sa vie avec la maladie ».

En France, l'article 84 de la Loi Hôpital Patients Santé et Territoires (HPST) définit l'ETP en distinguant l'éducation thérapeutique et l'accompagnement du malade : « L'ETP s'inscrit dans le parcours de soins du patient. Elle a pour objectif de rendre le patient plus autonome en facilitant son adhésion aux traitements prescrits et en améliorant sa qualité de vie. Elle n'est pas opposable au malade et ne peut conditionner le taux de remboursement de ses actes et des médicaments afférents à sa maladie ». … « Les actions d'accompagnement font partie de l'éducation thérapeutique. Elles ont pour objet d'apporter une assistance et un soutien aux malades, ou à leur entourage, dans la prise en charge de la maladie. »

Les autres pays européens parlent d'éducation du patient (Patient education) et n'ont pas instauré de cadre réglementaire.

ÉTUDES FRANÇAISES

Abidli, Y., Piette, D. et Casini, A. (2015). "Proposition d'une méthode conceptuelle d'accompagnement du patient partenaire de soins." Santé Publique **27**: 31-39, fig.

> [BDSP. Notice produite par EHESP R0x8CHnk. Diffusion soumise à autorisation]. L'accompagnement du patient co-actif dans sa prise en charge fait l'objet d'un large consensus à travers le monde. Toutefois, en pratique, on relève peu d'approches "patient partenaire de soins" (PPS). Le postulat posé par les auteurs est que le manque d'investissement dans l'accompagnement du patient partenaire de soin est lié au manque d'intérêt porté aux compétences qui sont nécessaires aux soignants pour un tel accompagnement. Cet article veut répondre à cette lacune. La méthode PPS est étudiée, adaptée et développée au départ de modèles existants. Elle complète, harmonise et intègre différents courants nés autour de ce besoin de replacer le patient au centre de ses soins et de sa vie en général. La méthode PPS comporte sept étapes par lesquelles le professionnel accompagne le patient dans son processus de soin. L'approche méthodologique de formation des professionnels à cette méthode vise à faire vivre aux professionnels le changement et la difficulté du changement qu'ils attendent du patient dans la relation de soin.

Aissou, M., Danos, J. P. et Jolivet, A. (2016). Structurer les parcours de soins et de santé : politiques, méthodes et outils pour la mise en oeuvre de la loi Santé. Bordeaux, LEH Editions

> Au cours des cinquante dernières années, le système de santé français a été construit autour de l'hôpital et des spécialités médicales pour les malades en phase aiguë. Ce système souffre d'importants cloisonnements, notamment avec le secteur médico-social ainsi qu'auprès des professionnels de santé de ville. Enfin, l'accès aux soins est loin d'être égalitaire sur le territoire français. Depuis bientôt une dizaine d'années et notamment avec la loi HPST, est apparue une autre manière de structurer notre système de santé. La montée en puissance de la notion de parcours de soins et de santé conduit à repenser notre système de santé et médico-social autour du patient et de ses besoins, dans un périmètre territorialisé. La stratégie nationale de santé intègre le vieillissement de la population et la prédominance des maladies chroniques et la nécessité de l'égalité d'accès aux soins. L'un des axes majeurs de la loi Santé est d'organiser les soins autour des parcours des patients

et en garantir l'égal accès. Mais comment mettre en oeuvre les nouvelles pratiques impliquées par cette loi inédite ? Cela revient à donner aux soins primaires et au médecin traitant un rôle pivot dans la gestion et l'accompagnement de ce parcours de soins et de santé. "L'organisation des soins doit être simplifiée, décloisonnée, recentrée autour du médecin traitant, articulant les interventions des professionnels, services et établissements d'un territoire autour de parcours." D'autre part, il s'agit de promouvoir des "prises en charge globales (promotion de la santé, éducation thérapeutique, dépistage, parcours pour maladies chroniques, handicap et perte d'autonomie, prise en charge de l'entourage, recherche coordonnée.)". Pour beaucoup de professionnels du monde de la santé, il s'agit d'une révolution copernicienne qui implique de penser, d'organiser et d'agir autrement. Le présent ouvrage est conçu comme un mode d'emploi de la loi Santé pour sa partie concernant la structuration des parcours de soins et de santé. Élaboré par des consultants, il offre des méthodologies, des outils et des exemples de pratiques avancées.

Albano, M. G., Gagnayre, R., de Andrade, V., et al. (2020). "L’éducation précédant la sortie de l’hôpital : nouvelle forme d’éducation thérapeutique. Critères de qualité et perspectives d’application à notre contexte." Rech Soins Infirm **141**(2): 70-77.
https://www.cairn.info/revue-recherche-en-soins-infirmiers-2020-2-page-70.htm

L’ETP sh (Éducation thérapeutique précédant la sortie de l’hôpital) est une pratique développée sous le nom de « discharge education » dans les pays anglo-saxons. Cette nouvelle forme d’éducation thérapeutique s’adresse à des patients aigus ou chroniques et intéresse toutes les spécialités hospitalières ; elle vise à faciliter la transition hôpital-domicile et éviter les réadmissions précoces. Cet examen de 43 études scientifiques porte spécifiquement sur la description, l’analyse et l’évaluation de l’ETP sh, ainsi que sur des recommandations. Près de la moitié des études sont publiées dans des revues de sciences infirmières. L’ETP sh est une intervention éducative intense et brève (de 30 minutes à une heure) délivrée majoritairement dans des situations aiguës. La pédiatrie représente, avec les soins postopératoires, le plus grand nombre de publications. Dans la plupart des études, l’ETP sh se révèle efficace pour améliorer des paramètres cliniques et psychosociaux, réduire les réadmissions précoces, augmenter les compétences et l’observance des patients. Pour atteindre ses buts, l’ETP sh doit être structurée et comporter un suivi systématique. Centrée sur les besoins, les capacités d’apprentissage du patient, elle fait appel à une pédagogie spécifique, interactive, à laquelle les soignants doivent être formés. L’analyse de la recherche internationale ne laisse aucun doute sur les apports positifs de l’ETP sh. Il serait important que soignants et décideurs s’en saisissent comme une opportunité d’améliorer la qualité des soins et de les humaniser.

Albano, M. G., Gagnayre, R., de Andrade, V., et al. (2020). "[Discharge education, a new type of therapeutic patient education. Quality criteria and perspective of application to our context]." Rech Soins Infirm(141): 70-77.

Patient education prior to discharge from hospital is a practice developed under the name of "discharge education" (DE) in the Anglo-Saxon countries. This new form of patient education targets acute and sometimes chronic patients and concerns all hospital specialties ; it aims to facilitate the transition "hospitalhome" and avoid early readmissions. In this article we want to outline a framework of indications and effects of DE, starting from an analysis of the international literature, and identify its quality criteria in order to forecast the conditions of its application to our context. A scoping review allowed us to examine 43 scientific studies specifically related to the description, analysis and evaluation of discharge education, as well as some recommendations. Almost half of the studies are published in Nursing Science journals. DE is an intense and short educational intervention (30 minutes to an hour) delivered mainly in acute situations. Paediatrics has the largest number of publications together with post-operative care. In most studies, DE is effective in improving clinical and psychosocial parameters, reducing early admissions, increasing skills and patient compliance. To achieve its goals, DE must be structured and include systematic follow up. Focused on the patient's needs and his learning ability, it uses a specific interactive pedagogy to which caregivers must be trained. The analysis of the international research leaves no doubt about the positive contributions of DE. It would be important for caregivers and policymakers to look at it as an opportunity to improve the quality of care and to humanize it.

Apima (2011). Sophia : Evaluation médico-économique du programme d'accompagnement des patients diabétiques. Evaluation à un an, Paris : Apima
http://www.apima.org/img_bronner/sophia_Eval_medico_eco.pdf

Ce document disponible sur le site d'Union Généraliste est une nouvelle présentation des résultats communiqués par la caisse nationale d?assurance maladie (Cnamts) lors de son point presse du 10 mars 2011. Le rapport complet (81 pages), réalisé par le bureau d'études Cemka-Eval, devait faire l'objet d'un article, rendant compte de l'ensemble des résultats de l'évaluation, dans une revue scientifique à comité de lecture, indique cette synthèse de 8 pages (a priori la Revue d'épidémiologie et de santé publique)

Artu Dumont, C., Péries, M. A., Tyzio, S., et al. (2019). "[Therapeutic education in children, progress and perspectives]." Soins Pediatr Pueric **40**(309): 35-38.

Therapeutic education in paediatrics forms part of the child's care pathway, from the discovery of the chronic disease, through to adulthood. Around fifteen years ago, this specific healthcare activity resulted in the creation of a multiple pathology therapeutic education centre at Robert-Debré university hospital in Paris. The centre has continued to develop over the years and further improved its interventions.

Ascodocpsy (2014). Education thérapeutique et maladie chronique, Lyon : Ascodocpsy
http://www.ascodocpsy.org/wp-content/uploads/2013/05/Biblio_EPM_educ_-therapeutique_maladie_chronique_201409.pdf

Dossier bibliographique contenant des références d'articles, d'ouvrages, rapports et études en ligne ainsi des textes officiels concernant l'éducation thérapeutique en lien avec les maladies chroniques.

Assemblée Nationale (2010). Éducation thérapeutique du patient : propositions pour une mise en oeuvre rapide et pérenne. Rapport au Premier ministre. Assemblée, N. Paris : Assemblée nationale.
http://www.ladocumentationfrancaise.fr/rapports-publics/104000364/index.shtml

En janvier 2010, le Premier ministre avait chargé une mission parlementaire d'élaborer des propositions concrètes susceptibles d'assurer un déploiement national rapide et pérenne des programmes d'éducation thérapeutique du patient (ETP), programmes inscrits désormais dans le parcours de soins par l'article 84 de la loi du 21 juillet 2009 portant réforme de l'hôpital et relative aux patients, à la santé et aux territoires. Il estimait que des incertitudes concernant notamment le mode de financement ou l'organisation pratique de ces programmes pourraient être de nature à entraver l'émergence de programmes de qualité. Ce rapport présente les travaux et conclusions de la mission parlementaire conduite par le député Denis Jacquat. Dans un premier point, la mission présente un état des lieux de l'ETP en France puis à l'étranger en concentrant son étude sur quatre pays européens ayant, soit une antériorité importante (Suisse, Belgique), soit des approches différentes avec des points d'ancrage hospitaliers (Pays-Bas) ou ambulatoires (Allemagne). Puis, dans un deuxième point, sur la base d'un certain nombre de constats - développement de l'ETP en France depuis une vingtaine d'années conduit sur un mode non structuré et non coordonné essentiellement en milieu hospitalier, formation initiale des professionnels de santé à l'ETP quasi inexistante, absence de structures dans le champ ambulatoire-la mission présente une vingtaine de propositions. Elle appelle notamment à la mise en place d'une politique nationale de l'ETP s'appuyant sur l'existant et associant organisations de patients, sociétés savantes et autorités compétentes. Elle appelle également à un effort conséquent de formation et à un positionnement de l'ARS au coeur du dispositif

Baudet, M., Daugareil, C., Laulom, P., et al. (2019). "[Therapeutic education in primary cardiovascular prevention]." Ann Cardiol Angeiol (Paris) **68**(1): 49-52.

BACKGROUND: As primary prevention against cardiovascular diseases, Patient Therapeutic Education helps to develop a protective lifestyle within a socioeconomic context where risk factors abound.

PATIENTS AND METHODS: Patient Therapeutic Education offers those eager to protect their cardiovascular health a program of six workshops. Upon enrolment, a Program aide conducts an educational diagnosis with the patient, specific to each workshop theme, so that he might understand the clinical, socio-professional, cognitive and psycho-affective dimensions. An evaluation of each workshop is requested from participants in the form of open and closed questions. RESULTS: The study comprised 2225people, majority women (79%), relatively old (age 63.9for women, 66.3for men), most often retired (65%). An analysis of the educational diagnosis notes a great frequency of classic risk factors; a good knowledge of the factors favoring them contrasting with the weak means implemented in everyday life to reduce their impact; the great majority of participants (68%) believe they have a well balanced diet; patients are greatly involved in their own health, with a slight external locus involving the general practitioner, the immediate entourage and society. The notes of the evaluation are usually maximum. CONCLUSION: Patient Therapeutic Education arouses strong interest in the public, allows a personalized approach that optimizes learning, increases knowledge and facilitates the use of new protective practices.

Baudier, F. et Leboube, G. (2007). Éducation thérapeutique du patient et disease management : pour une 3e voie "à la française" ? Sante Publique(4)
Éducation thérapeutique.

[BDSP. Notice produite par ENSP PR0x7i4b. Diffusion soumise à autorisation]. Il y a un peu plus de dix ans, les auteurs étaient quelques-uns à penser que le développement de l'éducation thérapeutique du patient (ETP) était un enjeu majeur pour améliorer l'offre de santé dans notre pays et la qualité de la prise en charge des patients atteints de pathologies chroniques. C'est au sein du Comité français d'éducation pour la santé (CFES), actuel Institut national de prévention et d'éducation pour la santé (INPES), que les auteurs agissent dans ce sens auprès des institutions, syndicats ou sociétés savantes concernés. Les échos étaient positifs mais une certaine prudence était affichée pour un domaine encore mal identifié entre "soins" et "prévention"

Baudier, F., Prigent, A. et Leboube, G. (2007). Le développement de l'éducation thérapeutique du patient au sein des régions françaises. Sante Publique(4)
Éducation thérapeutique.

[BDSP. Notice produite par ENSP 1srR0x1A. Diffusion soumise à autorisation]. L'éducation thérapeutique du patient (ETP) constitue une offre de soins et de prévention nouvelle en France. Ce travail présente un état des lieux sur son organisation actuelle. Il a été réalisé à partir d'un questionnaire adressé à l'ensemble des Unions régionales des caisses d'assurance maladie (URCAM). La presque totalité des régions bénéficient d'un groupe de pilotage régional, le plus souvent animé par l'Assurance maladie. Le développement de l'ETP est très majoritairement structuré au sein du Plan régional de santé publique. Les formations destinées aux professionnels de santé restent encore très erratiques. L'hôpital continue à jouer, avec les réseaux de santé, un rôle moteur dans le développement de l'ETP. L'implication du médecin traitant et l'organisation d'une offre de qualité (à travers la publication de plusieurs cahiers des charges) sont des priorités.

Baumann, l., Bohme, P., Criton, C., et al. (2017). L'ETP au fil des mots : Glossaire en éducation thérapeutique du patient, Nancy : Pôle lorrain de compétences en ETP
http://www.etp-lorraine.fr/wordpress/wp-content/uploads/glossaire.pdf

L'éducation thérapeutique du patient (ETP) au fil des mots est un projet lorrain de constitution d’une ressource terminologique en éducation thérapeutique du patient (ETP) réunissant l’Inist-CNRS, le CHRU de Nancy, l’école de santé publique de l’Université de Lorraine (ESP), l’ARS Grand Est, le Pôle lorrain de compétences en ETP et le réseau Régional LORDIAMN. Son objectif est de servir au partage des savoirs disciplinaires et des compétences au sein de la communauté des professionnels de l’ETP. L’idée est de proposer chaque mois plusieurs concepts cœur, avec des définitions issues des grandes instances de santé et/ou de publications scientifiques en ETP.

Beauchamp, I., Guiraud-Baro, E., Bougerol, T., et al. (2010). "Education thérapeutique des patients psychotiques : impact sur la ré-hospitalisation." Education Therapeutique Du Patient **2**(2): 93-104.
http://www.etp-journal.org/articles/tpe/abs/2010/02/tpe10014/tpe10014.html

> La schizophrénie est une pathologie chronique, la non-observance au traitement avoisinant les 50 %, avec, en résultat, un taux de ré-hospitalisation de 75 %. Cette étude évalue l'impact d'un dispositif d'éducation thérapeutique sur la diminution du taux de rechute avec hospitalisation à 14 mois, chez des patients psychotiques.

Ben Aroyo, A. (2010). La philosophie du soins : éthique, médecine et société, Paris : Presses Universitaires de France
http://www.decitre.fr/livres/La-philosophie-du-soin.aspx/9782130582038

> Le soin ne désigne pas seulement un domaine particulier de l'activité médicale, au sens où l'on parle par exemple des soins infirmiers ou des soins palliatifs. Il ne correspond pas non plus à un " supplément d'âme " de la médecine, mais il en constitue une, sinon la finalité essentielle. Car le soin est aujourd'hui le point où s'articulent la médecine, l'éthique et la société dans leur ensemble, à la fois dans les expériences, les pratiques et les institutions. Partout, le soin est une référence, un souci et une valeur, parfois un prétexte et un leurre, toujours un problème. Le but de cet ouvrage est de décrire et d'interroger le soin sous tous ses aspects et à partir de disciplines et d'approches différentes dans les champs de la médecine, de la philosophie et des sciences sociales. Destiné aux philosophes, médecins, citoyens, soignants mais aussi soignés que nous sommes ou serons tous un jour, il fait apparaître combien le soin nous aide à penser au plus près le moment actuel

Bertrand, D. (2011). "Education thérapeutique du patient en France." Bulletin de L'Academie Nationale de Medecine **195**(7).

> L'éducation thérapeutique du patient prend une part de plus en plus privilégiée dans la stratégie thérapeutique médicale, dans les maladies chroniques. Or, les affections de longue durée (ALD) représentent 12 % de la population et augmenteront dans les prochaines années. L'ETP a pour objectif de responsabiliser et de solliciter la participation active du patient au processus de soins afin d'améliorer la prise en charge de la maladie et de la qualité des soins. La loi Hôpital Patients Santé et Territoire a inscrit ce principe dans le Code de la santé publique en différenciant l'éducation thérapeutique personnalisée, les actions d'accompagnement et les programmes d'apprentissage.

Blanchard, P., Eslous, L., Yeni, I., et al. (2014). Evaluation de la coordination d'appui aux soins. Rapport Igas ; 2014-010R. Paris IGAS**:** 123.
http://www.igas.gouv.fr/IMG/pdf/2014-010R_Evaluation_coordination_appui_soins.pdf

> A la demande de la ministre en charge de la santé, l'IGAS a été chargée de « procéder à un inventaire et à une analyse de l'ensemble des coordinations d'appui aujourd'hui déployées ». Cette mission a été envisagée dans le cadre de la Stratégie nationale de santé (SNS). Après un diagnostic de la situation, le rapport propose une nouvelle organisation de la coordination d'appui aux soins, reposant sur l'initiative des médecins. La coordination d'appui aux soins proposée est ainsi destinée à éviter toute rupture dans la prise en charge globale des patients grâce à la mobilisation de l'ensemble des professionnels qui peuvent y concourir. Concrètement, la mission propose que ce soit le médecin de premier recours, et lui seul, qui puisse la déclencher en concertation avec le patient. Le médecin de premier recours pourrait ainsi choisir de recourir à différentes modalités en fonction de sa pratique et de ses habitudes.

Böhme, P., Nguyen Thi, P. L., Germain, L., et al. (2018). Connaissance, perception et définition du concept « Patient Partenaire de Soins » : données d'une enquête lorraine réalisée au cours d'un séminaire sur l'éducation thérapeutique. X congres francophone de psychologie de la santé. Metz, France.
https://hal.univ-lorraine.fr/hal-02963859

Borot, S., Benhamou, P. Y., Atlan, C., et al. (2018). "Practical implementation, education and interpretation guidelines for continuous glucose monitoring: A French position statement." Diabetes Metab **44**(1): 61-72.

> The use by diabetes patients of real-time continuous interstitial glucose monitoring (CGM) or the FreeStyle Libre(®) (FSL) flash glucose monitoring (FGM) system is becoming widespread and has changed diabetic practice. The working group bringing together a number of French experts has proposed the present practical consensus. Training of professionals and patient education are crucial for the success of CGM. Also, institutional recommendations must pay particular attention to the indications for and reimbursement of CGM devices in populations at risk of hypoglycaemia. The rules of good practice for CGM are the precursors of those that need to be enacted, given the oncoming emergence of artificial pancreas devices. It is necessary to have software combining user-friendliness, multiplatform usage and average glucose profile (AGP) presentation, while integrating glucose and insulin data as well as events. Expression of CGM data must strive for standardization that facilitates patient phenotyping and their follow-up, while integrating indicators of variability. The introduction of CGM involves a transformation of treatment support, rendering it longer and more complex as it also includes specific educational and technical dimensions. This complexity must be taken into account in discussions of organization of diabetes care.

Bourdillon, F. et Grimaldi, A. (2007). "Éducation thérapeutique du patient ou disease management." Sante Publique(4).

> [BDSP. Notice produite par ENSP JR0xg9lD. Diffusion soumise à autorisation]. Depuis quelques années, il existe une prise de conscience de l'importance de la prise en charge des maladies chroniques. Au-delà de leur diagnostic et du traitement à mettre en oeuvre, on s'accorde à penser qu'il est important que les patients comprennent leur maladie et leur traitement et concilient leur projet de vie avec les contraintes de leur maladie et celles de leur traitement. De nombreuses études montrent les bénéfices d'une stratégie d'éducation thérapeutique du patient sur la qualité de vie, la réduction du nombre de complications, la diminution du nombre d'hospitalisations. L'observance thérapeutique est meilleure et les exigences hygiéno-diététiques mieux prise en compte. La question qui est posée est celle de l'intégration durable de l'éducation thérapeutique du patient dans notre système de santé. Les uns proposent le renforcement des dispositifs et des structures d'éducation thérapeutique existants, des modes de rémunération forfaitaire, et une harmonisation des modes de financement. Les autres jugent que le système de santé actuel n'est pas adapté et proposent de s'inspirer d'exemples anglo-saxons appeler "chronic care model" et suggèrent l'expérimentation de programme de "disease management"

Bourhis Cathy, T. F. (2013). "Éducation pour la santé : mieux s'adapter aux attentes des parents. Résultats d'une enquête quantitative et qualitative dans le Morbihan." Sante Publique**25**(1).

> [BDSP. Notice produite par EHESP nR0xG9Cs. Diffusion soumise à autorisation]. Les actions d'éducation pour la santé menées auprès des enfants et des adolescents sont plus efficaces si leurs objectifs sont partagés, soutenus et relayés par les parents. Les professionnels, les politiques et les institutionnels recherchent donc leur implication. Cependant, ils partagent une même interrogation : comment mobiliser les parents ? Pour dépasser la difficulté à mobiliser les parents, il est utile d'interroger directement leurs préoccupations et leurs attentes. Les professionnels doivent ensuite adapter les réponses qu'ils proposent aux besoins et demandes qu'ils ont identifiés. Cette mise en perspective est un principe méthodologique et éthique de base en éducation pour la santé dont l'application requiert une capacité à renouveler les regards et les pratiques en s'attachant à prendre en compte les attentes réelles des populations

Bousquet, F., Van Dererf, Fago-6Camapgna, A., et al. (2015). La prévention du diabète de type 2 par des programmes de changement des modes de vie : quels enseignements des expériences de mise en oeuvre "en vie réelle" : une analyse de la littérature, Paris : Cnam

> Cette étude a été réalisée par un groupe de travail de la Caisse nationale de l'Assurance maladie des travailleurs salariés. Elle a visé à éclairer les réflexions du groupe d'experts sur la prévention primaire

du diabète de type 2 dont les conclusions et les recommandations sont présentées dans un second document intitulé « Introduction d'un programme pilote de prévention du diabète de type 2 chez les personnes à haut risque : avis et recommandations du groupe d'experts ». Cette étude ne constitue pas une revue de littérature systématique et exhaustive, mais elle couvre néanmoins très largement les données disponibles publiées dans la littérature académique ou grise. A cet égard, nous remercions les membres du groupe des experts qui nous ont fourni de nombreuses références. Par ailleurs, cette étude a pu être enrichie par l'organisation d'un séminaire international organisé en mai 2014.

Brahmy, B. (2007). "L'éducation à la santé en milieu pénitentiaire en questions." Actualite Et Dossier En Sante Publique(61-62).
http://www.hcsp.fr/hcspi/docspdf/adsp/adsp-61/ad611798.pdf

[BDSP. Notice produite par EHESP JI9EHR0x. Diffusion soumise à autorisation]. Bien que la loi prévoie l'éducation à la santé pour les détenus, quelques questions sur sa définition et les conditions de sa mise en oeuvre se posent

Bras, P. L., Duhamel, G. et Grass, E. (2006). "Améliorer la prise en charge des malades chroniques : les enseignements des expériences étrangères de disease management." Pratiques Et Organisation Des Soins **37**(4).
http://www.ameli.fr/fileadmin/user_upload/documents/Disease_management1.pdf

Depuis le début des années 90, les programmes américains de disease management ont été une des réponses des assureurs privés américains à l'épuisement du modèle du managed care. Ils se matérialisent pour l'essentiel par des communications téléphoniques réalisées par des infirmières vers les patients à partir de centres d'appels. Leur succès réside dans leur capacité à exercer quatre fonctions mal assumées dans le système de soins : l'éducation thérapeutique, la motivation des patients (coaching), la coordination des soins et le suivi de l'état de santé des malades chroniques. La qualité de la stratification des patients est essentielle, en s'appuyant parfois sur des modèles prédictifs. Cette démarche se développe en parallèle de l'action du médecin sans de réelles interactions. Le succès de ces interventions est relativement consensuel sur le plan sanitaire. Il est plus débattu sur le plan financier. En particulier, la logique selon laquelle l'intervention est autofinancée par les économies qu'elle génère, est difficile à vérifier et débattue. Elle n'est certainement pas avérée pour toutes les pathologies. La démarche se concentre sur un petit nombre de pathologies : diabète, insuffisances respiratoires, maladies cardio-vasculaires. La France gagnerait à envisager cette démarche. Les transpositions du disease management en Allemagne et au Royaume-Uni montrent que le contexte général du système de soins implique souvent d'importantes adaptations du modèle américain. Ils montrent aussi que le succès n'est pas certain. C'est pourquoi, dans un premier temps, une expérimentation pourrait être envisagée dans plusieurs régions par l'Assurance maladie, dans des conditions de nature à garantir une évaluation des résultats et en ménageant la capacité pour elle de se désengager. Plusieurs questions sont posées pour définir le contenu de cette expérimentation, notamment celle des relations avec les médecins

Brun, N., Hirsch, E. et Kivits, J. e. A. (2011). Rapport de la mission « Nouvelles attentes du citoyen, acteur de santé ».
http://www.ladocumentationfrancaise.fr/rapports-publics/114000098/index.shtml

Le présent rapport fait partie des trois missions confiées dans le cadre du dispositif « 2011, année des patients et de leurs droits », dont le thème principal porte sur le droit des patients et de leurs proches dans les établissements de santé. Le rapport s'intéresse à la place des patients dans le système de santé, aux nouveaux comportements (usage de l'Internet) et aux nouvelles attentes concernant la gestion de leur santé. Un chapitre est consacré à l'éducation thérapeutique et aux programmes d'accompagnement pour les personnes atteintes d'une maladie chronique. Le rapport fait également le point sur les transformations liées aux nouvelles technologies de la santé, dont la télémédecine

Cambon, M. (2018). Education thérapeutique du patient et maladies chroniques : Bibliographie sélective, Toulouse : Ireps
https://www.ireps-occitanie.fr/se-documenter/bibliographies/download/139/266/21.html

> Cette bibliographie sélective, régulièrement mise à jour, est réalisée dans le cadre de la formation "Conception et animation d'un programme d'ETP". Elle donne le cadre législatif de l'ETP et signale de nombreux documents de référence. Ces références sont également accompagnées de listes de ressources pédagogiques, revues électroniques et sites internet-ressource. Un système de signets et un sommaire interactif facilitent votre navigation dans les différentes parties de la bibliographie.

Cemka-Eval (2013). Evaluation médico-économique du programme d'accompagnement des patients diabétiques Sophia : Evaluation à 1 an. Eval.Paris.FRA, C.-.
http://www.ameli.fr/fileadmin/user_upload/documents/Evaluation_sophia_a_1_an.pdf

> La Caisse Nationale de l'Assurance Maladie des Travailleurs Salariés (Cnamts) a mis en place un programme d'accompagnement différencié des patients présentant des maladies chroniques et s'adressant dans un premier temps à l'ensemble des diabétiques de type 1 et 2 volontaires répondant à un ensemble de critères d'inclusion et d'exclusion définis. Ce programme propose des conseils et des informations adaptés à la situation de chaque personne, en relais des recommandations du médecin traitant. Il vise à permettre une meilleure prise en charge des patients diabétiques, à améliorer leur état de santé, leur qualité de vie et à maîtriser l'augmentation des coûts de prise en charge. L'objectif de ce rapport est de faire une évaluation à un an de ce programme

Chabrol, A. (2009). "Education thérapeutique : vers des patients acteurs de leur santé." Medecins : Bulletin D'Information de L'Ordre National des Medecins(7).
http://bulletin.conseil-national.medecin.fr/IMG/pdf/dossier_2009-09.pdf

> Le concept d'éducation thérapeutique du patient (ETP) a fait son apparition en France il y a une dizaine d'années. Plan national d'éducation à la santé en 2001 ; programmes nationaux diabète, maladies cardio-vasculaires, asthme ; guide méthodologique de la HAS en 2007 ; rapport Saout-Charbonnel-Bertrand en 2008... Promue sans relâche par les autorités sanitaires, cette notion reste cependant mal connue des médecins comme du grand public. Selon l'OMS [1], « l'éducation thérapeutique a pour objectif d'aider les patients à acquérir ou maintenir les compétences dont ils ont besoin pour gérer au mieux leur vie avec une maladie chronique. Elle fait partie intégrante et de façon permanente de la prise en charge du patient. Elle comprend les activités organisées, y compris le soutien psychosocial. Cela a pour but de les aider (ainsi que leur famille) à comprendre leur maladie et leur traitement, à collaborer ensemble et à assumer leurs responsabilités dans leur propre prise en charge afin de les aider à maintenir et améliorer leur qualité de vie. » L'ETP est destinée en priorité aux patients atteints de pathologies chroniques entraînant une détérioration régulière de la santé : diabète, asthme, obésité, insuffisance cardiaque, hypertension artérielle, insuffisance rénale, etc. Grâce à une adhésion étroite à leur traitement (prise de médicaments, réalisation de gestes techniques, suivi de régime) et à leur surveillance (paramètres biologiques, etc.), ils peuvent en effet éviter ou retarder la survenue de complications et améliorer leur autonomie et leur qualité de vie

Cherillat, M. S., Berland, P., Odoul, J., et al. (2020). "Perception du malade chronique chez les professionnels de santé : une évolution marquée par les indicateurs d'évaluation de programmes d'éducation thérapeutique du patient entre 2011 et 2017 au CHU de Clermont-Ferrand, France." Revue D'epidemiologie Et De Sante Publique.
http://www.sciencedirect.com/science/article/pii/S039876202030482X

> Position du problème Depuis 2010, en France, les programmes d'éducation thérapeutique du patient (ETP) sont soumis à autorisation par l'Agence régionale de santé (ARS). Tous les quatre ans, les programmes sont obligatoirement réévalués, ce qui implique la possibilité de changer les critères utilisés pour gérer chaque programme. Dans notre hôpital, nous étudions l'évolution des indicateurs d'évaluation d'ETP dans 17 programmes qui ont été autorisés et renouvelés au moins une fois par l'ARS. Méthode L'ensemble des indicateurs d'évaluation de programmes d'ETP est classé en structure, processus, résultats et sont aussi considérés l'activité du programme, les indicateurs pédagogiques et

psychosociaux, ainsi que les indicateurs biocliniques. Nous avons étudié si les indicateurs étaient complétés, utilisés et à la fin, reconduits ou créés pour le renouvellement des programmes. Les tests statistiques ont été utilisés afin de comparer les changements du nombre d'indicateurs dans chaque catégorie avant et après le processus de renouvellement. Résultats À la première autorisation, il y a eu 533 indicateurs, et 550 à la deuxième. Les changements concernent la réduction du nombre d'indicateurs de résultats (43,7 % à 35,1 %), alors que les indicateurs de processus augmentent (36,8 % à 43,1 %) (p=0,0141). La catégorie d'indicateurs la plus collectée (55,5 %) est la catégorie activité du programme (54,7 %) en comparaison à la catégorie des indicateurs pédagogiques et psychosociaux et des indicateurs biocliniques (p<0,0001). La catégorie activité du programme augmente au cours des renouvellements (67,6 %) (p=0,0002). Les indicateurs pédagogiques et psychosociaux ne sont pas collectés, ou très peu. Parmi les indicateurs pédagogiques et psychosociaux, il existe une importante augmentation des indicateurs relatifs aux compétences et changements en faveur de comportements favorables à la santé. Les indicateurs strictement biocliniques sont abandonnés au profit d'indicateurs en lien avec l'évolution de la maladie, son impact et la gestion des risques. Conclusion L'importance donnée aux indicateurs de processus et de structure traduit le fait que les indicateurs sont structurés en grande partie par les demandes de l'ARS. Même si cette première étude est à approfondir, elle montre une évolution dans la conception des évaluations pédagogiques et psychosociales chez les professionnels de santé, susceptible de traduire un intérêt de ces professionnels de santé pour la manière dont les patients gèrent leur maladie, leur mode de vie et leur quotidien.

Chevreul, K., Berg Brigham, K. et Bouche, C. (2014). "The burden and treatment of diabetes in France." Globalization and Health **10**(6).
http://www.globalizationandhealth.com/content/pdf/1744-8603-10-6.pdf

Background: The objective of this review was to describe and situate the burden and treatment of diabetes within the broader context of the French health care system. Methods: Literature review on the burden, treatment and outcomes of diabetes in France, complemented by personal communication with diabetes experts in the Paris public hospital system. Results: Prevalence of diabetes in the French population is estimated at 6%. Diabetes has the highest prevalence among all chronic conditions covered 100% by France's statutory health insurance (SHI), and the number of covered patients has doubled in the past 10 years. In 2010, the SHI cost for pharmacologically-treated diabetes patients amounted to _17.7 billion, including an estimated _2.5 billion directly related to diabetes treatment and prevention and _4.2 billion for treatment of diabetes-related complications. In 2007, the average annual SHI cost was _6 930 for patients with type 1 diabetes and _4 890 for patients with type 2 diabetes. Complications are associated with significantly increased costs. Diabetes is a leading cause of adult blindness, amputation and dialysis in France, which also has one of the highest rates of end-stage renal disease in Europe. Cardiovascular disease is the leading cause of death among people with diabetes. Historically, the French health care system has been more oriented to curative acute care rather than preventive medicine and management of long-term chronic diseases. More recently, the government has focused on primary prevention as part of its national nutrition and health program, with the goal of reducing overweight and obesity in adults and children. It has also recognized the critical role of the patient in managing chronic diseases such as diabetes and has put into place a free patient support program called "sophia". Additional initiatives focus on therapeutic patient education (TPE) and the development of personalized patient pathways. Conclusions: While France has been successful in protecting patients from the financial consequences of diabetes through its SHI coverage, improvements are necessary in the areas of prevention, monitoring and reducing the incidence of complications.

Cnam (2010). Accompagnement des patients asthmatiques : une nouvelle étape de l'action de l'assurance maladie, Paris : Cnam

En France, l'asthme constitue l'une des maladies chroniques les plus fréquentes : selon les données de l'Assurance Maladie en 2009, 3,6 millions de personnes, âgées de 5 à 44 ans, étaient traitées au moins une fois dans l'année par un médicament anti-asthmatique. Parmi elles, plus de 750 000 recevaient un traitement régulier pour asthme1, soit une prévalence de 2,5% au sein de cette population. Le coût de cette maladie est également élevé, ainsi les remboursements de médicaments à visée anti-asthmatique atteignaient plus d?1 milliard d’euros en 2009. Insuffisamment pris en charge ou mal contrôlé, l’asthme peut avoir des répercussions importantes sur la qualité de vie : gênes respiratoires, crises d’asthme fréquentes, sommeil perturbé mais aussi hospitalisations voire décès dans les cas les plus graves. Face à cet enjeu majeur de santé publique, l’Assurance Maladie a développé un programme pour améliorer le contrôle de l’asthme, dans le cadre de la loi de Santé Publique du 9 août 2004 et du plan national pour améliorer la qualité de vie des patients atteints de maladies chroniques. En 2008 et 2009, une 1ère action a été menée auprès des médecins et des assurés, qui ont évalué de manière positive cette démarche. L’Assurance Maladie déploie aujourd’hui un nouveau volet de son programme, plus particulièrement orienté vers les pharmaciens. L’objectif de cette nouvelle étape est de conforter le rôle du pharmacien dans l’accompagnement des malades asthmatiques, notamment pour la prise des traitements médicamenteux, préventif et de la crise. Pour la 1ère fois, l’Assurance Maladie accompagne les pharmaciens dans leur rôle de conseil auprès des patients, en mettant à leur disposition des outils d’aide.

Cnam (2010). "Sophia : premiers résultats des études de satisfaction auprès des adhérents et des médecins
Sophia : premiers résultats des études de satisfaction auprès des adhérents et des médecins." Point D'Information (Cnamts).

Comme dans la plupart des pays développés, le diabète représente en France un enjeu de santé publique majeur : 2,5 millions de personnes diabétiques en France dont 8 sur 10 sont prises en charge à 100% au titre d'une affection de longue durée. En matière de soins préventifs délivrés aux patients diabétiques, une étude récente du Commonwealth Fund montre que la France a encore du retard. Seuls 31% des adultes diabétiques ont un suivi complet comprenant les quatre examens recommandés : l'hémoglobine glyquée, l'examen des pieds, l'examen du fond de l'oeil et le bilan du cholestérol. D'autres pays comme les Pays-Bas et le Royaume-Uni sont à 60 % voire à près de 70% de patients bénéficiant d'un suivi complet. D'importants progrès restent à accomplir malgré les évolutions positives enregistrées ces dernières années dans la prise en charge des malades. C'est pourquoi l'Assurance Maladie a fait de l'accompagnement des patients atteints de pathologies chroniques l'une de ses actions prioritaires pour mieux prévenir l'apparition des complications, souvent très graves. Du côté des médecins, des indicateurs conformes aux référentiels de prise en charge du diabète ont été intégrés dans le contrat d'amélioration des pratiques individuelles (CAPI). Avec sophia, l'Assurance Maladie poursuit l'objectif d'améliorer la qualité de vie des patients et mieux prévenir les complications liées à leur maladie

Cnam (2011). 100 000 adhérents pour Sophia et des premiers résultats médico-économiques encourageants, Paris : Cnam

En France, 2,9 millions de personnes sont diabétiques et 8 sur 10 sont prises en charge à 100% au titre d’une affection de longue durée. La prévention de la maladie, de ses complications et l’amélioration de la qualité de vie des malades chroniques représentent un enjeu majeur pour l’assurance Maladie, à la fois sur le plan médical et économique. En 2008, l’assurance Maladie a lancé Sophia, un service en santé innovant. L’objectif de ce service, initialement proposé dans 10 départements pilotes : accompagner les patients qui le souhaitent, en fonction de leur état de santé et en relais du médecin traitant, pour les aider à mieux vivre avec la maladie et en prévenir les complications. Près de trois ans plus tard, Sophia poursuit son déploiement à grande échelle. Aujourd’hui, plus de 100 000 personnes1 ont adhéré à Sophia. Le service constitue désormais l’un des plus importants de ce type en Europe.

Cnam (2013). "Sophia : un service accessible à plus d?1,8 million de patients diabétiques, une évolution positive du recours aux soins confirmée
Sophia : un service accessible à plus d'1,8 million de patients diabétiques, une évolution positive du recours aux soins confirmée." Point D'Information (Cnamts).

Le dispositif Sophia, mis en place en 2008, franchit une étape décisive en s'étendant depuis le début 2013 à toute la France. Destiné aux patients diabétiques, ce service est désormais accessible à 1,8 million de patients. En février 2013, 226 000 personnes y adhèrent et 55 800 médecins traitants sont concernés par le service. l'Assurance Maladie s'est fixé pour objectif pour l'année 2013 d'élargir le service à 350 000 adhérents. Après une première évaluation médico-économique en 2010, l'Assurance maladie a dévoilé lors du point presse le bilan de la période 2009-2011. Elle note que le suivi des adhérents à Sophia s'est amélioré sur la quasi-totalité des indicateurs. Et sur cette période, les adhérents ont, à caractéristiques égales, des dépenses de soins moins élevées que la population témoin, autant au niveau des soins de ville que d'hospitalisation. Mais la différence de coûts entre les adhérents et les témoins reste faible. L'accompagnement téléphonique est un élément-clé du service sophia. Actuellement, 140 conseillers en santé au total proposent aux adhérents des clés pour prendre soin d'eux et mieux équilibrer leur diabète. Fin 2013, ce sont près de 270 infirmiers conseillers en santé qui seront répartis dans six centres et unités d'accompagnement. A noter par ailleurs que l'Assurance maladie ambitionne d'étendre ce service aux patients asthmatiques, dans le cadre d'une expérimentation dans 18 départements français, d'ici la fin de l'année

Cnam (2015). Sophia : Evaluation médico-économique 2014 et évolutions du service pour 2016, Paris : Cnam
http://www.ameli.fr/fileadmin/user_upload/documents/DP_etude_medicoeco_Sophia_15092015.pdf

L'Assurance Maladie a mené une troisième analyse médico-économique du Programme d'accompagnement des patients diabétiques Sophia, généralisé en 2012 (619 000 adhérents). Cette évaluation a eu lieu entre juin 2014 et juin 2015 et elle a porté sur la réalisation des examens de surveillance recommandés dans le suivi du diabète et sur les dépenses de soins des patients. Les résultats confirment les effets bénéfiques du service sur le suivi des examens recommandés dans la prise en charge du diabète avec une meilleure progression du taux de réalisation annuel d'au moins 2 dosages d'HbA1c et du dosage de la micro-albuminurie. Les effets sont particulièrement notables la 1ère année après l'adhésion avec un amoindrissement des résultats la 2e année. Les orientations prises à partir de 2013 vont être renforcées par de nouvelles modalités d'accompagnement et de recrutement à partir de janvier 2016. Le service va s'attacher à convaincre en priorité les patients dont le suivi des examens est le plus éloigné des recommandations de prise en charge. Les examens de suivi les plus nécessaires pour prévenir les complications graves comme l'examen du fond d'oeil et le bilan rénal vont être priorisés dans le cadre des différentes communications à destination des adhérents. L'envoi de brochures et de livrets repères, qui contribuent à une meilleure connaissance de la maladie et des examens à réaliser, sera renforcé sur les 24 premiers mois suivant l'adhésion pour installer des réflexes chez les nouveaux adhérents. Enfin, le médecin traitant pourra désormais choisir le thème prioritaire d'accompagnement pour chacun des patients diabétiques qu'il suit et qui ont adhéré au service. Les évaluations concluent enfin à une absence d'impact financier sur les dépenses de santé ou à une légère augmentation selon les méthodes utilisées pour mesurer l'évolution de la dépense totale de soins. La CNAMTS souligne que la période d'observation (recul de 1 à 2 ans selon les cohortes), est trop courte pour pouvoir évaluer l'impact du service sur la réduction de complications liées à la maladie.

Cnam (2019). Nouvelles évaluations du service sophia : Un impact positif notamment sur les adhérents en écart par rapport au suivi recommandé. Paris : Cnam, Paris : Cnam
https://www.ameli.fr/l-assurance-maladie/statistiques-et-publications/evaluation-du-service-sophia/evaluation-du-service-sophia-diabete.php

Sophia est un programme d'accompagnement personnalisé du patient diabétique, expérimenté en 2008 dans neuf départements puis étendu à l'ensemble du territoire en 2013, avant d'être étendu progressivement aux personnes asthmatiques à partir de 2014. Aujourd'hui, le service s'appuie sur 220 infirmiers-conseillers en santé et compte plus de 790 000 adhérents diabétiques et 72 000 adhérents asthmatiques. Pour la première fois, la longévité du service d'accompagnement des patients diabétiques permet d'avoir un recul suffisant pour mesurer des résultats en termes de santé publique (morbi-mortalité). Une nouvelle étude réalisée en 2018 évalue l'impact à huit ans du service sophia (2008-2016) auprès des premiers adhérents de l'année 2008. Par ailleurs, depuis son lancement en 2014, le service d'accompagnement des patients asthmatiques, sophia a fait l'objet d'une seconde évaluation médicale et économique à deux ans de ce service. La note de synthèse publiée par la Cnam en février constitue la troisième évaluation du dispositif. Les résultats montrent que ce service est très apprécié par ses 870 000 adhérents et contribue à une amélioration de leur suivi médical recommandé et de leur santé. Cela conforte l'Assurance maladie à poursuivre ce service en focalisant son action sur les personnes ayant le plus besoin de soutien. Des adaptations du service vont ainsi être menées pour mieux cibler ses actions de recrutement et d'accompagnement, diversifier ses modes d'actions en utilisant les médias digitaux (emails, SMS, apps) et encore mieux relayer les recommandations des professionnels de santé.

Coldefy, M. et Lucas-Gabrielli, V. (2012). "Le territoire, un outil d'organisation des soins et des politiques de santé ? Évolution de 2003 à 2011." Questions D'economie De La Sante (Irdes)(175): 1-8.
http://www.irdes.fr/Publications/2012/Qes175.pdf

En 2003, lors de l'élaboration des Schémas régionaux d'organisation des soins de troisième génération (Sros 3), le territoire de santé devient le cadre réglementaire de l'organisation des soins, se substituant à la carte sanitaire créée en 1970. Le territoire de santé est pensé comme un élément structurant de l'organisation des soins encadré par des objectifs quantifiés de l'offre de soins et un projet médical de territoire ; il est également un espace de concertation entre acteurs de santé à travers les conférences sanitaires de territoire. Dans ce nouveau contexte, les régions sont incitées à repenser le territoire et son découpage. D'abord centré sur l'hôpital avec les agences régionales de hospitalisation (ARH), le territoire est ensuite élargi à des activités de santé publique et d'accompagnement médico-social dans le cadre de la loi Hôpital, santé et territoires (HPST) de 2009, avec les Agences régionales de santé (ARS). Comment les régions ont-elles fait évoluer ce maillage ? Un panorama de la territorialisation en santé de 2003 à 2011.

Cordier, A. (2013). Un projet global pour la stratégie nationale de santé : 19 Recommandations du comité des « sages ».
http://www.astrid-online.it/Politiche-/Documenti/-Rapport-Cordier_sant-_21_06_13.pdf

Ce rapport rassemble les propositions du comité des sages mis en place en mars dernier pour préciser le contenu d'une stratégie nationale de santé. D'autres démarches et réflexions importantes ont eu lieu, telles que le Pacte de confiance pour l'hôpital, ou sont en cours, notamment sur la généralisation de la couverture de la complémentaire santé, qui doit faire l'objet d'un très prochain avis du Haut Conseil pour l'avenir de l'assurance maladie (HCAAM). Le gouvernement travaille, sur la base des différentes analyses qu'il a sollicitées, à l'élaboration d'une feuille de route déclinant les principales orientations qu'il retient et les chantiers à lancer au plan opérationnel. Des débats et consultations s'ensuivront tant au niveau national qu'en région sur ces axes, certaines mesures pouvant être prises en compte dès le PLFSS(Projet de loi de financement de la sécurité sociale) déposé au Parlement en octobre

Cour des Comptes (2018). La lutte contre les maladies cardioneurovasculaires : une priorité à donner à la prévention et à la qualité des soins. Paris Cour des Comptes**:** 209-246, tab., graph., fig.
www.ccomptes.fr/fr/publications/securite-sociale-2018

Pour l'année 2015, la Cnam estime ainsi à 4,5 millions le nombre de patients atteints d'une maladie cardio-neurovasculaire diagnostiquée et traitée. Le coût de ces prises charge, soit 16,1 Md€ pour l'ensemble des régimes d'assurance maladie en 2016, augmente plus rapidement que la moyenne des dépenses de santé. Il va continuer à s'accroître : selon la Cnam, le nombre de patients pourrait atteindre 5,1 millions en 2020. Au-delà de leurs conséquences sur la santé humaine, les maladies cardio-neurovasculaires présentent ainsi un important enjeu pour la soutenabilité des dépenses d'assurance maladie. Or, malgré certains progrès, ce dernier est encore insuffisamment pris en compte dans les objectifs et l'organisation de notre système de santé. Sous l'effet d'une hausse préoccupante de leur prévalence, les maladies cardio-neurovasculaires représentent un coût élevé et croissant pour le système de santé français. Après les progrès partiels intervenus dans l'organisation de la prise en charge des accidents vasculaires cérébraux (AVC), l'ensemble des soins à l'hôpital devraient être réorganisés afin d'en accroître les bénéfices individuels pour les patients. Au-delà, la gravité de la situation sanitaire liée aux maladies cardio-neurovasculaires appelle la mise en oeuvre d'actions convergentes, notamment en matière de prévention, afin d'améliorer les chances de chacun, dès avant comme à tous les stades de l'évolution de ces pathologies.

Couralet, P. E. (2015). Evaluation médico-économique du programme Sophia 2010-2013. Paris CNAMTS**:** 249 , tabl., graph.
http://www.ameli.fr/fileadmin/user_upload/documents/Rapport_d_evaluation_sophia_2010-2013.pdf

> Le programme Sophia est un programme d'accompagnement personnalisé des patients diabétiques piloté par la Caisse Nationale d'Assurance Maladie des travailleurs Salariés (Cnamts). Son déploiement s'est fait au cours de deux périodes distinctes : une phase expérimentale de 2008 à 2012, puis une phase de généralisation à partir de la fin de l'année 2012. Depuis son lancement en 2008, le service Sophia a fait l'objet de trois évaluations médico-économiques ayant pour objectif de mesurer l'impact du service sur la réalisation des examens de surveillance recommandés dans le suivi du diabète et observer son incidence sur les dépenses de soins des patients diabétiques. Cette nouvelle évaluation médico-économique réalisée par Pierre-Emmanuel Couralet porte sur les périodes suivantes : les années 2011 et 2012 pour les patients éligibles lors de la troisième vague de l'expérimentation, entrés fin 2010 dans le programme, l'année 2013 pour les patients éligibles lors de la généralisation fin 2012-début 2013. Elle confirme les observations des deux précédentes, soit une amélioration plus importante de la réalisation des examens recommandés chez les patients diabétiques adhérents au service Sophia que chez les patients diabétiques ne bénéficiant pas de ce service. La mise en place du service Sophia a amélioré le suivi de l'ensemble de la population diabétique mais n'a pas d'impact significatif à court terme sur la dépense totale de soins.

Crozet, C., Van, B., V, D'Ivernois, J. F., et al. (2006). "Éducation cardiovasculaire de patients âgés. Évaluation d'un programme." Concours Medical **128**(29-30).

> [BDSP. Notice produite par ORSRA MhF50R0x. Diffusion soumise à autorisation]. La MSA a mis en oeuvre de septembre 2004 à septembre 2005, dans 9 régions de France, une expérience d'éducation thérapeutique des patients en ALD atteints de maladies cardio-vasculaires. Cet article présente le programme d'éducation thérapeutique mis en place, ainsi que les résultats de son évaluation : évaluation des connaissances chez les patients, évaluation des opinions chez les médecins généralistes. Ce programme d'éducation devrait être généralisé à toute à la France auprès des assurés de la MSA

Czernichow, P. (2015). "Un système de santé plus intégré pour mieux prendre en charge les maladies chroniques. Éditorial." Santé Publique **27**: 7-8.

> [BDSP. Notice produite par EHESP rrR0x8II. Diffusion soumise à autorisation]. L'avènement des maladies chroniques modifie l'équilibre entre patients et professionnels de santé en ce sens que la démocratie sanitaire et l' "alliance thérapeutique" constituent un nouveau modèle de relations de soins. Le patient, d'un point de vue individuel, mais aussi collectif, devient plus autonome. L'éducation thérapeutique est emblématique de ce nouveau rôle des patients dans leurs soins. Cette transition s'illustre également par un développement de nouveaux métiers. Ces évolutions du système de santé doivent accompagner une transition politique nécessaire, pour tendre vers un système intégré de santé, associant promotion de la santé, prévention et soins coordonnés.

De Andrade, V., Margat, A., Verheye, J.-C., et al. (2018). "Information, patient education and health literacy." Éducation thérapeutique du patient / Therapeutic patient education **10**(1): 10502.
https://hal-univ-paris13.archives-ouvertes.fr/hal-01916186

> La politique de santé de plusieurs pays, dont les États-Unis, incite fortement les bibliothèques publiques à soutenir l'information et l'éducation du patient. La prise en compte de la littératie en santé des populations est un enjeu majeur. S'il existe des initiatives en France, celles-ci n'ont pas l'ampleur des expériences internationales. Pourtant, rien n'empêcherait qu'au sein des bibliothèques, les bibliothécaires/ documentalistes favorisent auprès de la population des apprentissages en santé. Une réflexion nous semble nécessaire pour concevoir, en France, l'implication des bibliothécaires/documentalistes dans ce but.

Deccache, A., Didier, A., Mayran, P., et al. (2018). "[Asthma: Adapting the therapeutic follow-up according to the medical and psychosocial profiles]." Rev Mal Respir **35**(3): 313-323.

> INTRODUCTION: This work is based on the data of REALISE, a survey conducted among 8000 European patients to identify the profiles of adult asthma patients and how these are linked with treatment adherence behaviors. METHODS: A cluster analysis was performed by combining data in three ways: control of asthma, attitude towards the disease, compliance with treatment. A multidisciplinary group analyzed the results for the 1024 French survey respondents. RESULTS: Four patient profiles were identified: "rather confident" (28% of patients), rather young patients with a low level of concern about their asthma. "Rather committed" (23%) patients considering themselves to be mostly healthy, reporting better therapeutic declared. "Rather questing" (26%), patients poorly controlled, seeking to manage their asthma themselves. "Rather concerned" profile (23%), a bit older, with poor clinical control, considering their asthma to be severe. CONCLUSIONS: Cluster analysis provides a multidimensional approach to understand the therapeutic behavior of the different patient profiles better and so adjust communication by and education of healthcare professionals.

Deccache, A. et van Ballekom, K. (2010). "From patient compliance to empowerment and consumer's choice: evolution or regression? An overview of patient education in French speaking European countries." Patient Educ Couns **78**(3): 282-287.

> OBJECTIVE: This paper presents a historical overview of patient education in French speaking (parts of) countries of Europe, as well as the emergence of new concepts in Health care and education. Further it describes the results of research and studies on current practice and political decisions and positions about patient education, based upon laws and regulations. The present trends will be discussed, and propose an overview of the next possible developmental steps. METHODS: Articles, reports and policy documents about publications on patient education in French speaking (parts of) countries of Europe. RESULTS: In the last years, in France, Belgium, Switzerland, Luxemburg, patient education has undergone a lot of changes whether in theories, models, policies or practice. These changes came with the emergence of concepts such as effectiveness of care, chronic disease follow-up, compliance, adherence, health promotion, empowerment, salutogenesis, resilience, patients' rights, health care costs control, coaching, disease management, consumer choice, and participation. Each of these concepts seems to have been defined and implemented in various ways, according to settings or countries. Political and social choices seem to have oriented choices from humanistic approaches to pragmatic decisions, with ethical problems rising. Consensus on definitions are often hard to reach, especially among policy makers, health care teams, health managers, and patient organizations, even though these concepts do coexist in daily practice, sometimes in very conflictual ways. CONCLUSIONS: Hard or subtle, changes are happening in patient education and cannot be ignored. PRACTICE IMPLICATION: Many questions rise on the future of patient education, wondering how to anticipate next models of health care practice, and their ethical and social stakes. Clear positions need to be taken.

Deschamps Jean-Pierre, F. C., Alla François, et al. (2013). "Éducation pour la santé : une place insuffisante dans la politique de santé ? Enjeux et pratiques d'une discipline à redécouvrir." Sante Publique

> [BDSP. Notice produite par EHESP 8CIR0xqF. Diffusion soumise à autorisation]. L'éducation pour la santé (EPS) a connu au cours des dernières décennies une considérable évolution de ses objectifs et de ses méthodes. Pourtant, dans plusieurs pays, en France particulièrement, l'EPS n'est pas reconnue comme un champ important des politiques publiques de santé. Les plans et les lois de santé publique des dernières années ne font qu'une place restreinte à l'EPS, quand ils ne l'ignorent pas totalement. Les objectifs de ce numéro thématique sont d'analyser ces évolutions et d'objectiver la réalité et la diversité des pratiques actuelles dans le domaine. Il est structuré en quatre parties. Une première partie est consacrée aux évolutions éthiques, historiques et politiques de l'éducation pour la santé en France. Une deuxième partie aborde les enjeux conceptuels et méthodologiques de l'éducation pour la santé en particulier à l'aune du développement de la promotion de la santé. Une troisième partie apporte quatre éclairages internationaux sur l'éducation pour la santé, issus du monde francophone, mais aussi de l'Amérique du Sud dont l'apport a été majeur dans le domaine. Une quatrième partie,

enfin, expose des pratiques et des actions d'éducation pour la santé qui se distinguent par leur rigueur méthodologique, leur souci d'évaluation, leur volonté de réduction des inégalités de santé et/ou leur inscription dans une perspective de promotion de la santé

Deschamps, J.-P., Ferron, C., Alla, F., et al. (2013). "L'éducation pour la santé, parent pauvre de la politique de santé ?" Santé Publique **25**: 81-82.

[BDSP. Notice produite par EHESP q8tR0xlF. Diffusion soumise à autorisation]. Plusieurs articles, dans ce numéro de Santé publique, évoquent des avancées de l'éducation pour la santé, l'intérêt porté par la plupart des Agences Régionales de Santé, le développement de l'éducation thérapeutique du patient. Mais le compte n'y est pas ; on est loin des politiques que décrivent nos collègues sud-américains, belges ou québécois. On est loin de ce qui pourrait enfin diminuer l'excessive mortalité prématurée signalée par tous les rapports récents sur l'état de santé en France, on est loin de la lutte contre les inégalités sociales de santé. Seule l'Éducation nationale a fait des efforts, notamment en développant les Comités d'éducation à la santé et à la citoyenneté (CESC) et la formation des enseignants.

Deschamps, J.-P., Ferron, C., Alla, F., et al. (2013). "Éducation pour la santé : une place insuffisante dans la politique de santé ? Enjeux et pratiques d'une discipline à redécouvrir." Santé Publique(2): S77-S240, tabl., fig.

[BDSP. Notice produite par EHESP 8CIR0xqF. Diffusion soumise à autorisation]. L'éducation pour la santé (EPS) a connu au cours des dernières décennies une considérable évolution de ses objectifs et de ses méthodes. Pourtant, dans plusieurs pays, en France particulièrement, l'EPS n'est pas reconnue comme un champ important des politiques publiques de santé. Les plans et les lois de santé publique des dernières années ne font qu'une place restreinte à l'EPS, quand ils ne l'ignorent pas totalement. Les objectifs de ce numéro thématique sont d'analyser ces évolutions et d'objectiver la réalité et la diversité des pratiques actuelles dans le domaine. Il est structuré en quatre parties. Une première partie est consacrée aux évolutions éthiques, historiques et politiques de l'éducation pour la santé en France. Une deuxième partie aborde les enjeux conceptuels et méthodologiques de l'éducation pour la santé en particulier à l'aune du développement de la promotion de la santé. Une troisième partie apporte quatre éclairages internationaux sur l'éducation pour la santé, issus du monde francophone, mais aussi de l'Amérique du Sud dont l'apport a été majeur dans le domaine. Une quatrième partie, enfin, expose des pratiques et des actions d'éducation pour la santé qui se distinguent par leur rigueur méthodologique, leur souci d'évaluation, leur volonté de réduction des inégalités de santé et/ou leur inscription dans une perspective de promotion de la santé.

D'Ivernois, J. et Gagnayre, R. (2007). "Propositions pour l'évaluation de l'éducation thérapeutique du patient." Actualite et Dossier en Sante Publique(58).

[BDSP. Notice produite par ENSP VgR0xXXp. Diffusion soumise à autorisation]. Trois centres universitaires, impliqués dans le développement de l'éducation thérapeutique, ont travaillé sur l'évaluation de cette pratique auprès du patient. Présentation de ces travaux et recommandations

Drahi, E. (2009). "Et si l'éducation thérapeutique des patients n'étaient pas à sa place ?" Medecine : Revue de L'Unaformec **5**(2).

Cet article propose des réflexions sur la définition de l'éducation thérapeutique, sur la formation des médecins dans ce domaine et sur la nécessité de l'acquisition de l'autonomie du patient dans le contrôle de sa propre santé

Dreux, C. (2013). La Culture de prévention en santé : des questions fondamentales. Paris : Académie nationale de médecine
http://www.academie-medecine.fr/articles-du-bulletin/publication/?idpublication=100189

Ce rapport a essentiellement pour but d'alerter les pouvoirs publics décisionnels sur les moyens à mettre en œuvre pour développer, en France, une véritable culture de prévention dans le domaine de la santé. Compte tenu de l'étendue du sujet, il a été décidé de traiter quelques questions fondamentales de la prévention sanitaire puis d'aborder plus particulièrement les questions relatives à certaines catégories spécifiques. Après une introduction "la prévention en médecine est un humanisme", ce rapport aborde les sujets suivants : Définition de la culture de prévention; Pourquoi et comment développer une culture de prévention en santé publique ?; prévention et inégalités sociales de santé; prévention et économie de la santé; éducation du public : Apport des procédures informatisées (TICS); l'importance majeure de la famille, de l'école et de la médecine scolaire; peut-on, à la naissance, prévoir les maladies de l'âge adulte ?; pour une prévention fondée sur les preuves

Dubreucq, J., Ycart, B., Gabayet, F., et al. (2019). "Towards an improved access to psychiatric rehabilitation: availability and effectiveness at 1-year follow-up of psychoeducation, cognitive remediation therapy, cognitive behaviour therapy and social skills training in the FondaMental Advanced Centers of Expertise-Schizophrenia (FACE-SZ) national cohort." Eur Arch Psychiatry Clin Neurosci **269**(5): 599-610.

Psychosocial Interventions (PIs) have shown positive effects on clinical and functional outcomes of schizophrenia (SZ) in randomized controlled trials. However their effectiveness and accessibility remain unclear to date in "real world" schizophrenia. The objectives of the present study were (i) to assess the proportion of SZ outpatients who benefited from PIs between 2010 and 2015 in France after an Expert Center Intervention in a national multicentric non-selected community-dwelling sample; (ii) to assess PIs' effectiveness at 1-year follow-up. 183 SZ outpatients were recruited from FondaMental Advanced Centers of Expertise for Schizophrenia cohort. Baseline and 1-year evaluations included sociodemographic data, current treatments, illness characteristics and standardized scales for clinical severity, adherence to treatment, quality of life, a large cognitive battery, and daily functioning assessment. Only 7 (3.8%) received a PI before the evaluation, and 64 (35%) have received at least one PI during the 1-year follow-up. Having had at least one PI during the follow-up has been associated in multivariate analyses with significantly higher improvement in positive and negative symptoms (respectively p =0.031; p = 0.011), mental flexibility (TMT B, p = 0.029; C-VF, p = 0.02) and global functioning (p =0.042). CBT and SST were associated with higher cognitive improvements, while CRT was associated with clinical improvement. These results have not been demonstrated before and suggest that the effect of each PI is larger than its initial target. The present study has confirmed the PIs' effectiveness in a large sample of community-dwelling SZ outpatients at 1 year follow-up. Efforts to improve access to PI should be reinforced in public health policies.

Ducos, J. (2012). "L'offre d'éducation thérapeutique pour diabétiques adultes en Ile-de-France : un défi à l'équité." Pratiques Et Organisation Des Soins(1). http://www.ameli.fr/fileadmin/user_upload/documents/POS1201_L_offre_d_education_therapeuthique_pour_diabetiques.pdf

[BDSP. Notice produite par CNAMTS lR0x9I88. Diffusion soumise à autorisation]. L'éducation thérapeutique du patient (ETP) vise à donner au malade des connaissances et des compétences lui permettant de mieux gérer sa maladie et d'améliorer sa qualité de vie. Les objectifs de cette enquête étaient d'établir un état des lieux de l'offre de programmes d'ETP pour les diabétiques adultes en Ile-de-France, hors diabète gestationnel, à l'hôpital comme en médecine ambulatoire, dans le but d'en adapter l'offre et d'évaluer l'équité de cette offre

Foucaud, J. (2008). "Pratiques formatives en éducation thérapeutique du patient en France." Santé Publique(14): 63-69.

Issu d'une collaboration entre l'INPES et des acteurs de l'éducation thérapeutique du patient, cet ouvrage rassemble des analyses d'interventions d'éducation thérapeutique mises en place en France et au Québec, dans le cadre de huit maladies chroniques : diabète, obésité, maladies cardio-vasculaires, VIH/sida, asthme, cancer, polyarthrite rhumatoïde et lombalgie. En rendant compte des modèles théoriques qui sous-tendent l'éducation thérapeutique et des démarches mises en oeuvre, les contributions mettent au jour une large diversité de pratiques. Qu'il soit professionnel de santé, formateur ou chercheur, le lecteur trouvera ainsi des pistes pour démarrer, développer et évaluer ses actions éducatives. Il trouvera aussi matière à éprouver ses conceptions de la santé et de l'éducation,

> notamment à travers la découverte de pratiques qui produisent des résultats très encourageants alors qu'elles se réfèrent à des cadres théoriques diversifiés et à des voies différenciées pour penser l'action éducative. Parce qu'elles ne montrent pas l'excellence d'une voie plutôt qu'une autre, ces analyses invitent au développement de nouvelles perspectives d'action et de recherche. L'ouvrage offre ainsi une ouverture précieuse dans un contexte général où l'éducation thérapeutique s'inscrit, en France, dans le code de santé publique, notamment à travers la loi Hôpital, patients, santé et territoires du 21 juillet 2009, qui en reconnaît l'importance pour l'amélioration de l'état de santé des personnes, en particulier de celles atteintes d'une maladie chronique.

Foucaud, J. (2010). Éducation thérapeutique du patient : modèles, pratiques et évaluation, St Denis : INPES
Pratiques formatives en éducation thérapeutique du patient en France

> Issu d'une collaboration entre l'INPES et des acteurs de l'éducation thérapeutique du patient, cet ouvrage rassemble des analyses d'interventions d'éducation thérapeutique mises en place en France et au Québec, dans le cadre de huit maladies chroniques : diabète, obésité, maladies cardio-vasculaires, VIH/sida, asthme, cancer, polyarthrite rhumatoïde et lombalgie. En rendant compte des modèles théoriques qui sous-tendent l'éducation thérapeutique et des démarches mises en oeuvre, les contributions mettent au jour une large diversité de pratiques. Qu'il soit professionnel de santé, formateur ou chercheur, le lecteur trouvera ainsi des pistes pour démarrer, développer et évaluer ses actions éducatives. Il trouvera aussi matière à éprouver ses conceptions de la santé et de l'éducation, notamment à travers la découverte de pratiques qui produisent des résultats très encourageants alors qu'elles se réfèrent à des cadres théoriques diversifiés et à des voies différenciées pour penser l'action éducative. Parce qu'elles ne montrent pas l'excellence d'une voie plutôt qu'une autre, ces analyses invitent au développement de nouvelles perspectives d'action et de recherche. L'ouvrage offre ainsi une ouverture précieuse dans un contexte général où l'éducation thérapeutique s'inscrit, en France, dans le code de santé publique, notamment à travers la loi Hôpital, patients, santé et territoires du 21 juillet 2009, qui en reconnaît l'importance pour l'amélioration de l'état de santé des personnes, en particulier de celles atteintes d'une maladie chronique

Foucaud, J. (2012). "[Coordination and promotion of policies favoring patient education]." Soins(764): 32-34.

> In the framework of therapeutic patient education (TPE), the definition of the actors' skills is an issue of growing importance. Work in this area has recently been carried out by the French national institute for prevention and health education (INPES).This work highlights a function which is seldom documented in literature: the coordination of TPE policies.

Foucaud, J., Bury, J. A. et Balcou-Debussche, M. (2010). Éducation thérapeutique du patient : modèles, pratiques et évaluation, St Denis : INPES

> Issu d'une collaboration entre l'INPES et des acteurs de l'éducation thérapeutique du patient, cet ouvrage rassemble des analyses d'interventions d'éducation thérapeutique mises en place en France et au Québec, dans le cadre de huit maladies chroniques : diabète, obésité, maladies cardio-vasculaires, VIH/sida, asthme, cancer, polyarthrite rhumatoïde et lombalgie. En rendant compte des modèles théoriques qui sous-tendent l'éducation thérapeutique et des démarches mises en oeuvre, les contributions mettent au jour une large diversité de pratiques. Qu'il soit professionnel de santé, formateur ou chercheur, le lecteur trouvera ainsi des pistes pour démarrer, développer et évaluer ses actions éducatives. Il trouvera aussi matière à éprouver ses conceptions de la santé et de l'éducation, notamment à travers la découverte de pratiques qui produisent des résultats très encourageants alors qu'elles se réfèrent à des cadres théoriques diversifiés et à des voies différenciées pour penser l'action éducative. Parce qu'elles ne montrent pas l'excellence d'une voie plutôt qu'une autre, ces analyses invitent au développement de nouvelles perspectives d'action et de recherche. L'ouvrage offre ainsi une ouverture précieuse dans un contexte général où l'éducation thérapeutique s'inscrit, en France, dans le code de santé publique, notamment à travers la loi Hôpital, patients, santé et territoires du 21 juillet 2009, qui en reconnaît l'importance pour l'amélioration de l'état de santé des personnes, en particulier de celles atteintes d'une maladie chronique.

Fournier, C. et Murphy, M. (2016). "L'autogestion des maladies chroniques, l'état de santé et l'utilisation des services hospitaliers : exploration de données d'enquêtes populationnelles." Zoom Sante(55): c, 19 , tabl., fig.
http://www.stat.gouv.qc.ca/statistiques/sante/bulletins/zoom-sante-201602.pdf

> Ce numéro du bulletin Zoom santé de l'Institut de la statistique du Québec (ISQ) s'intéresse à l'autogestion des maladies chroniques d'après l'expérience vécue de personnes aux prises avec l'une des cinq maladies chroniques faisant l'objet d'une surveillance particulière par le ministère de la Santé et des Services sociaux, soit : l'arthrite, le diabète, la bronchite chronique, l'hypertension et les maladies cardiaques. Les éléments d'autogestion examinés par l'étude concernent : l'acquisition d'informations et de compétences pour maintenir un bon état de santé, le renforcement de l'autonomie de la personne afin qu'elle reconnaisse les signes avant-coureurs de la maladie et agisse adéquatement et le soutien à l'adoption de saines habitudes.

Fournier, C., Cittée, J., Brugerolles, H., et al. (2018). "[Improving the complementarity of patient education proposals: Experience feedback and recommendations]." Santé Publique **30**(3): 307-311.

> INTRODUCTION: Implementing patient education (PE) in a defined geographic area, based on a population-based approach, implies using community resources according to a logic of complementarity, in order to mitigate the risk of rupture in patient care. METHODS: The PE Resource Centre for the Ile-de-France Region convened a multidisciplinary and multi-setting meeting attended by 45 participants in order to define the ways to improve the complementarity of all available PE resources, while taking into account the diversity of patients' needs. Three working groups successively explored three dimensions: structure, processes and outcomes, in order to assess this complementarity. RESULTS: Each group worked on three aspects: PE resources; patient's health trajectory in a defined geographic area, and a multidisciplinary team approach.Participants identified various deficits: clustering and lack of visibility for PE resources, programme framing constraints and difficulties of access for patients. Nevertheless, they highlighted several positive elements emerging from their shared experience. They recommend: 1) sharing of the available resources by developing communication and multidisciplinary training and more flexible programme formats; 2) building links between stakeholders, by promoting local PE programmes, and by encouraging coordination and practice analysis; 3) using and articulating a diversity of evaluation approaches, while reinforcing the multidimensional nature of PE contributions, not only for patients but also for professionals and the healthcare system. DISCUSSION: PE Resource Centres may facilitate implementation of these recommendations by supporting a collective and dynamic approach, contributing to a reduction of social inequalities in PE access.

Gagnayre, R. et Lombrail, P. (2015). "De la pratique à la recherche en éducation thérapeutique du patient." Questions De Sante Publique(29): 4.
http://www.iresp.net/files/2015/06/QSP_IReSP-n--29.Web_.pdf

> [BDSP. Notice produite par EHESP nR0xo9p7. Diffusion soumise à autorisation]. La France est probablement le seul pays au monde à avoir inscrit dans la loi le développement de l'éducation thérapeutique du patient (ETP). Comme tout autre champ portant sur les pratiques en santé, il doit faire l'objet d'un effort de recherche structuré pour en améliorer continûment l'efficacité, l'efficience et l'équité. Cet article dresse un état des lieux de la recherche sur l'ETP et en dégage des perspectives, suite à un colloque organisé par l'IReSP le 29 janvier 2015 sur la thématique.

Gallois, P., Vallee, J. P. et Le, N. Y. (2006). "L'observance des prescriptions médicales : quels sont les facteurs en cause ? Comment l'améliorer ?" Medecine : Revue de L'Unaformec **2**(9).

> L'objectif de ce dossier est de mieux comprendre ce que recouvre le concept d'observance. Une bonne observance s'explique autant, sinon plus, par la façon de prescrire que par la façon de suivre la prescription. Médecin et malade y ont donc chacun une part de responsabilité. Certains des facteurs d'une bonne observance sont liés à la maladie, d'autres à la nature de la prescription (celle d'un médicament, d'une modification des modes de vie...), d'autre encore à sa durée etc.. A tous les niveaux de cette chaîne complexe, une meilleure connaissance des facteurs en cause doit permettre

d'identifier le taux d'observance, et surtout aider le prescripteur à adopter des comportements qui favorisent une bonne observance (tiré de l'introduction)

Gallois, P., Vallee, J. P. et Le, N. Y. (2012). "Education thérapeutique du patient." Medecine : Revue de L'Unaformec **8**(1).

Que vient faire « l'éducation » dans le champ de la santé ? Selon les propositions de ses promoteurs (depuis largement plus d'une décennie...), « éduquer », c'est rendre le patient plus autonome à propos de sa maladie, plus acteur qu'observateur, plus « participant » aux décisions qui le concernent directement. Avec deux limites a priori : qu'il le souhaite et que son état de santé le lui permette... Construire avec lui une démarche originale et nouvelle suppose lui reconnaître une expertise propre, et par conséquent d'admettre qu'il est « aussi » au moins dans certains cas formateur de ses professionnels, bien loin d'une simple recherche d'amélioration de l'observance. Les enjeux sont nombreux et compliqués, d'où ce deuxième dossier consacré à ce sujet, après une première approche en 2009. S'il faut se donner, comme nous le disions alors, les moyens d'un réel transfert de compétences des soignants vers les patients, peut-être faut-il aujourd'hui aller plus loin et essayer de faire de ce transfert un échange à double courant

Genolini, J. P., Roca, R., Rolland, C., et al. (2011). ""L'éducation" du patient en médecine générale : une activité périphérique ou spécifique de la relation de soin ?" SCIENCES SOCIALES ET SANTE **29**(3): 81-122.

L'éducation du patient concernant les habitudes hygiénodiététiques est officiellement intégrée à la spécialisation de la médecine générale mais faiblement objectivée par les travaux sur le recensement des activités médicales. La recherche analyse, dans la pratique ordinaire des médecins, la façon dont se déploient les recommandations d'hygiène. les interactions médecin-patient sont décryptées sur 50 consultations de suivi (risques cardiovasculaires). Elles montrent que les échanges sur les habitudes de vie sont plutôt périphériques et peu influencées par le niveau de l'atteinte mais aussi, pour une partie des consultations, qu'ils déterminent un contexte spécifique à l'éducation du patient. Le travail entrepris par le médecin sur le changement comportemental est une "négociation" qui oscille entre le registre d'une médicalisation du style de vie et celui d'une communication ordinaire. (R.A.).

Grenier, B., Bourdillon, F. et Gagnayre, R. (2007). Le développement de l'éducation thérapeutique en France : politiques publiques et offres de soins actuelles. Sante Publique (4)
Éducation thérapeutique.

[BDSP. Notice produite par ENSP es5R0xaX. Diffusion soumise à autorisation]. L'éducation thérapeutique du patient (ETP) connaît depuis quelques années un essor important. Le présent article montre les principales orientations qui ont permis le développement de l'éducation thérapeutique en France et ont contribué à sa place dans l'offre de soins actuelle. L'organisation de l'ETP en France y est analysée et y sont décrites les initiatives menées en établissement de santé, en ville, dans les structures médicales, médico-sociales ou associatives. Cette analyse suggère quelques propositions afin de structurer et intégrer durablement l'éducation thérapeutique à l'ensemble du territoire

Grimaldi, A., Caille, Y., Pierru, F., et al. (2017). Les maladies chroniques : vers la 3e médecine, Paris : Odile Jacob
http://www.odilejacob.fr/catalogue/medecine/medecine-generale/maladies-chroniques_9782738135261.php

Vingt millions de Français souffrent de maladies chroniques, soit un tiers de la population – une véritable épidémie. Hier encore, on mourait de ces maladies, aujourd'hui, elles nous accompagnent toute notre vie. Diabète, cancers, hypertension artérielle, sida, insuffisance respiratoire, mucoviscidose, myopathies, maladies inflammatoires de l'intestin, polyarthrite rhumatoïde, asthme, lupus, insuffisance rénale, cirrhoses hépatiques, séquelles d'accidents vasculaires cérébraux, insuffisance cardiaque, sclérose en plaques, maladie de Parkinson, maladies psychiatriques, maladie d'Alzheimer, obésité… La France doit à présent se doter de tous les moyens pour améliorer la vie de tous les patients atteints de ces maladies. Nous sommes entrés dans l'ère de la 3e médecine, véritable médecine de la personne, aux côtés de la médecine des maladies aiguës bénignes et de la médecine des maladies graves. Pour le patient, une nouvelle façon de vivre ; pour le médecin, une nouvelle façon d'exercer son métier, à l'heure des grandes avancées médicales et techno-logiques.Soixante-quatorze médecins, patients et experts se sont associés ici pour relever le défi des maladies chroniques.

Harry Isabelle, G. R. (2013). "Temporalité et usage des forums asynchrones dans le diabète de type 1. Contribution à l'Éducation thérapeutique du patient." Sante Publique**25**(4).

[BDSP. Notice produite par EHESP 8qFoqR0x. Diffusion soumise à autorisation]. L'objectif de cette étude est de comprendre la notion de temporalité dans l'usage des forums de discussion utilisés par les sujets confrontés au diabète de type 1 : adultes et parents d'enfants. Dans un premier temps, a été traduit en compétences le contenu des messages, puis leur temporalité a été analysée, en particulier par la durée d'activité des threads. Deux types de temporalité interfèrent dans l'usage des forums : le temps prescrit gouverné par les exigences thérapeutiques liées à la maladie chronique et les décisions à prendre, le temps social ouvert qu'offrent les forums d'Internet et les processus réflexifs différés qui en découlent. Les résultats montrent que les thèmes de discussion relatifs aux compétences d'auto-soins et d'adaptation sont sans cesse abordés par l'introduction fréquente de nouveaux threads. On constate une forte diversité de l'activité des threads, la majorité d'entre eux étant cependant actifs sur de courtes périodes. Suite à cette étude, les perspectives de recherche interrogent d'une part, la manière dont les patients et leur famille peuvent concilier la temporalité dictée par la maladie chronique (temps prescrit) avec le temps social ouvert de l'internet, et d'autre part comment cette temporalité est une caractéristique de l'apprentissage des patients par l'usage des forums de discussion. Dans ces futures recherches, le concept de rythmo-apprenance, appliqué à l'éducation thérapeutique du patient, peut prendre toute sa place

Gérard, A. C. (2018). "[Improving the management of heart failure in the Vendée]." Rev Infirm **67**(240): 35-37.

Heart failure is a serious condition which affects mainly elderly people. In the Vendée region, where many people choose to retire, hospital teams have noticed an increase in hospitalisations for heart failure. To optimise the management of these patients, a follow-up service was set up in July 2016 comprising a PRADO programme specifically supporting the return home of patients with heart failure.

Guillen, A. S., Guillen, A. et Combres, L. (2020). "Quelle place pour la subjectivité du malade dans la pratique médicale ?" Éthique & Santé **17**(2): 65-70.
https://doi.org/10.1016/j.etiqe.2020.03.002

Résumé La médecine expérimentale produit un savoir sur l'objet maladie, mais nécessite d'exclure la subjectivité du patient. Cette exclusion a été redoublée par la médecine paternaliste qui pouvait laisser le malade en dehors des décisions concernant ses soins. Le sentiment de certains malades de ne pas être entendu les a amenés à réaffirmer leur demande de participer de manière plus active aux soins. Cette demande a été prise en compte par la Loi du 4 mars 2002 : le savoir du médecin doit être mis à la portée du malade. L'éducation thérapeutique connaît dès lors un nouvel essor, car elle donne accès aux connaissances médicales pour acquérir un certain pouvoir sur la maladie. Mais certains patients continuent à ressentir le manque d'un espace pour subjectiver ce qui leur arrive. Il faut donc s'appuyer sur d'autres dispositifs, tels que l'art ou la psychanalyse, pour autoriser et favoriser des constructions subjectives.

Guirimand, N., Mazereau, P. et Leplege, A. (2018). Les nouveaux enjeux du secteur social et médico-social : décloisonner & coordonner les parcours de vie et de soin, Nimes : Champ social éditions

La notion de parcours de vie impose une transformation profonde des modalités d'organisation du secteur médico-social, sanitaire, éducatif ou d'accès aux structures de droit commun. Lorsqu'il s'agit de suivre et d'accompagner des personnes en situation de handicap ou de dépendance, ainsi que des malades chroniques, elle implique de définir avec les usagers leur projet de vie. En conséquence, ce travail impulse une dynamique d'élaboration et de prise de décision à la croisée de plusieurs secteurs. Accompagner les personnes en situation de handicap ou malades chroniques dans l'élaboration de leur parcours de vie, favoriser l'accessibilité aux services de droit commun, les aider à s'autonomiser et à trouver des réponses à leurs besoins et attentes, implique la mise en œuvre de dispositifs innovants en matière d'éducation thérapeutique, d'inclusion scolaire et péri-scolaire, mais aussi de soutien à la parentalité pour les familles les plus vulnérables. La pluralité des modalités de mise en œuvre de programmes d'éducation thérapeutique et de dispositifs sanitaires et médico-sociaux d'accompagnement rend difficile la lecture des services proposés à la fois pour les usagers et pour les agents impliqués dans leur mise en œuvre. Si de manière consensuelle, la pluridisciplinarité est reconnue comme indispensable, la coopération entre les intervenants, elle, est essentielle. Pourtant cette coopération nécessite d'être pensée et analysée dans sa complexité, c'est-à-dire au point d'intersection entre les intérêts et les enjeux des agents à et pour cette pratique éducative, les moyens dont ils disposent pour sa mise en œuvre, sa temporalité (hospitalisation de jour, moyen séjour, stage intensif), les lieux d'exercice (service hospitalier, pôle de santé, domicile du patient, etc.). La coordination des parcours de vie appelle donc une exploration multidimensionnelle : sociologique, psychologique, philosophique, politique et anthropologique approfondie de toutes ces dimensions. Cet ouvrage tente d'apporter des éléments de compréhension en interrogeant, dans un même mouvement, les mécanismes implicites et explicites de la collaboration interprofessionnelle, les questions de l'inclusion sociale et scolaire, de l'éducation thérapeutique des jeunes en situation de handicap, ainsi que les transformations identitaires des acteurs qui coopèrent à la construction des parcours de vie.

Hannane, A., Misane, L., Devouassoux, G., et al. (2019). "Asthma patients' perception on their care pathway: a qualitative study." NPJ Prim Care Respir Med **29**(1): 9.

Because of insufficient asthma control in many patients, the collaboration between stakeholders is regarded as a promising strategy to improve asthma outcomes. This study explored the perceptions of French adult asthma patients on their care pathway. We conducted a qualitative study based on the interviews of 30 asthma patients aged 18-40 years, recruited in French primary care. We performed a thematic analysis of the data collected, using the NVivo software. According to the patients, the stakeholders involved in asthma management included those visible to healthcare professionals (patient, general practitioner, specialist(s), pharmacist, physiotherapist, family and friends) and those concealed by the patients (complementary and alternative practitioners); other stakeholders, such as nurses and occupational physicians, were not involved. Asthma management at diagnosis and follow-up phases proved to be unstructured, and were associated with poor patient education. This was supported by patients' ambivalence (in relation to illness and treatments), poor communication between patients and healthcare professionals (lack of listening and use of inappropriate vocabulary by physicians, underreporting of alternative medicine use by patients) and weak cooperation between professionals (limited to interaction between the general practitioner and the specialist, either pulmonologist or allergist). Asthma management would probably benefit from a more coordinated care pathway at each phase of the disease that is consistent with the expectations and goals of the patients. It should be based on improved organization (involvement of other healthcare professionals and the patient as partners) and processes (regular follow-up, specific tools such as peak flow meter or action plan).

HAS (2014). "Cahier des charges pour la mise en oeuvre de l'éducation thérapeutique du patient (ETP) dans le cadre de l'expérimentation PAERPA."
http://www.has-sante.fr/portail/upload/docs/application/pdf/2014-05/cahier_des_charges_etp_paerpa__web.pdf

Ce fascicule présente un cahier des charges élaboré par la HAS pour la mise en œuvre de l'éducation thérapeutique dans le cadre de l'expérimentation PAERA, à la demande de la Direction de la Sécurité sociale. Ce cahier des charges doit permettre de garantir la qualité de l'ETP ainsi que les modalités de sa mise en pratique. Il définit les thèmes sur lesquels une efficacité potentielle est démontrée, les compétences requises de la part du patient pour être réceptif et l'adaptation des méthodes à la personne âgée Il rappelle également les principes fondamentaux de l'ETP et leur application dans le modèle PAERPA

HAS (2007). L'éducation thérapeutique dans la prise en charge des maladies chroniques : Analyse économique et organisationnelle**:** 96p.

L'éducation thérapeutique est aujourd'hui reconnue comme un élément essentiel de la prise en charge des patients atteints d'une pathologie chronique. Cependant, l'analyse du contexte et les différentes enquêtes de terrain existantes montrent que l'ETP pose de nombreux problèmes de mise en ouvre concrète : hétérogénéité des pratiques, implication variable des professionnels et des patients, modalités de financement et d'organisation incertaines, etc. Or, les études médico-économiques mettent en évidence que, dans ces conditions, le résultat clinique et économique que l'on peut attendre d'une action d'éducation thérapeutique est pour le moins incertain. En conséquence, si l'on veut développer l'ETP, cela doit impérativement se faire dans le cadre d'une stratégie globale visant à rendre cohérents les différents vecteurs possibles de l'offre d'ETP et à garantir la qualité de l'ETP dispensée. Le développement de l'éducation thérapeutique doit reposer sur le respect de deux principes opérationnels fondamentaux : la coordination de l'offre sur le territoire et la promotion d'une démarche qualité. Concrètement, une coordination en trois niveaux peut être mise en place. - Au niveau national, la définition des orientations générales du développement de l'ETP en France (organisation, recommandations professionnelles, etc.) peut reposer sur des structures existantes, dont une serait chargée en outre d'assurer une veille sur l'activité. - Au niveau régional, il s'agit de coordonner l'offre et le financement de l'éducation thérapeutique tout en disposant d'un centre d'information pour les patients et les professionnels de santé. - Au niveau local, des structures et acteurs prestataires garantiraient une offre de proximité. Les méthodes permettant de mettre en place rapidement une démarche qualité existent (certification, évaluation des pratiques professionnelles) mais les outils permettant leur adaptation à l'ETP doivent encore être élaborés : recommandations de pratiques professionnelles déclinées par pathologie, cahiers des charges listant les critères de qualité d'une structure prestataire, référentiel d'évaluation des pratiques professionnelles. Deux autres éléments sont indispensables en amont du développement d'une éducation thérapeutique de qualité et adaptée aux besoins de la population : l'inscription de l'ETP dans la formation initiale et continue des professionnels de santé concernés ; le financement harmonisé des actions d'ETP mises en ouvre par des structures ou des professionnels inscrits dans une démarche qualité.

HCSP (2013). Évaluation du plan pour l'amélioration de la qualité de vie des personnes atteintes de maladies chroniques : 2007-2011. Paris : HCSP.
http://www.hcsp.fr/Explore.cgi/Telecharger?NomFichier=hcspr20130328_evalplanqualviemalchronique.pdf

La prise en charge des malades chroniques est un enjeu sanitaire et sociétal majeur des prochaines années. Ce plan, conduit avec une forte implication des associations de patients, a permis de promouvoir les notions de maladie chronique, d'autonomisation des patients et de prise en charge transversale. Le Haut Conseil de la santé publique considère que si le plan a constitué une avancée importante, l'effort d'adaptation du système de santé doit être poursuivi et propose des principes d'actions et des objectifs stratégiques pour un futur plan

HCSP (2015). Avis relatif à la mise en oeuvre de l'éducation thérapeutique du patient depuis la loi n°2009-879 du 21 juillet 2009 portant réforme de l'hôpital et relative aux patients, à la santé et aux territoires (HPST). Paris HCSP**:** 20.
http://www.hcsp.fr/explore.cgi//avisrapportsdomaine?clefr=528

Au terme d'un processus d'évaluation participatif, cet avis conforte l'éducation thérapeutique comme composante du parcours de soins des personnes atteintes de maladies chroniques. L'avis prend en compte la question des inégalités sociales et territoriales de santé. Il incite à un enrichissement des connaissances dans ce domaine. Il suggère des évolutions ou des précisions réglementaires dans le domaine de la formation des intervenants. Il requiert une plus grande visibilité et accessibilité de l'offre disponible Il invite à explorer, tester et évaluer de nouveaux « modèles » de mise en œuvre de l'éducation thérapeutique du patient (résumé des éditeurs).

Hélaine, A. et Podevin, M. (2020). "The role of patients' associations." Bull Cancer **107**(3): 381-384.

The role of patient groups has grown steadily stronger since the first General Meeting of cancer patients in 1999 and the emergence of the rare diseases issue in the mid-eighties. This article demonstrates the role of a patient group (SOS DESMOIDE) gathering people suffering from a rare disease (the desmoid tumor) in the stimulation of scientific and medical research as well as the improvement of patient care, information and support provided to patients. It substantiates these elements with numerous socio-medico-psychological surveys, scientific publications and medical research implemented by medical teams and supported, even sometimes initiated, by SOS DESMOIDE. This research effort illustrates the significant impact of a partnership between patients and physicians-researchers on medical and scientific breakthroughs in a specific pathological field.

Igas (2007). Encadrement des programmes d'accompagnement des patients associés à un traitement médicamenteux financés par les entreprises pharmaceutiques. Paris La Documentation française**:** 96.
http://www.ladocumentationfrancaise.fr/rapports-publics/084000049/index.shtml

Le droit communautaire dans le domaine du médicament (DDACM) a donné lieu à un projet de loi d'adaptation de ce droit en droit français afin d'autoriser le gouvernement à régir par ordonnance "les programmes d'accompagnement des patients soumis à des traitements médicamenteux lorsque ces programmes sont financés par des établissements pharmaceutiques". Ayant suscité de nombreuses réactions défavorables, tant auprès des représentants des professions de santé que des institutions de santé, ce projet a été retiré après son examen à l'Assemblée nationale. Ce rapport fait le point sur cette pratique (application aux patients, situation juridique) et constate les difficultés de la discussion parlementaire, le projet ayant été retiré avant son examen par le Sénat. Il étudie ensuite les enjeux de cette observance thérapeutique, le rôle du médecin, les risques de l'accès direct au patient et estime qu'une trop grande place est donnée aux laboratoires dans le système de santé. Il émet des recommandations, notamment en vue d'interdire tout contact direct ou indirect entre les laboratoires pharmaceutiques et le public.

Inpes (2009). Agences régionales de santé : : financer, professionnaliser et coordonner la prévention. SaintDenis, INPES

Inpes (2012). Etat des lieux et recommandations sur l'éducation pour la santé en milieu pénitentiaire. Santé., I Paris : Inpes.
http://www.inpes.sante.fr/30000/pdf/sante-penitentiaire.pdf

Cette enquête dresse l'état des lieux de l'organisation et de la réalisation de l'éducation pour la santé en milieu pénitentiaire et des conditions dans lesquelles elle se déroule. Son objectif est de décrire les pratiques d'éducation pour la santé en milieu pénitentiaire, d'identifier les besoins, les difficultés et les facteurs facilitant selon les équipes des UCSA (unités de consultations et de soins ambulatoires) et de recueillir leurs attentes. Les résultats doivent permettre d'orienter la suite des travaux de l'INPES (Institut National de Prévention et d'Education pour la santé) pour renforcer et faciliter la mise en oeuvre de l'éducation pour la santé en milieu pénitentiaire, notamment l'élaboration d'un référentiel d'intervention.

Jacquat, D. r. (2010). Éducation thérapeutique du patient : propositions pour une mise en oeuvre rapide et pérenne. Rapport au Premier ministre. Paris La Documentation française**:** 65.
http://www.ladocumentationfrancaise.fr/rapports-publics/104000364/index.shtml

En janvier 2010, le Premier ministre avait chargé une mission parlementaire d'élaborer des propositions concrètes susceptibles d'assurer un déploiement national rapide et pérenne des programmes d'éducation thérapeutique du patient (ETP), programmes inscrits désormais dans le parcours de soins par l'article 84 de la loi du 21 juillet 2009 portant réforme de l'hôpital et relative aux patients, à la santé et aux territoires. Il estimait que des incertitudes concernant notamment le mode de financement ou l'organisation pratique de ces programmes pourraient être de nature à entraver l'émergence de programmes de qualité. Ce rapport présente les travaux et conclusions de la mission parlementaire conduite par le député Denis Jacquat. Dans un premier point, la mission présente un état des lieux de l'ETP en France puis à l'étranger en concentrant son étude sur quatre pays européens ayant, soit une antériorité importante (Suisse, Belgique), soit des approches différentes avec des points d'ancrage hospitaliers (Pays-Bas) ou ambulatoires (Allemagne). Puis, dans un deuxième point, sur la base d'un certain nombre de constats - développement de l'ETP en France depuis une vingtaine d'années conduit sur un mode non structuré et non coordonné essentiellement en milieu hospitalier, formation initiale des professionnels de santé à l'ETP quasi inexistante, absence de structures dans le champ ambulatoire-la mission présente une vingtaine de propositions. Elle appelle notamment à la mise en place d'une politique nationale de l'ETP s'appuyant sur l'existant et associant organisations de patients, sociétés savantes et autorités compétentes. Elle appelle également à un effort conséquent de formation et à un positionnement de l'ARS au coeur du dispositif.

Jaffiol, C., Corvol, P., Reach, G., et al. (2013). "L'éducation thérapeutique du patient (ETP), une pièce maîtresse pour répondre aux nouveaux besoins de la médecine." Bulletin De L'academie Nationale De Medecine **197**(9): 1747-1781.

L'expansion des maladies chroniques a mis en évidence l'impossibilité de concevoir et de mettre en oeuvre dans l'avenir une réelle politique de santé publique sans impliquer les patients dans le suivi de leur maladie, et sans donner parallèlement aux médecins la possibilité d'être plus à leur écoute et plus disponibles en termes de temps et de compétence éducative. L'éducation thérapeutique du patient (ETP), etelle qu'elle a été définie officiellement par l'Organisation mondiale de la santé (OMS) est légalisée en France, depuis son inscription dans l'article 84 de la loi HPST (Hôptal, Patients, Santé et Territoire) du 21 juillet 2009, qui en précise le principe et les modalités. Cet article identifie les obstacles culturels et structurels s'opposant à la mise en oeuvre de l'ETP, depuis la formation médicale, trop déconnectée du patient, l'absence de travail d'équipe entre les divers intervenants de soins, le manque de coordination territoriale, une tarification inadaptée.

Jouet, E., Flora, L. et Las Verghnas, O. (2020). Construction et reconnaissance des savoirs expérientiels des patients : Note de synthèse, HAL
https://hal.archives-ouvertes.fr/hal-00645113/document

Les schémas de production et de reconnaissance des savoirs dans le domaine de la santé se modifient profondément : pour les pathologies chroniques notamment, les expertises propres aux malades émergent comme sources de savoirs : les stratégies classiques d'éducation thérapeutique, proposées par les soignants pour améliorer l'observance des traitements, se doublent de nouveaux courants issus des communautés de malades qui rattachent les maladies à des formations expérientielles, voire à des épisodes autodidactes. Après avoir été resituée historiquement comme constitutive de l'idée de démocratie sanitaire, cette reconnaissance des savoirs expérientiels des patients – en marche dans de multiples lieux – fait ici l'objet d'une revue de littérature qui en regarde les enjeux épistémologiques, thérapeutiques et de pouvoir.

Jourdan, D. (2012). "La prévention : Une priorité de santé publique, un enjeu éthique, un défi pour la pratique en médecine de ville." Concours Medical **134**(6).

[BDSP. Notice produite par ORSRA mmIR0x8k. Diffusion soumise à autorisation]. En santé publique, la prévention joue un rôle primordial. Les médecins généralistes sont en première ligne pour adopter et mettre en place une démarche de prévention et d'éducation. Cet article est une réflexion concernant les questionnements et dilemmes éthiques posés par les pratiques de prévention

Kerzanet, S. (2012). "Un siècle d'éducation pour la santé." Sante de L'Homme (La) (420).

[BDSP. Notice produite par INPES E89R0xHF. Diffusion soumise à autorisation]. Frise chronologique de 1902 à 2010 qui retrace l'histoire de l'éducation pour la santé (lois, textes de référence, institutions.)

Lacroix, A., Haxaire, C., Pelicand, J., et al. (2009). Théories et concepts. Actualite et Dossier en Sante Publique (66)
Éducation thérapeutique : concepts et enjeux, Paris : Haut Comité de la Santé Publique

[BDSP. Notice produite par EHESP E9mR0xEH. Diffusion soumise à autorisation]. L'éducation thérapeutique se construit autour de la rencontre des sciences médicales, humaines et sociales. Complémentaires ou en opposition, les concepts et modèles théoriques sur lesquels elle se fonde font l'objet d'un débat aussi vif qu'intéressant. Les premières tentatives d'éducation thérapeutique consistaient à diffuser des savoirs médicaux relatifs à la maladie alors qu'il s'agissait surtout, pour les patients concernés, d'être entraînés à gérer leur traitement. Or, s'agissant de la maladie, s'approprier des savoirs ne garantit pas leur mise en oeuvre en comportements pertinents. Pour le malade et son entourage, la maladie est expérience vécue, ancrée dans leur histoire, dans leur culture, dans leur milieu social et économique, expérience cadrée ou contrainte par les modes de prise en charge accessibles, expérience de bouleversement du quotidien et de limitation durable de la vie parfois. Dans sa pratique soignante et éducative avec des personnes atteintes de maladies chroniques, le soignant est confronté à deux lieux d'ambivalence. Le premier tient à l'évolution du partage de pouvoir et de responsabilité technique entre patient et soignant. Le second est lié au fait d'accepter que le patient définisse ses propres normes de santé et de prise en charge, même lorsque celles-ci l'exposent à un risque accru de souffrir de complications de sa maladie. En matière de maladies chroniques, cependant, la guérison est par définition exclue et le mieux que le soignant puisse faire est de soulager le patient. Seulement soulager, en sachant renoncer au phantasme de l'éradication du mal et de l'atteinte du bonheur

Laforest, L., Belhassen, M., Devouassoux, G., et al. (2017). "[Therapeutic adherence in asthma in France: A general review]." Rev Mal Respir **34**(3): 194-222.

INTRODUCTION: Adherence in asthma is a paramount issue of disease management. A general review of the French publications on this topic has been conducted. METHODS: Research equations used for bibliographic databases (MEDLINE, Science Direct, Banque de donnees en sante publique, Cochrane and Cairn.info) comprised the following keywords: "asthma", "therapeutic adherence" and "France". These publications unrelated to asthma, focused on asthma management without exploring adherence, or those conducted in populations without French patients were excluded. RESULTS: A total of 82 articles have been selected (36 surveys, 4 randomized trials and 42 reviews/syntheses). Whatever the methodology used and publication year, the inadequate therapeutic adherence in asthma was steadily reported, notably for controllers and the quality of use of inhaled devices. CONCLUSION: The present review highlights the sustainability of adherence-related issues in asthma and the need to improve patients' knowledge on asthma and the finality of therapy. It also highlights the need of an improved communication between patients and physicians is also advocated. Further studies with more recent data are desirable to assess changes in disease management of asthma and the impact of potential future corrective interventions.

Lagger, G. (2009). "Efficacité de l'éducation thérapeutique." Revue de Medecine Suisse (5).

L'éducation thérapeutique se développe de manière continue depuis plus de 30 ans pour mieux soigner les malades chroniques. Cet article propose une synthèse des méta-analyses récentes ayant pour objet d'évaluer son efficacité. L'analyse reflète plus de 500 études concernant une dizaine de maladies. Il en ressort que les interventions éducatives sont peu décrites et qu'il est fréquent que les groupes contrôles aient bénéficié d'une éducation sommaire. En dépit de ces biais, l'efficacité de l'éducation thérapeutique est clairement démontrée pour la majorité des études (60%), et ceci quels que soient les pathologies et les indicateurs utilisés. Concernant l'obésité, on se situe exactement dans la même tendance, avec des pertes de poids conséquentes et durables

Lagger, G., Chambouleyron, M., Lasserre-Moutet, A., et al. (2008). "Education thérapeutique. 2ème partie : mise en pratique des modèles en 5 dimensions." Medecine : Revue de L'Unaformec **4**(5).

L'éducation thérapeutique ne peut se pratiquer que dans le cadre d'une relation privilégiée entre patients et soignants, bénéficiant du développement des compétences des soignants dans leur capacité à accroître la qualité de cette relation. Ce second article décrit succinctement des modèles psycho-sociaux qui sont autant de grilles de lecture d'une situation clinique suggérant des pistes concrètes d'interaction. Il s'agit de partir des ressources des patients pour les développer, d'autant mieux que cela prend un sens pour eux. Le travail à partir des conceptions du patient est ainsi primordial. La mise en place systémique des enseignements dans 5 dimensions (cognitive, affective, perceptive, infra- et méta-cognitive) permet au patient d'apprendre, mais surtout de relier cet apprentissage à la mise en place de changements

Lahoreau, G. (2013). "Education thérapeutique. Quand le patient se prend en main." Science et Santé (12): 34-35.

Launois, R., Megnibeto, A. C., Perez, V., et al. (2002). "Expérimentation de la prise en charge de l'asthme en Réseau de Soins Coordonnés : bilan de l'expérience RESALIS dans l'Eure, 18 mois avant et 12 mois après l'intervention." Journal D'Economie Medical **20**(6).

[BDSP. Notice produite par ORSRA uLpR0xkr. Diffusion soumise à autorisation]. Alliance Médica et la CPAM de l'Eure se sont associées pour mettre en place un programme de prise en charge globale de la maladie asthmatique. Cinq interventions ont été mises en oeuvre : - l'informatisation des cabinets médicaux, - l'éducation des patients, - la formation des médecins tant sur le plan diagnostique que thérapeutique, - la définition de recommandations de bonnes pratiques cliniques adaptées aux réalités locales, - l'échange d'informations entre les professionnels de santé concernés. L'objet de ce premier travail est de dresser un état des lieux 18 mois avant et 12 mois après la mise en place de ce dispositif

Lang, J. P., Jurado, N., Herdt, C., et al. (2019). "[Education care in patients with psychiatric disorders in France: Psychoeducation or therapeutic patient education?]." Rev Epidemiol Sante Publique **67**(1): 59-64.

CONTEXT: Psychoeducation and therapeutic patient education can be effectively included in treatments for patients with psychiatric disorders. These two effective educational therapies have the common purpose of improving disorder-related morbidity, compliance with treatment and patients' quality of life. While they have different methods of application, both teach patients to play an active role in their own care. However, it is still critical to combine them for care of patients with psychiatric and addiction disorders in a manner that allows for specificity. To do this, the differences between psychoeducation and therapeutic patient education must be considered, and their potential for the management of patients with psychiatric and addiction disorders must be determined. METHODS: In our article, we review the literature concerning therapeutic education programs for patients and discuss the literature based on the experiences of psychiatrists trained in these therapies. RESULTS: Despite rather nonrestrictive guidelines, and after reviewing numerous studies, we found that psychoeducation seems to be rarely used in psychiatry. The use of therapeutic patient education programs for psychiatric patients has doubled in four years but still accounts for less than 4% of validated programs in France. Only 154 programs were developed in 1175 public psychiatric facilities in 2016. Therapeutic patient education has a legal framework and recommendations, which make it suitable for inclusion in care and in the training of care providers. The rigor in the development of therapeutic patient education programs and the requirement for training and financial support reinforce the need for their establishment in healthcare institutions. As such, they could help to modify professional practices and the culture of care in mental health fields. CONCLUSION: There is a place for therapeutic patient education in psychiatry as it provides a real benefit for patients. It could modify care practices and costs, and is suitable for patients with psychiatric or addiction disorders by helping them play an active role in their care, thereby improving treatment outcomes and quality of life.

Le Bouler, S. (2006). Evaluation des écoles de l'asthme en France. Paris : Ministère chargé de la santé.
http://lesrapports.ladocumentationfrancaise.fr/BRP/064000547/0000.pdf

La Direction générale de la santé a souhaité voir mener une évaluation des écoles de l'asthme en France, dans le cadre de la préparation du plan national en faveur de la qualité de vie des malades atteints d'une maladie chronique. Le plan "Asthme 2002-2005", lancé en janvier 2002, avait identifié 5 objectifs pour améliorer la prise en charge et la qualité de vie des malades asthmatiques, dont le développement de l'éducation thérapeutique. A ce jour, plus de 100 écoles de l'asthme sont en place, mais cet effort paraît encore insuffisant au regard des difficultés observées dans l'observance thérapeutique et de la répartition de ces structures sur le territoire. Le rapport d'évaluation s'efforce de répondre aux questions suivantes : les actions développées au sein des écoles de l'asthme sont-elles adaptées à l'objectif poursuivi ? Est-il possible d'en évaluer l'impact sur la qualité de la prise en charge du patient asthmatique et son état de santé ? Quel est le taux de couverture de la population cible par ces écoles de l'asthme ? On sait que le nombre d'asthmatiques est estimé à 2,5-3 millions de personnes. L'accès des patients à ces structures d'éducation est-il aisé, équitable ? En d'autres termes : quel est l'impact individuel de ces structures sur le devenir des patients ? Quel est l'impact collectif sur la prise en charge de la maladie asthmatique en France ? Et quelles sont les pistes d'amélioration à promouvoir dans ce domaine

Lehmann, H. (2019). "[A new support given to patients in retail pharmacies: The "shared checkup of medication"]." Ann Pharm Fr **77**(4): 265-275.

In accordance with the recommendations of the HPST law of 21st July 2009, the retail pharmacists heavily put a lot into new missions, concerning as well prevention and screening as therapeutic education of patient. In that context, two types of pharmaceutical conversations relative to patient's therapeutic training were primarily planned : the first one concerns patients with thrombosis' risk treated by oral anticoagulants (antivitamin K or direct oral anticoagulant), whereas the second one is intended to asthmatics cured by corticoids' inhalation. Then the publication in 2017 and 2018 respectively of amendments no 11 et 12 to the National convention of 4th April 2012 organizing relationships between titular pharmacists and health insurance planned a third type of support called « shared checkup of medication ». It is a matter of program of personalized pharmaceutical monitoring intended to patients at least 65 years old and suffering from one or several long-lasting affection(s), and also to patients at least 75 years old and chronically treated by at least five different active substances. Those new pharmaceutical conversations aim on the one hand to improve observance of chronic medications - current by elderly patients - and on the other hand to prevent drug iatrogenesis - favored by polymedication - while reasserting the major role of the retail pharmacist as health professional.

Lelorain, S., Bachelet, A., Goncalves, V., et al. (2019). "Nurses' and nursing assistants' emotional skills: A major determinant of motivation for patient education." J Adv Nurs **75**(11): 2616-2626.

AIMS: To explore professionals' (i.e. nurses and nursing assistants) motivation for Patient Education according to their emotional skills. DESIGN: A cross-sectional study using a convenience sample of professionals completing self-reported questionnaires assessing their general emotional skills and their Patient-Education-related sense of competence, autonomy and relatedness, according to the theory of basic psychological needs. METHODS: Professionals from 27 French hospitals working in various departments completed paper and web-based questionnaires between January 2015 - May 2017. Mediation analyses were performed controlling for the already known variables associated with motivation for patient education. RESULTS: Usable questionnaires (N = 185) were analysed. Professionals' emotional skills were associated with their motivation for Therapeutic Patient Education both directly and indirectly (i.e. partial mediation) via a higher sense of competence in Patient Education. Among the covariates, professionals who had received a high-level training in Patient Education, those with a high recognition of their work in patient education and nurses (compared with nursing assistants) were the most motivated. CONCLUSION: Professionals' emotional skills are the mainstay of their motivation for Patient Education. Training should aim to develop these skills so that professionals can manage their own emotions better (e.g. frustration when faced with non-motivated patients) and those of patients (e.g. discouragement) and thus effectively support patient self-management. IMPACT: The study addressed nurses' and nursing assistants' motivation for patient education. Their emotional skills were directly and indirectly - via a higher sense of patient-education-related competence - associated with higher motivation. Training for professionals should therefore develop their emotional skills.

Lemaire, N. et Von, L. F. (2009). Le disease management, une réponse aux défis des maladies chroniques. Traité d'économie et de gestion de la santé. Paris : Editions de Santé ; Paris : SciencesPo Les Presses

Levesque, J. F., Feldman, D. et Dufresne, C. (2009). "Barrières et éléments facilitant à l'implantation de modèles intégrés de prévention et de gestion des maladies chroniques." Pratiques Et Organisation Des Soins(4).
http://www.ameli.fr/fileadmin/user_upload/documents/Pos_094_Integration_de_la_prevention_aux_soins.pdf

[BDSP. Notice produite par CNAMTS srnpR0xr. Diffusion soumise à autorisation]. Les maladies chroniques représentent un fardeau croissant pour les systèmes de soins des pays développés. Pour faire face à leur nature multifactorielle, des modèles intégrés de prévention et de gestion ont été suggérés. Bien que ces modèles aient démontré qu'ils améliorent les résultats des soins des personnes atteintes de maladies chroniques, leur implantation à l'échelle des systèmes de santé demeure un défi. Cette étude avait pour objectif d'identifier les facteurs qui faciliteraient ou nuiraient à l'implantation de ces modèles de soins

Lombrail, P. (2013). "Pour une stratégie nationale de santé qui ne se limite pas à l'optimisation des parcours de soins individuels." Sante Publique // **25**(4).

[BDSP. Notice produite par EHESP 8DDlIR0x. Diffusion soumise à autorisation]. La stratégie nationale de santé (SNS) a pour ambition de définir un cadre de l'action publique pour les années futures, pour combattre les injustices et inégalités de santé et d'accès au système de soins et adapter le système de santé français aux besoins des patients, ainsi qu'aux mutations qui sont à l'oeuvre. L'auteur de cet article regrette que l'essentiel des recommandations porte sur le système de soins (et de protection sociale), alors qu'une seule (même si c'est la première) nomme en propre l'objectif de promotion de la santé et de prévention et qu'aucune n'est consacrée aux enjeux de santé et d'environnement (cinq lignes sont consacrées à la santé au travail, par exemple). Certes, parmi les décisions figure bien celle de renforcer l'aspect sanitaire de l'étude d'impact des projets de loi ", mais c'est, avec l'invite au" renforcement des équipes de santé scolaire et universitaire en y consacrant une part des crédits des 60 000 emplois créés dans l'éducation nationale ", une des rares allusions, selon l'auteur de l'article, à la nécessité de développer une approche intersectorielle des questions de santé

Lonne, M. (2019). Histoire de l'éducation thérapeutique du patient. Limoges Université de lImoges, Université de Limoges. Limoges. FRA. **Thèse pour le diplôme d'État de docteur en Médecine:** 78 , fig.
aurore.unilim.fr/theses/nxfile/default/3711db6c-37fd-4be6-b29e-c0911189a124/blobholder:0/M20193102.pdf

L'Éducation Thérapeutique du Patient (ETP) s'impose comme une réponse indispensable au développement des maladies chroniques. Nombres d'études lui sont consacrées, et confirment pour la plupart ses bénéfices indéniables. Loin de la simple information, elle permet au patient d'acquérir les compétences nécessaires à la gestion de sa maladie et à l'optimisation de sa qualité de vie. Les soignants formés s'aident de programmes structurés, et s'appuient sur une communication adaptée afin de développer une relation de qualité, nécessaire au bon déroulement du programme. Outre la médecine, l'ETP puise dans de nombreuses disciplines. La socio-anthropologie étudie la relation médecin-patient et apporte la notion de contextualisation. La psychologie permet d'accompagner au mieux le patient selon les stades d'acceptation de la maladie. La pédagogie procure plusieurs techniques d'apprentissage. Les nouvelles technologies fournissent des outils complémentaires. Enfin, l'art peut être une puissante thérapie. Historiquement, bien que l'on trouve des précurseurs comme Raspail au XIXème siècle ou Joslin au début du XXème, on considère que l'ETP est née en 1922 avec l'insulinothérapie et la chronicisation du diabète. S'en suivent d'autres progrès médicaux permettant de chroniciser d'autres pathologies. Tandis que les médecins réalisent qu'ils ne peuvent être en permanence auprès des patients pour leur prodiguer les soins quotidiens, ces derniers réclament plus d'autonomie et s'organisent en associations. L'ETP devient alors une nécessité. Miller et Goldstein en 1972 objectivent les bénéfices médicaux et économiques engendrés par l'ETP. Des programmes se développent, des services hospitaliers y sont dédiés. Finalement les instances gouvernementales montrent un intérêt grandissant pour l'ETP, qui aboutit à son inscription dans la loi Hôpital Patient Santé Territoires en 2009.

Lorenzo, P. (2008). "De l'éducation thérapeutique du patient en milieu pénitentiaire." Pratiques Et Organisation Des Soins(1).
http://www.ameli.fr/fileadmin/user_upload/documents/Education_therapeutique_du_patient_en_prison_01.pdf

[BDSP. Notice produite par CNAMTS R0x9kCqF. Diffusion soumise à autorisation]. Les conditions de la prise en charge des détenus atteints de maladies chroniques constituent un domaine encore à explorer en France. L'objectif de cette recherche était d'évaluer la prévalence des maladies chroniques dans les établissements pénitentiaires de Picardie, puis d'analyser les prises en charge et les pratiques éducationnelles en milieu pénitentiaire. La connaissance de la maladie chronique par les surveillants, les formations sur des prises en charge particulières, la poursuite de programme d'éducation pour la santé, sont autant d'éléments devant être renforcés pour améliorer l'état de santé des patients détenus

Lucet, C., Dupouy, J. et Laqueille, X. (2018). "Principes généraux de l'éducation thérapeutique du patient." Laennec **66**(2): 7-16.
https://www.cairn.info/revue-laennec-2018-2-page-7.htm

L'allongement de l'espérance de vie et le progrès médical ont pour corollaire l'augmentation des maladies chroniques qui constituent un enjeu majeur en termes de santé publique. Responsables de 63% des décès, elles représentent la toute première cause de mortalité dans le monde et sont liées en grande partie à des comportements de santé inadaptés (mauvaise alimentation, sédentarité, addictions…) [1]. Leur expansion a mis en évidence la nécessité de concevoir et de mettre en œuvre une politique de santé publique centrée sur l'éducation du patient. Considéré aujourd'hui comme un acteur de sa propre santé, le patient demande à être informé et impliqué dans le suivi de sa maladie, tout en étant accompagné par des professionnels de santé compétents et à l'écoute de ses besoins.

M'Bailara, K., Minois, I., Zanouy, L., et al. (2019). "[Therapeutic education: A lever to change perceptions of bipolar disorder in family caregivers]." Encephale **45**(3): 239-244.

OBJECTIVES: The patient with bipolar disorder and his family are caught in a reciprocal interaction: on one hand, the pathology leads to family sufferings and on the other hand, family behavior affects the disease of the patient and its development. Therefore, it seems of core importance that the psychologist should work with the family on their perception of bipolar disorder, that is to say, on their knowledge and psychological representations of the pathology. The aim of our study is to assess whether the initial perception of bipolar disorder evolves after a therapeutic education program. METHOD: Our research was conducted at the Bipolar Expertise Centre in Bordeaux/Centre Expert Bipolaire in Bordeaux on a sample of 145 participants (78patients and 67 family caregivers). They were all interviewed before and after the therapeutic education program (12 sessions in 6months). The Brief Illness Perception Questionnaire Revised (Moss-Morris, 2002) measures the perception of bipolar disorder and the BP Quizz (Fondation Fondamental) assesses the degree of knowledge of the disorder. RESULTS: Results show that therapeutic education helps families to level up their knowledge about bipolar disorder. Furthermore, representations on bipolar disorder have globally changed so that on average, bipolar disorder is viewed as less threatening by families after 12 sessions of therapeutic education. More precisely, after the program, families have a better understanding and a better insight of the disorder, which is then perceived as being less severe. On the emotional level, anxiety and stress have decreased. So there are an increase of knowledge and a change in perception. CONCLUSION: Our study shows that the therapeutic education program enables families to change their perception of the disease, that is to say, their knowledge but also their representations of the disease, which is a fundamental element according to the models of therapeutic education. Our results point out one of the active processes of therapeutic education at work in the sessions: in the perception of the disease, which is composed of both knowledge and representations of the disease, just a change in representations constitutes a lever for therapeutic education. Therefore, working on representations should be a therapeutic target. As a conclusion, we can say that therapeutic education of families cannot be reduced to an educational dimension which would only consist of gaining knowledge. Then, the right posture of the psychologist is to hold each participant's own development and changing process of representations.

Marquillier, T., Trentesaux, T. et Gagnayre, R. (2017). "Éducation thérapeutique en odontologie pédiatrique : analyse des obstacles et leviers au développement des programmes en France en 2016." Santé Publique **29**(6): 781-792.

[BDSP. Notice produite par EHESP AR0xnmAs. Diffusion soumise à autorisation]. L'étude rapporte que la formation à l'ETP a investi ces dernières années le champ de la médecine bucco-dentaire. La prise en charge de la carie précoce de l'enfant a évolué pour y intégrer une dimension éducative. Quels leviers et quels freins au développement de programmes autorisés d'ETP et quelles alternatives ?

Martinez, M. (2012). "Les recommandations ADA/EASD 2012 au plus proche du patient." Sante Education : Journal de L'Afdet **22**(3).

Les deux sociétés savantes ADA (American Diabetes Association) et EASD (European Association Study of Diabetes) ont publié récemment des recommandations communes de prise en charge du patient diabétique de type 2 (traduction disponible sur le site de la SFD société française de diabétologie). Cet article présente ces recommandations

Maunoury, F., Derouineau, J., Farinetto, C., et al. (2011). Évaluation économique du Club Santé Active proposée par la Caisse Primaire d'Assurance Maladie de la Sarthe. Journal D'Economie Medicale **29**(8)
Évaluation des pratiques et des organisations de santé. **29**.

[BDSP. Notice produite par ORSRA D8HR0xsF. Diffusion soumise à autorisation]. Objectif : L'objectif de cette étude est d'évaluer sous un angle économique l'impact d'une structure d'accompagnement et d'éducation à la santé des assurés sociaux de la Sarthe. Cette structure dénommée "Club Santé Active" (CSA), a été créée par la Caisse Primaire d'Assurance Maladie de la Sarthe en janvier 2006. L'analyse économique est proposée dans la perspective de l'Assurance Maladie. Il s'agit d'une étude observationnelle rétrospective fondée sur l'exploitation des données de remboursement de soins sollicités entre 2005 et 2009 par les assurés sociaux du régime général de la Sarthe. Méthode : 563 patients ont été inclus dans le groupe CSA et 832 dans le groupe témoin. Une méthode statistique comparable à celle du score de propension a été utilisée afin d'assurer la comptabilité des deux groupes étudiés à partir de la prise en compte de neuf covariables disponibles. Aussi, une analyse statistique des séries temporelles de consommation médicale des assurés de chaque groupe a-t-elle été réalisée afin d'évaluer l'impact économique tendanciel du Club Santé Active. Les dépenses de santé remboursées par l'Assurance Maladie (coûts directs médicaux et non médicaux, indemnités journalières) constituent le critère final de jugement de l'efficacité économique de la stratégie évaluée et la non-adhésion au Club Santé Active définit la stratégie de référence. Résultats : Une moindre évolution tendancielle des consommations par rapport au groupe témoin (hors CSA) a été relevée chez les membres du CSA sur les catégories de personnes et de groupes de prestations suivants : les personnes en affection longue durée (ALD) âgées de 40 à 60 ans pour les analgésiques et le recours aux soins de la médecine générale, les personnes en ALD âgées de plus de 60 ans pour les analgésiques et les inhibiteurs de la pompe à proton (IPP), les personnes sans ALD âgées de 40 à 60 ans pour les IPP, les psychotropes, le recours aux soins de kinésithérapie et le nombre d'indemnités journalières versées. A l'inverse, un seul cas d'évolution supérieure pour les adhérents du Club a été recensé : il s'agit du recours aux soins infirmiers pour les personnes en ALD de plus de 60 ans. Ce dernier résultat doit toutefois être mis en perspective avec la particularité de la démographie médicale des infirmiers en Sarthe, où l'accès à ce type de soins n'est a priori pas satisfaisant, le département étant l'un des moins bien pourvus de toute la France. Conclusion : Les signes d'évolution constatées sur les soins de ville ne sont pas la contrepartie d'un report de dépenses sur les soins hospitaliers, ces prestations ayant été contrôlées. Ces résultats tendent ainsi à confirmer que l'accompagnement des assurés peut aboutir à une modification significative des comportements de recours au système de soins, notamment sur le champ des soins de ville

Ministère chargé de la Santé (2019). Feuille de route : prise en charge des personnes en situation d'obésité, Paris : Ministère chargé de la santé
https://solidarites-sante.gouv.fr/IMG/pdf/feuille_de_route_obesite_2019-2022.pdf

> Huit millions de Français sont touchés par cette pathologie chronique et complexe qu'est l'obésité. L'enjeu est de mieux la prévenir, de mieux coordonner l'ensemble des professionnels de santé autour du patient dès le repérage et jusqu'aux traitements des complications. Il est aussi de traiter avec une meilleure pertinence cette affection, notamment ses formes sévères. La réalisation des chirurgies bariatriques dont la fréquence a triplé en 10 ans sera mieux encadrée et sécurisée.

Ministère chargé de la Santé (2010). Plan pour l'amélioration de la qualité de vie des personnes atteintes de maladies chroniques 2007-2011. Rapport annuel du comité de suivi 2009. Paris : Ministère chargé de la Santé.
http://www.sante-sports.gouv.fr/IMG/pdf/Rapport_annuel_du_comite_de_suivi_2009_juin_2009_.pdf

> A l'occasion de la publication du second rapport annuel d'activité du comité de suivi du plan national pour l'amélioration de la qualité de vie des personnes atteintes de maladies chroniques 2007-2011, le ministère de la santé rappelle les mesures concrètes initiées et mises en oeuvre dans le cadre de ce plan en étroite collaboration avec des patients et les associations de patients. Les principales avancées en 2009 concernent : la reconnaissance par la loi relative à la réforme de l'hôpital, aux patients, à la santé et aux territoires (loi HPST) du 21 juillet 2009 de l'éducation thérapeutique et de l'accompagnement du patient, et l'élaboration des textes d'application qui se concrétisera prochainement dans les régions par l'autorisation des programmes d'éducation thérapeutique du patient (ETP) en ville ou à l'hôpital par les agences régionales de santé ; Le maintien à domicile grâce à la création de nouvelles places en appartements thérapeutiques et l'augmentation substantielle du nombre de journées d'hospitalisation à domicile (HAD) ainsi que des services de soins infirmiers à domicile (SSIAD) ; Une amélioration et une meilleure connaissance des outils d'évaluation des incapacités des personnes handicapées : formation des MDPH (maisons départementales des personnes handicapées) au guide barème et création d'un nouveau certificat médical pour personne handicapée ; La prise en charge de nouveaux produits de santé concernant notamment la mucoviscidose ; La poursuite de divers travaux de recherche ayant trait notamment à la consolidation de données épidémiologiques et à la qualité de vie des patients atteints de maladie chronique. A mi-parcours, soit deux ans après l'installation du comité de suivi, 80% des mesures du plan ont été lancées et les objectifs initiaux parfois dépassés notamment en matière de maintien à domicile.

Morel, A., Lecoq, G. et Jourdain-Menninger, D. (2012). Évaluation de la prise en charge du diabète. Rapport Igas ; 2012 033. Paris : Igas
http://www.ladocumentationfrancaise.fr/var/storage/rapports-publics/124000256/0000.pdf

> [BDSP. Notice produite par MIN-SANTE DIt8rR0x. Diffusion soumise à autorisation]. L'Inspection générale des affaires sociales (IGAS) a mené une mission d'évaluation transversale de la politique de santé publique relative à la prise en charge du diabète, devenue en 2010 la première des maladies chroniques en France (3 millions de personnes atteintes). La mission observe que le coût du diabète progresse ces dernières années à raison d'un milliard d'euros par an, et ce en dépit des actions volontaristes des pouvoirs publics et de l'assurance maladie, mises en place depuis plus de dix ans. Au-delà de stratégies de dépistage ou de prévention spécifiques qui gagneraient à être améliorées, elle estime que cette pathologie chronique, comme toutes les autres, questionne le système de soin de premier recours sur son organisation et son efficacité à accompagner des patients au long cours, notamment par l'éducation thérapeutique (ET), mais aussi le rôle de l'hôpital et son articulation avec la ville. Cette réflexion est complétée par une analyse de l'accessibilité de certains actes en ville ainsi que de la qualité et sécurité des antidiabétiques oraux. Une synthèse des recommandations figure en fin du rapport

Naudin, D., Gagnayre, R. et Reach, G. (2017). "Éducation thérapeutique du patient et concept de vicariance. L'exemple du diabète de type 1." Médecine des Maladies Métaboliques **11**(3): 283-292.
http://www.sciencedirect.com/science/article/pii/S195725571730069X

> Résumé Les patients diabétiques doivent constamment agir pour ajuster et équilibrer leur glycémie. Ces ajustements imposent qu’ils remplacent l’organe malade par des processus cognitifs acquis par l’expérience et l’apprentissage. Le but de cet article est de caractériser cette substitution, à l’aide du concept de vicariance emprunté à la psychologie cognitive et aux neurosciences. Ce texte décrit les différents chemins cognitifs pour agir, et souligne l’importance des fonctions exécutives et leurs implications concrètes pour les patients. Il fait le lien entre ces fonctions exécutives et les pratiques pédagogiques dans l’Éducation Thérapeutique du Patient (ETP). Summary Diabetic patients must constantly act to adjust and balance their blood sugar. These adjustments require that they replace the suffering organ by cognitive processes acquired through experience and learning. The goal of this article is to characterize this substitution, using the concept of vicariance borrowed from cognitive psychology and neurosciences. This paper describes the different cognitive pathways for action and emphasizes the importance of executive functions and their concrete involvement for patients. It makes the link between these executive functions and the pedagogical practices in patient education.

Neill, G., Naiditch, M., Pomey, M. P., et al. (2008). Information, expression et pouvoirs des usagers : pour quelle qualité ? : résumé des discussions. Sante Societe et Solidarite : Revue de L'Observatoire Franco-Quebecois (2)

Paraponaris, A., Guerville, M.-A., Cabut, S., et al. (2011). "Éducation thérapeutique des patients et hospitalisation à domicile : opinions et pratiques des médecins généralistes libéraux dans cinq régions françaises." Etudes Et Resultats (Drees)(753): 8 , tabl., graph.
http://www.drees.sante.gouv.fr/IMG/pdf/er753.pdf

> [BDSP. Notice produite par MIN-SANTE R0xABr8q. Diffusion soumise à autorisation]. La cinquième vague du panel (Basse-Normandie, Bretagne, Bourgogne, Provence-Alpes-Côte d'Azur, Pays de la Loire) portait à l'été 2009 sur l'éducation thérapeutique du patient (ETP) et sur l'hospitalisation à domicile (HAD). Neuf médecins interrogés sur dix sont favorables à la mise en place d'un programme d'ETP, pour tous ou certains de leurs patients atteints de maladie chronique (diabète, obésité, maladies cardiovasculaires). Les trois quarts des praticiens se déclarent prêts à réaliser eux-mêmes des actions d'ETP dans leur cabinet, avec une formation et une rémunération adaptées. Une majorité accepterait aussi de les déléguer à des professionnels non médicaux formés. L'hospitalisation à domicile est un dispositif apprécié des médecins interrogés, même si 55% d'entre eux indiquent que ce service n'est pas présent dans leur zone d'exercice. Un tiers des généralistes du panel ont prescrit une HAD au cours des 12 derniers mois, plus souvent ceux qui adhèrent à un réseau de santé et se réfèrent aux recommandations de bonne pratique. Neuf praticiens sur dix se disent satisfaits de la qualité de la prise en charge, les autres invoquant notamment la lourdeur des démarches administratives.

Parron, S., Gentile, S., Enel, P., et al. (2013). "Éducation thérapeutique du patient : état des lieux des programmes en région Provence-Alpes-Côte d'Azur en 2008 avant la parution des textes officiels sur les autorisations de l'Agence régionale de santé." Revue D'epidemiologie Et De Sante Publique **61**(1): 57-65.

> [BDSP. Notice produite par ORSRA HoR0x9Fl. Diffusion soumise à autorisation]. Position du problème : Dans le cadre du plan 2007-2011 d'amélioration de la qualité de vie des personnes atteintes de maladies chroniques et à la demande de l'Agence régionale de l'hospitalisation, cette étude a eu pour but de dresser le bilan régional des programmes d'éducation thérapeutique du patient en 2008 en région Provence-Alpes-Côte d'Azur (PACA), avant la parution des décrets relatifs à l'éducation thérapeutique et des autorisations de l'Agence régionale de santé. Méthodes : Une enquête transversale conduite dans les structures sanitaires de la région, réalisée sur les trois secteurs de prise en charge que sont les établissements de santé, les structures ambulatoires et les réseaux de santé, a permis d'identifier, dans un premier temps, les structures déclarant avoir mis en place des programmes d'éducation thérapeutique, puis de mettre en évidence, dans un second temps, les modalités de conception et de mise en oeuvre des programmes préalablement identifiés. Résultats : Cette étude a permis de recenser 491 programmes qui se répartissent géographiquement de façon inégale en région PACA et ciblent essentiellement le diabète, les maladies respiratoires et les maladies cardiovasculaires. Les principaux objectifs visés par ces programmes sont la qualité de vie, l'observance thérapeutique et les comportements préventifs. Les programmes des établissements de

santé ciblent préférentiellement les 36 à 60 ans, alors que ceux du secteur ambulatoire et des réseaux de santé ciblent les plus de 60 ans. Plus de 50% des professionnels impliqués dans les programmes n'ont pas été formés à l'éducation thérapeutique du patient. Conclusion : Cette étude a mis en évidence de nombreux points importants qui doivent être améliorés dans l'organisation de l'éducation thérapeutique, notamment l'implication et la formation des professionnels.

Pauchet-Traversat, A. F. (2012). "[Patient education, facilitating its implementation and its assessment]." Soins(764): 29-31.

Therapeutic education, facilitating its implementation and its assessment. Therapeutic education programmes (TEP) must conform to national specifications and be self-assessed each year by the teams which implement them. On the basis of its previous work, the French national authority for health has published a guide, tested in the field, which specifies the framework of this approach.

Peljak, D. (2011). "L'éducation thérapeutique du patient : la nécessité d'une approche globale, coordonnée et pérenne." Santé Publique **23**(2): 135-141.

[BDSP. Notice produite par EHESP 7ppjR0xs. Diffusion soumise à autorisation]. L'éducation thérapeutique du patient s'est développée progressivement en France depuis ces vingt dernières années, jusqu'à la loi HPST de juillet 2009 et ses décrets d'application qui lui apportent une reconnaissance législative. Alors qu'aujourd'hui l'éducation thérapeutique est inscrite dans le parcours de soins du patient et a pour objectif de le rendre plus autonome, le développement des maladies chroniques impose une planification plus globale de l'offre des soins et tout particulièrement en ville, une coordination locale face aux besoins de la population et un mode de fonctionnement pérenne.

Pellecchia, A., Certain, A., Mohammed, R., et al. (2019). "[Training and conditions improving the integration of patients in the co-facilitation of collective sessions of therapeutic education]." Santé Publique **31**(5): 683-692.

Purpose of research: The purpose of this research was to promote the involvement and intervention of patient-partners (PPs) in collective sessions of therapeutic patient education (TPE), including training and support for the implementation of these sessions, in co-facilitation with a health professional (HP). Therefore, the matter was to co-construct a training model, to experiment with its implementation and to define favorable conditions for this collaboration. METHODS: Collaborative research oriented by the design, led by a steering committee representative of different categories of stakeholders, which has been spread over 2 years, in Paris area and Montpellier, in 4 phases: 1/ exploration (bibliographic review and investigation); 2/ recruitment of PPs affected by different pathologies; 3/ implementation and evaluation of PPs training in inter-pathology; 4/ implementation and evaluation of co-facilitated group sessions. RESULTS: 35 patients solicited, 24 (69%) included. Of these, 22 (92%) completed the training entirely; 17 sessions were conducted in co-facilitation (15 planned) for 151 patients (150 expected). Satisfaction rates for PPs, HPs and patient beneficiaries were very high. CONCLUSIONS: This research validated a training model for patient-partners in therapeutic education and identified some conditions that could facilitate their integration into TPE programs.

Perrier, C. et Perrin, C. (2018). "Éduquer le patient ou transformer l’action publique ?Analyse socio-historique d’une association pour le développement de l’éducation thérapeutique du patient." SCIENCES SOCIALES ET SANTE **36**(2): 5-31.
https://www.cairn.info/revue-sciences-sociales-et-sante-2018-2-page-5.htm

En France, l’Éducation Thérapeutique du Patient s’est développée au travers de la formation des professionnels et d’activités de recherche portées par les mondes associatifs et académiques. L’étude socio-historique d’une des associations françaises les plus anciennes (l’Afdet) mobilise conjointement des cadres théoriques de sociologie de la santé et de science politique. Elle analyse le corpus des revues publiées depuis 1990 par l’association et un recueil de vingt-deux entretiens avec des acteurs-clés. Si la posture réformatrice apparaît comme une continuité de l’histoire de l’association, elle fait l’objet de tensions entre les acteurs à l’origine de deux reconfigurations importantes. C’est une conception nouvelle du processus de soin et de santé qu'entend diffuser ce collectif analysé comme un « laboratoire d'ingénierie des idées », révélateur d'une contribution à l'action publique en marge des institutions.

Peze, V., Lumediluna, M., Thill, J. C., et al. (2017). "Représentations et vécus associés au diabète et à l'éducation thérapeutique? une étude qualitative." EDP Sciences **8**(1): 36 , tab., graph., fig.
https://hal-amu.archives-ouvertes.fr/hal-01648417/document

Cette étude qualitative a pour objectif d'appréhender les représentations que les patients associent à l'expérience de leur maladie et à l'éducation thérapeutique (ETP) en les mettant en lien avec leurs caractéristiques socioéconomiques (niveau d'étude, activité professionnelle, revenu) et leur participation à un programme d'ETP. 3 entretiens semi-directifs ont été réalisés auprès de patients atteints de diabète de Type 2 issus de divers milieux socioéconomiques.

Pommier, J. et Ferron, C. (2013). "La promotion de la santé, enfin ? L'évolution du champ de l'éducation pour la santé au cours des dix dernières années." Santé Publique **25**: 113-118.

[BDSP. Notice produite par EHESP 7kE9R0xr. Diffusion soumise à autorisation]. Des changements législatifs, structurels et organisationnels ont eu des impacts importants sur la santé publique en France au cours des dix dernières années. L'objectif de cet article est de mettre en évidence les conséquences de ces changements en termes d'évolution du champ de l'éducation pour la santé dans cette même période. Six grandes évolutions sont ainsi identifiées : le développement de la recherche en éducation pour la santé, l'éducation pour la santé comme stratégie de réduction des inégalités sociales et de santé, l'éducation pour la santé comme champ d'intervention spécialisé, l'émergence de l'éducation thérapeutique du patient, la fragilisation économique sans précédent des associations d'éducation pour la santé et l'évolution du regard des pouvoirs publics. L'ancrage de l'éducation pour la santé dans la promotion de la santé reste crucial, car c'est un levier qui lui permet de développer ses potentialités dans le cadre d'un travail intersectoriel, en s'alliant à d'autres stratégies pour déployer une plus grande portée d'intervention.

Pourin, C., Daugareil, C., Tastet-Dominguez, S., et al. (2009). "ETAPE en Aquitaine : mise en place régionale d'une équipe d'accompagnement et d'évaluation en éducation thérapeutique." Pratiques Et Organisation Des Soins(1): 1-8, fig.
http://www.ameli.fr/fileadmin/user_upload/documents/Evaluation_en_education_therapeutique.pdf

[BDSP. Notice produite par CNAMTS 88rr7R0x. Diffusion soumise à autorisation]. L'objectif de cette étude est de présenter la démarche régionale d'accompagnement des établissements de santé en matière d'évaluation et d'amélioration des programmes d'éducation thérapeutique du patient, en termes de structuration régionale, d'outils et de modalités de leur évaluation, ainsi que les premiers enseignements issus de cette démarche.

Rusch, E. (2017). "Éducation thérapeutique du patient et éthique : de l'impératif de santé publique aux droits des personnes et des usagers." Santé Publique **29**(5): 601-603.

[BDSP. Notice produite par EHESP C9qtR0xn. Diffusion soumise à autorisation]. Afin d'améliorer la qualité éthique de la pratique éducative, l'élaboration et la mise en oeuvre de l'ETP doivent être l'occasion d'interroger la posture des acteurs de l'ETP (vers une relation partenariale entre professionnel et patient), l'engagement du patient (de l'information passive à l'implication active), sa littératie en santé, sa capacité d'agir ("empowerment"), et ses capabilités.

Rycke, Y. d., Dib, F., Guillo, S., et al. (2017). Evaluation médico-économique du programme d'accompagnement des patients asthmatiques Sophia Asthme. Résultats Vague A. Paris Cnamts**:** 361 , tab., graph., fig.
http://www.ameli.fr/fileadmin/user_upload/documents/Rapport_Sophia_Asthme_Vague_A.pdf

Ce rapport s'inscrit dans le cadre général d'un mandat que la Caisse Nationale de l'Assurance Maladie des Travailleurs Salariés (Cnamts) a octroyé à l'Inserm Unité 1123 – Epidémiologie Clinique, Evaluation économique, population Vulnérables (ECEVE). Il s'agissait d'évaluer la phase initiale du programme Sophia Asthme 1 à l'aide des données de remboursement de l'assurance maladie (SNIIRAM) chaînées aux données du programme de médicalisation des systèmes d'information (PMSI) et de données spécifiques recueillies auprès des participants au programme Sophia Asthme.

Sandrin, B. (2013). "Éducation thérapeutique et promotion de la santé : quelle démarche éducative ?" Santé Publique **25**: 125-135, tabl.

[BDSP. Notice produite par EHESP rECBR0xo. Diffusion soumise à autorisation]. L'objectif du présent article est d'aider les acteurs de santé publique qui se réfèrent à la promotion de la santé, et les soignants impliqués dans l'éducation thérapeutique, à mettre en oeuvre une démarche éducative cohérente avec leur conception de la santé ou des soins. Est d'abord fait le constat d'une convergence de valeurs entre la charte de promotion de la santé et la charte de l'éducation populaire. Ensuite, la présentation du parcours et de la pensée de Paulo Freire, du modèle pédagogique d'Ira Shor puis de l'approche centrée sur la personne de Carl Rogers montrent en quoi les travaux de ces praticiens, chercheurs et théoriciens de l'éducation, peuvent aider les professionnels de santé à mettre en oeuvre une démarche éducative authentiquement "promotrice de santé" ou "thérapeutique" (au sens de "soignante"). Au fil du texte, sont mentionnés certains pièges tendus aux professionnels de santé qui s'engagent sur le chemin de l'éducation sans prendre le temps d'analyser les valeurs véhiculées par les modèles pédagogiques qu'ils utilisent.

Sandrin, B. et Vincent, I. (2012). "Éducation thérapeutique du patient, retour vers le futur." Sante De L'homme (La)(420): 39-42.

[BDSP. Notice produite par INPES kB8ER0xG. Diffusion soumise à autorisation]. Retour dans le passé. 1955 : l'éducation du patient au sanatorium de Beaurouvre. Le docteur J. - J. Hazemann relate son expérience dans un article de La Santé de l'homme. Son projet est l'illustration de ce que les autorités de santé proposent d'inscrire aujourd'hui dans les programmes qu'elles promeuvent. et va même au-delà.

Sandrin, B. B., Carpentier, P. et QUERE, I. (2007). Associer des patients à la conception d'un programme d'éducation thérapeutique. Sante Publique //
Éducation thérapeutique.

[BDSP. Notice produite par ENSP NQvpR0xa. Diffusion soumise à autorisation]. Un groupe de professionnels de santé, composé de praticiens hospitaliers, de médecins généralistes, d'infirmières, de masseurs kinésithérapeutes et de diététiciennes, s'est initié à l'éducation thérapeutique en concevant un programme destiné aux personnes atteintes d'artériopathie oblitérante des membres inférieurs. Parallèlement, une enquête par questionnaire puis quatre réunions ont permis de recueillir auprès de personnes malades leurs attentes vis-à-vis d'un tel programme et leur point de vue à chaque étape de son élaboration. Cet article analyse la contribution des patients à la conception du programme d'éducation thérapeutique : leur influence sur le contenu, sur la démarche proposée mais aussi sur les représentations que les professionnels de santé ont de la maladie, des différents traitements et des personnes malades. La discussion met en évidence la diversité des objectifs que l'on peut espérer atteindre par la mise en place de moments d'échanges entre personnes souffrant d'une même maladie

Sandrin-Berthon, B. et Zimmermann, C. (2009). "Éducation thérapeutique du patient : de quoi s'agit-il ?" Actualite Et Dossier En Sante Publique(66): 10-15.

[BDSP. Notice produite par EHESP AAs7R0xp. Diffusion soumise à autorisation]. L'éducation thérapeutique doit aider les patients à prendre soin d'eux-mêmes. Avec l'augmentation du nombre de personnes atteintes de maladies chroniques (15 millions en France), elle devient partie prenante des soins et doit être formalisée. L'éducation thérapeutique a pour but d'aider les patients à prendre soin d'eux-mêmes, à agir dans un sens favorable à leur santé, à leur bien-être. Elle relève donc de l'éducation pour la santé, s'inscrivant dans le prolongement des actions destinées au grand public, ou mises en oeuvre sur les lieux de vie, à l'école ou au travail. Sa particularité est de s'adresser à des personnes qui requièrent des soins, qu'elles soient porteuses d'une maladie, d'un handicap, d'un facteur de risque pour leur santé, ou simplement enceintes. À juste titre, les soignants disent qu'ils s'emploient depuis toujours à dispenser des informations et des conseils à leurs patients pour les inciter à prendre soin d'eux-mêmes, à prévenir les maladies, leur aggravation. Le terme "soignant" désigne ici tout professionnel qui intervient dans la chaîne des soins : médecin, infirmier, aide soignant, diététicien, kinésithérapeute, podologue, pharmacien, psychologue, etc. leurs complications ou leurs récidives

Saout, C. (2009). Dix commandements pour l'éducation thérapeutique. Actualite et Dossier en Sante Publique (66)

[BDSP. Notice produite par EHESP 9nR0x8Fo. Diffusion soumise à autorisation]. À côté du soin mis en oeuvre par les soignants, l'association Aides a développé des actions d'éducation thérapeutique et/ou d'accompagnement des patients qui se sont révélées être un peu plus que des adjuvants du soin. Elles ont permis à beaucoup de personnes séropositives de trouver le chemin d'une "vie bonne" malgré l'aléa de la maladie. Présentation des dix commandements, proposés par les usagers, pour une éducation thérapeutique respectueuse et efficace, au service du patient atteint de maladies chroniques

Saout, C., Charbonnel, B. et Bertrand, D. (2008). Pour une politique nationale d'éducation thérapeutique du patient. Paris : Ministère chargé de la santé
http://www.ladocumentationfrancaise.fr/rapports-publics/084000578/index.shtml

Ce rapport vise à promouvoir une politique nationale d'éducation thérapeutique des patients atteints de maladies chroniques. Dans une première partie, un bilan des programmes actuellement en cours est réalisé. La deuxième partie du rapport consiste en une analyse des diverses problématiques soulevées par l'éducation thérapeutique du patient et par des propositions permettant d'y apporter une solution. Parmi les 24 recommandations, l'autonomisation du patient grâce à l'éducation thérapeutique dans le cadre d'un plan coordonné de soins est mise en avant de même que le rôle que devraient jouer les agences régionales de santé dans l'habilitation, le financement, la planification du maillage régional et l'évaluation des programmes et des équipes impliquées. Le rapport préconise également que la problématique, la méthodologie et les spécificités selon les différentes pathologies chroniques de l'éducation thérapeutique devraient être dispensées lors de la formation initiale des professions médicales et paramédicales ainsi que lors de la formation permanente. En ce qui concerne le financement des activités d'éducation thérapeutique du patient, plusieurs propositions sont faites, notamment l'intégration de la tarification spécifique de ces activités dans le cadre de la réforme en cours de la T2A ou une tarification par forfait

Saout, C., Charbonnel, B. et Bertrand, D. (2010). Pour une politique nationale d'éducation thérapeutique. Rapport complémentaire sur les actions d'accompagnement. Santé. Paris : Ministère chargé de la santé
http://www.sante-sports.gouv.fr/IMG/pdf/rapport_accompagnement.pdf

Ce rapport de la mission consacrée à l'éducation thérapeutique du patient rédigé par Christian Saout, président du comité inter-associatif sur la santé (CISS), Bernard Charbonnel, professeur de diabétologie à Nantes et Dominique Bertrand, professeur de santé publique à Paris, vient compléter la mission qui leur a été confiée en 2008 par la ministre de la Santé et des Sports portant sur la politique nationale de l'éducation thérapeutique. Cette nouvelle mission a un triple objet : dresser une typologie des actions d'accompagnement, préciser l'articulation de ces actions d'accompagnement avec les programmes d'éducation thérapeutique, réaliser un état des lieux du financement actuel des actions d'accompagnement ainsi que des ressources qui pourraient être utilement mobilisées en complément dans un contexte contraint de dépenses publiques.

Saugeron, B., Sonnier, P. et Marchais, S. (2016). "COMETE : un outil pour développer les compétences psychosociales en éducation thérapeutique du patient." Santé Publique **28**(2): 157-161.

[BDSP. Notice produite par EHESP EFIpR0xs. Diffusion soumise à autorisation]. Les programmes d'éducation thérapeutique visent à développer les compétences d'auto-soins et psychosociales des patients. L'outil COMETE permet d'aider les équipes soignantes à identifier, développer ou évaluer les compétences psychosociales en éducation du patient. Cet article a pour objectif de présenter de façon détaillée l'élaboration de l'outil et son utilisation. Conçu sous la forme d'une mallette, COMETE propose des activités et des fiches méthodologiques permettant d'aborder les compétences psychosociales lors d'un bilan éducatif partagé, de séances collectives ou encore lors d'une évaluation individuelle. Cet outil s'intègre dans une démarche d'accompagnement des équipes soignantes aux bénéfices des patients atteints de maladies chroniques.

Simon, D. (2013). Education thérapeutique : prévention et maladies chroniques, Paris : Elsevier Masson //

Depuis plusieurs années, le nombre de patients atteints de maladies chroniques ne cesse d'augmenter. Vivre avec ces maladies requiert une connaissance approfondie de ces dernières et de leurs traitements et demande également aux patients de développer leurs capacités d'auto-surveillance et d'adaptation. L'éducation thérapeutique permet au patient l'apprentissage de ce nouveau quotidien. Cet ouvrage offre à l'ensemble des professionnels de santé un guide pratique pour répondre aux questions de son patient et pour l'accompagner tout au long de sa maladie. Cette nouvelle édition conserve tous les éléments qui ont fait son succès tout en complétant son contenu par les plus récentes approches pluridisciplinaires dans ce domaine : l'art-thérapie, le théâtre du vécu, le parcours éducatif, etc. Les spécialités des pathologies chroniques les plus courantes (cardiologie, pneumologie, rhumatologie, ...) sont l'objet d'un chapitre spécifique, chacun écrit par une équipe de spécialistes et de formateurs non-cliniciens engagés activement dans une démarche éducative. Cet ouvrage pratique aidera le soignant à se positionner face au dispositif de l'éducation thérapeutique, se révélant indispensable pour tous les professionnels concernés par la formation du patient à la prise en charge de son traitement (4e de couverture)

Simon, P. (2017). "Les leçons apprises des principales études sur les objets connectés en télémédecine et santé mobile." European Research in Telemedicine / La Recherche Européenne en Télémédecine **6**(2): 67-77.
http://www.sciencedirect.com/science/article/pii/S2212764X17300651

Résumé Introduction Les bénéfices et les risques de l'usage des objets connectés en télémédecine et santé mobile sont mal connus des professionnels de santé engagés dans les pratiques nouvelles de la télémédecine et de la santé connectée. Bien que les données de la littérature soient nombreuses, les résultats publiés restent controversés, souvent à cause de la faiblesse méthodologique des études. L'objet de cet article est de faire le point en 2016 sur un usage fiable et sécurisé des objets connectés et applis mobiles à finalité médicale, à partir de quelques études récentes choisies. Méthodologie Ce travail s'appuie sur de récentes publications de la littérature médicale, choisies pour le service médical rendu (SMR) aux patients par l'usage des dispositifs médicaux, des objets connectés, des applis mobiles, des SMS et des emails. Ces études ont été également sélectionnées parce que leurs auteurs avaient fait des revues exhaustives de la littérature dans les bases Medline, Cochrane et Scopus. Pour la télémédecine et les DMC de telemonitoring, les deux grandes études européennes Whole Systems Demonstrator (2009–13) et Renewing Health (2010–14) ont été analysées, ainsi que certaines études françaises. Pour l'usage de la santé connectée mobile, les importants travaux de deux équipes anglaises, dont celle du National Health Service, ont été choisis. Ces équipes ont évalué l'usage des technologies numériques mobiles, des objets connectés et applis en santé, des SMS et emails entre 1993 et 2015. Résultats De nombreuses publications ont été écartées par les auteurs de ces revues par insuffisance méthodologique. Parmi celles retenues, la majorité n'a pas montré de réel SMR aux patients, tant par les systèmes de telemonitoring à domicile pour les patients atteints de maladies chroniques, que par les différentes technologies numériques mobiles dans l'exercice quotidien des professionnels de santé. L'impact économique de l'usage des objets connectés à finalité médicale n'a pas montré de réduction des coûts. Les rares études qui ont démontré des bénéfices cliniques demeurent anecdotiques et leurs résultats demandent à être confirmés par de nouvelles études. Les travaux sur la santé mobile ont concerné essentiellement les pays développés à hauts revenus. Il est possible que la santé mobile, dans les pays en développement, apporte des bénéfices qui ne sont pas encore publiés. Discussion Les causes possibles de ces résultats décevants sont discutées à la lumière des conclusions des auteurs de ces études. Le défaut d'organisation professionnelle dans l'usage de ces nouvelles technologies, le manque de coopération entre les industriels, les patients et les professionnels de santé pour assurer une fiabilité et une sécurité des usages, une méthodologie d'étude non adaptée aux usages habituels des professionnels de santé sont les principales causes retenues. Les dernières études publiées seraient en faveur d'une amélioration des méthodes d'évaluation. Conclusions L'usage des technologies numérique dans l'exercice de la médecine du XXIe siècle n'est pas remis en cause dans les études analysées. Les bénéfices apportés par ces nouveaux outils passent par une co-construction et une recherche commune entre les industriels, les patients et les professionnels de santé.

Thariat, J., Creisson, A., Chamignon, B., et al. (2016). "Éducation thérapeutique du patient, concepts et mise en œuvre." Bulletin du Cancer **103**(7): 674-690.
http://www.sciencedirect.com/science/article/pii/S0007455116300649

Résumé Contexte L'éducation thérapeutique du patient (ETP) est une démarche visant à aider les patients à acquérir ou maintenir les compétences nécessaires pour gérer au mieux leur vie avec une maladie chronique. En cela, l'ETP implique un changement profond de paradigme dans la conception du soin chez les professionnels de santé. L'ETP est un enjeu dans les politiques de santé successives depuis 30ans, y compris la loi HPST et le plan Cancer 2014–2019. Un programme d'ETP ambulatoire dans les cancers du sein fut instauré en établissement privé d'intérêt collectif en cours de certification v2014. Méthodes La formation d'une équipe pluridisciplinaire et transversale constituée de professionnels de santé et patientes ressource a précédé la demande d'autorisation quadriennale et de financement pour pratiquer l'ETP auprès de l'ARS. La gestion du projet a nécessité la création d'une unité fonctionnelle pour traçabilité des actes d'ETP ambulatoire non comptabilisables dans la tarification à l'acte. Sous l'impulsion d'un coordonnateur et de chefs de projets, des réunions de concertation ETP et une stratégie de communication dans l'établissement et des échéanciers (avec rétroplanning) ont permis de réaliser un programme modulaire personnalisé d'ETP pour les patients. Résultats Le programme (diagnostic éducatif, 8 ateliers collectifs et 3 individuels, au choix sur 4 mois) a été effectif en 4 mois et l'objectif de plus de 60 patients atteint en 3 mois. Le programme mobilise 0,35 équivalent temps plein médical, et une équipe paramédicale, réunis hebdomadairement par réunion de concertation ETP. Les concepts d'autonormativité, les freins et solutions rencontrés sont développés. Discussion L'ETP est perçue très positivement par les patients participants. L'ETP participe à l'attractivité des établissements mais l'incitation financière pour l'ETP est actuellement faible. La pérennisation de l'ETP nécessite de mettre en place des outils spécifiques et de développer une prospective pour favoriser l'engagement des médecins et des patients dans le long terme.

Tomas-Bouil, A., De Andrade, V. et Gagnayre, R. (2016). "Santé au travail et éducation thérapeutique du patient atteint d'asthme ou de lombalgie chronique." Santé Publique **28**(3): 321-330.
https://www.cairn.info/revue-sante-publique-2016-3.htm

[BDSP. Notice produite par EHESP oH9pHR0x. Diffusion soumise à autorisation]. L'essor des maladies chroniques a conduit à un renouvellement de l'offre de soins développant les dispositifs d'accompagnement comme l'éducation thérapeutique du patient (ETP). Par l'acquisition de compétences, le patient devient acteur dans la gestion de la maladie au quotidien. Cependant, la poursuite d'une activité professionnelle reste difficile pour ces patients. Comment alors les acteurs de l'ETP s'emparent de la question de la santé au travail dans les dispositifs éducatifs ? Cette étude descriptive explore les programmes d'ETP d'Île-de-France du point de vue de la composante santé travail pour deux pathologies : la lombalgie chronique et l'asthme de l'adulte. Les données ont été recueillies à partir du site de recensement CART'EP® et de la réalisation de 18 entretiens téléphoniques avec les coordonnateurs des programmes.

Tourette-Turgis, C. (2013). "L'effet Framingham en éducation thérapeutique : de l'enquête épidémiologique à l'enquête sur soi. (Commentaire)." Sciences Sociales et Sante // **31**(2).

[BDSP. Notice produite par ORSMIP n9R0xJGk. Diffusion soumise à autorisation]. Ce commentaire fait suite à l'article de ce même numéro : "Prévenir le risque cardiovasculaire : le travail éducatif au coeur du dépistage" (p. 5-30)

Tourette-Turgis, C. (2015). L'éducation thérapeutique du patient : la maladie comme occasion d'apprentissage, Bruxelles : De Boeck
http://superieur.deboeck.com/titres/132536/9782804190811-l-education-therapeutique-du-patient.html

Cet ouvrage porte un regard nouveau sur les malades chroniques et l'éducation thérapeutique du patient (ETP). L'auteure décrit les compétences qu'un être humain déploie tout au long de la trajectoire de la maladie et de ses soins.

Traynard, P. Y., Baud, D., Veyer, A. S., et al. (2008). "Dossier Éducation thérapeutique." Concours Medical **130**(18).

[BDSP. Notice produite par ORSRA rR0x8l7E. Diffusion soumise à autorisation]. L'éducation thérapeutique ne se prescrit pas, car elle ne peut se faire, au gré de l'évolution de la maladie, sans la participation du patient, et c'est là sa principale difficulté. Pour éviter les incidents thérapeutiques, certains évoquent la notion d'urgence pédagogique. Ce dossier s'intéresse à la façon de proposer une éducation, de structurer un programme éducatif (mode d'emploi de la Haute Autorité de Santé), et propose des démarches et outils au service des médecins. L'exemple est donné d'une consultation éducative avec un patient atteint de psoriasis

Troisoeufs, A., Fournier, C. et Bungener, M. (2018). Soigner les relations pour rapprocher. Le rôle de l'éducation thérapeutique autour de la stimulation cérébrale profonde dans le traitement de la maladie de Parkinson. La simulation cérébrale profonde, de l'innovation au soin. Les neurosciences cliniques à la lumière des sciences humaines et sociales., Paris : Editions Hermann**:** 197-216.
http://www.editions-hermann.fr/5487-la-stimulation-cerebrale-profonde-de-linnovation-au-soin-9791037000958.html

Comme de nombreuses maladies chroniques, la maladie de Parkinson appelle le développement d'une « médecine de l'incurable » (Mino, Frattini et Fournier, 2008), tournée non vers la guérison des personnes, mais vers leur accompagnement dans la gestion de leur vie quotidienne avec une maladie qui reste évolutive malgré les traitements. Dans ce chapitre, nous examinons dans quelle mesure des programmes d'éducation thérapeutique du patient (ETP) mis en place pour la maladie de Parkinson, dont certains spécifiques à la stimulation cérébrale profonde (SCP), contribuent à un « rapprochement » entre patients et professionnels. La SCP, l'ETP et les mouvements associatifs dans le champ de la maladie de Parkinson se développent depuis la fin du siècle dernier. Toutefois, leur articulation n'a pas encore attiré l'attention de la recherche en sciences humaines et sociales. Ce chapitre a l'ambition d'initier cette démarche. Avant d'aborder les pratiques associées à la SCP, il importe de les situer dans le développement de pratiques d'ETP au cours des dernières décennies (résumé d'auteur).

Tubach, F. et et al. (2019). Evaluation médico-économique du service d'accompagnement des individus asthmatiques Sophia Asthme. Deuxième année de déploiement : Rapport d'étude, protocole et annexes. Paris Cnam**:** 3 vol. (187 +198 +153).

Depuis son lancement en 2014, le service sophia asthme a fait l'objet de deux évaluations médico-économiques ; ces évaluations avaient comme but d'estimer l'impact du service sur le contrôle de l'asthme, les délivrances de traitement de fond et plus généralement le recours aux soins des personnes asthmatiques ainsi que de mesurer son impact sur les dépenses de soins. La phase initiale de mise en œuvre du service sophia asthme a été conduite dans un cadre expérimental, dans 19 sites pilotes depuis fin 2014. Les personnes pouvant potentiellement bénéficier du service sophia asthme ont été identifiées à deux moments différents de l'année 2014 : début 2014 (vague A) et fin 2014 (vague B). La vague A comprend l'ensemble des personnes asthmatiques repérées durant l'année 2013 et la vague B comprend uniquement les personnes nouvellement repérées comme asthmatiques entre octobre 2013 et septembre 2014. La première évaluation à un an de l'expérimentation du

service sophia asthme a été réalisée par un prestataire externe : l'équipe 1123 de l'Inserm dirigée par le Professeur Florence Tubach. La deuxième évaluation à deux ans a été confiée au centre de pharmaco-épidémiologie de l'AP-HP dirigé par le Professeur Florence Tubach. La généralisation du service sophia asthme a eu lieu en 2018.

Vachey, L., Allot, F. et Scotte, N. (2020). Rapport d'analyse des retours d'expériences de la crise COVID-19 dans le secteur de la santé mentale et de la psychiatrie. Paris Ministère chargé de la santé**:** 45.
http://www.igf.finances.gouv.fr/files/live/sites/igf/files/contributed/IGF%20internet/2.RapportsPublics/2020/2020-M-033-02_Rapport_Branche_Autonomie-vf.pdf

Ce document présente un échantillon de retours d'expériences de la Crise COVID dans le secteur de la santé mentale et de la psychiatrie qui témoigne de l'importante mobilisation, de la réactivité et de l'inventivité des équipes pour s'adapter à cette situation inédite. Les pratiques ont été bouleversées de façon brutale et pourtant les missions ont été tenues. Les dispositifs mis en oeuvre ont ouvert de nouvelles perspectives de transformation des offres en santé mentale dans les territoires. Afin de conserver toute la richesse des expériences qui ont été majoritairement singulières, nous nous sommes abstenus d'en faire une synthèse « stricto sensu ». Ce document constitue plutôt une « banque d'informations » pour un partage d'expériences et, à ce titre, devenir source d'inspiration, de transposition pour les établissements. Enfin, ce retour d'expériences illustre les immenses besoins qui sont nés durant la crise et les très nombreux domaines et publics qui nécessitent des compétences en santé mentale. La feuille de route « Santé mentale et psychiatrie » qui sera adaptée s'attachera à en tenir compte

Vayssette, P. (2014). "Education thérapeutique : friche ambulatoire." Reseaux Sante & Territoire //(56).

Plus de 3 000 programmes d'éducation thérapeutique seraient autorisés par les Agences régionales de santé (ARS) en France. L'offre peut paraître importante, mais elle est loin de couvrir les besoins pour les patients atteints de maladies chroniques, en particulier dans l'ambulatoire. Hors les murs des hôpitaux, les initiatives se multiplient, tant en termes de recherche de modèle adapté, de soutien aux équipes de soins primaires que de pédagogie auprès des patients

Vicarelli, G. (2012). "Le family learning socio-sanitaire : une approche innovante en éducation thérapeutique. Évaluation de la satisfaction des patients et de leur famille." Pratiques Et Organisation Des Soins(3): 187-195.
http://www.ameli.fr/l-assurance-maladie/statistiques-et-publications/la-revue-pratiques-et-organisation-des-soins/index.php

[BDSP. Notice produite par CNAMTS qR0xpl8n. Diffusion soumise à autorisation]. L'objectif de cet article était de présenter une expérience innovante d'éducation thérapeutique (family learning socio-sanitaire, FLSS) et son acceptation de la part des participants dans une région italienne : Les Marches. La réalisation de la première formation en 2010 constitue une phase intermédiaire dans le processus d'expérimentation et d'évaluation du FLSS. Sur le plan de l'organisation et sur le plan théorique-scientifique, on peut avancer quelques considérations. D'un côté, la formation apparaît peu coûteuse et capable de faciliter l'intégration socio-sanitaire ainsi que l'autotutelle des individus et des familles. De l'autre, le FLSS se différencie des programmes de self-management mis en place aux USA et en Grande-Bretagne (éducation thérapeutique du patient).

Vincent, I., Loaec, A. et Fournier, C. (2010). Modèles et pratiques en éducation du patient : apports internationaux. 5èmes journées de la prévention. Paris, 2-3 avril 2009. Collection Séminaires. St Denis INPES**:** 167.

La session « Modèles et pratiques en éducation du patient : apports internationaux », qui s?est tenue aux Journées de la prévention 2009, a produit des contributions et des éléments de débats pouvant nourrir la réfl exion sur les pratiques françaises. Cet ouvrage, qui restitue ce temps d?échanges, souligne la complémentarité des différentes approches mises en oeuvre en éducation du patient. La première partie de l'ouvrage s?intéresse aux besoins des patients. La deuxième s?articule autour de deux notions fondamentales : les transformations du patient liées à la maladie chronique et au

processus éducatif, ainsi que le type de compétences que le patient va devoir acquérir ou renforcer tout au long de sa vie avec la maladie. La troisième partie est davantage centrée sur le rôle et les pratiques des professionnels. La quatrième partie restitue les éléments de discussion de la table ronde qui concluait cette session : les questions de systématisation, de standardisation de l?éducation du patient versus sa personnalisation et son adaptation auprès de certains publics ont été abordées, de même que le rôle des patients dans l?éducation.

ÉTUDES INTERNATIONALES

(2009). "Chronic disease management and remote patient monitoring." Eurohealth **15**(1).
http://www.euro.who.int/document/OBS/Eurohealth15_1.pdf

This issue focuses on chronic disease management and remote patient monitoring with six articles discussing policies in Europe and the US. The issue also includes articles on the EU Directive on patients? rights in cross-border health care, the EU Green Paper on the health care workforce, and pharmaceutical policies in the Republic of Srpska, Bosnia and Herzegovina. Finally, country snapshots look at mental health in Norway and long term care insurance in Korea

Ashrafzadeh, S. et Hamdy, O. (2019). "Patient-Driven Diabetes Care of the Future in the Technology Era." Cell Metab **29**(3): 564-575.

The growing burden of diabetes is fueled by obesity-inducing lifestyle behaviors including high-calorie diets and lack of physical activity. Challenges in access to diabetes specialists and educators, low adherence to medications, and inadequate motivational support for proper disease self-management contribute to poor glycemic control in patients with diabetes. Simultaneously, high patient volumes and low reimbursement rates limit physicians' time spent on lifestyle behavior counseling. These barriers to efficient diabetes care lead to high rates of diabetes-related complications, driving healthcare costs up and reducing the quality of patients' lives. Considering recent advancements in healthcare delivery technologies such as smartphone applications, telemedicine, m-health, device connectivity, machine-learning technology, and artificial intelligence, there is significant opportunity to achieve better efficiency in diabetes care and increase patient involvement in diabetes self-management, which ultimately may put an end to soaring diabetes-related healthcare expenditures. This review explores the patient-driven diabetes care of the future in the technology era.

Black, R. L. et Duval, C. (2019). "Diabetes Discharge Planning and Transitions of Care: A Focused Review." Curr Diabetes Rev **15**(2): 111-117.

BACKGROUND: Diabetes is a growing problem in the United States. Increasing hospital admissions for diabetes patients demonstrate the need for evidence-based care of diabetes patients by inpatient providers, as well as the importance of continuity of care when transitioning patients from inpatient to outpatient providers. METHODS: A focused literature review of discharge planning and transitions of care in diabetes, conducted in PubMed is presented. Studies were selected for inclusion based on content focusing on transitions of care in diabetes, risk factors for readmission, the impact of inpatient diabetes education on patient outcomes, and optimal medication management of diabetes during care transitions. American Diabetes Association (ADA) guidelines for care of patients during the discharge process are presented, as well as considerations for designing treatment regimens for a hospitalized patient transitioning to various care settings. RESULTS: Multiple factors may make transitions of care difficult, including poor communication, poor patient education, inappropriate follow-up, and clinically complex patients. ADA recommendations provide guidance, but an individualized approach for medication management is needed. Use of scoring systems may help identify patients at higher risk for readmission. Good communication with patients and outpatient providers is needed to prevent patient harm. A team-based approach is needed, utilizing the skills of inpatient and outpatient providers, diabetes educators, nurses, and pharmacists. CONCLUSION: Structured discharge planning per guideline recommendations can help improve transitions in care for

> patients with diabetes. A team based, patient-centered approach can help improve patient outcomes by reducing medication errors, delay of care, and hospital readmissions.

Boutin, H., Robichaud, P. et Hôpital Laval. Direction des soins, i. (2007). Guide d'élaboration d'un programme d'enseignement aux usagers. Québec, Hôpital Laval Direction des soins infirmiers

College of Medecine (2014). Patient, manager, expert: individual : improving the sustainability of the healthcare system by removing barriers for people with long-term conditions. Londres Angleterre, College of Medecine

Coulter, A., Parsons, S. et Askham, J. (2008). Where are the patients in decision-making about their own care? Policy brief : Health systems and policy analysis. Santé., O. M. d. l.
http://www.euro.who.int/document/hsm/3_hsc08_ePB_6.pdf

> Patients can play a distinct role in protecting their health, choosing appropriate treatments for episodes of ill health and managing chronic disease. Considerable evidence suggests that patient engagement can improve their experience and satisfaction and also can be effective clinically and economically. This policy brief outlines what the research evidence tells us about the effects of engaging patients in their clinical care, and it reviews policy interventions that have been (or could be) implemented in different health care systems across Europe. In particular, it focuses on strategies to improve : health literacy, treatment decision-making and self-management of chronic conditions

D'Ivernois, J.-F. et Gagnayre, R. (2011). Apprendre à éduquer le patient : : approche pédagogique. Paris, Maloine

> Ce livre analyse les principes théoriques sur lesquels se fonde l'éducation du patient. Il présente une approche et un ensemble de méthodes pédagogiques qui en font un guide méthodologique indispensable à tous les professionnels de santé qui souhaitent développer et structurer l'éducation thérapeutique du patient.-- Résumé de l'éditeur

Du Pré, A. (2010). Communicating about health: current issues and perspectives. New York, Oxford University Press

Dziedzic, K. S., Healey, E. L., Porcheret, M., et al. (2018). "Implementing core NICE guidelines for osteoarthritis in primary care with a model consultation (MOSAICS): a cluster randomised controlled trial." Osteoarthritis Cartilage **26**(1): 43-53.

> OBJECTIVE: To determine the effectiveness of a model osteoarthritis consultation, compared with usual care, on physical function and uptake of National Institute for Health and Care Excellence (NICE) osteoarthritis recommendations, in adults ≥45 years consulting with peripheral joint pain in UK general practice. METHOD: Two-arm cluster-randomised controlled trial with baseline health survey. Eight general practices in England. PARTICIPANTS: 525 adults ≥45 years consulting for peripheral joint pain, amongst 28,443 population survey recipients. Four intervention practices delivered the model osteoarthritis consultation to patients consulting with peripheral joint pain; four control practices continued usual care. The primary clinical outcome of the trial was the SF-12 physical component score (PCS) at 6 months; the main secondary outcome was uptake of NICE core recommendations by 6 months, measured by osteoarthritis quality indicators. A Linear Mixed Model was used to analyse clinical outcome data (SF-12 PCS). Differences in quality indicator outcomes were assessed using logistic regression. RESULTS: 525 eligible participants were enrolled (mean age 67.3 years, SD 10.5; 59.6% female): 288 from intervention and 237 from control practices. There were no statistically significant differences in SF-12 PCS: mean difference at the 6-month primary endpoint was -0.37 (95% CI -2.32, 1.57). Uptake of core NICE recommendations by 6 months was statistically significantly higher in the intervention arm compared with control: e.g., increased written exercise information, 20.5% (7.9, 28.3). CONCLUSION: Whilst uptake of core NICE recommendations was increased, there was no evidence of benefit of this intervention, as delivered in this pragmatic randomised trial, on the primary outcome of physical functioning at 6 months. TRIAL REGISTRATION: ISRCTN06984617.

Entwistle, V. A., Cribb, A., Watt, I. S., et al. (2018). ""The more you know, the more you realise it is really challenging to do": Tensions and uncertainties in person-centred support for people with long-term conditions." Patient Educ Couns **101**(8): 1460-1467.

> OBJECTIVE: To identify and examine tensions and uncertainties in person-centred approaches to self-management support - approaches that take patients seriously as moral agents and orient support to enable them to live (and die) well on their own terms. METHODS: Interviews with 26 UK clinicians about working with people with diabetes or Parkinson's disease, conducted within a broader interdisciplinary project on self-management support. The analysis reported here was informed by philosophical reasoning and discussions with stakeholders. RESULTS: Person-centred approaches require clinicians to balance tensions between the many things that can matter in life, and their own and each patient's perspectives on these. Clinicians must ensure that their supportive efforts do not inadvertently disempower people. When attending to someone's particular circumstances and perspectives, they sometimes face intractable uncertainties, including about what is most important to the person and what, realistically, the person can or could do and achieve. The kinds of professional judgement that person-centred working necessitates are not always acknowledged and supported. CONCLUSION: Practical and ethical tensions are inherent in person-centred support and need to be better understood and addressed. PRACTICE IMPLICATIONS: Professional development and service improvement initiatives should recognise these tensions and uncertainties and support clinicians to navigate them well.

Glanz, K., Rimer, B. K. et Viswanath, K. (2008). Health behavior and health education : : theory, research, and practice. San Francisco, JosseyBass

Glasgow, R. E., Dickinson, P., Fisher, L., et al. (2011). "Use of RE-AIM to develop a multi-media facilitation tool for the patient-centered medical home." Implement. Sci **6**: 118.
http://www.ncbi.nlm.nih.gov/pubmed/22017791

> BACKGROUND: Much has been written about how the medical home model can enhance patient-centeredness, care continuity, and follow-up, but few comprehensive aids or resources exist to help practices accomplish these aims. The complexity of primary care can overwhelm those concerned with quality improvement. METHODS: The RE-AIM planning and evaluation model was used to develop a multimedia, multiple-health behavior tool with psychosocial assessment and feedback features to facilitate and guide patient-centered communication, care, and follow-up related to prevention and self-management of the most common adult chronic illnesses seen in primary care. RESULTS: The Connection to Health Patient Self-Management System, a web-based patient assessment and support resource, was developed using the RE-AIM factors of reach (e.g., allowing input and output via choice of different modalities), effectiveness (e.g., using evidence-based intervention strategies), adoption (e.g., assistance in integrating the system into practice workflows and permitting customization of the website and feedback materials by practice teams), implementation (e.g., identifying and targeting actionable priority behavioral and psychosocial issues for patients and teams), and maintenance/sustainability (e.g., integration with current National Committee for Quality Assurance recommendations and clinical pathways of care). Connection to Health can work on a variety of input and output platforms, and assesses and provides feedback on multiple health behaviors and multiple chronic conditions frequently managed in adult primary care. As such, it should help to make patient-healthcare team encounters more informed and patient-centered. Formative research with clinicians indicated that the program addressed a number of practical concerns and they appreciated the flexibility and how the Connection to Health program could be customized to their office. CONCLUSIONS: This primary care practice tool based on an implementation science model has the potential to guide patients to more healthful behaviors and improved self-management of chronic conditions, while fostering effective and efficient communication between patients and their healthcare team. RE-AIM and similar models can help clinicians and media developers create practical products more likely to be widely adopted, feasible in busy medical practices, and able to produce public health impact

Gucciardi, E., Demelo, M., Offenheim, A., et al. (2008). "Factors contributing to attrition behavior in diabetes self-management programs: a mixed method approach." BMC Health Serv Res **8**: 33.
http://www.ncbi.nlm.nih.gov/pubmed/18248673

> BACKGROUND: Diabetes self-management education is a critical component in diabetes care. Despite worldwide efforts to develop efficacious DSME programs, high attrition rates are often reported in clinical practice. The objective of this study was to examine factors that may contribute to attrition behavior in diabetes self-management programs. METHODS: We conducted telephone interviews with individuals who had Type 2 diabetes (n = 267) and attended a diabetes education centre. Multivariable logistic regression was performed to identify factors associated with attrition behavior. Forty-four percent of participants (n = 118) withdrew prematurely from the program and were asked an open-ended question regarding their discontinuation of services. We used content analysis to code and generate themes, which were then organized under the Behavioral Model of Health Service Utilization. RESULTS: Working full and part-time, being over 65 years of age, having a regular primary care physician or fewer diabetes symptoms were contributing factors to attrition behaviour in our multivariable logistic regression. The most common reasons given by participants for attrition from the program were conflict between their work schedules and the centre's hours of operation, patients' confidence in their own knowledge and ability when managing their diabetes, apathy towards diabetes education, distance to the centre, forgetfulness, regular physician consultation, low perceived seriousness of diabetes, and lack of familiarity with the centre and its services. There was considerable overlap between our quantitative and qualitative results. CONCLUSION: Reducing attrition behaviour requires a range of strategies targeted towards delivering convenient and accessible services, familiarizing individuals with these services, increasing communication between centres and their patients, and creating better partnerships between centres and primary care physicians

Halabi, I. O., Scholtes, B., Voz, B., et al. (2020). "“Patient participation” and related concepts: A scoping review on their dimensional composition." Patient Education and Counseling **103**(1): 5-14.
http://www.sciencedirect.com/science/article/pii/S0738399119303179

> Objectives Several concepts on collaboration between patients and healthcare systems have emerged in the literature but there is little consensus on their meanings and differences. In this study, “patient participation” and related concepts were studied by focusing on the dimensions that compose them. This review follows two objectives: (1) to produce a detailed and comprehensive overview of the “patient participation” dimensions; (2) to identify differences and similarities between the related concepts. Methods A scoping review was performed to synthesize knowledge into a conceptual framework. An electronic protocol driven search was conducted in two bibliographic databases and a thematic analysis was used to analyse the data. Results The search process returned 39 articles after exclusion for full data extraction and analysis. Through the thematic analysis, the dimensions, influencing factors and expected outcomes of “patient participation” were determined. Finally, differences between the included concepts were identified. Conclusion This global vision of “patient participation” allows us to go beyond the distinctions between the existing concepts and reveals their common goal to include the patient in the healthcare system. Practice implications This scoping review provides useful information to propose a conceptual model of “patient participation”, which could impact clinical practice and medical training programs.

Higgins, O., European Centre for Disease, p. et Control (2011). A literature review on health information-seeking behaviour on the web: a health consumer and health professional perspective : insights into health communication. Stockholm, European Centre for Disease prevention and Control
http://www.ecdc.europa.eu/en/publications/Publications/Literature%20review%20on%20health%20information-seeking%20behaviour%20on%20the%20web.pdf

Lamont, T., Barber, N., Pury, J. d., et al. (2016). "New approaches to evaluating complex health and care systems." BMJ **352**.
http://www.bmj.com/bmj/352/bmj.i154.full.pdf

T. Lamont and colleagues discuss how researchers can help service leaders to evaluate rapidly changing models of care, with a range of approaches depending on needs and resourcesThe NHS has many examples of effective service changes that took too long to implement, from structured patient education in diabetes1 to enhanced recovery programmes in surgery.2 Other initiatives have seemed promising but didn't deliver—or made things worse. For example, telephone triage and some types of case management increase demand for services rather than divert pressure from urgent care.3 Without the right evaluation, it is difficult to know which innovations are worth adopting. The scale of opportunity and real costs of implementing untested innovations and ignoring lessons learnt elsewhere are substantial. In 2015 a large international summit was held in London, convened by the National Institute for Health Research, the Health Foundation, the Medical Research Council (MRC), Universities UK, and AcademyHealth, which led to an authoritative overview of the array of methods available to evaluate healthcare services.4 Here we summarise a parallel discussion that took place between research funders, practitioners, and leaders to identify the institutional barriers to healthcare evaluation and potential solutions. We argue for closer partnership between service leaders and researchers, based on a shared culture of basic principles and awareness of a range of options for evaluation.Time to evaluateAt a time of straitened resources we cannot afford to make poor choices. As Twain said, "Supposing is good, but finding out is better." This is the right time for researchers to get more engaged in supporting service change. In 2014 the NHS Five Year Forward View set out clearly the case for major system innovations and new ways of working.5 It suggests that future gains will come as much from changes in process and service delivery …

Langberg, E. M., Dyhr, L. et Davidsen, A. S. (2019). "Development of the concept of patient-centredness - A systematic review." Patient Educ Couns **102**(7): 1228-1236.

OBJECTIVE: Patient-centredness is often linked to high-quality patient care, but the concept is not well-defined. This study aims to provide an overview of how patient-centredness has been defined in the literature since Mead and Bower's review in 2000, and to provide an updated definition of the concept. METHOD & DESIGN: We performed a systematic literature search in PubMed to identify original articles with a sufficient definition of patient-centredness. We analysed extracted data defining patient-centredness. RESULTS: Eighty articles were included. The dimensions "biopsychosocial", "patient-as-person", "sharing power and responsibility" and "therapeutic alliance" corresponded to four of five dimensions described by Mead and Bower. "Coordinated care" was a new dimension. CONCLUSION: The identified dimensions are encompassed by three elements: the patient, the doctor-patient relationship and the framework of care i.e. the health care system. The additional focus on coordinated care could reflect increasing complexity of the health care system. PRACTICE IMPLICATIONS: Narrowing down the understanding of patient-centredness to these three focus areas, viz. 1) understanding of the patients' experience of the illness in their life situation, 2) the professional's relationship with the patient, and 3) coordination of care in the system, could make the operationalisation and implementation of a patient-centred approach more manageable.

McCormack, B. et McCance, T. (2016). Person-centred practice in nursing and health care: theory and practice. Chichester Angleterre , Ames IA, John Wiley Sons Inc

Michielutte, R., Sharp, P. C., Foley, K. L., et al. (2005). "Intervention to increase screening mammography among women 65 and older." Health Educ Res **20**(2): 149-162.
http://www.ncbi.nlm.nih.gov/pubmed/15254001

This paper reports the results of a practice-based intervention program to increase mammography screening among women 65 and older who receive their health care in the private sector. Forty-three primary-care practices and 2147 women in central and western North Carolina were enrolled in the study, and 1911 women completed all phases of the study. The intervention was a three-stage educational and counseling program designed to become progressively more intensive at each stage. The interventions included provider education in the form of current information on issues in mammography for older women, simply written educational materials on breast cancer and screening mailed to women, and a brief telephone counseling session for the women. While the analysis

revealed no overall effect across all three stages of the intervention program, tests for interaction indicated a significant program effect for women who were 80 or older, had less than 9 years of education, were black, or had no private insurance to supplement Medicare. The results suggested that providing primary-care physicians with information on screening older women and providing the women with useful educational materials can increase participation in screening mammography among subgroups of women currently least likely to receive mammography screening

Pal, K., Eastwood, S. V., Michie, S., et al. (2013). "Computer-based diabetes self-management interventions for adults with type 2 diabetes mellitus." Cochrane Database Syst Rev **3**: CD008776.

BACKGROUND: Diabetes is one of the commonest chronic medical conditions, affecting around 347 million adults worldwide. Structured patient education programmes reduce the risk of diabetes-related complications four-fold. Internet-based self-management programmes have been shown to be effective for a number of long-term conditions, but it is unclear what are the essential or effective components of such programmes. If computer-based self-management interventions improve outcomes in type 2 diabetes, they could potentially provide a cost-effective option for reducing the burdens placed on patients and healthcare systems by this long-term condition. OBJECTIVES: To assess the effects on health status and health-related quality of life of computer-based diabetes self-management interventions for adults with type 2 diabetes mellitus. SEARCH METHODS: We searched six electronic bibliographic databases for published articles and conference proceedings and three online databases for theses (all up to November 2011). Reference lists of relevant reports and reviews were also screened. SELECTION CRITERIA: Randomised controlled trials of computer-based self-management interventions for adults with type 2 diabetes, i.e. computer-based software applications that respond to user input and aim to generate tailored content to improve one or more self-management domains through feedback, tailored advice, reinforcement and rewards, patient decision support, goal setting or reminders. DATA COLLECTION AND ANALYSIS: Two review authors independently screened the abstracts and extracted data. A taxonomy for behaviour change techniques was used to describe the active ingredients of the intervention. MAIN RESULTS: We identified 16 randomised controlled trials with 3578 participants that fitted our inclusion criteria. These studies included a wide spectrum of interventions covering clinic-based brief interventions, Internet-based interventions that could be used from home and mobile phone-based interventions. The mean age of participants was between 46 to 67 years old and mean time since diagnosis was 6 to 13 years. The duration of the interventions varied between 1 to 12 months. There were three reported deaths out of 3578 participants.Computer-based diabetes self-management interventions currently have limited effectiveness. They appear to have small benefits on glycaemic control (pooled effect on glycosylated haemoglobin A1c (HbA1c): -2.3 mmol/mol or -0.2% (95% confidence interval (CI) -0.4 to -0.1; P = 0.009; 2637 participants; 11 trials). The effect size on HbA1c was larger in the mobile phone subgroup (subgroup analysis: mean difference in HbA1c -5.5 mmol/mol or -0.5% (95% CI -0.7 to -0.3); P < 0.00001; 280 participants; three trials). Current interventions do not show adequate evidence for improving depression, health-related quality of life or weight. Four (out of 10) interventions showed beneficial effects on lipid profile.One participant withdrew because of anxiety but there were no other documented adverse effects. Two studies provided limited cost-effectiveness data - with one study suggesting costs per patient of less than $140 (in 1997) or 105 EURO and another study showed no change in health behaviour and resource utilisation. AUTHORS' CONCLUSIONS: Computer-based diabetes self-management interventions to manage type 2 diabetes appear to have a small beneficial effect on blood glucose control and the effect was larger in the mobile phone subgroup. There is no evidence to show benefits in other biological outcomes or any cognitive, behavioural or emotional outcomes

Phaneuf, M. (2011). La relation soignant-soigné: rencontre et accompagnement : vers l'utilisation thérapeutique de soi. Montréal, Chenelièreéducation

Phaneuf, M. (2016). La relation soignant-soigné: l'accompagne thérapeutique. Montréal, Chenelièreéducation

Richard, C. et Lussier, M.-T. (2016). La communication professionnelle en santé. Montréal, Éditions du Renouveau pédagogique

Sepucha, K. R., Fagerlin, A., Couper, M. P., et al. (2010). "How does feeling informed relate to being informed? The DECISIONS survey." Med Decis. Making **30**(5 Suppl): 77S-84S.
http://www.ncbi.nlm.nih.gov/pubmed/20881156

> BACKGROUND: An important part of delivering high-quality, patient-centered care is making sure patients are informed about decisions regarding their health care. The objective was to examine whether patients' perceptions about how informed they were about common medical decisions are related to their ability to answer various knowledge questions. METHODS: A cross-sectional survey was conducted November 2006 to May 2007 of a national sample of US adults identified by random-digit dialing. Participants were 2575 English-speaking US adults aged 40 and older who had made 1 of 9 medication, cancer screening, or elective surgery decisions within the previous 2 years. Participants rated how informed they felt on a scale of 0 (not at all informed) to 10 (extremely well-informed), answered decision-specific knowledge questions, and completed standard demographic questions. RESULTS: Overall, 36% felt extremely well informed (10), 30% felt well informed (8-9), and 33% felt not at all to somewhat informed (0-7). Multivariate logistic regression analyses showed no overall relationship between knowledge scores and perceptions of being extremely well informed (odds ratio [OR] = 0.94, 95% confidence interval [CI] 0.63-1.42, P = 0.78). Three patterns emerged for decision types: a negative relationship for cancer screening decisions (OR = 0.58, CI 0.33-1.02, P = 0.06), no relationship for medication decisions (OR = 0.99, CI 0.54-1.83, P = 0.98), and a positive relationship for surgery decisions (OR = 3.07, 95% CI 0.90-10.54, P = 0.07). Trust in the doctor was associated with feeling extremely well-informed for all 3 types of decisions. Lower education and lower income were also associated with feeling extremely well informed for medication and screening decisions. Retrospective survey data are subject to recall bias, and participants may have had different perspectives or more factual knowledge closer to the time of the decision. CONCLUSIONS: Patients facing common medical decisions are not able to accurately assess how well informed they are. Clinicians need to be proactive in providing adequate information to patients and testing patients' understanding to ensure informed decisions

Smarr, K. L., Musser, D. R., Shigaki, C. L., et al. (2011). "Online self-management in rheumatoid arthritis: a patient-centered model application." Telemed. J E Health **17**(2): 104-110.
http://www.ncbi.nlm.nih.gov/pubmed/21361817

> OBJECTIVE: The aim of this study was to describe the online transformation of an empirically validated, clinic-based, self-management (SM) program for rheumatoid arthritis. MATERIALS AND METHODS: A cognitive-behavioral framework served as the theoretical basis for the intervention. As with the clinic-based approach, the psychoeducational program included educational modules, weekly homework assignments, and self-evaluation. The dynamic online environment included secure communication tools to support a virtual community for the participants to garner peer support. In addition to peer support, weekly follow-up support was provided by a trained clinician via telephone. We describe the process and structure of the online self-management (OSM) intervention. Administrative issues including clinical monitoring and management, data collection, and security safeguards are considered. Utilization and management data are provided and explored for 33 initial subjects. RESULTS: Individuals who volunteer to participate in an online modality are eager to receive this home-based programming. They readily engaged with all aspects of the OSM program and experienced few difficulties navigating the environment. CONCLUSION: An OSM site provides a convenient, effective, and securely maintained health service, once restricted to clinic settings. The OSM application can be used to extend the benefits of SM programs to broad target audiences and serves as a model for the emerging generation of Internet-based clinical management/delivery systems

Swanwick, T. (2014). Understanding medical education: evidence, theory and practice. Chichester Angleterre, Wiley Blackwell

Talbot, M., Horne, E., Inhaber, S., et al. (2001). La communication efficace... à votre service : bonnes pratiques préventives et la communication dans la relation de soin, Ottawa : Santé canada

http://publications.gc.ca/collections/Collection/H88-3-30-2001/pdfs/com/tt2res_f.pdf

> Le domaine de la communication efficace médecin-patient a suscité énormément d'intérêt depuis la parution du document Outils de communication 1 — Une meilleure communication médecin-patient pour de meilleurs résultats auprès des patients publié par l'Initiative canadienne sur le cancer du sein (ICCS), en 1998. Partout au Canada, les médecins praticiens, les facultés de médecine et les patients ont choisi de préciser leurs efforts en vue d'améliorer la qualité des rapports médecins-patients et d'établir des pratiques davantage centrées sur les besoins des patients.

Éducation thérapeutique du patient : la place des médecins généralistes

FOCUS : LES PRATIQUES EDUCATIVES DES MEDECINS GENERALISTES EN FRANCE

Une étude française récente, basée sur une recherche sociologique menée par entretiens auprès de médecins généralistes,[4] démontre que « les médecins généralistes développent tous de manière variable des pratiques éducatives intégrées à leurs consultations, mais qu'ils orientent rarement les patients vers d'autres offres éducatives ou vers des programmes d'ETP. Leurs pratiques apparaissent différenciées selon la situation sociale des patients. Néanmoins, certains s'engagent dans des dynamiques professionnelles et institutionnelles susceptibles d'améliorer à la fois leurs pratiques éducatives et l'équité de l'accès donné à d'autres ressources en participant à des échanges de pratiques ou en se formant à l'ETP ; en se tenant informés de l'offre éducative disponible sur leur territoire ; en développant des organisations du travail pluriprofessionnelles et intersectorielles, qui facilitent la connaissance des ressources éducatives complémentaires et l'orientation des patients ; en développant des ressources éducatives ou pluripathologiques, en proximité. Enfin, pour certains médecins, se former et pratiquer l'ETP aide à transformer leurs pratiques pour mieux répondre aux besoins des patients, notamment les plus défavorisés socialement. »

REVUES SYSTEMATIQUES DE LA LITTERATURE

Albano, M.-G., De Andrade, V., Léocadie, M., et al. (2016). "A bibliometric analysis of the international studies published on patient education." Educ Ther Patient/Ther Patient Educ **8**(1): 10103.
https://hal-univ-paris13.archives-ouvertes.fr/hal-01567558

> Abstract – A bibliometric analysis of the international studies published on patient education. Introduction: We performed a bibliometric analysis of the international studies published on patient education (PE) over the past 40 years. Methods: The query of six major databases showed a dramatic increase of the number of studies from 1970 to 2014, reaching 77854 articles (PubMed), namely an average annual increase at 3 digits. On this subject, 1695 books have been published. Results: The peak is reached during the period 2004–2014 with 13109 literature reviews, 5977 RCTs, 397 meta-analyzes. Oncology, cardiology, diabetology, neurology and psychiatry are the five disciplines more involved in research on PE. Conclusion: our analysis illustrates the exponential growth of research in patient education and its scientific legitimacy in the therapy of chronic diseases.
> – Introduction : Nous avons réalisé une analyse bibliométrique des études internationales publiées sur l'édu-cation des patients (EP) au cours des 40 dernières années. Méthodes : L'interrogation de six bases de données majeures a montré un accroissement spectaculaire des études de 1970 à 2014, atteignant 77 854 articles (PubMed), soit une progression annuelle moyenne à 3 chiffres. Sur ce sujet, 1695 ouvrages ont été publiés. Résultats : Le pic est la période 2004–2014 avec 13 109 revues de littérature, 5 977 RCT, 397 méta analyses. L'oncologie, la cardiologie, la diabétolo-gie, la neurologie et la psychiatrie sont les 5 disciplines qui consacrent le plus de recherches à l'EP. Conclusion : notre analyse illustre la progression exponentielle de la recherche sur l'éducation du patient qui a obtenu ainsi une légitimité scientifique dans la thérapeutique des maladies chroniques.

Albury, C., Hall, A., Syed, A., et al. (2019). "Communication practices for delivering health behaviour change conversations in primary care: a systematic review and thematic synthesis." BMC Fam Pract **20**(1): 111.

> BACKGROUND: Clinical guidelines exhort clinicians to encourage patients to improve their health behaviours. However, most offer little support on how to have these conversations in practice. Clinicians fear that health behaviour change talk will create interactional difficulties and discomfort for both clinician and patient. This review aims to identify how healthcare professionals can best communicate with patients about health behaviour change (HBC). METHODS: We included studies which used conversation analysis or discourse analysis to study recorded interactions between healthcare professionals and patients. We followed an aggregative thematic synthesis approach. This

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[4] Fournier, C., Naiditch, M. et Frattini, M. O. (2018). "Comment les médecins généralistes peuvent-ils contribuer à un accès plus équitable à l'éducation thérapeutique ?" Medecine : De La Medecine Factuelle a Nos Pratiques **14**(6)

involved line-by-line coding of the results and discussion sections of included studies, and the inductive development and hierarchical grouping of descriptive themes. Top-level themes were organised to reflect their conversational positioning. RESULTS: Of the 17,562 studies identified through systematic searching, ten papers were included. Analysis resulted in 10 top-level descriptive themes grouped into three domains: initiating; carrying out; and closing health behaviour change talk. Of three methods of initiation, two facilitated further discussion, and one was associated with outright resistance. Of two methods of conducting behaviour change talk, one was associated with only minimal patient responses. One way of closing was identified, and patients did not seem to respond to this positively. Results demonstrated a series of specific conversational practices which clinicians use when talking about HBC, and how patients respond to these. Our results largely complemented clinical guidelines, providing further detail on how they can best be delivered in practice. However, one recommended practice - linking a patient's health concerns and their health behaviours - was shown to receive variable responses and to often generate resistance displays. CONCLUSIONS: Health behaviour change talk is smoothly initiated, conducted, and terminated by clinicians and this rarely causes interactional difficulty. However, initiating conversations by linking a person's current health concern with their health behaviour can lead to resistance to advice, while other strategies such as capitalising on patient initiated discussions, or collaborating through question-answer sequences, may be well received.

Alders, I., Smits, C., Brand, P., et al. (2017). "Does patient coaching make a difference in patient-physician communication during specialist consultations? A systematic review." Patient Educ Couns **100**(5): 882-896.

OBJECTIVE: To systematically review the literature on the effectiveness of a patient coach intervention on patient - physician communication in specialists consultations. METHODS: PubMed, Cochrane, PsycInfo, Cinahl and Embase were searched until November 2015. Included were papers describing interventions directed at adult outpatients in secondary care with a variety of somatic diseases. Outcomes had to be measured in communication effectivity from a patient's perspective. RESULTS: Seventeen publications met the inclusion criteria (involving 3787 patients), describing 13 unique interventions. Most interventions were single one-on-one sessions taking between 20 and 40min before consultation. Research quality in ten studies was high. These studies showed significant improvement on immediate, intermediate and long-term patient - physician communication. CONCLUSION: We found limited evidence suggesting an improvement of patient - physician communication by having multiple patient coaching encounters during which questions are prepared and rehearsed and consultations are evaluated and reflected upon, sometimes supported by audio recording the consultation. PRACTICE IMPLICATIONS: The results of this review contribute to the (re-)design of an effective model for patient coaching, a profile and training approach of patient coaches. Future research should aim at determining which patients will benefit most from coaching interventions.

Baker, E. et Fatoye, F. (2017). "Clinical and cost effectiveness of nurse-led self-management interventions for patients with copd in primary care: A systematic review." Int J Nurs Stud **71**: 125-138.

BACKGROUND AND OBJECTIVE: Chronic obstructive pulmonary disease is increasing in prevalence and constitutes a major cause of morbidity and mortality globally. As well as contributing to a significant decline in health status in many patients, this condition creates a considerable burden on healthcare providers. Self-management interventions are frequently implemented in community settings to limit the impact of chronic obstructive pulmonary disease on everyday life of individuals and to manage pressure on health systems. Nurses are the most likely professional group to provide self-management support. This systematic review aims to evaluate the clinical and cost effectiveness of nurse-led self-management for patients with chronic obstructive pulmonary disease in primary care. DESIGN: A systematic review was conducted to identify randomized controlled studies comparing nurse-led self-management interventions to usual care DATA SOURCES: Seven electronic databases, including British Nursing Index, MEDLINE, CINAHL, AMED, EMBASE, Cochrane Library and NHS Economic Evaluation Database, were searched for relevant studies. REVIEW METHODS: The Preferred Reporting Items for Systematic Reviews and Meta-Analyses checklist was used to guide the structure of the review. The relevance of citations was assessed based on inclusion criteria, with full texts retrieved as required to reach a decision. Data extraction was performed independently by two reviewers. The Cochrane risk of bias tool was used to undertake a quality review. A narrative summary method was used to describe review findings. RESULTS: Twenty-six articles describing 20 randomised controlled trials were included in the analysis. Self-management interventions were heterogeneous, with a variable number of components, level of support, mode of delivery and length of follow up. The review demonstrated that nurse-led self-management programmes may be associated with reductions in anxiety and unscheduled physician visits and increases in self-efficacy, but definitive conclusions could not be reached. Few studies addressed economic outcomes and the diverse perspectives, time frames and settings made comparisons difficult. Evidence on cost-effectiveness was inconclusive. CONCLUSIONS: Some nurse-led self-management programmes in this systematic review produced beneficial effects in terms of reducing unscheduled physician visits, lowering patients' anxiety and increasing self-efficacy, but there is insufficient evidence to reach firm conclusions on the clinical or cost-effectiveness of the interventions. Further research should aim to identify the optimal components of these programmes and to identify those patients most likely to benefit. The inclusion of economic analyses in future studies would facilitate decisions by policy makers on the implementation of self-management interventions.

Berkhout, C., Zgorska-Meynard-Moussa, S., Willefert-Bouche, A., et al. (2018). "Audiovisual aids in primary healthcare settings' waiting rooms. A systematic review." Eur J Gen Pract **24**(1): 202-210.

BACKGROUND: Health promotion is part of GPs' commitments. Some waiting rooms have therefore been implemented with audiovisual aids (posters, pamphlets or screens) for health promotion purposes. Few studies have assessed the effect of audiovisual aids in primary care. OBJECTIVES: To identify, describe and appraise studies that have investigated the effects of audiovisual aids on health promotion in primary healthcare waiting rooms. To determine which factors influence this impact through literature review. METHODS: Systematic review. Two independent researchers using predefined keywords searched databases. Additional publications were extracted from the reference lists of the selected articles. The selection of the articles was performed on the title and abstract, followed by complete reading and assessment. Bias and level of evidence were analysed. RESULTS: A total of 909 articles were collected. Most of them were not in primary care settings. Fourteen peer-reviewed articles fully meeting inclusion criteria were included and analysed. Good quality studies were scarce. Eight of these articles using videos or slideshows on TV screens or tablets indicated effects: three of them were significant on patient knowledge with acceptable evidence and three on health behaviour on surrogate endpoints. Audiovisual aids seem to be used or noticed by patients and can induce conversations with physicians. The relevant factors that might influence these effects (duration of exposure, conception quality, theme, target population and time spent in the waiting room) are insufficiently investigated. CONCLUSION: Audiovisual aids broadcasting messages using screens (TVs, computers, tablets, and smartphones with Bluetooth(®) pairing) probably enhance patients' knowledge. A change in health behaviour remains controversial.

Bhuyan, S. S., Chandak, A., Smith, P., et al. (2015). "Integration of public health and primary care: A systematic review of the current literature in primary care physician mediated childhood obesity interventions." Obes Res Clin Pract **9**(6): 539-552.

INTRODUCTION: Childhood obesity, with its growing prevalence, detrimental effects on population health and economic burden, is an important public health issue in the United States and worldwide. There is need for expansion of the role of primary care physicians in obesity interventions. The primary aim of this review is to explore primary care physician (PCP) mediated interventions targeting childhood obesity and assess the roles played by physicians in the interventions. METHODS: A systematic review of the literature published between January 2007 and October 2014 was conducted using a combination of keywords like "childhood obesity", "paediatric obesity", "childhood overweight", "paediatric overweight", "primary care physician", "primary care settings", "healthcare teams", and "community resources" from MEDLINE and CINAHL during November 2014. Author name(s), publication year, sample size, patient's age, study and follow-up duration, intervention components, role of PCP, members of the healthcare team, and outcomes were extracted for this review. RESULTS: Nine studies were included in the review. PCP-mediated interventions were composed of behavioural, education and technological interventions or a combination of these. Most interventions led to positive changes in Body Mass Index (BMI), healthier lifestyles and increased satisfaction among parents. PCPs participated in screening and diagnosing, making referrals for intervention, providing nutrition counselling, and promoting physical activity. PCPs, Dietitians and nurses were often part of the healthcare team. CONCLUSION: PCP-mediated interventions have the potential to effectively curb childhood obesity. However, there is a further need for training of PCPs, and explain new types of interventions such as the use of technology.

Brouwers, M., Rasenberg, E., van Weel, C., et al. (2017). "Assessing patient-centred communication in teaching: a systematic review of instruments." Med Educ **51**(11): 1103-1117.

CONTEXT: Patient-centred communication is a key component of patient centredness in medical care. Therefore, adequate education in and assessment of patient-centred communication skills are necessary. In general, feedback on communication skills is most effective when it is provided directly and is systematic. This calls for adequate measurement instruments. OBJECTIVES: The aim of this study was to provide a systematic review of existing instruments that measure patient centredness in doctor-patient communication and can be used to provide direct feedback. METHODS: A systematic review was conducted using an extensive validated search strategy for measurement instruments in PubMed, EMBASE, PsycINFO and CINAHL. The databases were searched from their inception to 1 July 2016. Articles describing the development or evaluation of the measurement properties of instruments that measure patient centredness (by applying three or more of the six dimensions of a published definition of patient centredness) in doctor-patient communication and that can be used for the provision of direct feedback were included. The methodological quality of measurement properties was evaluated using the COSMIN checklist. RESULTS: Thirteen articles describing 14 instruments measuring patient centredness in doctor-patient communication were identified. These studies cover a wide range of settings and patient populations, and vary in the dimensions of patient centredness applied and in methodological quality on aspects of reliability and validity. CONCLUSIONS: This review gives a comprehensive overview of all instruments available for the measurement of patient centredness in doctor-patient communication that can be used for the provision of direct feedback and are described in the literature. Despite the widely felt need for valid and reliable instruments for the measurement of patient-centred communication, most of the instruments currently available have not been thoroughly investigated. Therefore, we recommend further research into and enhancement of existing instruments in terms of validity and reliability, along with enhancement of their generalisability, responsiveness and aspects of interpretability in different contexts (real patients, simulated patients, doctors in different specialties, etc.). Comprehensibility and feasibility should also be taken into account.

Caro-Bautista, J., Kaknani-Uttumchandani, S., García-Mayor, S., et al. (2020). "Impact of self-care programmes in type 2 diabetes mellitus population in primary health care: Systematic review and meta-analysis." J Clin Nurs **29**(9-10): 1457-1476.

AIMS AND OBJECTIVES: To evaluate the effectiveness of self-care programmes in type 2 diabetes mellitus (T2DM) population in primary health care. BACKGROUND: The impact of educational interventions on T2DM has been evaluated in various contexts, but there is uncertainty about their impact in that of primary care. DESIGN: Systematic review and meta-analysis. METHODS: A search was conducted in PubMed, CINAHL, WOS and Cochrane databases for randomised controlled trials carried out in the period January 2005-December 2017, including studies with at least one face-to-face educational interventions. The quality of the evidence for the primary outcome was evaluated using the GRADE System. A meta-analysis was used to determine the effect achieved although only the results classified as critical or important were taken into consideration. Checklist of Preferred Reporting Items for Systematic Reviews and Meta-analyses has been followed. PROSPERO registration Number: CRD42016038833. RESULTS: In total, 21 papers (20 studies) were analysed, representing a population of 12,018 persons with T2DM. For the primary outcome, HbA(1) c, the overall reduction obtained was -0.29%, decreasing the effect in long-term follow-up. The quality of the evidence was low/very low due to very serious risk of bias, inconsistency and indirectness of results. Better results were obtained for individual randomised trials versus cluster designs and in those programmes in which nurses leaded the interventions. The findings for other cardiovascular risk factors were inconsistent. CONCLUSIONS: Educational interventions in primary care addressing T2DM could be effective for metabolic control, but the low quality of the evidence and the lack of measurement of critical results generates uncertainty and highlights the need for high-quality trials. RELEVANCE TO CLINICAL PRACTICE: Most of self-care programmes for T2DM in primary care are focused on metabolic control, while other cardiovascular profile variables with greater impact on mortality or patient-reported outcomes are less intensely addressed.

Carvajal, R., Wadden, T. A., Tsai, A. G., et al. (2013). "Managing obesity in primary care practice: a narrative review." Ann N Y Acad Sci **1281**: 191-206.

This narrative review examines randomized controlled trials of the management of obesity in primary care practice, in light of the Centers for Medicare and Medicaid Services' decision to support intensive behavioral weight loss counseling provided by physicians and related health professionals. Mean weight losses of 0.1-2.3 kg were observed with brief (10- to 15-min) behavioral counseling delivered by primary care providers (PCPs) at monthly to quarterly visits. Losses increased to 1.7-7.5 kg when brief PCP counseling was combined with weight loss medication. Collaborative treatment, in which medical assistants delivered brief monthly behavioral counseling in conjunction with PCPs, produced losses of 1.6-4.6 kg in periods up to two years. Remotely delivered, intensive (>monthly contact) behavioral counseling, as offered by telephone, yielded losses of 0.4-5.1 kg over the same period. Further study is needed of the frequency and duration of visits required to produce clinically meaningful weight loss (>5%) in primary care patients. In addition, trials are needed that examine the cost-effectiveness of PCP-delivered counseling, compared with that potentially provided by registered dietitians or well-studied commercial programs.

Charalampopoulos, D., Hesketh, K. R., Amin, R., et al. (2017). "Psycho-educational interventions for children and young people with Type 1 Diabetes in the UK: How effective are they? A systematic review and meta-analysis." Plos One **12**(6): e0179685.

AIMS: To synthesise evidence from UK-based randomised trials of psycho-educational interventions in children and young people (CYP) with Type 1 Diabetes (T1D) to inform the evidence-base for adoption of such interventions into the NHS. METHODS: We searched Medline, Embase, Cochrane, PsycINFO, CINAHL, and Web of Science up to March 2016. Two reviewers independently selected UK-based randomised trials comparing psycho-educational interventions for improving management of T1D for CYP with a control group of usual care or attention control. The main outcome was glycaemic control measured by percentage of glycated haemoglobin (HbA1c); secondary outcomes included psychosocial functioning, diabetes knowledge, adverse and other clinical outcomes. A narrative synthesis and meta-analysis were conducted. Pooled effect sizes of standardised mean difference (SMD) were calculated. RESULTS: Ten eligible trials of three educational and seven psycho-educational interventions were identified. Most interventions were delivered by non-psychologists and targeted adolescents with more than one year duration of diabetes. Meta-analysis of nine of these trials (N = 1,838 participants) showed a non-significant reduction in HbA1c attributable to the intervention (pooled SMD = -0.06, 95% CI: -0.21 to 0.09). Psycho-educational interventions aiming to increase children's self-efficacy had a moderate, beneficial effect (SMD = 0.50, 95% CI: 0.13 to 0.87). No benefits on diabetes knowledge and other indicators of psychosocial functioning were identified. CONCLUSIONS: There is insufficient evidence to recommend the use of particular psycho-educational programme for CYP with T1D in the UK. Further trials with sufficient power and reporting standards are needed. Future trials could consider active involvement of psychological specialists in the delivery of psychologically informed interventions and implementation of psycho-educational interventions earlier in the course of the disease. SYSTEMATIC REVIEW REGISTRATION: PROSPERO CRD42015010701.

Colston, S., Gentile, S., Cote, J., et al. (2014). "Spécificités pédiatriques du concept d'éducation thérapeutique du patient : analyse de la littérature de 1998 à 2012." Santé Publique **26**(3): 283-295.

[BDSP. Notice produite par EHESP oR0xrnJH. Diffusion soumise à autorisation]. Le concept général d'éducation thérapeutique du patient (ETP), défini par le Bureau européen de l'Organisation Mondiale de la Santé (OMS) en 1998, pourrait être discutable lorsqu'il est appliqué à l'enfant, en raison des nombreuses spécificités de cette population dans le champ de la santé et de l'éducation. L'objectif propose d'identifier les spécificités de l'Éducation Thérapeutique du Patient appliquée à la population pédiatrique en s'appuyant sur la méthode de Rodgers. Trente-cinq publications ont été incluses dans cette clarification de concept. Cinq attributs ont émergé : la triade relationnelle, les partenariats collaboratifs, l'adaptation de l'apprentissage, l'acquisition progressive et évolutive des compétences, et la créativité. Les résultats issus de cette première analyse de concept permettent d'éclairer le processus de transfert de connaissances à travers le temps. Les cinq spécificités, en cohésion avec le domaine de la promotion de la santé, pourraient être consolidées par une théorisation ancrée.

Corson, K., Doak, M. N., Denneson, L., et al. (2011). "Primary care clinician adherence to guidelines for the management of chronic musculoskeletal pain: results from the study of the effectiveness of a collaborative approach to pain." Pain Med **12**(10): 1490-1501.

OBJECTIVE: We assessed primary care clinician-provided guideline-concordant care as documented in patients' medical records, predictors of documented guideline-concordant care, and its association with pain-related functioning. Patients were participants in a randomized trial of collaborative care for chronic musculoskeletal pain. The intervention featured patient and primary care clinician education, symptom monitoring and feedback to clinicians by the intervention team. METHODS: To assess concordance with the evidence-based treatment guidelines upon which our intervention was based, we developed an 8-item chart review tool, the Pain Process Checklist (PPC). We then reviewed electronic medical records for 365 veteran patients treated by 42 primary care clinicians over 12 months. Intervention status, demographic, and clinical variables were tested as predictors of PPC scores using generalized estimating equations (GEE). GEE was also used to test whether PPC scores predicted treatment response (>/=30% decrease in Roland-Morris Disability Questionnaire score). RESULTS: Rates of documented guideline-concordant care varied widely among PPC items, from 94% of patients having pain addressed to 17% of patients on opioids having side effects addressed. Intervention status was unrelated to item scores, and PPC-7 totals did not differ significantly between intervention and treatment-as-usual patients (61.2%, standard error [SE] = 3.3% vs 55.2%, SE = 2.6%, P = 0.15). In a multivariate model, higher PPC-7 scores were associated with receiving a prescription for opioids (odds ratio [OR] = 1.07, P = 0.007) and lower PPC-7 scores with patient age (10-year difference OR = 0.97, P = 0.004). Finally, intervention patients who received quantitative pain and depression assessments were less likely to respond to treatment (assessed vs not: 18% vs 33%, P = 0.008, and 13% vs 28%, P = 0.001, respectively). CONCLUSIONS: As measured by medical record review, additional training and clinician feedback did not increase provision of documented guideline-concordant pain care, and adherence to guidelines by primary care clinicians did not improve clinical outcomes for patients with chronic musculoskeletal pain.

Costa, B. M., Fitzgerald, K. J., Jones, K. M., et al. (2009). "Effectiveness of IT-based diabetes management interventions: a review of the literature." BMC Fam Pract **10**: 72.

BACKGROUND: Information technology (IT) is increasingly being used in general practice to manage health care including type 2 diabetes. However, there is conflicting evidence about whether IT improves diabetes outcomes. This review of the literature about IT-based diabetes management interventions explores whether methodological issues such as sample characteristics, outcome measures, and mechanisms causing change in the outcome measures could explain some of the inconsistent findings evident in IT-based diabetes management studies. METHODS: Databases were searched using terms related to IT and diabetes management. Articles eligible for review evaluated an IT-based diabetes management intervention in general practice and were published between 1999 and 2009 inclusive in English. Studies that did not include outcome measures were excluded. RESULTS: Four hundred and twenty-five articles were identified, sixteen met the inclusion criteria: eleven GP focussed and five patient focused interventions were evaluated. Nine were RCTs, five non-randomised control trials, and two single-sample before and after designs. Important sample characteristics such as diabetes type, familiarity with IT, and baseline diabetes knowledge were not addressed in any of the studies reviewed. All studies used HbA1c as a primary outcome measure, and nine reported a significant improvement in mean HbA1c over the study period; only two studies reported the HbA1c assay method. Five studies measured diabetes medications and two measured psychological outcomes. Patient lifestyle variables were not included in any of the studies reviewed. IT was the intervention method considered to effect changes in the outcome measures. Only two studies mentioned alternative possible causal mechanisms. CONCLUSION: Several limitations could affect the outcomes of IT-based diabetes management interventions to an unknown degree. These limitations make it difficult to attribute changes solely to such interventions.

Cullen, W., Broderick, N., Connolly, D., et al. (2012). "What is the role of general practice in addressing youth mental health? A discussion paper." Ir J Med Sci **181**(2): 189-197.

BACKGROUND: Mental and substance use disorders are a leading cause of morbidity among young people. Policy and clinical services in Ireland are endeavouring to address these twin issues. AIMS: To review the emerging literature on the role of general practice in addressing youth mental health and to discuss the implications of this literature for further research, education and service delivery. METHODS: We conducted a review of 'PubMed' and a web search of relevant national/international primary/mental healthcare agencies and professional bodies. RESULTS: Although general practice has an important role in addressing youth mental health, there are challenges in how young people seek help. Specifically, young people do not engage with healthcare agencies and many factors which act as barriers and enablers in this regard have been identified. The detection and treatment of mental and substance use disorders by GPs can be improved and implementing interventions to improve screening and early intervention are likely to be valuable. CONCLUSIONS: General practice is a central agency in addressing youth mental health and complex multifaceted interventions (education, clinical guidelines, and promoting awareness) are likely to support its role. Further research exploring this issue is a priority.

Davis, S., Roudsari, A., Raworth, R., et al. (2017). "Shared decision-making using personal health record technology: a scoping review at the crossroads." J Am Med Inform Assoc **24**(4): 857-866.

Objective: This scoping review aims to determine the size and scope of the published literature on shared decision-making (SDM) using personal health record (PHR) technology and to map the literature in terms of system design and outcomes. Materials and Methods: Literature from Medline, Google Scholar, Cumulative Index to Nursing and Allied Health Literature, Engineering Village, and Web of Science (2005-2015) using the search terms "personal health records," "shared decision making," "patient-provider communication," "decision aid," and "decision support" was included. Articles (n = 38) addressed the efficacy or effectiveness of PHRs for SDM in engaging patients in self-care and decision-making or ways patients can be supported in SDM via PHR. Results: Analysis resulted in an integrated SDM-PHR conceptual framework. An increased interest in SDM via PHR is apparent, with 55% of articles published within last 3 years. Sixty percent of the literature originates from the United States. Twenty-six articles address a particular clinical condition, with 10 focused on diabetes, and one-third offer empirical evidence of patient outcomes. The tethered and standalone PHR architectural types were most studied, while the interconnected PHR type was the focus of more recently published methodological approaches and discussion articles. Discussion: The study reveals a scarcity of rigorous research on SDM via PHR. Research has focused on one or a few of the SDM elements and not on the intended complete process. Conclusion: Just as PHR technology designed on an interconnected architecture has the potential to facilitate SDM, integrating the SDM process into PHR technology has the potential to drive PHR value.

Davy, C., Bleasel, J., Liu, H., et al. (2015). "Effectiveness of chronic care models: opportunities for improving healthcare practice and health outcomes: a systematic review." BMC Health Serv Res **15**: 194.

BACKGROUND: The increasing prevalence of chronic disease and even multiple chronic diseases faced by both developed and developing countries is of considerable concern. Many of the interventions to address this within primary healthcare settings are based on a chronic care model first developed by MacColl Institute for Healthcare Innovation at Group Health Cooperative. METHODS: This systematic literature review aimed to identify and synthesise international evidence on the effectiveness of elements that have been included in a chronic care model for improving healthcare practices and health outcomes within primary healthcare settings. The review broadens the work of other similar reviews by focusing on effectiveness of healthcare practice as well as health outcomes associated with implementing a chronic care model. In addition, relevant case series and case studies were also included. RESULTS: Of the 77 papers which met the inclusion criteria, all but two reported improvements to healthcare practice or health outcomes for people living with chronic disease. While the most commonly used elements of a chronic care model were self-management support and delivery system design, there were considerable variations between studies regarding what combination of elements were included as well as the way in which chronic care model elements were implemented. This meant that it was impossible to clearly identify any optimal combination of chronic care model elements that led to the reported improvements. CONCLUSIONS: While the main argument for excluding papers reporting case studies and case series in systematic literature reviews is that they are not of sufficient quality or generalizability, we found that they provided a more detailed account of how various chronic care models were developed and implemented. In particular, these papers suggested that several factors including supporting reflective healthcare practice, sending clear messages about the importance of chronic disease care and ensuring that leaders support the implementation and sustainability of interventions may have been just as important as a chronic care model's elements in contributing to the improvements in healthcare practice or health outcomes for people living with chronic disease.

de Bont, E. G., Alink, M., Falkenberg, F. C., et al. (2015). "Patient information leaflets to reduce antibiotic use and reconsultation rates in general practice: a systematic review." BMJ Open **5**(6): e007612.

OBJECTIVE: Patients' knowledge and expectations may influence prescription of antibiotics. Therefore, providing evidence-based information on cause of symptoms, self-management and treatment is essential. However, providing information during consultations is challenging. Patient information leaflets could facilitate consultations by increasing patients' knowledge, decrease unnecessary prescribing of antibiotics and decrease reconsultations for similar illnesses. Our objective was to systematically review effectiveness of information leaflets used for informing patients about common infections during consultations in general practice. DESIGN, SETTING AND PARTICIPANTS: We systematically searched PubMed/MEDLINE and EMBASE for studies evaluating information leaflets on common infections in general practice. Two reviewers extracted data and assessed article quality. PRIMARY AND SECONDARY OUTCOME MEASURES: Antibiotic use and reconsultation rates. RESULTS: Of 2512 unique records, eight studies were eligible (7 randomised, controlled trials, 1 non-randomised study) accounting for 3407 patients. Study quality varied from reasonable to good. Five studies investigated effects of leaflets during consultations for respiratory tract infections; one concerned conjunctivitis, one urinary tract infections and one gastroenteritis and tonsillitis. Three of four studies presented data on antibiotic use and showed significant reductions of prescriptions in leaflet groups with a relative risk (RR) varying from 0.53 (0.40 to 0.69) to 0.96 (0.83 to 1.11). Effects on reconsultation varied widely. One large study showed lower reconsultation rates (RR 0.70 (0.53 to 0.91), two studies showed no effect, and one study showed increased reconsultation rates (RR 1.53 (1.03 to 2.27)). Studies were too heterogenic to perform a meta-analysis. CONCLUSIONS: Patient information leaflets during general practitioners consultations for common infections are promising tools to reduce antibiotic prescriptions. Results on reconsultation rates for similar symptoms vary, with a tendency toward fewer reconsultations when patients are provided with a leaflet. Use of information leaflets in cases of common infections should be encouraged. Their contributing role in multifaceted interventions targeting management of common infections in primary care needs to further exploration.

Deccache, C., Albano, M. G., de Andrade, V., et al. (2014). "Therapeutic patient education for patients with multimorbidity: a recent literature review." Educ Ther Patient/Ther Patient Educ **6**(2): 20105.
https://doi.org/10.1051/tpe/2014015

Dennis, S., Williams, A., Taggart, J., et al. (2012). "Which providers can bridge the health literacy gap in lifestyle risk factor modification education: a systematic review and narrative synthesis." BMC Fam Pract **13**: 44.

BACKGROUND: People with low health literacy may not have the capacity to self-manage their health and prevent the development of chronic disease through lifestyle risk factor modification. The aim of this narrative synthesis is to determine the effectiveness of primary healthcare providers in developing health literacy of patients to make SNAPW (smoking, nutrition, alcohol, physical activity and weight) lifestyle changes. METHODS: Studies were identified by searching Medline, Embase, Cochrane Library, CINAHL, Joanna Briggs Institute, Psychinfo, Web of Science, Scopus, APAIS, Australian Medical Index, Community of Science and Google Scholar from 1 January 1985 to 30 April 2009. Health literacy and related concepts are poorly indexed in the databases so a list of text words were developed and tested for use. Hand searches were also conducted of four key journals. Studies published in English and included males and females aged 18 years and over with at least one SNAPW risk factor for the development of a chronic disease. The interventions had to be implemented within primary health care, with an aim to influence the health literacy of patients to make SNAPW lifestyle changes. The studies had to report an outcome measure associated with health literacy (knowledge, skills, attitudes, self efficacy, stages of change, motivation and patient activation) and SNAPW risk factor.The definition of health literacy in terms of functional, communicative and critical health literacy provided the guiding framework for the review. RESULTS: 52 papers were included that described interventions to address health literacy and lifestyle risk factor modification provided by different health professionals. Most of the studies (71%, 37/52) demonstrated an improvement in health literacy, in particular interventions of a moderate to high intensity.Non medical health care providers were effective in improving health literacy. However this was confounded by intensity of intervention. Provider barriers impacted on their relationship with patients. CONCLUSION: Capacity to provide interventions of sufficient intensity is an important condition for effective health literacy support for lifestyle change. This has implications for workforce development and the organisation of primary health care.

Di Lorenzo, L., Goglia, C. et Pappagallo, M. (2011). "Managing osteoarthritis and joint pain at work: helping the primary care physician educate patients who rely on non-prescription NSAIDs." G Ital Med Lav Ergon **33**(2): 193-200.

AIMS: To inform physicians who utilise over-the-counter (OTC) analgesics to treat osteoarthritis (OA) pain on differences among agents and to guide decisions in therapy selection. METHODS: A search of medical literature was conducted to identify articles on the treatment of OA published between 1990 and 2009. MEDLINE, EMBASE and SCISEARCH databases were searched using the terms: OTC NSAIDs, NSAIDs, naproxen, low-dose aspirin, ibuprofen, acetaminophen and COX-2-selective NSAIDs. A total of 396 publications were identified. After a review of the literature, 63 publications were considered sufficiently relevant for inclusion in the manuscript. RESULTS: The majority of working patients with OA pain will require exercise, weight control but above all pharmacotherapy. OTC analgesics, including acetaminophen and NSAIDs, provide an effective option for pain management but vary in regard to their safety and efficacy profiles. Selection of an appropriate agent should be based on an evaluation of pain severity, comorbidities and concomitant medications, as well as efficacy and safety of the individual agents. CONCLUSION: The key to effective OTC therapy for OA pain at work is to suggest exercise and weight control but above all to select an agent that will optimally provide effective clinical benefits with a good safety and tolerability profile.

Dineen-Griffin, S., Garcia-Cardenas, V., Williams, K., et al. (2019). "Helping patients help themselves: A systematic review of self-management support strategies in primary health care practice." Plos One **14**(8): e0220116.

BACKGROUND: Primary health professionals are well positioned to support the delivery of patient self-management in an evidence-based, structured capacity. A need exists to better understand the active components required for effective self-management support, how these might be delivered within primary care, and the training and system changes that would subsequently be needed. OBJECTIVES: (1) To examine self-management support interventions in primary care on health outcomes for a wide range of diseases compared to usual standard of care; and (2) To identify the effective strategies that facilitate positive clinical and humanistic outcomes in this setting. METHOD: A systematic review of randomized controlled trials evaluating self-management support interventions was conducted following the Cochrane handbook & PRISMA guidelines. Published literature was systematically searched from inception to June 2019 in PubMed, Scopus and Web of Science. Eligible studies assessed the effectiveness of individualized interventions with follow-up, delivered face-to-face to adult patients with any condition in primary care, compared with usual standard of care. Matrices were developed that mapped the evidence and components for each intervention. The methodological quality of included studies were appraised. RESULTS: 6,510 records were retrieved. 58 studies were included in the final qualitative synthesis. Findings reveal a structured patient-provider exchange is required in primary care (including a one-on-one patient-provider consultation, ongoing follow up and provision of self-help materials). Interventions should be tailored to patient needs and may include combinations of strategies to improve a patient's disease or treatment knowledge; independent monitoring of symptoms, encouraging self-treatment through a personalized action plan in response worsening symptoms or exacerbations, psychological coping and stress management strategies, and enhancing responsibility in medication adherence and lifestyle choices. Follow-up may include tailored feedback, monitoring of progress with respect to patient set healthcare goals, or honing problem-solving and decision-making skills. Theoretical models provided a strong base for effective SMS interventions. Positive outcomes for effective SMS included improvements in clinical indicators, health-related quality of life, self-efficacy (confidence to self-manage), disease knowledge or control. An SMS model has been developed which sets the foundation for the design and evaluation of practical strategies for the construct of self-management support interventions in primary healthcare practice. CONCLUSIONS: These findings provide primary care professionals with evidence-based strategies and structure to deliver SMS in practice. For this collaborative partnership approach to be more widely applied, future research should build on these findings for optimal SMS service design and upskilling healthcare providers to effectively support patients in this collaborative process.

Durand, M. A., Carpenter, L., Dolan, H., et al. (2014). "Do interventions designed to support shared decision-making reduce health inequalities? A systematic review and meta-analysis." Plos One **9**(4): (13), fig., tabl.
http://www.plosone.org/article/fetchObject.action?uri=info%3Adoi%2F10.1371%2Fjournal.pone.0094670&representation=PDF

Background: Increasing patient engagement in healthcare has become a health policy priority. However, there has been concern that promoting supported shared decision-making could increase health inequalities. Objective: To evaluate the impact of SDM interventions on disadvantaged groups and health inequalities. Design: Systematic review and meta-analysis of randomised controlled trials and observational studies. Data Sources: CINAHL, the Cochrane Register of Controlled Trials, the Cochrane Database of Systematic Reviews, EMBASE, HMIC, MEDLINE, the NHS Economic Evaluation Database, Open SIGLE, PsycINFO and Web of Knowledge were searched from inception until June 2012. Study Eligibility Criteria: We included all studies, without language restriction, that met the following two criteria: (1) assess the effect of shared decision-making interventions on disadvantaged groups and/or health inequalities, (2) include at least 50% of people from disadvantaged groups, except if a separate analysis was conducted for this group. Results: We included 19 studies and pooled 10 in a meta-analysis. The meta-analyses showed a moderate positive effect of shared decision-making interventions on disadvantaged patients. The narrative synthesis suggested that, overall, SDM interventions increased knowledge, informed choice, participation in decision-making, decision self-efficacy, preference for collaborative decision making and reduced decisional conflict among disadvantaged patients. Further, 7 out of 19 studies compared the intervention's effect between high and low literacy groups. Overall, SDM interventions seemed to benefit disadvantaged groups (e.g. lower literacy) more than those with higher literacy, education and socioeconomic status. Interventions that were tailored to disadvantaged groups' needs appeared most effective. Conclusion: Results indicate that shared decision-making interventions significantly improve outcomes for disadvantaged patients. According to the narrative synthesis, SDM interventions may be more beneficial to disadvantaged groups than higher literacy/socioeconomic status patients. However, given the small sample sizes and variety in the intervention types, study design and quality, those findings should be interpreted with caution.

Esch, T., Mejilla, R., Anselmo, M., et al. (2016). "Engaging patients through open notes: an evaluation using mixed methods." BMJ Open **6**(1): e010034.

OBJECTIVES: (A) To gain insights into the experiences of patients invited to view their doctors' visit notes, with a focus on those who review multiple notes; (B) to examine the relationships among fully transparent electronic medical records and quality of care, the patient-doctor relationship, patient engagement, self-care, self-management skills and clinical outcomes. DESIGN: Mixed methods qualitative study: analyses of survey data, including content analysis of free-text answers, and quantitative-descriptive measures combined with semistructured individual interviews, patient activation measures, and member checks. SETTING: Greater Boston, USA. PARTICIPANTS: Patients cared for by primary care physicians (PCPs) at the Beth Israel Deaconess Medical Center who had electronic access to their PCP visit notes. Among those submitting surveys, 576 free-text answers were identified and analysed (414 from female patients, 162 from male patients; 23-88 years). In addition, 13 patients (9 female, 4 male; 58-87 years) were interviewed. RESULTS: Patient experiences indicate improved understanding (of health information), better relationships (with doctors), better quality (adherence and compliance; keeping track) and improved self-care (patient-centredness, empowerment). Patients want more doctors to offer access to their notes, and some wish to contribute to their generation. Those patients with repeated experience reviewing notes express fewer concerns and more perceived benefits. CONCLUSIONS: As the use of fully transparent medical records spreads, it is important to gain a deeper understanding of possible benefits or harms, and to characterise target populations that may require varying modes of delivery. Patient desires for expansion of this practice extend to specialty care and settings beyond the physician's office. Patients are also interested in becoming involved actively in the generation of their medical records. The OpenNotes movement may increase patient activation and engagement in important ways.

Fayn, P. G., Des Garets, V. et Bura-Riviere, A. (2017). "Mieux comprendre le processus d'empowerment du patient." Recherches En Sciences De Gestion(119): 55-73.

Co-décideur de son traitement, co-rédacteur des lois, le patient est sorti du silence et de l'invisibilité. Sa prise de pouvoir s'étend à la production de connaissances et de solutions nouvelles. Cet article propose une meilleure compréhension du processus d'empowerment du patient chronique. Après une revue de littérature multidisciplinaire autour des concepts d'empowerment et de Patient-Centered-Care, une étude exploratoire a été réalisée auprès de quatre experts. Elle conduit à l'identification de quatre phases structurant le processus d'empowerment du patient : individuel, collectif, collaboratif et productif. Phénomène social, l'empowerment des patients transforme la relation de soin en une nouvelle alliance plus symétrique.

Finney, A., Healey, E., Jordan, J. L., et al. (2016). "Multidisciplinary approaches to managing osteoarthritis in multiple joint sites: a systematic review." BMC Musculoskelet Disord **17**: 266.

BACKGROUND: The National Institute for Health and Care Excellence's Osteoarthritis (OA) guidelines recommended that future research should consider the benefits of combination therapies in people with OA across multiple joint sites. However, the clinical effectiveness of such approaches to OA management is unknown. This systematic review therefore aimed to identify the clinical and cost effectiveness of multidisciplinary approaches targeting multiple joint sites for OA in primary care. METHODS: A systematic review of randomised controlled trials. Computerised bibliographic databases were searched (MEDLINE, EMBASE, CINAHL, PsychINFO, BNI, HBE, HMIC, AMED, Web of Science and Cochrane). Studies were included if they met the following criteria; a randomised controlled trial (RCT), a primary care population with OA across at least two different peripheral joint sites (multiple joint sites), and interventions undertaken by at least two different health disciplines (multidisciplinary). The Cochrane 'Risk of Bias' tool and PEDro were used for quality assessment of eligible studies. Clinical and cost effectiveness was determined by extracting and examining self-reported outcomes for pain, function, quality of life (QoL) and health care utilisation. The date range for the search was from database inception until August 2015. RESULTS: The search identified 1148 individual titles of which four were included in the review. A narrative review was conducted due to the heterogeneity of the included trials. Each of the four trials used either educational or exercise interventions facilitated by a range of different health disciplines. Moderate clinical benefits on pain, function and QoL were reported across the studies. The beneficial effects of exercise generally decreased over time within all studies. Two studies were able to show a reduction in healthcare utilisation due to a reduction in visits to a physiotherapist or a reduction in x-rays and orthopaedic referrals. The intervention that showed the most promise used educational interventions delivered by GPs with reinforcement by practice nurses. CONCLUSIONS: There are currently very few studies that target multidisciplinary approaches suitable for OA across multiple joint sites, in primary care. A more consistent approach to outcome measurement in future studies of this nature should be considered to allow for better comparison.

Flynn, D., Knoedler, M. A., Hess, E. P., et al. (2012). "Engaging patients in health care decisions in the emergency department through shared decision-making: a systematic review." Acad Emerg Med **19**(8): 959-967.

BACKGROUND: Many decisions in the emergency department (ED) may benefit from patient involvement, even though this setting has been considered least conducive to shared decision-making (SDM). OBJECTIVES: The objective was to conduct a systematic review to evaluate the approaches, methods, and tools used to engage patients or their surrogates in SDM in the ED. METHODS: Five electronic databases were searched in conjunction with contacting content experts, reviewing selected bibliographies, and conducting citation searches using the Web of Knowledge database. Two reviewers independently selected eligible studies that addressed patient involvement and engagement in decision-making in the ED setting via the use of decision support interventions (DSIs), defined as decision aids or decision support designed to communicate probabilistic information on the risks and benefits of treatment options to patients as part of an SDM process. Eligible studies described and assessed at least one of the following outcomes: patient knowledge, experiences and perspectives on participating in treatment or management decisions, clinician or patient satisfaction, preference for involvement and/or degree of engagement in decision-making and treatment preferences, and clinical outcomes (e.g., rates of hospital admission/readmission, rates of medical or surgical interventions). Two reviewers extracted data on study characteristics, methodologic quality, and outcomes. The authors also assessed the extent to which SDM interventions adhered to good practice for the presentation of information on outcome probabilities (eight probability items from the International Patient Decision Aid Standards Instrument [IPDASi]) and had comprehensive development processes. RESULTS: Five studies met inclusion criteria and were synthesized using a narrative approach. Each study was of satisfactory methodologic quality and used a DSI to engage patients or their surrogates in decision-making in the ED across four domains: 1) management options for children with small lacerations; 2) options for rehydrating children presenting with vomiting or diarrhea or both; 3) risk of bacteremia (and associated complications), tests, and treatment options for febrile children; and 4) short-term risk of acute coronary syndrome (ACS) in adults with low-risk nontraumatic chest pain. Three studies had poor IPDASi probabilities and development process scores and lacked development informed by theory or involvement of clinicians and patients in development and usability testing. Overall, DSIs were associated with improvements in patients' knowledge and satisfaction with the explanation of their care, preferences for involvement, and engagement in decision-making and demonstrated utility for eliciting patients' preferences and values about management and treatment options. Two computerized DSIs (designed to predict risk of ACS in adults presenting to the ED with chest pain) were shown to reduce health care use without evidence of harm. None of the studies reported lack of feasibility of SDM in the ED. CONCLUSIONS: Early investigation of SDM in the ED suggests that patients may benefit from involvement in decision-making and offers no empirical evidence to suggest that SDM is not feasible. Future work is needed to develop and test additional SDM interventions in the ED and to identify contextual barriers and facilitators to implementation in practice.

Fonte, D., Lagouanelle-Simeoni, M.-C., Apostolidis, T., et al. (2014). "Compétences psychosociales et éducation thérapeutique du patient diabétique de type 1 : une revue de littérature." Santé Publique **26**(6): 763-777.

[BDSP. Notice produite par EHESP 8lks9R0x. Diffusion soumise à autorisation]. En éducation thérapeutique, il est établi que les compétences psychosociales doivent être renforcées chez les patients pour les aider à mieux gérer leur maladie et les traitements associés. Actuellement, ce travail est difficilement réalisable en raison de questions conceptuelles, méthodologiques et opérationnelles qui restent en suspens. En particulier, se posent celles de l'identification et de l'évaluation des compétences psychosociales pertinentes à développer.

Galbraith, L., Jacobs, C., Hemmelgarn, B. R., et al. (2018). "Chronic disease management interventions for people with chronic kidney disease in primary care: a systematic review and meta-analysis." Nephrol Dial Transplant **33**(1): 112-121.

BACKGROUND: Primary care providers manage the majority of patients with chronic kidney disease (CKD), although the most effective chronic disease management (CDM) strategies for these patients are unknown. We assessed the efficacy of CDM interventions used by primary care providers managing patients with CKD. METHODS: The Medline, Embase and Cochrane Central databases were systematically searched (inception to November 2014) for randomized controlled trials (RCTs) assessing education-based and computer-assisted CDM interventions targeting primary care providers managing patients with CKD in the community. The efficacy of CDM interventions was assessed using quality indicators [use of angiotensin-converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB), proteinuria measurement and achievement of blood pressure (BP) targets] and clinical outcomes (change in BP and glomerular filtration rate). Two independent reviewers evaluated studies for inclusion, quality and extracted data. Random effects models were used to estimate pooled odds ratios (ORs) and weighted mean differences for outcomes of interest. RESULTS: Five studies (188 clinics; 494 physicians; 42 852 patients with CKD) were included. Two studies compared computer-assisted intervention strategies with usual care, two studies compared education-based intervention strategies with computer-assisted intervention strategies and one study compared both these intervention strategies with usual care. Compared with usual care, computer-assisted CDM interventions did not increase the likelihood of ACEI/ARB use among patients with CKD {pooled OR 1.00 [95% confidence interval (CI) 0.83-1.21]; I2 = 0.0%}. Similarly, education-related CDM interventions did not increase the likelihood of ACEI/ARB use compared with computer-assisted CDM interventions [pooled OR 1.12 (95% CI 0.77-1.64); I2 = 0.0%]. Inconsistencies in reporting methods limited further pooling of data. CONCLUSIONS: To date, there have been very few randomized trials testing CDM interventions targeting primary care providers with the goal of improving care of people with CKD. Those conducted to date have shown minimal impact, suggesting that other strategies, or multifaceted interventions, may be required to enhance care for patients with CKD in the community.

Gardener, A. C., Ewing, G., Kuhn, I., et al. (2018). "Support needs of patients with COPD: a systematic literature search and narrative review." Int J Chron Obstruct Pulmon Dis **13**: 1021-1035.

INTRODUCTION: Understanding the breadth of patients' support needs is important for the delivery of person-centered care, particularly in progressive long-term conditions such as chronic obstructive pulmonary disease (COPD). Existing reviews identify important aspects of managing life with COPD with which patients may need support (support needs); however, none of these comprehensively outlines the full range of support needs that patients can experience. We therefore sought to systematically determine the full range of support needs for patients with COPD to inform development of an evidence-based tool to enable person-centered care. METHODS: We conducted a systematic search and narrative review of the literature. Medline (Ovid), EMBASE, PsycINFO, Cochrane Library, and CINAHL were systematically searched for papers which included data addressing key aspects of support need, as identified by patients with COPD. Relevant data were extracted, and a narrative analysis was conducted. RESULTS: Thirty-one papers were included in the review, and the following 13 domains (broad areas) of support need were identified: 1) understanding COPD, 2) managing symptoms and medication, 3) healthy lifestyle, 4) managing feelings and worries, 5) living positively with COPD, 6) thinking about the future, 7) anxiety and depression, 8) practical support, 9) finance work and housing, 10) families and close relationships, 11) social and recreational life, 12) independence, and 13) navigating services. These 13 domains of support need were mapped to three of the four overarching categories of need commonly used in relevant national strategy documents (ie, physical, psychological, and social); however, support needs related to the fourth category (spiritual) were notably absent. CONCLUSION: This review systematically identifies the comprehensive set of domains of support need for patients with COPD. The findings provide the evidence base for a tool to help patients identify and express their support needs, which underpins a proposed intervention to enable the delivery of person-centered care: the Support Needs Approach for Patients (SNAP).

Gibbons, C., Singh, S., Gibbons, B., et al. (2018). "Using qualitative methods to understand factors contributing to patient satisfaction among dermatology patients: a systematic review." J Dermatolog Treat **29**(3): 290-294.

PURPOSE: In this systematic review, we aimed to synthesize data that identify factors contributing to patient satisfaction in dermatology care using qualitative methods. MATERIALS AND METHODS: We performed a comprehensive search of the literature using the PubMed database for articles published between January 1, 2000 and February 9, 2015. The initial search yielded 186 articles, of which 13 were included after applying inclusion and exclusion criteria. RESULTS: The systematic review of 13 articles included a total of 330 patients. Using in-field observations and semistructured interviews, studies found that qualitative methods and analysis increased the provider's sensitivity to patient needs and enhanced patient care. Analyses using qualitative methods found increased patient satisfaction in their healthcare provider is associated with (1) confidence in the provider's diagnosis, (2) perception of patient-centered, individualized recommendations and (3) quality of patient education and provider explanation during a visit. CONCLUSIONS: Patient satisfaction is measured using either quantitative or qualitative methods. Quantitative methods result in standardized data that often does not capture the nuances of patient experience. In contrast, qualitative methodology is integral to gathering patient perspectives on patient care and satisfaction and should be included in future research models.

Gordon, M., Gupta, S., Thornton, D., et al. (2020). "Patient/service user involvement in medical education: A best evidence medical education (BEME) systematic review: BEME Guide No. 58." Med Teach **42**(1): 4-16.

Background: The extent to which patients and service users are involved in medical education varies widely. There is a need for an up to date systematic review of the literature that examines what involvement (description), the potential outcome of such involvement (justification) and 'why' such involvement impacts students (clarification).Methods: Systematic searches of four databases were undertaken. Citations were screened and consensus reached for inclusion/exclusion of studies. Quality of study design and interventional presentation were assessed.Results: Of the 39 studies included in the review, 4 studies were encounter based, 17 sharing experiences, 16 with patients involved in teaching, 2 studies describing consumers as tutors, and none with involvement at the institutional level. Outcomes in terms of benefits to learners included increased empathy and understanding of illness as experienced by patients, improved communication with patients and a greater understanding of patient-center care. Educational quality assessment showed specific weaknesses in theoretical underpinning, curriculum outcomes, content or pedagogy.Conclusions: Patients can enrich medical education by allowing learners to explore patient-centered perspectives in holistic care. For educators this review highlights the lack of an underpinning conceptual basis for which to translate theory into practice.

Grady, A., Carey, M., Bryant, J., et al. (2017). "A systematic review of patient-practitioner communication interventions involving treatment decisions." Patient Educ Couns **100**(2): 199-211.

OBJECTIVES: To examine the: 1) methodological quality of interventions examining strategies to improve patient-practitioner communication involving treatment decisions; 2) effectiveness of strategies to improve patient-practitioner communication involving treatment decisions; and 3) types of treatment decisions (emergency/non-emergency) in the included studies. METHODS: Medline, PsychINFO, CINAHL, and Embase were searched to identify intervention studies. To be included, studies were required to examine patient-practitioner communication related to decision making about treatment. Study methodological quality was assessed using Cochrane's Effective Practice and Organisation of Care risk of bias criteria. Study design, sample characteristics, intervention details, and outcomes were extracted. RESULTS: Eleven studies met the inclusion criteria. No studies were rated low risk on all nine risk of bias criteria. Two of the three interventions aimed at changing patient behaviour, two of the five practitioner directed, and one of the three patient-practitioner directed interventions demonstrated an effect on decision-making outcomes. No studies examined emergency treatment decisions. CONCLUSIONS: Existing studies have a high risk of bias and are poorly reported. There is some evidence to suggest patient-directed interventions may be effective in improving decision-making outcomes. PRACTICE IMPLICATIONS: It is imperative that an evidence-base is developed to inform clinical practice.

Fu, Y., McNichol, E., Marczewski, K., et al. (2016). "Patient-professional partnerships and chronic back pain self-management: a qualitative systematic review and synthesis." Health Soc Care Community **24**(3): 247-259.

Chronic back pain is common, and its self-management may be a lifelong task for many patients. While health professionals can provide a service or support for pain, only patients can actually experience it. It is likely that optimum self-management of chronic back pain may only be achieved when patients and professionals develop effective partnerships which integrate their complementary knowledge and skills. However, at present, there is no evidence to explain how such partnerships can influence patients' self-management ability. This review aimed to explore the influence of patient-professional partnerships on patients' ability to self-manage chronic back pain, and to identify key factors within these partnerships that may influence self-management. A systematic review was undertaken, aiming to retrieve relevant studies using any research method. Five databases were searched for papers published between 1980 and 2014, including Cochrane Library, CINAHL, Medline, EMBASE and PsycINFO. Eligible studies were those reporting on patients being supported by professionals to self-manage chronic back pain; patients being actively involved for self-managing chronic back pain; and the influence of patient-professional partnerships on self-management of chronic back pain. Included studies were critically appraised for quality, and findings were extracted and analysed thematically. A total of 738 studies were screened, producing 10 studies for inclusion, all of which happened to use qualitative methods. Seven themes were identified: communication, mutual understanding, roles of health professionals, information delivery, patients' involvement, individualised care and healthcare service. These themes were developed into a model suggesting how factors within patient-professional partnerships influence self-management. Review findings suggest that a partnership between patients and professionals supports patients' self-management ability, and effective communication is a fundamental factor underpinning their partnerships in care. It also calls for the development of individualised healthcare services offering self-referral or telephone consultation to patients with chronic conditions.

Gibbons, C., Singh, S., Gibbons, B., et al. (2018). "Using qualitative methods to understand factors contributing to patient satisfaction among dermatology patients: a systematic review." J Dermatolog Treat **29**(3): 290-294.

PURPOSE: In this systematic review, we aimed to synthesize data that identify factors contributing to patient satisfaction in dermatology care using qualitative methods. MATERIALS AND METHODS: We performed a comprehensive search of the literature using the PubMed database for articles published between January 1, 2000 and February 9, 2015. The initial search yielded 186 articles, of which 13 were included after applying inclusion and exclusion criteria. RESULTS: The systematic review of 13 articles included a total of 330 patients. Using in-field observations and semistructured interviews, studies found that qualitative methods and analysis increased the provider's sensitivity to patient needs and enhanced patient care. Analyses using qualitative methods found increased patient satisfaction in their healthcare provider is associated with (1) confidence in the provider's diagnosis, (2) perception of patient-centered, individualized recommendations and (3) quality of patient education and provider explanation during a visit. CONCLUSIONS: Patient satisfaction is measured using either quantitative or qualitative methods. Quantitative methods result in standardized data that often does not capture the nuances of patient experience. In contrast, qualitative methodology is integral to gathering patient perspectives on patient care and satisfaction and should be included in future research models.

Glazier, R. H., Bajcar, J., Kennie, N. R., et al. (2006). "A systematic review of interventions to improve diabetes care in socially disadvantaged populations." Diabetes Care **29**(7): 1675-1688.
http://www.ncbi.nlm.nih.gov/pubmed/16801602

OBJECTIVE: To identify and synthesize evidence about the effectiveness of patient, provider, and health system interventions to improve diabetes care among socially disadvantaged populations. RESEARCH DESIGN AND METHODS: Studies that were included targeted interventions toward socially disadvantaged adults with type 1 or type 2 diabetes; were conducted in industrialized countries; were measured outcomes of self-management, provider management, or clinical outcomes; and were randomized controlled trials, controlled trials, or before-and-after studies with a contemporaneous control group. Seven databases were searched for articles published in any language between January 1986 and December 2004. Twenty-six intervention features were identified and analyzed in terms of their association with successful or unsuccessful interventions. RESULTS: Eleven of 17 studies that met inclusion criteria had positive results. Features that appeared to have the most consistent positive effects included cultural tailoring of the intervention, community educators or lay people leading the intervention, one-on-one interventions with individualized assessment and reassessment, incorporating treatment algorithms, focusing on behavior-related tasks, providing feedback, and high-intensity interventions (>10 contact times) delivered over a long duration (>or=6 months). Interventions that were consistently associated with the largest negative outcomes included those that used mainly didactic teaching or that focused only on diabetes knowledge. CONCLUSIONS: This systematic review provides evidence for the effectiveness of interventions to improve diabetes care among socially disadvantaged populations and identifies key intervention features that may predict success. These types of interventions would require additional resources for needs assessment, leader training, community and family outreach, and follow-up

Gross, O., De Andrade V. et Gagnayre, R. (2017). "Pratiques et apport des recherches communautaires en éducation thérapeutique : une revue de littérature." Santé Publique **29**(4): 551-562.

[BDSP. Notice produite par EHESP os8R0xC8. Diffusion soumise à autorisation]. Introduction : Les recherches communautaires en santé (RC) associent chercheurs et personnes concernées par les résultats de recherches. Elles visent à améliorer le pouvoir d'agir des populations en partant de leur exposition au phénomène étudié. Leur présence dans le champ de l'ETP est à interroger car ces domaines partagent des caractéristiques comme la volonté de promouvoir l'autonomie et la participation des personnes et la culture de l'interdisciplinarité. Objectif : Caractériser les RC dans le champ de l'éducation thérapeutique. Méthode : Une recherche bibliographique à partir des mots-clés "Community based (participatory) research" "patient education" "self care" et "self management" sur PUBMED a rapporté 121 articles. L'analyse a porté sur le type de recherche réalisée, les caractéristiques des populations concernées et des co-chercheurs ; les actions collaboratives analysées à partir d'une grille issue de la littérature ; les difficultés dans leur mise en oeuvre. Résultats : Trente-et-une études ont été retenues. Dix études portent sur des recherches méthodologiques tendant à démontrer la plus-value de la collaboration avec des usagers dans la mise en oeuvre d'un programme d'ETP par rapport aux méthodes standards. Pour les 21 articles restants, il s'agit de descriptions de co-conceptions et/ou co-réalisations d'un nouveau programme éducatif. Il a été identifié cinq actions qui renvoient à une phase préparatoire des recherches et 17 actions collaboratives qui renvoient à la priorisation des recherches, à leur réalisation, à leur analyse et à la dissémination des résultats. Des possibles difficultés d'ordre méthodologiques, organisationnelles, éthiques, émotionnelles appellent des mesures préventives. Discussion/Perspectives : Le repérage de 22 actions devrait être confirmé par d'autres études. À terme, la grille d'analyse pourrait devenir un outil guidant les chercheurs en ETP souhaitant développer une RC.

HAS (2007). L'éducation thérapeutique dans la prise en charge des maladies chroniques : Analyse critique de la littérature. Etudes d'évaluation économique ou avec des données de recours aux soins. Evaluation économique. Paris HAS**:** 69.
https://www.has-sante.fr/portail/upload/docs/application/pdf/2008-08/document_de_travail._analyse_critique_de_la_litterature.pdf

L'éducation thérapeutique est aujourd'hui reconnue comme un élément essentiel de la prise en charge des patients atteints d'une pathologie chronique. Cependant, l'analyse du contexte et les différentes enquêtes de terrain existantes montrent que l'ETP pose de nombreux problèmes de mise en ouvre concrète : hétérogénéité des pratiques, implication variable des professionnels et des patients, modalités de financement et d'organisation incertaines, etc. Ce document de travail présente les résultats de l'analyse exhaustive des études économiques ou des essais cliniques étudiant l'impact sur le recours aux soins. L'objectif de cette analyse de la littérature est de documenter l'hypothèse selon laquelle l'éducation thérapeutique, en renforçant les capacités d'adaptation à la maladie par la mise en œuvre de compétences et de processus adéquats, permettrait : d'une part, de réduire à court ou moyen terme le recours aux soins lié à la prise en charge ordinaire de la maladie ; d'autre part, de limiter ou de retarder les incidents et complications liés à la maladie, avec pour conséquence une réduction à long terme des recours associés. Les résultats sont présentés par pathologie.

Hudon, C., Fortin, M., Haggerty, J. L., et al. (2011). "Measuring patients' perceptions of patient-centered care: a systematic review of tools for family medicine." Ann Fam Med **9**(2): 155-164.

PURPOSE: Patient-centered care is widely acknowledged as a core value in family medicine. In this systematic review, we aimed to identify and compare instruments, subscales, or items assessing patients' perceptions of patient-centered care in family medicine. METHODS: We conducted a systematic literature review using the MEDLINE, Embase, and Cochrane databases covering 1980 through April 2009, with a specific search strategy for each database. The search strategy was supplemented with searching by hand and expert suggestions. We looked for articles meeting all of the following criteria: (1) describing self-administered instruments measuring patient perceptions of patient-centered care; (2) reporting quantitative or psychometric results of development or validation; (3) being relevant to an ambulatory family medicine context. The quality of each article retained was assessed using a modified version of the Standards for Reporting of Diagnostic Accuracy. Instrument' items were mapped to dimensions of a patient-centered care conceptual framework. RESULTS: Of the 3,045 articles identified, 90 were examined in detail, and 26, covering 13 instruments, met our inclusion criteria. Two instruments (5 articles) were dedicated to patient-centered care: the Patient Perception of Patient-Centeredness and the Consultation Care Measure, and 11 instruments (21 articles) included relevant subscales or items. CONCLUSIONS: The 2 instruments dedicated to patient-centered care address key dimensions but are visit-based, limiting their applicability for the study of care processes over time, such as chronic illness management. Relevant items from the 11 other instruments provide partial coverage of the concept, but these instruments were not designed to provide a specific assessment of patient-centered care.

Hsieh, P. L. et Chen, C. M. (2016). "[Nurse-Led Care Models in the Context of Community Elders With Chronic Disease Management: A Systematic Review]." Hu Li Za Zhi **63**(4): 35-49.

BACKGROUND: Longer average life expectancies have caused the rapid growth of the elderly as a percentage of Taiwan's population and, as a result of the number of elders with chronic diseases and disability. Providing continuing-care services in community settings for elderly with multiple chronic conditions has become an urgent need. PURPOSE: To review the nurse-led care models that are currently practiced among elders with chronic disease in the community and to further examine the effectiveness and essential components of these models using a systematic review method. METHODS: Twelve original articles on chronic disease-care planning for the elderly or on nurse-led care management interventions that were published between 2000 and 2015 in any of five electronic databases: MEDLINE, PubMed, CINAHL (Cumulative Index to Nursing and Allied Health Literature) Plus with Full Text, Cochrane Library, and CEPS (Chinese Electronic Periodicals Servicewere selected and analyzed systematically. RESULTS: Four types of nurse-led community care models, including primary healthcare, secondary prevention care, cross-boundary models, and case management, were identified. Chronic disease-care planning, case management, and disease self-management were found to be the essential components of the services that were provided. The care models used systematic processes to conduct assessment, planning, implementation, coordination, and follow-up activities as well as to deliver services and to evaluate disease status. The results revealed that providing continuing-care services through the nurse-led community chronic disease-care model and cross-boundary model enhanced the ability of the elderly to self-manage their chronic diseases, improved healthcare referrals, provided holistic care, and maximized resource utilization efficacy. CONCLUSIONS / IMPLICATIONS FOR PRACTICE: The present study cross-referenced all reviewed articles in terms of target clients, content, intervention, measurements, and outcome indicators. Study results may be referenced in future implementations of nurse-led community care models as well as in future research.

Hussain, J. A., Flemming, K., Murtagh, F. E., et al. (2015). "Patient and health care professional decision-making to commence and withdraw from renal dialysis: a systematic review of qualitative research." Clin J Am Soc Nephrol **10**(7): 1201-1215.

BACKGROUND AND OBJECTIVE: To ensure that decisions to start and stop dialysis in ESRD are shared, the factors that affect patients and health care professionals in making such decisions must be understood. This systematic review sought to explore how and why different factors mediate the choices about dialysis treatment. DESIGN, SETTING, PARTICIPANTS, & MEASUREMENTS: MEDLINE, Embase, CINAHL, and PsychINFO were searched for qualitative studies of factors that affect patients' or health care professionals' decisions to commence or withdraw from dialysis. A thematic synthesis was conducted. RESULTS: Of 494 articles screened, 12 studies (conducted from 1985 to 2014) were included. These involved 206 patients (most receiving hemodialysis) and 64 health care professionals (age ranges: patients, 26-93 years; professionals, 26-61 years). For commencing dialysis, patients based their choice on "gut instinct," as well as deliberating over the effect of treatment on quality of life and survival. How individuals coped with decision-making was influential: Some tried to take control of the problem of progressive renal failure, whereas others focused on controlling their emotions. Health care professionals weighed biomedical factors and were led by an instinct to prolong life. Both patients and health care professionals described feeling powerless. With regard to dialysis withdrawal, only after prolonged periods on dialysis were the realities of life on dialysis fully appreciated and past choices questioned. By this stage, however, patients were physically dependent on treatment. As was seen with commencing dialysis, individuals coped with treatment withdrawal in a problem- or emotion-controlling way. Families struggled to differentiate between choosing versus allowing death. Health care teams avoided and queried discussions regarding dialysis withdrawal. Patients, however, missed the dialogue they experienced during predialysis education. CONCLUSIONS: Decision-making in ESRD is complex and dynamic and evolves over time and toward death. The factors at work are multifaceted and operate differently for patients and health professionals. More training and research on open communication and shared decision-making are needed.

Jaarsma, T., Brons, M., Kraai, I., et al. (2013). "Components of heart failure management in home care; a literature review." Eur J Cardiovasc Nurs **12**(3): 230-241.

BACKGROUND: Patients with heart failure (HF) need long-term and complex care delivered by healthcare professionals in primary and secondary care. Although guidelines on optimal HF care exist, no specific description of components that are applied for optimal HF care at home exist. The objective of this review was to describe which components of HF (home) care are found in research studies addressing homecare interventions in the HF population. METHODS: The Pubmed, Embase, Cinahl, and Cochrane databases were searched using HF-, homecare services-, and clinical trial-related search terms. RESULTS: The literature search identified 703 potentially relevant publications, out of which 70 articles were included. All articles described interventions with two or more of the following components: multidisciplinary team, continuity of care and care plans, optimized treatment according to guidelines, educational and counselling of patients and caregivers, and increased accessibility to care. Most studies (n=65, 93%) tested interventions with three components or more and 20 studies (29%) used interventions including all five components. CONCLUSIONS: There a several studies on HF care at home, testing interventions with a variety in number of components. Comparing the results to current standards, aspects such as collaboration between primary care and hospital care, titration of medication, and patient education can be improved.

Jaensch, D., Baker, N. et Gordon, S. (2019). "Contemporaneous patient and health professional views of patient-centred care: a systematic review." Int J Qual Health Care **31**(10): G165-g173.

OBJECTIVE: To understand the domains of agreement and disagreement, related to person-centred care, between the patient and healthcare professional during a shared episode of care. DESIGN: A systematic review following the PRISMA protocol searched PubMed (Medline), CINAHL, PsychInfo and

Scopus using keywords for health professionals, patients and patient-centred care. A descriptive-interpretive method was used to identify domains described in the person-centred care framework. SETTING: Research conducted in all healthcare settings (inpatient, outpatient, community) were included. PARTICIPANTS: Research which presented the contemporaneous perspectives of a health professional and the person they were providing services to were included. INTERVENTION(S): Research regarding the delivery of any type of health service was included. MAIN OUTCOME MEASURE(S): The person-centred care framework which includes Structure, Process and Outcome as measures for implementing person-centred care was used to interpret and summarize the data. RESULTS: After title and abstract screening against inclusion and exclusion criteria, 15 of 1,406 studies were critically appraised. High levels of contemporaneous agreement were identified for easily accessible, supportive and accommodating environments, where information sharing occurred. Contemporaneous agreement occurred most often between patients and healthcare professionals in the importance of sharing information across all geographical settings, with greatest disagreement of patient involvement in the European and American hospital environments. CONCLUSIONS: Greater understanding of the context of information sharing and drivers for management preferences may support shared decision-making and increase satisfaction. More information regarding contemporaneous experiences of healthcare episodes is required to further inform patient-centred care practices and optimize health outcomes.

Janssen, S. M. et Lagro-Janssen, A. L. (2012). "Physician's gender, communication style, patient preferences and patient satisfaction in gynecology and obstetrics: a systematic review." Patient Educ Couns **89**(2): 221-226.

OBJECTIVE: Review of studies published in the last 10 years about women seeking gynecological- or obstetrical care and physician's gender in relation to patient preferences, differences in communication style and patient satisfaction. METHODS: Studies were identified by searching the online databases PubMed, PsycINFO, Embase and the Cochrane Library. The search strategies 'gender'; 'obstetrics' and 'gynecology' were combined with 'communication'; 'physician-patient relations'; 'patient preference' and 'patient satisfaction'. RESULTS: After screening title and abstract, evaluating full text and quality assessment, 9 articles were included in this review. Most patients preferred a female rather than a male gynecologist-obstetrician. This was partly explained by a more patient-centered communication style used by female gynecologists-obstetricians. Also experience and clinical competence were important factors in choosing a gynecologist-obstetrician. It was not clear whether patient's age or ethnicity influenced patients gender preference. Patient satisfaction increased when gynecologists-obstetricians used a patient-centered communication style. CONCLUSION: Preference for a female gynecologist-obstetrician might be explained by a more patient-centered communication style used by female gynecologists-obstetricians. Using a patient-centered communication style increases patient satisfaction. PRACTICE IMPLICATIONS: To increase patient satisfaction, gynecologists-obstetricians should learn to integrate patient-centered communication style into the consultation.

Jørgensen, C. R., Thomsen, T. G., Ross, L., et al. (2018). "What Facilitates "Patient Empowerment" in Cancer Patients During Follow-Up: A Qualitative Systematic Review of the Literature." Qual Health Res **28**(2): 292-304.

Empowerment is a concept of growing importance in cancer care, but little is known about cancer patients' experiences of empowerment during follow-up. To explore this area, a qualitative systematic literature review was conducted in PubMed, CINAHL, and PsycINFO. A total of 2,292 papers were identified and 38 articles selected and included in the review. The thematic synthesis of the papers resulted in seven analytical themes being identified: empowerment as an ongoing process, knowledge is power, having an active role, communication and interaction between patients and health care professionals, support from being in a group, religion and spirituality, and gender. Very few articles explicitly explored the empowerment of cancer patients during follow-up, and the review identified a lack of attention to patients' own understandings of empowerment, a lack of specific focus on empowerment during follow-up, and insufficient attention to collective empowerment, as well as ethnic, social, and gender differences.

Jolly, K., Sidhu, M. S., Bates, E., et al. (2018). "Systematic review of the effectiveness of community-based self-management interventions among primary care COPD patients." NPJ Prim Care Respir Med **28**(1): 44.

> COPD self-management reduces hospital admissions and improves health-related quality of life (HRQoL). However, whilst most patients are managed in primary care, the majority of self-management trials have recruited participants with more severe disease from secondary care. We report the findings of a systematic review of the effectiveness of community-based self-management interventions in primary care patients with COPD. We systematically searched eleven electronic databases and identified 12 eligible randomised controlled trials with seven included in meta-analyses for HRQoL, anxiety and depression. We report no difference in HRQoL at final follow-up (St George's Respiratory Questionnaire total score -0.29; 95%CI -2.09, 1.51; I(2) 0%), nor any difference in anxiety or depression. In conclusion, supported self-management interventions delivered in the community to patients from primary care do not appear to be effective. Further research is recommended to identify effective self-management interventions suitable for primary care populations, particularly those with milder disease.

Jones, D., Dunn, L., Watt, I., et al. (2019). "Safety netting for primary care: evidence from a literature review." Br J Gen Pract **69**(678): e70-e79.

> BACKGROUND: Ensuring patient safety is vital in primary care. One mechanism to increase patient safety is through a practice known as safety netting. Safety netting is widely recommended in national guidelines; however, a variety of definitions exist with no consensus on when safety netting should be used and what advice or actions it should contain. AIM: This study aimed to identify different definitions of safety netting to provide conceptual clarity and propose a common approach to safety netting in primary care. DESIGN AND SETTING: Literature review and evidence synthesis of international articles relating to safety netting in primary care. METHOD: An electronic database and grey-literature search was conducted using terms around the theme of safety netting with broad inclusion criteria. RESULTS: A total of 47 studies were included in the review. Safety netting was defined as a consultation technique to communicate uncertainty, provide patient information on red-flag symptoms, and plan for future appointments to ensure timely re-assessment of a patient's condition. Safety-netting advice may include information on the natural history of the illness, advice on worrying symptoms to look out for, and specific information on how and when to seek help. In addition to advice within the consultation, safety netting includes follow-up of investigations and hospital referrals. Safety netting was considered to be particularly important when consulting with children, the acutely unwell, patients with multimorbidity, and those with mental health problems. CONCLUSION: Safety netting is more than solely the communication of uncertainty within a consultation. It should include plans for follow-up as well as important administrative aspects, such as the communication of test results and management of hospital letters.

Khalil, H., Shahid, M. et Roughead, L. (2017). "Medication safety programs in primary care: a scoping review." JBI Database System Rev Implement Rep **15**(10): 2512-2526.

> BACKGROUND: Medication safety plays an essential role in all healthcare organizations; improving this area is paramount to quality and safety of any wider healthcare program. While several medication safety programs in the hospital setting have been described and the associated impact on patient safety evaluated, no systematic reviews have described the impact of medication safety programs in the primary care setting. A preliminary search of the literature demonstrated that no systematic reviews, meta-analysis or scoping reviews have reported on medication safety programs in primary care; instead they have focused on specific interventions such as medication reconciliation or computerized physician order entry. This scoping review sought to map the current medication safety programs used in primary care. OBJECTIVE: The current scoping review sought to examine the characteristics of medication safety programs in the primary care setting and to map evidence on the outcome measures used to assess the effectiveness of medication safety programs in improving patient safety. INCLUSION CRITERIA TYPES OF PARTICIPANTS: The current review considered participants of any age and any condition using care obtained from any primary care services. CONCEPT: We considered studies that focussed on the characteristics of medication safety programs

and the outcome measures used to measure the effectiveness of these programs on patient safety in the primary care setting. CONTEXT: The context of this review was primary care settings, primary healthcare organizations, general practitioner clinics, outpatient clinics and any other clinics that do not classify patients as inpatients. TYPES OF STUDIES: We considered all quantitative studied published in English. SEARCH STRATEGY: A three-step search strategy was utilized in this review. DATA EXTRACTION: Data were extracted from the included studies to address the review question. The data extracted included type of medication safety program, author, country of origin, aims and purpose of the study, study population, method, comparator, context, main findings and outcome measures. RESULTS: The objectives, inclusion criteria and methods for this scoping review were specified in advance and documented in a protocol that was previously published. This scoping review included nine studies published over an eight-year period that investigated or described the effects of medication safety programs in primary care settings. We classified each of the nine included studies into three main sections according to whether they included an organizational, professional or patient component. The organizational component is aimed at changing the structure of the organization to implement the intervention, the professional component is aimed at the healthcare professionals involved in implementing the interventions, and the patient component is aimed at counseling and education of the patient. All of the included studies had different types of medication safety programs. The programs ranged from complex interventions including pharmacists and teams of healthcare professionals to educational packages for patients and computerized system interventions. The outcome measures described in the included studies were medication error incidence, adverse events and number of drug-related problems. CONCLUSION: Multi-faceted medication safety programs are likely to vary in characteristics. They include educational training, quality improvement tools, informatics, patient education and feedback provision. The most likely outcome measure for these programs is the incidence of medication errors and reported adverse events or drug-related problems.

Köchling, A., Löffler, C., Reinsch, S., et al. (2018). "Reduction of antibiotic prescriptions for acute respiratory tract infections in primary care: a systematic review." Implement Sci **13**(1): 47.

BACKGROUND: Although most respiratory tract infections (RTIs) are due to viral infections, they cause the majority of antibiotic (Abx) prescriptions in primary care. This systematic review summarises the evidence on the effectiveness of interventions in primary care aiming to reduce Abx prescriptions in patients ≥ 13 years for acute RTI. METHODS: We searched the databases "MEDLINE/PubMed" and "Cochrane Library" for the period from January 1, 2005, to August 31, 2016, for randomised controlled trials (RCTs) in primary care aiming at the reduction of Abx prescriptions for patients suffering from RTI. Out of 690 search results, 67 publications were retrieved and 17 RCTs were included. We assumed an absolute change of 10% as minimal important change. RESULTS: Twelve out of 17 included RCTs showed statistically significant lower Abx prescription rates in the intervention groups, but only six of them reported a clinically relevant reduction according to our definition. Communication skills training (CST) and point-of-care testing (POCT) were the most effective interventions. Pre-intervention Abx prescription rates varied between 13.5% and 80% and observed reductions ranged from 1.5 to 23.3%. Studies with post-intervention rates lower than 20% had no significant effects. Post-intervention observation periods ranged from 2 weeks up to 3.5 years. The design of the trials was heterogeneous precluding calculation of pooled effect size. The reporting of many RCTs was poor. CONCLUSIONS: CST and POCT alone or as adjunct can reduce antibiotic prescriptions for RTI. Eleven out of 17 trials were not successfully reducing Abx prescription rates according to our definition of minimal important change. However, five of them reported a statistically significant reduction. Trials with initially lower prescription rates were less likely to be successful. Future trials should investigate sustainability of intervention effects for a longer time period. The generalisability of findings was limited due to heterogeneous designs and outcome measures. Therefore, a consensus of designing and reporting of studies aiming at reducing antibiotic prescriptions is urgently needed to generate meaningful evidence.

Lamore, K., Montalescot, L. et Untas, A. (2017). "Treatment decision-making in chronic diseases: What are the family members' roles, needs and attitudes? A systematic review." Patient Educ Couns **100**(12): 2172-2181.

> OBJECTIVE: This systematic review aims to examine the roles of family members (FMs) in treatment decision-making for adult patients without cognitive or psychiatric disorders affecting their ability to participate in decision-making. METHODOLOGY: A comprehensive, systematic search of the Cochrane Library, PsycINFO, PubMed and ScienceDirect databases, with relevant keywords, was conducted. Two authors evaluated the eligibility of the studies independently, then cross-checked for accuracy. The quality of included studies were assessed using standardized criteria. RESULTS: Out of the 12.137 studies identified, 40 were included. Results highlighted the different roles and influences FMs have in the decision-making process. Moreover, several factors ranging from personal to cultural and family-related factors influence their level of involvement. Regardless of the illness, some similarities in family influence exist (e.g., social support). However, the type of family involvement varies according to the illness, the treatment choice and the patients' culture. CONCLUSION: FMs have an important role in the decision-making process. In fact, the final decision is often made by the patients after consulting their families. FMs can support both patients and medical teams, and thus facilitate the process. PRACTICE IMPLICATIONS: Physicians should include FMs in treatment decision-making when the patients and their FMs wish to be included.

Laurant, M., van der Biezen, M., Wijers, N., et al. (2018). "Nurses as substitutes for doctors in primary care." Cochrane Database of Systematic Reviews(7).
https://doi.org//10.1002/14651858.CD001271.pub3

Lerch, M. F. et Thrane, S. E. (2019). "Adolescents with chronic illness and the transition to self-management: A systematic review." J Adolesc **72**: 152-161.

> INTRODUCTION: Chronic illness effects one in ten adolescents worldwide. Adolescence involves a desire for autonomy from parental control and the necessity to transition care from parent to child. This review investigates the transition to adolescent self-management of chronic illness treatment behaviors in the context of parent-adolescent relationships. METHODS: A systematic search of PubMed, CINAHL, and Web of Science was conducted from earliest database records to early June 2017. Articles were included if they focused on adolescents, addressed illness self-management, discussed the parent-adolescent relationship, and were published in English. Articles were excluded if the chronic illness was a mental health condition, included children younger than 10 years of age, or lacked peer review. RESULTS: Nine studies met inclusion criteria. Outcomes included challenges to adolescent self-management, nature of the parent-adolescent relationship, illness representation, perceptions of adolescent self-efficacy in compliance, medical decision making, laboratory measures, and adolescent self-management competence. Across diagnoses, parents who were available to monitor, be a resource, collaborate with their adolescent, and engage in ongoing dialogue were key in the successful transition to autonomous illness management. CONCLUSIONS: There is a paucity of research addressing the experiences of adolescents in becoming experts in their own care.

Le Berre, M., Maimon, G., Sourial, N., et al. (2017). "Impact of Transitional Care Services for Chronically Ill Older Patients: A Systematic Evidence Review." J Am Geriatr Soc **65**(7): 1597-1608.

> Transitions in care from hospital to primary care for older patients with chronic diseases (CD) are complex and lead to increased mortality and service use. In response to these challenges, transitional care (TC) interventions are being widely implemented. They encompass education on self-management, discharge planning, structured follow-up and coordination among the different healthcare professionals. We conducted a systematic review to determine the effectiveness of interventions targeting transitions from hospital to the primary care setting for chronically ill older patients.. Randomized controlled trials were identified through Medline, CINHAL, PsycInfo, EMBASE (1995-2015). Two independent reviewers performed the study selection, data extraction and assessment of study quality (Cochrane "Risk of Bias"). Risk differences (RD) and number needed to treat (NNT) or mean differences (MD) were calculated using a random-effects model. From 10,234 references, 92 studies were included. Compared to usual care, significantly better outcomes were observed: a lower mortality at 3 (RD: -0.02 [-0.05, 0.00]; NNT: 50), 6, 12 and 18 months post-discharge, a lower rate of ED visits at 3 months (RD: -0.08 [-0.15, -0.01]; NNT: 13), a lower rate of readmissions at 3 (RD: -0.08 [-0.14, -0.03]; NNT: 7), 6, 12 and 18 months and a lower mean of

readmission days at 3 (MD: -1.33; [-2.15, -0.52]), 6, 12 and 18 months. No significant differences were observed in quality of life. In conclusion, TC improves transitions for older patients and should be included in the reorganization of healthcare services.

Margat, A., Gagnayre, R., Lombrail, P., et al. (2017). "Interventions en littératie en santé et éducation thérapeutique : une revue de littérature." Santé Publique **29**(6): 811-820.

[BDSP. Notice produite par EHESP CR0xo8Cn. Diffusion soumise à autorisation]. Un faible niveau de littératie en santé constitue un obstacle à l'éducation thérapeutique du patient, particulièrement pour les personnes en situation de vulnérabilité. Une revue de littérature a été effectuées entre novembre 2014 et janvier 2016. Une sélection de 40 études sur 206 a conduit à catégoriser les interventions selon deux grands types : des interventions spécifiques favorisant le compréhension des ressources destinées aux patients, et des interventions généralement complexes, visant à soutenir et améliorer les compétences en littératie en santé. Des recherches devraient questionner les modalités pédagogiques à mettre en oeuvre pour adapter les programmes d'ETP à la LS.

McCleary, N., Andrews, A., Morrow, S., et al. (2016). "Educating professionals to support self-management in people with asthma or diabetes: protocol for a systematic review and scoping exercise." BMJ Open **6**(10): e011937.

INTRODUCTION: Supported self-management for asthma helps people adjust their treatment in response to symptom changes. This improves day-to-day control and reduces the risk of asthma attacks and the need for emergency healthcare. However, implementation remains poor in routine clinical practice. This systematic review is part of a programme of work developing an intervention to help primary care practice teams embed self-management support into routine asthma care. The aim of the review is to synthesise the evidence regarding the effectiveness of educational interventions for professionals supporting self-management in people with asthma or diabetes (type 1 and type 2). These two conditions have the most robust evidence base for the effectiveness of implementing supported self-management. METHODS AND ANALYSIS: Electronic searches will be conducted in CENTRAL, MEDLINE, EMBASE, ISI Web of Science, CINAHL, PsycINFO, AMED, Global Health, WHO Global Health Library, ERIC, BNI, RDRB/CME and Google Scholar. Eligible studies are randomised controlled trials or controlled clinical trials published between 1990 and 2016 which evaluated professional education interventions facilitating asthma or diabetes supported self-management. Further relevant work will be identified from trial registries, citation searching and through contact with authors of included studies. This will be supplemented by scoping potentially relevant educational packages described in English language policy literature or health service websites. Screening, data extraction and risk of bias assessment (using the Cochrane Risk of Bias Tool) will be completed by two independent reviewers, with a third reviewer arbitrating where necessary. We plan a theoretically informed narrative synthesis of the aggregated data as heterogeneity is likely to preclude meta-analysis. ETHICS AND DISSEMINATION: Ethical approval is not required for this systematic review. The results will be described in a paper submitted for peer-reviewed publication and will inform the development of an implementation intervention. STUDY REGISTRATION NUMBER: PROSPERO CRD42016032922.

Mathijssen, E. G. E., van den Bemt, B. J. F., van den Hoogen, F. H. J., et al. (2020). "Interventions to support shared decision making for medication therapy in long term conditions: A systematic review." Patient Educ Couns **103**(2): 254-265.

OBJECTIVE: 1) To examine the effectiveness of interventions to support shared decision making (SDM) for medication therapy in long term conditions on patient outcomes; 2) to identify characteristics of SDM interventions that are associated with positive patient outcomes. METHODS: A systematic search for randomized controlled trials up to February 2019. A best evidence synthesis was performed. Intervention characteristics that are likely to be associated with positive patient outcomes were identified using descriptive statistics. RESULTS: Twenty-five articles reporting 23 studies were included. Seventeen patient outcomes were assessed using a variety of measurement instruments. There was evidence for a positive effect of SDM interventions on risk estimation and involvement in decision making. Evidence for no effect was found on four outcomes (e.g. medication adherence) and conflicting evidence on ten outcomes (e.g. decisional conflict). Electronically delivered SDM interventions and those comprising value clarification exercises were likely to be associated with positive patient outcomes. CONCLUSION: There is a lack of evidence for a positive effect of SDM interventions on the majority of patient outcomes. The mode and content of SDM interventions seem to affect patient outcomes. PRACTICE IMPLICATIONS: There is a need for standardization of patient outcomes and measurement instruments to evaluate SDM interventions.

Messina, J., Campbell, S., Morris, R., et al. (2017). "A narrative systematic review of factors affecting diabetes prevention in primary care settings." Plos One **12**(5): e0177699.

BACKGROUND: Type 2 diabetes is impacting millions of people globally; however, many future cases can be prevented through lifestyle changes and interventions. Primary care is an important setting for diabetes prevention, for at-risk populations, because it is a patient's primary point of contact with the health care system and professionals can provide lifestyle counselling and support, as well as monitoring health outcomes. These are all essential elements for diabetes prevention for at-risk adults. AIM: To understand the factors related to the delivery and uptake of type 2 diabetes prevention interventions within primary care in higher income countries. METHODS: For this narrative systematic review, we combined qualitative and quantitative studies of diabetes prevention within a primary care setting for patients at-risk of developing the condition. We used an iterative approach for evidence collection, which included using several databases (MEDLINE, Embase, Pysch info, BNI, SSCI, CINAHL, ASSIA), where we combined diabetes terms with primary care terms. Narrative and thematic synthesis were utilised to identify the prominent themes emerging from the data. RESULTS: A database of 6646 records was screened by the research team, and 18 papers were included. Three major themes were identified in this review. The first theme of context and setting of diabetes progression includes the risk and progression of diabetes, primary care as a setting, and where the responsibility for change is thought to lie. This review also found mixed views on the value of preventative services within primary care. The second theme focused on the various patient factors associated with diabetes prevention such as a patient's motivation to modify their current lifestyle, perceptions and knowledge (or lack thereof) of the impacts of diabetes, lack of follow-up in healthcare settings, and trust in healthcare professionals. The third theme was centred on professional factors impacting on diabetes prevention which included workload, time constraints, resources, self-efficacy and knowledge as well as professionals' perception of patient motivations towards change. CONCLUSION: This review explored the factors influencing diabetes prevention in primary care, and identified the context of prevention, as well as patient and professional factors related to preventative services being offered in primary care. This systematic review complements previous reviews of real-world settings by exploring the significant factors in prevention, and the findings are relevant to academics, policymakers, patients and practitioners interested in understanding the factors associated with the delivery and uptake of diabetes prevention interventions.

Morkisch, N., Upegui-Arango, L. D., Cardona, M. I., et al. (2020). "Components of the transitional care model (TCM) to reduce readmission in geriatric patients: a systematic review." BMC Geriatr **20**(1): 345.

BACKGROUND: Demographic changes are taking place in most industrialized countries. Geriatric patients are defined by the European Union of Medical Specialists as aged over 65 years and suffering from frailty and multi-morbidity, whose complexity puts a major burden on these patients, their family caregivers and the public health care system. To counteract negative outcomes and to maintain consistency in care between hospital and community dwelling, the transitional of care has emerged over the last several decades. Our objectives were to identify and summarize the components of the Transitional Care Model implemented with geriatric patients (aged over 65 years, with multi-morbidity) for the reduction of all-cause readmission. Another objective was to recognize the Transitional Care Model components' role and impact on readmission rate reduction on the transition of care from hospital to community dwelling (not nursing homes). METHODS: Randomized controlled trials (sample size ≥50 participants per group; intervention period ≥30 days), with geriatric patients were included. Electronic databases (MEDLINE, CINAHL, PsycINFO and The Cochrane Central Register of Controlled Trials) were searched from January 1994 to December 2019 published in English or

German. A qualitative synthesis of the findings as well as a systematic assessment of the interventions intensities was performed. RESULTS: Three articles met the inclusion criteria. One of the included trials applied all of the nine Transitional Care Model components described by Hirschman and colleagues and obtained a high-intensity level of intervention in the intensities assessment. This and another trial reported reductions in the readmission rate ($p < 0.05$), but the third trial did not report significant differences between the groups in the longer follow-up period (up to 12 months). CONCLUSIONS: Our findings suggest that high intensity multicomponent and multidisciplinary interventions are likely to be effective reducing readmission rates in geriatric patients, without increasing cost. Components such as type of staffing, assessing and managing symptoms, educating and promoting self-management, maintaining relationships and fostering coordination seem to have an important role in reducing the readmission rate. Research is needed to perform further investigations addressing geriatric patients well above 65 years old, to further understand the importance of individual components of the TCM in this population.

Morilla-Herrera, J. C., Garcia-Mayor, S., Martin-Santos, F. J., et al. (2016). "A systematic review of the effectiveness and roles of advanced practice nursing in older people." Int J Nurs Stud **53**: 290-307.
https://www.ncbi.nlm.nih.gov/pubmed/26542652

OBJECTIVES: To identify, assess and summarize available scientific evidence about the effect of interventions deployed by advanced practice nurses when providing care to older people in different care settings, and to describe the roles and components of the interventions developed by these professionals. BACKGROUND: In older people, evidence of advanced practice roles remains dispersed along different contexts, approaches and settings; there is little synthesis of evidence, and it is not easy to visualize the different practice models, their components, and their impact. DESIGN: Systematic review. DATA SOURCES: Sixteen electronic databases were consulted (1990-2014). The research also included screening of original studies in reviews and reports from Centers of Health Services Research and Health Technology Agencies. REVIEW METHODS: Studies were assessed by two reviewers with the Cochrane risk of bias tool. They were classified depending on the type of follow-up (long and short-term care) and the scope of the service (advanced practice nurses interventions focused on multimorbid patients, or focused on a specific disease). RESULTS: Fifteen studies were included. In long-term settings, integrative, multi-component and continuous advanced practice nursing care, reduced readmissions, and increased patients' and caregivers' satisfaction. Advanced practice nurses were integrated within multidisciplinary teams and the main interventions deployed were patient education, multidimensional assessments and coordination of multiple providers. CONCLUSION: Positive results have been found in older people in long-term care settings, although it is difficult to discern the specific effect attributable to them because they are inserted in multidisciplinary teams. Further investigations are needed to evaluate the cost-effectiveness of the two modalities detected and to compare internationally the interventions developed by advanced practice nurses.

Morrison, D., Wyke, S., Agur, K., et al. (2014). "Digital asthma self-management interventions: a systematic review." J Med Internet Res **16**(2): e51.

BACKGROUND: Many people with asthma tolerate symptoms and lifestyle limitations unnecessarily by not utilizing proven therapies. Better support for self-management is known to improve asthma control, and increasingly the Internet and other digital media are being used to deliver that support. OBJECTIVE: Our goal was to summarize current knowledge, evidenced through existing systematic reviews, of the effectiveness and implementation of digital self-management support for adults and children with asthma and to examine what features help or hinder the use of these programs. METHODS: A comprehensive search strategy combined 3 facets of search terms: (1) online technology, (2) asthma, and (3) self-management/behavior change/patient experience. We undertook searches of 14 databases, and reference and citation searching. We included qualitative and quantitative systematic reviews about online or computerized interventions facilitating self-management. Title, abstract, full paper screening, and quality appraisal were performed by two researchers independently. Data extraction was undertaken using standardized forms. RESULTS: A total of 3810 unique papers were identified. Twenty-nine systematic reviews met inclusion criteria: the majority were from the United States (n=12), the rest from United Kingdom (n=6), Canada (n=3), Portugal (n=2), and Australia, France, Spain, Norway, Taiwan, and Greece (1 each). Only 10 systematic reviews fulfilled pre-determined quality standards, describing 19 clinical trials. Interventions were heterogeneous: duration of interventions ranging from single use, to 24-hour access for 12 months, and incorporating varying degrees of health professional involvement. Dropout rates ranged from 5-23%. Four RCTs were aimed at adults (overall range 3-65 years). Participants were inadequately described: socioeconomic status 0/19, ethnicity 6/19, and gender 15/19. No qualitative systematic reviews were included. Meta-analysis was not attempted due to heterogeneity and inadequate information provision within reviews. There was no evidence of harm from digital interventions. All RCTs that examined knowledge (n=2) and activity limitation (n=2) showed improvement in the intervention group. Digital interventions improved markers of self care (5/6), quality of life (4/7), and medication use (2/3). Effects on symptoms (6/12) and school absences (2/4) were equivocal, with no evidence of overall benefits on lung function (2/6), or health service use (2/15). No specific data on economic analyses were provided. Intervention descriptions were generally brief making it impossible to identify which specific "ingredients" of interventions contribute most to improving outcomes. CONCLUSIONS: Digital self-management interventions show promise, with evidence of beneficial effects on some outcomes. There is no evidence about utility in those over 65 years and no information about socioeconomic status of participants, making understanding the "reach" of such interventions difficult. Digital interventions are poorly described within reviews, with insufficient information about barriers and facilitators to their uptake and utilization. To address these gaps, a detailed quantitative systematic review of digital asthma interventions and an examination of the primary qualitative literature are warranted, as well as greater emphasis on economic analysis within trials.

Munce, S. E. P., Perrier, L., Shin, S., et al. (2017). "Strategies to improve the quality of life of persons post-stroke: protocol of a systematic review." Syst Rev **6**(1): 184.

BACKGROUND: While many outcomes post-stroke (e.g., depression) have been previously investigated, there is no complete data on the impact of a variety of quality improvement strategies on the quality of life and physical and psychological well-being of individuals post-stroke. The current paper outlines a systematic review protocol on the impact of quality improvement strategies on quality of life as well as physical and psychological well-being of individuals with stroke. METHODS: MEDLINE, CINAHL, EMBASE, and PsycINFO databases will be searched. Two independent reviewers will conduct all levels of screening, data abstraction, and quality appraisal. Only randomized controlled trials that report on the impact of quality improvement strategies on quality of life outcomes in people with stroke will be included. The secondary outcomes will be physical and psychological well-being. Quality improvement strategies include audit and feedback, case management, team changes, electronic patient registries, clinician education, clinical reminders, facilitated relay of clinical information to clinicians, patient education, (promotion of) self-management, patient reminder systems, and continuous quality improvement. Studies published since 2000 will be included to increase the relevancy of findings. Results will be grouped according to the target group of the varying quality improvement strategies (i.e., health system, health care professionals, or patients) and/or by any other noteworthy grouping variables, such as etiology of stroke or by sex. DISCUSSION: This systematic review will identify those quality improvement strategies aimed at the health system, health care professionals, and patients that impact the quality of life of individuals with stroke. Improving awareness and utilization of such strategies may enhance uptake of stroke best practices and reduce inappropriate health care utilization costs. SYSTEMATIC REVIEW REGISTRATION: PROSPERO, CRD42017064141.

Muth, C., Blom, J. W., Smith, S. M., et al. (2019). "Evidence supporting the best clinical management of patients with multimorbidity and polypharmacy: a systematic guideline review and expert consensus." J Intern Med **285**(3): 272-288.

The complexity and heterogeneity of patients with multimorbidity and polypharmacy renders traditional disease-oriented guidelines often inadequate and complicates clinical decision making. To address this challenge, guidelines have been developed on multimorbidity or polypharmacy. To systematically analyse their recommendations, we conducted a systematic guideline review using the Ariadne principles for managing multimorbidity as analytical framework. The information synthesis included a multistep consensus process involving 18 multidisciplinary experts from seven countries. We included eight guidelines (four each on multimorbidity and polypharmacy) and extracted about 250 recommendations. The guideline addressed (i) the identification of the target population (risk factors); (ii) the assessment of interacting conditions and treatments: medical history, clinical and psychosocial assessment including physiological status and frailty, reviews of medication and encounters with healthcare providers highlighting informational continuity; (iii) the need to incorporate patient preferences and goal setting: eliciting preferences and expectations, the process of shared decision making in relation to treatment options and the level of involvement of patients and carers; (iv) individualized management: guiding principles on optimization of treatment benefits over possible harms, treatment communication and the information content of medication/care plans; (v) monitoring and follow-up: strategies in care planning, self-management and medication-related aspects, communication with patients including safety instructions and adherence, coordination of care regarding referral and discharge management, medication appropriateness and safety concerns. The spectrum of clinical and self-management issues varied from guiding principles to specific recommendations and tools providing actionable support. The limited availability of reliable risk prediction models, feasible interventions of proven effectiveness and decision aids, and limited consensus on appropriate outcomes of care highlight major research deficits. An integrated approach to both multimorbidity and polypharmacy should be considered in future guidelines.

Nicoll, R., Robertson, L., Gemmell, E., et al. (2018). "Models of care for chronic kidney disease: A systematic review." Nephrology (Carlton) **23**(5): 389-396.

AIM: Chronic kidney disease (CKD) is common and presents an increasing burden to patients and health services. However, the optimal model of care for patients with CKD is unclear. We systematically reviewed the clinical effectiveness of different models of care for the management of CKD. METHODS: A comprehensive search of eight databases was undertaken for articles published from 1992 to 2016. We included randomized controlled trials that assessed any model of care in the management of adults with pre-dialysis CKD, reporting renal, cardiovascular, mortality and other outcomes. Data extraction and quality assessment was carried out independently by two authors. RESULTS: Results were summarized narratively. Nine articles (seven studies) were included. Four models of care were identified: nurse-led, multidisciplinary specialist team, pharmacist-led and self-management. Nurse and pharmacist-led care reported improved rates of prescribing of drugs relevant to CKD. Heterogeneity was high between studies and all studies were at high risk of bias. Nurse-led care and multidisciplinary specialist care were associated with small improvements in blood pressure control. CONCLUSION: Evidence of long term improvements in renal, cardiovascular or mortality endpoints was limited by short follow up. We found little published evidence about the effectiveness of different models of care to guide best practice for service design, although there was some evidence that models of care where health professionals deliver care according to a structured protocol or guideline may improve adherence to treatment targets.

Noordman, J., van der Weijden, T. et van Dulmen, S. (2012). "Communication-related behavior change techniques used in face-to-face lifestyle interventions in primary care: a systematic review of the literature." Patient Educ Couns **89**(2): 227-244.

OBJECTIVES: To systematically review the literature on the relative effectiveness of face-to-face communication-related behavior change techniques (BCTs) provided in primary care by either physicians or nurses to intervene on patients' lifestyle behavior. METHODS: PubMed, EMBASE, PsychINFO, CINAHL and The Cochrane Library were searched for studies published before October 2010. Fifty studies were included and assessed on methodological quality. RESULTS: Twenty-eight studies reported significantly favorable health outcomes following communication-related BCTs. In these studies, 'behavioral counseling' was most frequently used (15 times), followed by motivational interviewing (eight times), education and advice (both seven times). Physicians and nurses seem equally capable of providing face-to-face communication-related BCTs in primary care. CONCLUSION: Behavioral counseling, motivational interviewing, education and advice all seem effective communication-related BCTs. However, BCTs were also found in less successful studies. Furthermore, based on existing literature, one primary care profession does not seem better equipped than the other to provide face-to-face communication-related BCTs. PRACTICE IMPLICATIONS: There is evidence that behavioral counseling, motivational interviewing, education and advice can be used as effective communication-related BCTs by physicians and nurses. However, further research is needed to examine the underlying working mechanisms of communication-related BCTs, and whether they meet the requirements of patients and primary care providers.

Oikarinen, A., Kaariainen, M. et Kyngas, H. (2014). "A framework of counseling for patients with stroke in nursing: a narrative literature review." J Neurosci Nurs **46**(5): E3-e14.

Stroke is a major cause of death in developed countries. Its prevalence and disability burden are expected to increase in the future because of an aging population. The consequences of stroke are specific to the individual. Whereas some patients experience long-term functional and cognitive deficits, others may recover completely and be discharged quickly. Counseling is needed to help patients and their families cope with the effects of stroke after discharge. This is a systematic literature review with a narrative analysis. The purpose was to describe the content and characteristics of stroke patients' counseling. A review of studies published between January 2000 and February 2013 describing stroke patients' counseling was conducted by CINAHL and Medline databases. Studies were selected based on inclusion criteria, and the quality of the included studies was assessed. The final data (n = 33) were extracted and synthesized. Seven prominent themes were identified in the literature relating to (a) information about the disease and concerns regarding stroke, (b) the aims of counseling, (c) counseling methods, (d) interaction as a method for counseling, (e) the stroke nurse as a counselor, (f) emotional support, and (g) decision making in patients' care. The results of the review show that stroke patients' counseling is a multifaceted phenomenon with distinctive characteristics. The findings of the review can be used to develop counseling for patients with stroke and their families. In addition, the review can be used when educating stroke nurses for stroke units.

Parker, S., Prince, A., Thomas, L., et al. (2018). "Electronic, mobile and telehealth tools for vulnerable patients with chronic disease: a systematic review and realist synthesis." BMJ Open **8**(8): e019192.

OBJECTIVES: The objective of this review was to assess the benefit of using electronic, mobile and telehealth tools for vulnerable patients with chronic disease and explore the mechanisms by which these impact patient self-efficacy and self-management. DESIGN: We searched MEDLINE, all evidence-based medicine, CINAHL, Embase and PsychINFO covering the period 2009 to 2018 for electronic, mobile or telehealth interventions. Quality was assessed according to rigour and relevance. Those studies providing a richer description ('thick') were synthesised using a realist matrix. SETTING AND PARTICIPANTS: Studies of any design conducted in community-based primary care involving adults with one or more diagnosed chronic health condition and vulnerability due to demographic, geographic, economic and/or cultural characteristics. RESULTS: Eighteen trials were identified targeting a range of chronic conditions and vulnerabilities. The data provided limited insight into the mechanisms underpinning these interventions, most of which sought to persuade vulnerable patients into believing they could self-manage their conditions through improved symptom monitoring, education and support and goal setting. Patients were relatively passive in the interaction, and the level of patient response attributed to their intrinsic level of motivation. Health literacy, which may be confounded with motivation, was only measured in one study, and eHealth literacy was not assessed. CONCLUSIONS: Research incorporating these tools with vulnerable groups is not comprehensive. Apart from intrinsic motivation, health literacy may also influence the reaction of vulnerable groups to technology. Social persuasion was the main way interventions sought to achieve better self-management. Efforts to engage patients by healthcare providers were lower than expected. Use of social networks or other eHealth mechanisms to link patients and provide opportunities for vicarious experience could be further explored in relation to vulnerable groups. Future research could also assess health and eHealth literacy and differentiate the specific needs for vulnerable groups when implementing health technologies.

Peytremann-Bridevaux, I., Arditi, C., Gex, G., et al. (2015). "Chronic disease management programmes for adults with asthma." Cochrane Database Syst Rev(5): Cd007988.

> BACKGROUND: The burden of asthma on patients and healthcare systems is substantial. Interventions have been developed to overcome difficulties in asthma management. These include chronic disease management programmes, which are more than simple patient education, encompassing a set of coherent interventions that centre on the patients' needs, encouraging the co-ordination and integration of health services provided by a variety of healthcare professionals, and emphasising patient self-management as well as patient education. OBJECTIVES: To evaluate the effectiveness of chronic disease management programmes for adults with asthma. SEARCH METHODS: Cochrane Central Register of Controlled Trials (CENTRAL), Cochrane Effective Practice and Organisation of Care (EPOC) Group Specialised Register, MEDLINE (MEDLINE In-Process and Other Non-Indexed Citations), EMBASE, CINAHL, and PsycINFO were searched up to June 2014. We also handsearched selected journals from 2000 to 2012 and scanned reference lists of relevant reviews. SELECTION CRITERIA: We included individual or cluster-randomised controlled trials, non-randomised controlled trials, and controlled before-after studies comparing chronic disease management programmes with usual care in adults over 16 years of age with a diagnosis of asthma. The chronic disease management programmes had to satisfy at least the following five criteria: an organisational component targeting patients; an organisational component targeting healthcare professionals or the healthcare system, or both; patient education or self-management support, or both; active involvement of two or more healthcare professionals in patient care; a minimum duration of three months. DATA COLLECTION AND ANALYSIS: After an initial screen of the titles, two review authors working independently assessed the studies for eligibility and study quality; they also extracted the data. We contacted authors to obtain missing information and additional data, where necessary. We pooled results using the random-effects model and reported the pooled mean or standardised mean differences (SMDs). MAIN RESULTS: A total of 20 studies including 81,746 patients (median 129.5) were included in this review, with a follow-up ranging from 3 to more than 12 months. Patients' mean age was 42.5 years, 60% were female, and their asthma was mostly rated as moderate to severe. Overall the studies were of moderate to low methodological quality, because of limitations in their design and the wide confidence intervals for certain results.Compared with usual care, chronic disease management programmes resulted in improvements in asthma-specific quality of life (SMD 0.22, 95% confidence interval (CI) 0.08 to 0.37), asthma severity scores (SMD 0.18, 95% CI 0.05 to 0.30), and lung function tests (SMD 0.19, 95% CI 0.09 to 0.30). The data for improvement in self-efficacy scores were inconclusive (SMD 0.51, 95% CI -0.08 to 1.11). Results on hospitalisations and emergency department or unscheduled visits could not be combined in a meta-analysis because the data were too heterogeneous; results from the individual studies were inconclusive overall. Only a few studies reported results on asthma exacerbations, days off work or school, use of an action plan, and patient satisfaction. Meta-analyses could not be performed for these outcomes. AUTHORS' CONCLUSIONS: There is moderate to low quality evidence that chronic disease management programmes for adults with asthma can improve asthma-specific quality of life, asthma severity, and lung function tests. Overall, these results provide encouraging evidence of the potential effectiveness of these programmes in adults with asthma when compared with usual care. However, the optimal composition of asthma chronic disease management programmes and their added value, compared with education or self-management alone that is usually offered to patients with asthma, need further investigation.

Rees, S. et Williams, A. (2009). "Promoting and supporting self-management for adults living in the community with physical chronic illness: A systematic review of the effectiveness and meaningfulness of the patient-practitioner encounter." JBI Libr Syst Rev **7**(13): 492-582.

> BACKGROUND: There has been a reported rise in the number of people with chronic illness (also referred to as long-term disease) in the Western world. One hundred million people in the United States have at least one chronic condition and in the United Kingdom (UK) as many as 17.5 million adults may be living with chronic disease. New models of care have been developed which recognise the complexities of managing care where there is overlap between the wider community, the health care system and provider organisations, for example, the Chronic Care Model and the Expert Patient

Programme. These new models herald a shift away from the idea of chronically ill patients as passive recipients of care towards active engagement, in partnership with health professionals, in managing their own care.Partnership, ideally, involves collaborative care and self-management education. This may support self-care alongside medical, preventative and health maintenance interventions. In this context the nature of the patient-practitioner consultation in promoting self-care takes on a new importance. OBJECTIVE: The overall objective of the review was to determine the best available evidence regarding the promotion and support of self-care management for adults living in the community with chronic illness during the patient-practitioner encounter. Specifically the review sought to determine: What is the effectiveness of the patient-practitioner encounter in promoting and supporting self-care management of people with chronic illness? What are the individual and organisational factors which help or hinder recognition, promotion and support of chronic disease self-care management strategies? What are the similarities and differences between how 'effectiveness' is defined in this context by patients and different practitioners? INCLUSION CRITERIA: The review focussed on self-caring adults aged nineteen years and older living in the community, with a physical chronic illness, and not currently being treated as an in-patient. For example, people with diabetes, asthma, arthritis, coronary disease, lung disease, heart failure, epilepsy, kidney disease and inflammatory bowel disease. Since patients meet various professionals in a variety of community settings regarding their care, a practitioner in this review included doctors (physicians and General Practitioners), nurses, nurse specialists, dieticians, podiatrists and community health workers.A variety of outcomes measures was used to evaluate effective self-care management. These included physiological measurements such as: HbA1c, blood pressure, body weight, lipids; lifestyle measurements, for example physical activity; and self-care determinants such as knowledge, attitude; and self-care behaviours regarding, for example, diet and physical exercise, and medication. The outcome measures used to explore the meaningfulness of the patient-practitioner encounter, concerned patients', physicians' and nurses' views and perceptions of self-care management and support.The review considered all types of quantitative and qualitative evidence regarding the patient-practitioner encounter where self-care in chronic illness was the focus. The quantitative studies reviewed included systematic reviews, randomised controlled trials (RCTs), quasi-experimental studies, and survey studies.Qualitative studies reviewed included interview designs, vignette technique, qualitative evaluation, grounded theory, and exploratory descriptive design. SEARCH STRATEGY: The search sought to find both published and unpublished studies between 1990 and 2005. The year 1990 was deemed appropriate since it precedes the development of the Chronic Care Model in which self-management support for people living with chronic illness is heralded as an important part of care-management. An initial search of CINAHL and MEDLINE databases was undertaken to identify appropriate search terms regarding self-care and chronic illness. A search strategy was then developed using all identified MeSH headings and key words and the following databases were searched: - Ovid CINAHL; Ovid MEDLINE (R); Ovid EMBASE; Ovid EBM Reviews (CDSR, ACP Journal Club, DARE, CCTR); ASSIA; SIGLE; Digital Dissertations; and British Library's Zetoc Services. DATA COLLECTION: Thirty-two papers were considered applicable to the review topic from the title and abstract. Two reviewers used the appropriate critical appraisal instruments designed by the Joanna Briggs Institute (JBI) to assess methodological quality of papers retrieved for review, and agreed on the papers for inclusion. A total of 18 papers reporting 16 studies were included in the review (3 papers reported from the same study): 12 quantitative studies, 5 qualitative studies and 1 study using mixed methods. These papers were heterogeneous in nature, diverse in subject matter and considered a wide range of physiological, psychological, sociological and behavioural self-care outcome measures. Data were extracted by the two independent reviewers using a variety of data extraction instruments developed by JBI. DATA ANALYSIS: The heterogeneous nature of the quantitative studies prevented meta-analysis and so these studies are presented in narrative summary. Meta-synthesis of the qualitative data was performed for the six qualitative pieces following the process of meta-synthesis set out in the JBI-QARI software package. The process of meta-synthesis embodied in this programme involves the aggregation or synthesis of findings. Seven syntheses were produced from fifty findings. RESULTS: For effective patient-centeredness to be established patients should be able to discuss their own ideas about self-care actions, including lifestyle management in an unhurried fashion and with a practitioner who has the time and who is willing to listen. Patient-centred interventions aimed at providers such as patient-centred training and patient-centred materials were shown to have a positive effect on the patient-centeredness of an encounter, but their effect on self-care outcomes was not clear. Interventions directed at enhancing patient participation in the encounter were shown to effect diabetes self-care and self-behaviour.Nurses were shown to have an effective role in educating patients and facilitating adherence to treatment. Patients found nurses approachable and some studies showed that when given the choice, patients were more likely to contact a nurse (than a doctor) regarding their care.Professional interventions such as education, and organisational interventions such as management of regular review and follow up, were shown to improve process outcomes in the management of a patient-practitioner encounter. When patient-orientated interventions were added to professional and organisational interventions, in which patient education and / or the role of the nurse was enhanced, patient health outcomes were improved.The different patient-orientated interventions reviewed highlighted some of the elements that can effectively support self-care management during a patient-practitioner encounter. These are information giving, including the use of a guidebook, the use of care plans, the structure of treatment using checklists, and education and support for staff in 'collaboratives'.Comprehensive, well-paced, user-friendly information is effective in supporting and promoting self-care management in a variety of ways. It informs and reassures patients and their families. It can be used during a doctor/patient consultation to assist communication between doctors and patients, and may help patients feel more involved in their care.For information to effect self-care management, it is important that it is given at diagnosis and from then onwards so that the implications of good self-care management in relation to long term health outcomes are established.Care plans and self-management plans can be useful in facilitating patients' discussion of self-care actions and lifestyle management.Organisational factors affect opportunities for professionals to support patient self-care management. These include time, resources, the existing configuration and expectations of a consultation, the opportunity for open access to appointments, the ability to see the same doctor and early referral to other professional groups.Correlational design studies indicated that individual psychological factors, such as attachment style and autonomy support given to a patient during a patient-practitioner encounter, have a relationship to self-care behaviours and outcomes.Correlational design studies indicated that both general communication and diabetic specific communication used during a patient-practitioner encounter have a positive effect on patient self-care management and outcomes for patients with diabetes.Consultations about self-care for patients with chronic illness tend to be medically focussed and do not always include discussion of patients' views of the routines and self-care actions. This can lead to tension and unresolved issues between the patient and professional.Studies in the context of diabetes self-management reveal that professionals can effectively support patients in a number of ways. These include assisting the orientation of patients towards skills and competencies needed for self-care; sharing knowledge and information; endorsing the patient's view that he or she is the most reliable and accurate source of information about his or her physiological function; trusting the patients' interpretations of their physiological function, and modifying advice in response to patients in accordance with their bodily cues and experiences. CONCLUSION: The nature of the patient-practitioner encounter is multifaceted involving patient, professional and organisational factors. Patient-orientated interventions are the most effective in effecting positive self-care behavioural and health outcomes. Patient participation in the patient-practitioner encounter is a key factor in influencing self-care outcomes. Patients' self-care management involves social as well as medical management. Professionals need to recognise and value patients' views and experiences in order to support their self-care management. IMPLICATIONS FOR PRACTICE: Patients need information at diagnosis and from then onwards to enable good self-care management. It is important to enable patient participation during the patient-practitioner encounter.For patients' self-care needs to be addressed opportunities for patients to talk about their diet, routines and lifestyle management need to be incorporated into the encounter. Extra time in consultations may be required. Care plans can help to facilitate this discussion.To support patients with their self-care management, both sharing of medical and nursing knowledge, and recognition of the value of patient's knowledge and experiences are vital.Nurses relate well to patients who want to discuss self-care management.Professional interventions and organisational interventions can improve the management of a patient-practitioner encounter. Patient-orientated interventions in addition to good management of the encounter can improve health care outcomes. IMPLICATIONS FOR RESEARCH: Patient focussed interventions have a positive effect on patient self-care outcomes. Further research regarding patients' self-care and health outcomes and behaviours is needed to establish which patient focussed interventions in particular are effective.Qualitative research has proved to be important in understanding the different ways that professionals and patients approach self-care management during an encounter. More qualitative research would assist an understanding of the processes that inspire effective partnership between patients and professionals to support the establishment of self-care management of chronic illness.

Reynolds, R., Dennis, S., Hasan, I., et al. (2018). "A systematic review of chronic disease management interventions in primary care." BMC Fam Pract **19**(1): 11.

BACKGROUND: Primary and community care are key settings for the effective management of long term conditions. We aimed to evaluate the pattern of health outcomes in chronic disease management interventions for adults with physical health problems implemented in primary or community care settings. METHODS: The methods were based on our previous review published in 2006. We performed database searches for articles published from 2006 to 2014 and conducted a systematic review with narrative synthesis using the Cochrane Effective Practice and Organisation of Care taxonomy to classify interventions and outcomes. The interventions were mapped to Chronic Care Model elements. The pattern of outcomes related to interventions was summarized by frequency of statistically significant improvements in health care provision and patient outcomes. RESULTS: A total of 9589 journal articles were retrieved from database searches and snowballing. After screening and verification, 165 articles that detailed 157 studies were included. There were few studies with Health Care Organization (1.9% of studies) or Community Resources (0.6% of studies) as the primary intervention element. Self-Management Support interventions (45.8% of studies) most frequently resulted in improvements in patient-level outcomes. Delivery System Design interventions (22.6% of studies) showed benefits in both professional and patient-level outcomes for a narrow range of conditions. Decision Support interventions (21.3% of studies) had impact limited to professional-level outcomes, in particular use of medications. The small number of studies of Clinical Information System interventions (8.9%) showed benefits for both professional- and patient-level outcomes. CONCLUSIONS: The published literature has expanded substantially since 2006. This review confirms that Self-Management Support is the most frequent Chronic Care Model intervention that is associated with statistically significant improvements, predominately for diabetes and hypertension.

Ricci-Cabello, I., Ruiz-Perez, I., Rojas-Garcia, A., et al. (2013). "Improving Diabetes Care in Rural Areas: A Systematic Review and Meta-Analysis of Quality Improvement Interventions in OECD Countries." Plos One **8**(12): (12), fig., tabl.
http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0084464

Background and Aims: Despite well documented disparities in health and healthcare in rural communities, evidence in relation to quality improvement (QI) interventions in those settings is still lacking. The main goals of this work were to assess the effectiveness of QI strategies designed to improve diabetes care in rural areas, and identify characteristics associated with greater success. Methods: We conducted a systematic review and meta-analysis. Systematic electronic searches were conducted in MEDLINE, EMBASE, CINAHL, and 12 additional bibliographic sources. Experimental studies carried out in the OECD member countries assessing the effectiveness of QI interventions aiming to improve diabetes care in rural areas were included. The effect of the interventions and their impact on glycated hemoglobin was pooled using a random-effects meta-analysis. Results: Twenty-six studies assessing the effectiveness of twenty QI interventions were included. Interventions targeted patients (45%), clinicians (5%), the health system (15%), or several targets (35%), and consisted of the implementation of one or multiple QI strategies. Most of the interventions produced a positive impact on processes of care or diabetes self-management, but a lower effect on health outcomes was observed. Interventions with multiple strategies and targeting the health system and/or clinicians were more likely to be effective. Six QI interventions were included in the meta-analysis (1,496 patients), which showed a significant reduction in overall glycated hemoglobin of 0.41 points from baseline in those patients receiving the interventions (95% CI -0.75% to -0.07%). Conclusions: This work identified several characteristics associated with successful interventions to improve the quality of diabetes care in rural areas. Efforts to improve diabetes care in rural communities should focus on interventions with multiple strategies targeted at clinicians and/or the health system, rather than on traditional patient-oriented interventions.

Rochfort, A., Beirne, S., Doran, G., et al. (2018). "Does patient self-management education of primary care professionals improve patient outcomes: a systematic review." BMC Fam Pract **19**(1): 163.

> BACKGROUND: Patient self-management support is recognised as a key component of chronic care. Education and training for health professionals has been shown in the literature to be associated with better uptake, implementation and effectiveness of self-management programs, however, there is no clear evidence regarding whether this training results in improved health outcomes for patients with chronic conditions. METHODS: A systematic review was undertaken using the PRISMA guidelines using the Cochrane Library, PubMEd, ERIC, EMBASE, CINAHL, PsycINFO, Web searches, Hand searches and Bibliographies. Articles published from inception to September 1st, 2013 were included. Systematic reviews, Meta-analysis, Randomized controlled trials (RCTs), Controlled clinical trials, Interrupted time series and Controlled before and after studies, which reported on primary care health professionals' continuing education or evidence-based medicine/education on patient self-management for any chronic condition, were included. A minimum of two reviewers participated independently at each stage of review. RESULTS: From 7533 abstracts found, only two papers provided evidence on the effectiveness of self-management education for primary healthcare professionals in terms of measured outcomes in patients. These two articles show improvement in patient outcomes for chronic back pain and diabetes based on RCTs. The educational interventions with health professionals spanned a range of techniques and modalities but both RCTs included a motivational interviewing component. CONCLUSIONS: Before and up to 2 years after the incorporation of patient empowerment for self-management into the WONCA Europe definition of general practice, there was a scarcity of high quality evidence showing improved outcomes for patients as a result of educating health professionals in patient self-management of chronic conditions.

Rodin, G., Mackay, J. A., Zimmermann, C., et al. (2009). "Clinician-patient communication: a systematic review." Support Care Cancer **17**(6): 627-644.

> GOAL OF WORK: The goal of this work was to identify methods of clinician-patient cancer-related communication that may impact patient outcomes associated with distress at critical points in the course of cancer care. MATERIALS AND METHODS: A systematic review of practice guidelines, systematic reviews, or randomized trials on this topic was conducted. Guidelines for quality was evaluated using the Appraisal of Guidelines for Research and Evaluation Instrument, and the contributive value for recommendations was assessed. Systematic reviews and randomized trials were also evaluated for methodological rigor. RESULTS: Four existing guidelines, eight systematic reviews and nine randomized trials were identified. Two of the guidelines were of high quality, and all systematic reviews reported clear search criteria and support for their conclusions; the randomized trials were of modest or low quality. For all situations and disease stages, guidelines consistently identified open, honest, and timely communication as important; specifically, there was evidence for a reduction in anxiety when discussions of life expectancy and prognosis were included in consultations. Techniques to increase patient participation in decision-making were associated with greater satisfaction but did not necessarily decrease distress. Few studies took cultural and religious diversity into account. CONCLUSIONS: There is little definitive evidence supporting the superiority of one specific method for communicating information compared to another. Evidence regarding the benefit of decision aids or other strategies to facilitate better communication is inconsistent. Since patients vary in their communication preferences and desire for active participation in decision making, there is a need to individualize communication style.

Rushton, M., Howarth, M., Grant, M. J., et al. (2017). "Person-centred discharge education following coronary artery bypass graft: A critical review." J Clin Nurs **26**(23-24): 5206-5215.

> AIMS AND OBJECTIVES: To examine the extent that individualised education helps reduce depression and anxiety and improves self-care for people who have undergone coronary artery bypass graft surgery. BACKGROUND: Individualised discharge planning is increasingly important following cardiac surgery due to recurrent admissions as well as the issue of anxiety and depression, often due to lack of preparation. The hospital to home transition is fundamental in the recovery process. Individualised education and person-centred care ensure that patients' educational needs are met. This empowers

patients, increasing self-efficacy or confidence, resulting in autonomy, a smoother discharge process and avoiding postdischarge problems and rehospitalisation. DESIGN: A critical review of published peer-reviewed literature was conducted. METHODS: Electronic databases searched included MEDLINE, CINAHL, the Cochrane Library and PsychInfo 2009-2015. RESULTS: Eight articles were identified for review, and a Critical Appraisal Skills Programme framework was used to determine the quality of the papers, all of the papers focussed on coronary artery bypass graft. The designs were typically experimental or quasi-experimental with two reviews. CONCLUSION: A greater understanding of the patients' needs allows tailored education to be provided, which promotes self-care management. This level of patient empowerment increases confidence and ultimately minimise anxiety and depression. Despite the varying teaching and learning methods associated with individualised education, patient-centred education has the potential to assist cardiac nurses in adequately preparing patients for discharge following their coronary artery bypass graft. RELEVANCE TO CLINICAL PRACTICE: Development of individualised education programmes is crucial in preparing patients for discharge. The reduction in readmission to hospital has a significant effect on already stretched resources, and the reduction in postoperative complications during the recovery period linked with depression and anxiety will have a positive effect on the individuals' ability to self-care, health and well-being.

Ryan, R., Santesso, N., Lowe, D., et al. (2014). "Interventions to improve safe and effective medicines use by consumers: an overview of systematic reviews." Cochrane Database Syst Rev(4): Cd007768.

BACKGROUND: Many systematic reviews exist on interventions to improve safe and effective medicines use by consumers, but research is distributed across diseases, populations and settings. The scope and focus of such reviews also vary widely, creating challenges for decision-makers seeking to inform decisions by using the evidence on consumers' medicines use.This is an update of a 2011 overview of systematic reviews, which synthesises the evidence, irrespective of disease, medicine type, population or setting, on the effectiveness of interventions to improve consumers' medicines use. OBJECTIVES: To assess the effects of interventions which target healthcare consumers to promote safe and effective medicines use, by synthesising review-level evidence. METHODS: SEARCH METHODS: We included systematic reviews published on the Cochrane Database of Systematic Reviews and the Database of Abstracts of Reviews of Effects. We identified relevant reviews by handsearching databases from their start dates to March 2012. SELECTION CRITERIA: We screened and ranked reviews based on relevance to consumers' medicines use, using criteria developed for this overview. DATA COLLECTION AND ANALYSIS: We used standardised forms to extract data, and assessed reviews for methodological quality using the AMSTAR tool. We used standardised language to summarise results within and across reviews; and gave bottom-line statements about intervention effectiveness. Two review authors screened and selected reviews, and extracted and analysed data. We used a taxonomy of interventions to categorise reviews and guide syntheses. MAIN RESULTS: We included 75 systematic reviews of varied methodological quality. Reviews assessed interventions with diverse aims including support for behaviour change, risk minimisation and skills acquisition. No reviews aimed to promote systems-level consumer participation in medicines-related activities. Medicines adherence was the most frequently-reported outcome, but others such as knowledge, clinical and service-use outcomes were also reported. Adverse events were less commonly identified, while those associated with the interventions themselves, or costs, were rarely reported.Looking across reviews, for most outcomes, medicines self-monitoring and self-management programmes appear generally effective to improve medicines use, adherence, adverse events and clinical outcomes; and to reduce mortality in people self-managing antithrombotic therapy. However, some participants were unable to complete these interventions, suggesting they may not be suitable for everyone.Other promising interventions to improve adherence and other key medicines-use outcomes, which require further investigation to be more certain of their effects, include:. simplified dosing regimens: with positive effects on adherence;. interventions involving pharmacists in medicines management, such as medicines reviews (with positive effects on adherence and use, medicines problems and clinical outcomes) and pharmaceutical care services (consultation between pharmacist and patient to resolve medicines problems, develop a care plan and provide follow-up; with positive effects on adherence and knowledge).Several other strategies showed some positive effects, particularly relating to adherence, and other outcomes, but their effects were less consistent overall and so need further study. These included:. delayed antibiotic prescriptions: effective to decrease antibiotic use but with mixed effects on clinical outcomes, adverse effects and satisfaction;. practical strategies like reminders, cues and/or organisers, reminder packaging and material incentives: with positive, although somewhat mixed effects on adherence;. education delivered with self-management skills training, counselling, support, training or enhanced follow-up; information and counselling delivered together; or education/information as part of pharmacist-delivered packages of care: with positive effects on adherence, medicines use, clinical outcomes and knowledge, but with mixed effects in some studies;. financial incentives: with positive, but mixed, effects on adherence.Several strategies also showed promise in promoting immunisation uptake, but require further study to be more certain of their effects. These included organisational interventions; reminders and recall; financial incentives; home visits; free vaccination; lay health worker interventions; and facilitators working with physicians to promote immunisation uptake. Education and/or information strategies also showed some positive but even less consistent effects on immunisation uptake, and need further assessment of effectiveness and investigation of heterogeneity.There are many different potential pathways through which consumers' use of medicines could be targeted to improve outcomes, and simple interventions may be as effective as complex strategies. However, no single intervention assessed was effective to improve all medicines-use outcomes across all diseases, medicines, populations or settings.Even where interventions showed promise, the assembled evidence often only provided part of the picture: for example, simplified dosing regimens seem effective for improving adherence, but there is not yet sufficient information to identify an optimal regimen.In some instances interventions appear ineffective: for example, the evidence suggests that directly observed therapy may be generally ineffective for improving treatment completion, adherence or clinical outcomes.In other cases, interventions may have variable effects across outcomes. As an example, strategies providing information or education as single interventions appear ineffective to improve medicines adherence or clinical outcomes, but may be effective to improve knowledge; an important outcome for promoting consumers' informed medicines choices.Despite a doubling in the number of reviews included in this updated overview, uncertainty still exists about the effectiveness of many interventions, and the evidence on what works remains sparse for several populations, including children and young people, carers, and people with multimorbidity. AUTHORS' CONCLUSIONS: This overview presents evidence from 75 reviews that have synthesised trials and other studies evaluating the effects of interventions to improve consumers' medicines use.Systematically assembling the evidence across reviews allows identification of effective or promising interventions to improve consumers' medicines use, as well as those for which the evidence indicates ineffectiveness or uncertainty.Decision makers faced with implementing interventions to improve consumers' medicines use can use this overview to inform decisions about which interventions may be most promising to improve particular outcomes. The intervention taxonomy may also assist people to consider the strategies available in relation to specific purposes, for example, gaining skills or being involved in decision making. Researchers and funders can use this overview to identify where more research is needed and assess its priority. The limitations of the available literature due to the lack of evidence for important outcomes and important populations, such as people with multimorbidity, should also be considered in practice and policy decisions.

Salkar, M., Rosenthal, M., Thakur, T., et al. (2020). "Patient Centered Studies Focusing on Diabetes Self-Management: A Scoping Review." Curr Diabetes Rev **16**(6): 557-569.

BACKGROUND: Type 2 diabetes continues to be a significant burden to patients and health systems globally. Addressing this condition from an alternative perspective, patients and various other stakeholders from three northern Mississippi communities co-created patient-centered research questions focused on type 2 diabetes management. OBJECTIVE: The objective of this scoping review was to explore current literature focusing on nine patient- centered research questions to establish current knowledge and identify future research needs in the area of type 2 diabetes. METHODS: A scoping review was conducted to obtain an overview of research related to the study purpose. The PubMed database was searched from March 2013 to March 2018 to identify patient-centered studies focused on type 2 diabetes and relevant to one of the nine research questions. RESULTS: A total of 33 studies were identified and included. For five of the research questions, there was either no previous research literature or only "related" studies could be identified. These largely unexplored topics included how the understanding of guidelines by healthcare providers, specialty, and communication of medication side-effects impact patients' understanding and outcomes, the impact of improving patients' preparedness to communicate with providers, and whether younger patients require weight management programs that account for this populations' needs. CONCLUSION: This lack of previous literature presents a unique opportunity to partner with patients to conduct this study and help improve the management of type 2 diabetes.

Scholl, I., LaRussa, A., Hahlweg, P., et al. (2018). "Organizational- and system-level characteristics that influence implementation of shared decision-making and strategies to address them - a scoping review." Implement Sci **13**(1): 40.

BACKGROUND: Shared decision-making (SDM) is poorly implemented in routine care, despite being promoted by health policies. No reviews have solely focused on an in-depth synthesis of the literature around organizational- and system-level characteristics (i.e., characteristics of healthcare organizations and of healthcare systems) that may affect SDM implementation. A synthesis would allow exploration of interventions to address these characteristics. The study aim was to compile a comprehensive overview of organizational- and system-level characteristics that are likely to influence the implementation of SDM, and to describe strategies to address those characteristics described in the literature. METHODS: We conducted a scoping review using the Arksey and O'Malley framework. The search strategy included an electronic search and a secondary search including gray literature. We included publications reporting on projects that promoted implementation of SDM or other decision support interventions in routine healthcare. We screened titles and abstracts, and assessed full texts for eligibility. We used qualitative thematic analysis to identify organizational- and system-level characteristics. RESULTS: After screening 7745 records and assessing 354 full texts for eligibility, 48 publications on 32 distinct implementation projects were included. Most projects (N = 22) were conducted in the USA. Several organizational-level characteristics were described as influencing the implementation of SDM, including organizational leadership, culture, resources, and priorities, as well as teams and workflows. Described system-level characteristics included policies, clinical guidelines, incentives, culture, education, and licensing. We identified potential strategies to influence the described characteristics, e.g., examples how to facilitate distribution of decision aids in a healthcare institution. CONCLUSIONS: Although infrequently studied, organizational- and system-level characteristics appear to play a role in the failure to implement SDM in routine care. A wide range of characteristics described as supporting and inhibiting implementation were identified. Future studies should assess the impact of these characteristics on SDM implementation more thoroughly, quantify likely interactions, and assess how characteristics might operate across types of systems and areas of healthcare. Organizations that wish to support the adoption of SDM should carefully consider the role of organizational- and system-level characteristics. Implementation and organizational theory could provide useful guidance for how to address facilitators and barriers to change.

Shang, L., Zuo, M., Ma, D., et al. (2019). "The Antecedents and Consequences of Health Care Professional-Patient Online Interactions: Systematic Review." J Med Internet Res **21**(9): e13940.

BACKGROUND: Online health care services effectively supplement traditional medical treatment. The development of online health care services depends on sustained interactions between health care professionals (HCPs) and patients. Therefore, it is necessary to understand the demands and gains of health care stakeholders in HCP-patient online interactions and determine an agenda for future work. OBJECTIVE: This study aims to present a systematic review of the antecedents and consequences of HCP-patient online interactions. It seeks to reach a better understanding of why HCPs and patients are willing to interact with each other online and what the consequences of HCP-patient online interactions are for health care stakeholders. Based on this, we intend to identify the gaps in existing studies and make recommendations for future research. METHODS: In accordance with the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) guidelines, a systematic retrieval was carried out from the Web of Science, PubMed, and Scopus electronic databases. The search results were confined to those papers published in English between January 1, 2000 and June 30, 2018. Selected studies were then evaluated for quality; studies that did not meet quality criteria were excluded from further analysis. Findings of the reviewed studies related to our research questions were extracted and synthesized through inductive thematic analysis. RESULTS: A total of

> 8440 records were found after the initial search, 28 papers of which were selected for analysis. Accessibility to HCPs, self-management, and unmet needs were the main triggers for patients to participate in online interaction. For HCPs, patient education, career needs, and self-promotion were the major reasons why they took the online approach. There were several aspects of the consequences of HCP-patient online interactions on health care stakeholders. Consequences for patients included patient empowerment, health promotion, and acquisition of uncertain answers. Consequences for HCPs included social and economic returns, lack of control over their role, and gaining more appointments. HCP-patient online interactions also improved communication efficiency in offline settings and helped managers of online health care settings get a better understanding of patients' needs. Health care stakeholders have also encountered ethical and legal issues during online interaction. CONCLUSIONS: Through a systematic review, we sought out the antecedents and consequences of HCP-patient online interactions to understand the triggers for HCPs and patients to participate and the consequences of participating. Potential future research topics are the influences on the chain of online interaction, specifications and principles of privacy design within online health care settings, and roles that sociodemographic and psychological characteristics play. Longitudinal studies and the adoption of text-mining method are worth encouraging. This paper is expected to contribute to the sustained progress of online health care settings.

Siltanen, H., Jylhä, V., Holopainen, A., et al. (2019). "Family members' experiences and expectations of self-management counseling while caring for a person with chronic obstructive pulmonary disease: a systematic review of qualitative evidence." JBI Database System Rev Implement Rep **17**(11): 2214-2247.

> OBJECTIVE: The objective of this review was to identify and synthesize existing evidence on the experiences and expectations of self-management counseling of adult family members who are informal caregivers of a person with chronic obstructive pulmonary disease (COPD) in the context of inpatient or outpatient care. INTRODUCTION: Chronic obstructive pulmonary disease is the fourth leading cause of mortality and morbidity worldwide. It is a progressive, lifelong and unpredictable disease. As the disease progresses, both the people with COPD and their family members require information and practical skills to manage the disease. The role of family members is particularly important at the advanced stage of COPD. This systematic review examined family members' experiences and expectations of self-management counseling. INCLUSION CRITERIA: This review considered qualitative studies that investigated adult (older than18 years) family members' experiences or expectations of COPD self-management counseling in the context of inpatient or outpatient care. "Family member" refers to a person who is an informal caregiver because of his or her relationship to the person with COPD. METHODS: A three-step search strategy was utilized in this review. The search strategy aimed to find published and unpublished studies in English and Finnish. The databases MEDLINE, CINAHL, PsycINFO, Scopus and the Finnish medical bibliographic database, Medic, were searched. The search was conducted in December 2015 and updated in September 2018. Titles and abstracts were screened by two independent reviewers for the review's inclusion criteria. Eligible studies were then critically appraised by two independent reviewers for methodological quality. The findings and illustrations of the findings were extracted and assigned a level of credibility. The qualitative research findings were pooled using the JBI method of meta-aggregation. RESULTS: Ten papers were selected for inclusion in this review. These studies were published from 2002 to 2017. The quality of all included studies was at least moderate. Each study had a total score between 7 and 10 on the JBI Critical Appraisal Checklist for Qualitative Research. The following four synthesized findings were aggregated from nine categories and 39 study findings: i) Family members' experiences with unresponsive behavior from health professionals, ii) Family members' experiences of unmet needs in self-management counseling, iii) Family members' information needs concerning COPD management, and iv) Family members' information needs concerning coping strategies. CONCLUSIONS: The synthesized findings indicate that family members are frustrated by the shortcomings of self-management counseling. They also feel unprepared for and uncertain about their caring role. They need more information about COPD and coping strategies for COPD. Counseling is essential to high-quality care and should be offered to family members caring for a loved one at any stage of COPD.

Smith, S. M., Wallace, E., O'Dowd, T., et al. (2016). "Interventions for improving outcomes in patients with multimorbidity in primary care and community settings." Cochrane Database Syst Rev **3**: Cd006560.

BACKGROUND: Many people with chronic disease have more than one chronic condition, which is referred to as multimorbidity. The term comorbidity is also used but this is now taken to mean that there is a defined index condition with other linked conditions, for example diabetes and cardiovascular disease. It is also used when there are combinations of defined conditions that commonly co-exist, for example diabetes and depression. While this is not a new phenomenon, there is greater recognition of its impact and the importance of improving outcomes for individuals affected. Research in the area to date has focused mainly on descriptive epidemiology and impact assessment. There has been limited exploration of the effectiveness of interventions to improve outcomes for people with multimorbidity. OBJECTIVES: To determine the effectiveness of health-service or patient-oriented interventions designed to improve outcomes in people with multimorbidity in primary care and community settings. Multimorbidity was defined as two or more chronic conditions in the same individual. SEARCH METHODS: We searched MEDLINE, EMBASE, CINAHL and seven other databases to 28 September 2015. We also searched grey literature and consulted experts in the field for completed or ongoing studies. SELECTION CRITERIA: Two review authors independently screened and selected studies for inclusion. We considered randomised controlled trials (RCTs), non-randomised clinical trials (NRCTs), controlled before-after studies (CBAs), and interrupted time series analyses (ITS) evaluating interventions to improve outcomes for people with multimorbidity in primary care and community settings. Multimorbidity was defined as two or more chronic conditions in the same individual. This includes studies where participants can have combinations of any condition or have combinations of pre-specified common conditions (comorbidity), for example, hypertension and cardiovascular disease. The comparison was usual care as delivered in that setting. DATA COLLECTION AND ANALYSIS: Two review authors independently extracted data from the included studies, evaluated study quality, and judged the certainty of the evidence using the GRADE approach. We conducted a meta-analysis of the results where possible and carried out a narrative synthesis for the remainder of the results. We present the results in a 'Summary of findings' table and tabular format to show effect sizes across all outcome types. MAIN RESULTS: We identified 18 RCTs examining a range of complex interventions for people with multimorbidity. Nine studies focused on defined comorbid conditions with an emphasis on depression, diabetes and cardiovascular disease. The remaining studies focused on multimorbidity, generally in older people. In 12 studies, the predominant intervention element was a change to the organisation of care delivery, usually through case management or enhanced multidisciplinary team work. In six studies, the interventions were predominantly patient-oriented, for example, educational or self-management support-type interventions delivered directly to participants. Overall our confidence in the results regarding the effectiveness of interventions ranged from low to high certainty. There was little or no difference in clinical outcomes (based on moderate certainty evidence). Mental health outcomes improved (based on high certainty evidence) and there were modest reductions in mean depression scores for the comorbidity studies that targeted participants with depression (standardized mean difference (SMD) -2.23, 95% confidence interval (CI) -2.52 to -1.95). There was probably a small improvement in patient-reported outcomes (moderate certainty evidence) although two studies that specifically targeted functional difficulties in participants had positive effects on functional outcomes with one of these studies also reporting a reduction in mortality at four year follow-up (Int 6%, Con 13%, absolute difference 7%). The intervention may make little or no difference to health service use (low certainty evidence), may slightly improve medication adherence (low certainty evidence), probably slightly improves patient-related health behaviours (moderate certainty evidence), and probably improves provider behaviour in terms of prescribing behaviour and quality of care (moderate certainty evidence). Cost data were limited. AUTHORS' CONCLUSIONS: This review identifies the emerging evidence to support policy for the management of people with multimorbidity and common comorbidities in primary care and community settings. There are remaining uncertainties about the effectiveness of interventions for people with multimorbidity in general due to the relatively small number of RCTs conducted in this area to date, with mixed findings overall. It is possible that the findings may change with the inclusion of large ongoing well-organised trials in future updates. The results suggest an improvement in health outcomes if interventions can be targeted at risk factors such as depression, or specific functional difficulties in people with multimorbidity.

So, C. F. et Chung, J. W. (2018). "Telehealth for diabetes self-management in primary healthcare: A systematic review and meta-analysis." J Telemed Telecare **24**(5): 356-364.

> Background Diabetes mellitus is prevalent worldwide and the majority of the patients with this metabolic disease are managed in primary healthcare settings. Self-management is, therefore, crucial for the health and wellbeing of people with diabetes. Due to the advancement of information technologies, telehealth intervention as self-management measures potentially offer a possible solution in the primary healthcare arena to cope with the increasing demand for diabetes control. Methods This study aims to systematically review the effectiveness of telehealth on diabetes control self-management in primary healthcare settings. A keyword search was conducted in six databases for randomised controlled trials. Data extraction and quality assessment of the reviewed studies were done with standardised forms and checklists. A meta-analysis was also performed in this review. Results Of the seven studies included in this review, all of them reported a decreasing level of glycated haemoglobin. Four studies examined the effect of telehealth interventions on fasting plasma glucose levels; however, the overall effects were insignificant. It is, nonetheless, encouraging to see two studies which investigated their effect on two-hour post-meal glucose levels, and showed positive effects for glycaemic control self-management in the short term. This finding, though only from two studies, points to a promising future of utilising telehealth interventions in controlling this metabolic disease in the primary healthcare arena. Conclusions This review showed positive effects of telehealth interventions for diabetes control self-management at the primary healthcare stage. Further studies are required to evaluate the cost-effectiveness of telehealth interventions.

Somerville, M., Ball, L., Sierra-Silvestre, E., et al. (2019). "Understanding the knowledge, attitudes and practices of providing and receiving nutrition care for prediabetes: an integrative review." Aust J Prim Health **25**(4): 289-302.

> To synthesise the literature on nutrition care for prediabetes from both the perspective of healthcare providers and patients, six databases (CINAHL, MEDLINE, Embase, PsycINFO, Scopus and ProQuest) were searched to identify qualitative or quantitative studies that focussed on nutrition care and prediabetes in primary care practice. Studies examining the perspectives of patients with prediabetes and healthcare providers were included. Outcomes of interest included knowledge of nutrition care for prediabetes, attitudes around providing or receiving nutrition care and actual nutrition care practices for prediabetes. Overall, 12851 studies were screened and 26 were included in the final review. Inductive analysis produced five themes: (i) nutrition care is preferable to pharmacological intervention; (ii) patients report taking action for behaviour change; (iii) healthcare providers experience barriers to nutrition care; (iv) healthcare providers tend not to refer patients for nutrition care; and (v) there are contradictory findings around provision and receipt of nutrition care. This review has revealed the contradictions between patients' and healthcare providers' knowledge, attitudes and practices around nutrition care for prediabetes. Further research is needed to shed light on how to resolve these disconnects in care and to improve nutrition care practices for people with prediabetes.

Spiby, H., McCormick, F., Wallace, L., et al. (2009). "A systematic review of education and evidence-based practice interventions with health professionals and breast feeding counsellors on duration of breast feeding." Midwifery **25**(1): 50-61.

> OBJECTIVE: to examine the effects of training, education and practice change interventions with health professionals and lay breast feeding educator/counsellors on duration of breast feeding. REVIEW METHODS: this was part of a series of reviews of interventions that affect duration of breast feeding. Full details of methods used, including search strategy, are reported separately. SELECTION CRITERIA FOR INCLUDED STUDIES: randomised controlled trials, non randomised controlled trials with concurrent controls and before after studies (cohort or cross-sectional), undertaken in a developed country, published between 1980 and 2003 in any language. The primary outcome was duration of breast feeding. Secondary and process outcomes, including attitude, knowledge and behaviour change of participants, were included from papers that also reported breast feeding duration outcomes.

STUDY-QUALITY ASSESSMENT: inclusion and exclusion criteria were applied, data extracted and study quality assessments made by one reviewer and independently checked by another, with a third reviewer to resolve differences, as recommended by the NHS Centre for Reviews and Dissemination's guidance for reviews. FINDINGS: the search identified nine papers. All were before after studies that included the education of health professionals; no studies were identified that related to breast feeding counsellors. In six of the studies, the participants were working with mothers and babies in hospitals (three in the UK, two in Italy and one in France); in three studies, the participants were working in community settings (Canada, Spain and the USA). Two UK studies and two non-UK studies (Spain and USA) involved mothers living in disadvantaged areas. Most interventions aimed to increase knowledge and change professional practice in support of breast feeding. KEY CONCLUSIONS: many of the studies reviewed have methodological limitations. Study settings and contexts vary and lack comparability. Evidence from these studies was insufficient to draw conclusions about overall benefit or harm associated with the interventions. From the studies identified, there seems to be no single way that consistently achieves changes in breast feeding duration. From one of the methodologically more robust studies, it seems that UNICEF/WHO Baby Friendly Hospital Initiative (BFI) training might have the potential to influence breast feeding duration. RECOMMENDATIONS FOR FURTHER RESEARCH: further testing of the BFI initiative within a controlled design. Future research into the education of health-care professionals that relates to the support of breast feeding women should have appropriate theoretical underpinning, describe educational programmes and the context of care delivery comprehensively and use standardised time points in the assessment of the effect of interventions. Intermediate outcomes should also be reported, including those related to the effect on education and practice.

Stenberg, U., Haaland-Øverby, M., Koricho, A. T., et al. (2019). "How can we support children, adolescents and young adults in managing chronic health challenges? A scoping review on the effects of patient education interventions." Health Expect **22**(5): 849-862.

OBJECTIVES: This scoping review aims to give a comprehensive and systematic overview of published evaluations and the potential impact of patient education interventions for children, adolescents and young adults who are living with chronic illness and/or impairment loss. METHODS: Relevant literature published between 2008 and 2018 has been comprehensively reviewed, with attention paid to variations in study, intervention and patient characteristics. Arksey and O'Malley's framework for scoping studies guided the review process, and thematic analysis was undertaken to synthesize extracted data. RESULTS: Of the 7214 titles identified, 69 studies were included in this scoping review. Participant-reported benefits of the interventions included less distress from symptoms, improved medical adherence and/or less use of medication, and improved knowledge. The majority of studies measuring physical activity and/or physiologic outcomes found beneficial effects. Interventions were also beneficial in terms of decreased use of urgent health care, hospitalization, visits to general practitioner and absence from school. By sharing experiences, participants had learned from each other and attained new insight on how they could manage illness-related challenges. DISCUSSION: Study results corroborate previous research suggesting that different types of patient education interventions have a positive impact on children, adolescents and young adults, but research on this field is still in a starting phase. The results summed up in the current review supports the utility of patient education interventions that employ behavioural strategies tailored to the developmental needs of children, adolescents and young adults with different cultural backgrounds.

Stenberg, U., Vagan, A., Flink, M., et al. (2018). "Health economic evaluations of patient education interventions a scoping review of the literature." Patient Educ Couns **101**(6): 1006-1035.

OBJECTIVES: To provide a comprehensive overview of health economic evaluations of patient education interventions for people living with chronic illness. METHODS: Relevant literature published between 2000 and 2016 has been comprehensively reviewed, with attention paid to variations in study, intervention, and patient characteristics. RESULTS: Of the 4693 titles identified, 56 articles met the inclusion criteria and were included in this scoping review. Of the studies reviewed, 46 concluded that patient education interventions were beneficial in terms of decreased hospitalization, visits to Emergency Departments or General Practitioners, provide benefits in terms of quality-adjusted life years, and reduce loss of production. Eight studies found no health economic impact of the interventions. CONCLUSIONS: The results of this review strongly suggest that patient education interventions, regardless of study design and time horizon, are an effective tool to cut costs. This is a relatively new area of research, and there is a great need of more research within this field. PRACTICE IMPLICATIONS: In bringing this evidence together, our hope is that healthcare providers and managers can use this information within a broad decision-making process, as guidance in discussions of care quality and of how to provide appropriate, cost-effective patient education interventions.

Strout, T. D., Hillen, M., Gutheil, C., et al. (2018). "Tolerance of uncertainty: A systematic review of health and healthcare-related outcomes." Patient Education and Counseling **101**(9): 1518-1537.
http://www.sciencedirect.com/science/article/pii/S0738399118301551

Background Uncertainty tolerance (UT) is thought to be a characteristic of individuals that influences various outcomes related to health, healthcare, and healthcare education. We undertook a systematic literature review to evaluate the state of the evidence on UT and its relationship to these outcomes. Methods We conducted electronic and bibliographic searches to identify relevant studies examining associations between UT and health, healthcare, or healthcare education outcomes. We used standardized tools to assess methodological quality and analyzed the major findings of existing studies, which we organized and classified by theme. Results Searches yielded 542 potentially relevant articles, of which 67 met inclusion criteria. Existing studies were heterogeneous in focus, setting, and measurement approach, were largely cross-sectional in design, and overall methodological quality was low. UT was associated with various trainee-centered, provider-centered, and patient-centered outcomes which were cognitive, emotional, and behavioral in nature. UT was most consistently associated with emotional well-being. Conclusions Uncertainty tolerance is associated with several important trainee-, provider-, and patient-centered outcomes in healthcare and healthcare education. However, low methodological quality, study design limitations, and heterogeneity in the measurement of UT limit strong inferences about its effects, and addressing these problems is a critical need for future research.

Taggart, J., Williams, A., Dennis, S., et al. (2012). "A systematic review of interventions in primary care to improve health literacy for chronic disease behavioral risk factors." BMC Fam Pract **13**: 49.
http://www.ncbi.nlm.nih.gov/pubmed/22656188

BACKGROUND: To evaluate the effectiveness of interventions used in primary care to improve health literacy for change in smoking, nutrition, alcohol, physical activity and weight (SNAPW). METHODS: A systematic review of intervention studies that included outcomes for health literacy and SNAPW behavioral risk behaviors implemented in primary care settings.We searched the Cochrane Library, Johanna Briggs Institute, Medline, Embase, CINAHL, Psychinfo, Web of Science, Scopus, APAIS, Australasian Medical Index, Google Scholar, Community of Science and four targeted journals (Patient Education and Counseling, Health Education and Behaviour, American Journal of Preventive Medicine and Preventive Medicine).Study inclusion criteria: Adults over 18 years; undertaken in a primary care setting within an Organisation for Economic Co-operation and Development (OECD) country; interventions with at least one measure of health literacy and promoting positive change in smoking, nutrition, alcohol, physical activity and/or weight; measure at least one outcome associated with health literacy and report a SNAPW outcome; and experimental and quasi-experimental studies, cohort, observational and controlled and non-controlled before and after studies.Papers were assessed and screened by two researchers (JT, AW) and uncertain or excluded studies were reviewed by a third researcher (MH). Data were extracted from the included studies by two researchers (JT, AW). Effectiveness studies were quality assessed. A typology of interventions was thematically derived from the studies by grouping the SNAPW interventions into six broad categories: individual motivational interviewing and counseling; group education; multiple interventions (combination of interventions); written materials; telephone coaching or counseling; and computer or web based interventions. Interventions were classified by intensity of contact with the subjects (High >/= 8 points of contact/hours; Moderate >3 and <8; Low </= 3 points of contact hours) and setting (primary health, community or other).Studies were analyzed by intervention category and whether significant positive changes in SNAPW and health literacy outcomes were reported. RESULTS: 52 studies were included.

Many different intervention types and settings were associated with change in health literacy (73% of all studies) and change in SNAPW (75% of studies). More low intensity interventions reported significant positive outcomes for SNAPW (43% of studies) compared with high intensity interventions (33% of studies). More interventions in primary health care than the community were effective in supporting smoking cessation whereas the reverse was true for diet and physical activity interventions. CONCLUSION: Group and individual interventions of varying intensity in primary health care and community settings are useful in supporting sustained change in health literacy for change in behavioral risk factors. Certain aspects of risk behavior may be better handled in clinical settings while others more effectively in the community. Our findings have implications for the design of programs

Taylor, C. A., Shaw, R. L., Dale, J., et al. (2011). "Enhancing delivery of health behaviour change interventions in primary care: a meta-synthesis of views and experiences of primary care nurses." Patient Educ Couns **85**(2): 315-322.

OBJECTIVE: To systematically find and synthesise qualitative studies that elicited views and experiences of nurses involved in the delivery of health behaviour change (HBC) interventions in primary care, with a focus on how this can inform enhanced delivery and adherence to a structured approach for HBC interventions. METHODS: Systematic search of five electronic databases and additional strategies to maximise identification of studies, appraisal of studies and use of meta-synthesis to develop an inductive and interpretative form of knowledge synthesis. RESULTS: Nine studies met the inclusion criteria. Synthesis resulted in the development of four inter-linking themes; (a) actively engaging nurses in the process of delivering HBC interventions, (b) clarifying roles and responsibilities of those involved, (c) engaging practice colleagues, (d) communication of aims and potential outcomes of the intervention. CONCLUSION: The synthesis of qualitative evidence resulted in the development of a conceptual framework that remained true to the findings of primary studies. This framework describes factors that should be actively promoted to enhance delivery of and adherence to HBC interventions by nurses working in primary care. PRACTICE IMPLICATIONS: The findings can be used to inform strategies for researchers, policymakers and healthcare providers to enhance fidelity and support delivery of HBC interventions.

Thota, A. B., Sipe, T. A., Byard, G. J., et al. (2012). "Collaborative care to improve the management of depressive disorders: a community guide systematic review and meta-analysis." Am J Prev Med **42**(5): 525-538.
http://www.ncbi.nlm.nih.gov/pubmed/22516495

CONTEXT: To improve the quality of depression management, collaborative care models have been developed from the Chronic Care Model over the past 20 years. Collaborative care is a multicomponent, healthcare system-level intervention that uses case managers to link primary care providers, patients, and mental health specialists. In addition to case management support, primary care providers receive consultation and decision support from mental health specialists (i.e., psychiatrists and psychologists). This collaboration is designed to (1) improve routine screening and diagnosis of depressive disorders; (2) increase provider use of evidence-based protocols for the proactive management of diagnosed depressive disorders; and (3) improve clinical and community support for active client/patient engagement in treatment goal-setting and self-management. EVIDENCE ACQUISITION: A team of subject matter experts in mental health, representing various agencies and institutions, conceptualized and conducted a systematic review and meta-analysis on collaborative care for improving the management of depressive disorders. This team worked under the guidance of the Community Preventive Services Task Force, a nonfederal, independent, volunteer body of public health and prevention experts. Community Guide systematic review methods were used to identify, evaluate, and analyze available evidence. EVIDENCE SYNTHESIS: An earlier systematic review with 37 RCTs of collaborative care studies published through 2004 found evidence of effectiveness of these models in improving depression outcomes. An additional 32 studies of collaborative care models conducted between 2004 and 2009 were found for this current review and analyzed. The results from the meta-analyses suggest robust evidence of effectiveness of collaborative care in improving depression symptoms (standardized mean difference [SMD]=0.34); adherence to treatment (OR=2.22); response to treatment (OR=1.78); remission of symptoms (OR=1.74); recovery from symptoms (OR=1.75); quality of life/functional status (SMD=0.12); and satisfaction with care (SMD=0.39) for patients diagnosed with depression (all effect estimates were significant). CONCLUSIONS: Collaborative care models are effective in achieving clinically meaningful improvements in depression outcomes and public health benefits in a wide range of populations, settings, and organizations. Collaborative care interventions provide a supportive network of professionals and peers for patients with depression, especially at the primary care level

Traeger, A. C., Hubscher, M., Henschke, N., et al. (2015). "Effect of Primary Care-Based Education on Reassurance in Patients With Acute Low Back Pain: Systematic Review and Meta-analysis." JAMA Intern Med **175**(5): 733-743.

> IMPORTANCE: Reassurance is a core aspect of daily medical practice, yet little is known on how it can be achieved. OBJECTIVE: To determine whether patient education in primary care increases reassurance in patients with acute or subacute low back pain (LBP). DATA SOURCES: Medline, EMBASE, Cochrane Central Register for Controlled Trials, and PsychINFO databases were searched to June 2014. DESIGN: Systematic review and meta-analysis of randomized and nonrandomized clinical trials. STUDY SELECTION: To be eligible, studies needed to be controlled trials of patient education for LBP that were delivered in primary care and measured reassurance after the intervention. Eligibility criteria were applied, and studies were selected by 2 independent authors. MAIN OUTCOMES AND MEASURES: The primary outcomes were reassurance in the short and long term and health care utilization at 12 months. DATA EXTRACTION AND SYNTHESIS: Data were extracted by 2 independent authors and entered into a standardized form. A random-effects meta-analysis tested the effects of patient education compared with usual care on measures of reassurance. To investigate the effect of study characteristics, we performed a preplanned subgroup analysis. Studies were stratified according to duration, content, and provider of patient education. RESULTS: We included 14 trials (n=4872) of patient education interventions. Trials assessed reassurance with questionnaires of fear, worry, anxiety, catastrophization, and health care utilization. There is moderate- to high-quality evidence that patient education increases reassurance more than usual care/control education in the short term (standardized mean difference [SMD], -0.21; 95% CI, -0.35 to -0.06) and long term (SMD, -0.15; 95% CI, -0.27 to -0.03). Interventions delivered by physicians were significantly more reassuring than those delivered by other primary care practitioners (eg, physiotherapist or nurse). There is moderate-quality evidence that patient education reduces LBP-related primary care visits more than usual care/control education (SMD, -0.14; 95% CI, -0.28 to -0.00 at a 12-month follow-up). The number needed to treat to prevent 1 LBP-related visit to primary care was 17. CONCLUSIONS AND RELEVANCE: There is moderate- to high-quality evidence that patient education in primary care can provide long-term reassurance for patients with acute or subacute LBP.

Unverzagt, S., Oemler, M., Braun, K., et al. (2014). "Strategies for guideline implementation in primary care focusing on patients with cardiovascular disease: a systematic review." Family Practice **31**(3): 247-266.
PM:24367069

> BACKGROUND: Guidelines should reduce inappropriate practice and improve the efficiency of treatment. Not only methodological quality but also acceptance and successful implementation in daily practice are crucial for the benefit on patients. Focusing on cardiovascular diseases (CVD), it is still unclear which implementation strategy can improve physician adherence to the recommendations of guidelines in primary care. METHODS: We conducted a systematic review on randomized controlled trials about guideline implementation strategies on CVD. Medline, Embase, CENTRAL, conference proceedings and registers of ongoing studies were searched. RESULTS: Eighty-four trials met our predefined inclusion criteria, of them 54 trials compared unimodal strategies and 30 multimodal strategies to usual care. Concerning unimodal strategies, 15 trials investigated provider reminder systems, 3 audit and feedback, 15 provider education, 4 patient education, 5 promotion of self-management and 14 organizational change. The strongest benefit of a unimodal implementation strategy was found due to organizational change (odds ratio 1.96; 95% CI 1.4 to 2.75), followed by patient education, provider education and provider reminder systems. Trials on the efficacy of audit and feedback and patient self-management showed differing results or small advantages in terms of physician adherence. Multimodal interventions showed almost similar effect measures and ranking of strategies. CONCLUSION: The use of implementation strategies for the distribution of guidelines on CVD can be convincingly effective on physician adherence, regardless whether based on a unimodal or multimodal design. Three distinct strategies should be well considered in such an attempt: organizational changes in the primary care team, patient education and provider education

van Dillen, S. M., van Binsbergen, J. J., Koelen, M. A., et al. (2013). "Nutrition and physical activity guidance practices in general practice: a critical review." Patient Educ Couns **90**(2): 155-169.

OBJECTIVE: The aim of this critical review is to provide insight into the main outcomes of research on communication about nutrition and/or physical activity between GPs and patients for prevention or treatment of overweight and obesity. METHODS: Relevant studies were identified by a computerized search of multiple electronic databases (MEDLINE, PsycINFO) for all available papers between 1 January 1995 and 1 January 2012. In addition, two independent reviewers judged all studies on ten quality criteria. RESULTS: In total, 41 studies were retrieved. More studies were found about the guidance of obese patients than of overweight patients. The most common weight guidance practice was discussion of weight. The range of communication strategies for nutrition showed to be more diverse than for physical activity. Twelve studies were considered as high-quality studies, 18 were having medium quality, and 11 were seen as low quality. CONCLUSION: We reflected on the fact that the content of advice about nutrition and physical activity was quite general. GPs' provision of combined lifestyle advice to overweight and obese patients seems to be rather low. PRACTICE IMPLICATIONS: Observational research is needed to unravel the quality of the advice given by GPs to overweight and obese patients.

Veronovici, N. R., Lasiuk, G. C., Rempel, G. R., et al. (2014). "Discharge education to promote self-management following cardiovascular surgery: an integrative review." Eur J Cardiovasc Nurs **13**(1): 22-31.

BACKGROUND: Nurses have a key role in teaching cardiovascular (CV) surgical patients to manage their post-surgical care after discharge. There is evidence that effective patient teaching contributes to improved quality of life, decreased anxiety and depression and fewer post-CV surgery emergency department visits and hospital readmissions. Despite this, there are no guidelines or standards for how best to educate CV surgical patients for discharge. AIM: To conduct a literature review of published research on discharge education for CV surgical patients to inform guidelines for educating CV surgical patients. METHOD: An exhaustive search of CINAHL, Medline, Web of Science, Cochrane Database of Systematic Reviews, and ERIC was executed using the following search terms: cardiovascular, cardiac, cardio*, heart, surg*, transplant, discharge, self-manage*, teach*, educat*, preop*, patient, care. In addition, an ancestry search of all reference lists was completed. Studies were included if they were published between 2007 and 2012 and focused on preoperative CV surgery adult patient education. RESULTS: The search yielded 20 studies, 12 were excluded because they did not meet the inclusion/exclusion criteria. Eight studies were included in the final review. Three studies reported statistically significant decreases in reported anxiety and depression and increased subjective health. Four studies had mixed results with both positive and neutral findings. No studies reported negative findings in relation to preoperative education. CONCLUSION: Patients and staff identified that patient education is essential. Standardized educational tools are appropriate as they can spare resources, but are only effective if used in conjunction with individualized education.

Villa-Roel, C., Nikel, T., Ospina, M., et al. (2016). "Effectiveness of Educational Interventions to Increase Primary Care Follow-up for Adults Seen in the Emergency Department for Acute Asthma: A Systematic Review and Meta-analysis." Acad Emerg Med **23**(1): 5-13.

OBJECTIVES: Patients with asthma commonly present to emergency departments (ED) with exacerbations. Asthma guidelines recommend close follow-up with a primary care provider (PCP) after ED discharge; however, this linkage is often delayed or absent. The objective of this study was to assess whether ED-directed educational interventions improve office follow-up with PCPs after ED discharge for acute asthma. METHODS: Comprehensive literature searches were conducted in seven electronic databases (1946 to 2014). Randomized controlled clinical trials examining the effectiveness of educational interventions to increase office follow-up with a PCP were included. Study quality was determined using the Cochrane risk of bias tool; fidelity of the interventions was assessed using the Treatment Fidelity Assessment Grid. Using study data, risk ratios (RRs),and the number needed to treat for benefit (NNTB) with 95% confidence intervals (CI) were calculated using random-effects models. RESULTS: From 427 potentially relevant studies, five (n = 825) were included. The overall risk of bias was unclear, and the description of intervention fidelity varied across the studies. Educational interventions targeting either patients or PCPs led to a greater likelihood of having primary care follow-up after ED discharge (RR = 1.6; 95% CI = 1.31 to 1.87; I(2) = 0%). The number needed to treat for benefit was six (95% CI = 4 to 11). No significant benefit was observed in reductions of relapses (RR = 1.3; 95% CI = 0.82 to 1.98; I(2) = 23%) and admissions (RR = 0.51; 95% CI = 0.24 to 1.06; I(2) = 0%). Due to the small number of studies for each comparison, publication bias was not formally assessed. CONCLUSIONS: ED-directed educational interventions targeting either patients or providers increase the chance of having office follow-up visits with PCPs after asthma exacerbations. Their impact on health-related outcomes (e.g., relapse and admissions) remains unclear.

Woods, L., Duff, J., Cummings, E., et al. (2019). "Evaluating the Development Processes of Consumer mHealth Interventions for Chronic Condition Self-management: A Scoping Review." Comput Inform Nurs **37**(7): 373-385.

Innovative, patient-centered mHealth interventions have the potential to help with the burden of chronic conditions. This review aims to describe the development of consumer mHealth interventions for chronic condition self-management. A scoping review methodology was used to search medical databases for eligible reports, published between January 1, 2010, and December 31, 2017, that provided information on consumer mHealth interventions for respiratory disease, cancer, diabetes, and cardiovascular disease. Twenty-one reports were included, representing the development of 14 mHealth interventions. Most were developed collaboratively, using user-centered and participatory design processes. Predesign work involved a thorough needs assessment, and redesign processes were described as iterative, engaging with usability testing and design improvements. Tensions from competing priorities between patients and healthcare professionals were uncovered, with the intention to develop a useful product for the patient while ensuring clinical relevance. This review provides clear evidence that consumer mHealth interventions are developed inconsistently even when engaging with participatory or user-centered design principles, sometimes without direct involvement of patients themselves. Further, the incomplete description of the development processes presents challenges to furthering the knowledge base as healthcare professionals need timely access to quality information on mHealth products in order to recommend safe, effective consumer mHealth interventions.

(2020). "Diminuer les réhospitalisations des patients âgés polymédiqués : une expérimentation prometteuse en Meurthe-et-Moselle." Revue Prescrire(435): 57-61.

Cet article rend compte d'une expérimentation menée à Luneville par des professionnels de santé pour réduire la réhospitalisation des personnes âgées polymédiqués. Au sein d'un programme dénommé Médisis, les patients bénéficient d'un parcours de soins comportant notamment une conciliation médicamenteuse à l'entrée d'une hospitalisation, l'évaluation de la pertinence des prescriptions ainsi que des séances d'accompagnement thérapeutique à l'hôpital et en ville. Au moyen de différents indicateurs, les professionnels de ce programme ont mesuré l'impact sur la qualité des soins.

Wijma, A. J., Bletterman, A. N., Clark, J. R., et al. (2017). "Patient-centeredness in physiotherapy: What does it entail? A systematic review of qualitative studies." Physiother Theory Pract **33**(11): 825-840.

PURPOSE: The literature review is aimed at examining and summarizing themes related to patient-centeredness identified in qualitative research from the perspectives of patients and physiotherapists. Following the review, a secondary aim was to synthesize the themes to construct a proposed conceptual framework for utilization within physiotherapy. METHODS: A systematic search of qualitative studies was conducted including all articles up to 2015 September. Methodological quality was examined with a checklist. The studies were examined for themes suggestive of the practice of patient centeredness from perspective of the therapists and/or the patients. Data were extracted using a data extraction form and analyzed following "thematic synthesis." RESULTS: Fourteen articles were included. Methodological quality was high in five studies. Eight major descriptive themes and four subthemes (ST) were identified. The descriptive themes were: individuality (ST "Getting to know the patient" and ST "Individualized treatment"), education, communication (ST "Non-verbal communication"), goal setting, support (ST "Empowerment"), social characteristics of a patient-centered physiotherapist, a confident physiotherapist, and knowledge and skills of a patient-centered physiotherapist. CONCLUSIONS: Patient-centeredness in physiotherapy entails the characteristics of offering an individualized treatment, continuous communication (verbal and non-verbal), education during all aspects of treatment, working with patient-defined goals in a treatment in which the patient is supported and empowered with a physiotherapist having social skills, being confident and showing specific knowledge.

ÉTUDES FRANÇAISES

(2020). "Diminuer les réhospitalisations des patients âgés polymédiqués : une expérimentation prometteuse en Meurthe-et-Moselle." Revue Prescrire(435): 57-61.

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(2010). "L'association Asalée : une coopération médecins-infirmières." Revue Prescrire **30**(318).

Depuis 2004, en France, des médecins généralistes libéraux et des infirmières salariées de l?Association Asalée collabore dans des cabinets médicaux pour la prise en charge des patients atteints de maladies chroniques. Les infirmières prodiguent des consultations d?éducation thérapeutiques et de prévention, et assurent le suivi des dossiers médicaux. Une étude médico-économique a montré une amélioration de la prise en charge des patients diabétiques de type 2, sans surcoût pour l?assurance maladie. Patients, infirmières et médecins semblent satisfaits de ce mode de collaboration

Ali-Kada, A., Charles, R., Valee, J., et al. (2018). "Education thérapeutique du patient diabétique en médecine générale." Medecine : De La Medecine Factuelle a Nos Pratiques **14**(10): 457-462.

L'éducation thérapeutique occupe une place importante dans le suivi et la prise en charge du patient diabétique de type 2, et doit lui permettre d'acquérir une réelle autonomie.Cet article a pour objectif de décrire les pratiques d'éducation thérapeutique des généralistes auprès de leurs patients diabétiques à partir d'une enquête réalisée par voie postale auprès de 50 % des médecins généralistes du Loiret et de l'Indre. Le taux de réponse a été de 51,5 %, soit 24,6 % des généralistes des deux départements ; 96,90 % des médecins généralistes répondeurs disaient pratiquer l'éducation thérapeutique ; 72,56 % estimaient manquer de temps ; 56,73 % la définissaient comme un enseignement concernant majoritairement le savoir (95,87 % de ceux qui parlent d'enseignement) ; 53,80 % des niveaux de négociation étaient du type dépendance/expertise. Les médecins adhérant à un réseau insistaient davantage sur le partenariat, le dialogue et l'écoute et étaient plus nombreux à avoir un type de négociation partenariat/coopération (81,25 % de ces médecins disaient utiliser le réseau comme ressource d'éducation) que les médecins hors réseau. Pour améliorer l'éducation thérapeutique de leurs patients, 21,64 % des médecins souhaitaient plus de temps et 15,79 % étaient demandeurs de plus de structures ou de leur amélioration. Les médecins généralistes ont une vision incomplète de la nature de l'éducation thérapeutique et connaissent peu ou mal les outils qu'ils peuvent proposer, alors qu'ils en utilisent sans doute déjà, et les structures sur lesquelles ils peuvent s'appuyer. Les méthodes d'éducation thérapeutique au cours de consultations de médecine générale prennent peu de temps, mais nécessitent des savoirs, savoir-faire et savoir-être qui ne sont pas enseignés en formation initiale. Une formation spécifique à l'éducation thérapeutique doit être réalisée dans le cursus universitaire et en formation continue. Le temps nécessaire à ces pratiques doit être reconnu et valorisé. Les médecins peuvent s'appuyer sur des structures existantes : services hospitaliers, réseaux, maisons du diabète. De nouvelles coordinations des tâches sont à développer autour de l'autonomie des patients.

Alvino, I. (2012). "[Implementing a patient education program in an outpatient health center]." Soins(764): 37-39.

Freelance health professionals have been brought together around a healthcare project which they created forming an outpatient multi-disciplinary team and health centre. This new organisation favours the recognition and remuneration of a new field of skills: the therapeutic education of patients suffering from chronic diseases.This new care is only provided after the professionals have received relevant training and in accordance with various constraints defined by law.

Arnould, P., Raineri, F., Hebbrecht, G., et al. (2011). "[Feasibility, in general practice, to give to the patients clear, loyal and appropriate information about the undesirable side effects of the medicines prescribed. EICLAT study]." Rev Prat **61**(10): 1394-1399.
http://www.ncbi.nlm.nih.gov/pubmed/22288353

Drug prescription in general practice is present in 78 to 83% of consultations; practitioners must give to their patient clear loyal and appropriate information about the undesirable side effects of the medicines prescribed. The object of the EICLAT study was to give some light on the feasibility to respect this obligation. To that effect the study evaluates, for a normal prescription activity, the average number of potential undesirable side effects (USE) in relation with the number of lines of different medicines prescribed in each doctor's prescription. A total of 8,382 doctor's prescriptions, generating 34,427 lines of prescriptions given by 175 general practitioners, were analysed. Amongst these prescriptions, 11% included only one line, 55% from 2 to 4 lines and 34% 5 lines or more. The average doctor's prescription was of 4 lines of medicines generating 407 potential USE, of which 194 were different (the same undesirable effect may be present twice or more in the same doctor's prescription), and 293 frequent or serious potential USE, of which 166 were different. The patent medicines with a major or important added medical value (AMV), present in 7,840 doctor's prescriptions for a total of 24,127 lines exposed the patient, in the average, to 151 frequent or serious USE different. The patent medicines with an insufficient AMV, present in 2,292 prescriptions for a total of 3,887 lines, exposed the patient to 37 frequent and/or serious potential USE. Supposing that the information provided by the legal authority is sufficiently adequate, precise and exhaustive, the volume of information that must be given to the patient is not compatible with the present conditions of exercise of the profession

Assyag, P., Renaud, T., Cohen-Solal, A., et al. (2009). "RESICARD: East Paris network for the management of heart failure: Absence of effect on mortality and rehospitalization in patients with severe heart failure admitted following severe decompensation." Archives of Cardiovascular Diseases **102**(1).
http://www.em-consulte.com/article/201927

L'insuffisance cardiaque (IC) représente un problème de santé publique majeur, lié à sa forte prévalence, et à l?augmentation croissante des hospitalisations. Une coordination de médecins généralistes et de cardiologues de ville et hospitaliers de l'Est de Paris s'est constituée dans le cadre d?un réseau ville-hôpital afin de maintenir à domicile les patients insuffisants cardiaques graves

Audureau, E., Merle, V., Kerleau, K., et al. (2010). "[Information for patients about hospital infections in psychiatry: An assessment of healthcare professionals' knowledge, opinion and attitude]." Encephale **36**(2): 132-138.

INTRODUCTION: French legislation makes mandatory for healthcare providers the disclosure of hospital infection (HI) risk and actual occurrence to the patient. Given the specific diseases encountered in psychiatry, some difficulties may be expected in practical application of this regulation. OBJECTIVES: The aim of our study was to describe the knowledge, declared practices and opinions of healthcare workers (HCW) in psychiatry concerning information for patients about HI. METHODS: We randomly selected doctors, nurses and head nurses from four hospitals with psychiatric activity in Normandy. The HCW were asked to self-complete an anonymous questionnaire, including data describing the responding HCW and questions aiming at describing his/her knowledge, attitude in routine daily practice and opinion about information to patients about HI. RESULTS: One hundred and forty-one HCW were initially selected, of which 114 (80.9%) eventually agreed to complete the questionnaire. Only eight HCW (7.0%) were considered to have a correct overall knowledge of legal obligations. Main errors concerned the obligation to inform the patient of the HI risk according to the medical procedures that are to be performed (43.9% of correct answers) and the obligation to inform the patient of the HI risk according to his/her medical condition (46.5%). The obligation to inform the patient of the occurrence of a HI was largely known (84.2%). HCW usually giving information about the risk of HI to patients without HI accounted for 5.3%. Main reasons advocated for not informing patients were a low level risk of HI in psychiatry (80.4%) and the lack of patients' demand (59.8%). In the case of HI occurrence, the percentage of HCW routinely informing patients was 13.2%. HCW systematically informing the patient's family about the occurrence of HI accounted for 9.6%. A large proportion of HCW supported delivering information to patients about HI (86.0%). HCW expected from information better approval of prevention programs by the patients (87.7%) but feared an increased anxiety in patients (75.4%) and a higher rate of care refusal (48.2%). CONCLUSION: Whereas a very large proportion of HCW in psychiatry support delivering information to patients about HI, our study shows HCW's lack of awareness of regulations and lack of declared practices. Among factors explaining this contrast, a lower perceived HI risk and severity level are to be mentioned. Training programs focusing on risk and mechanisms of HI could be offered to professionals in psychiatry. The issue of specific communication difficulties with psychiatric patients should be addressed as well. In order to develop information on HI, specific methods suited to those patients should be developed.

Auger, F. et Gradeler, J. D. (2010). "ETP : un regard "Balintien"." REVUE DU PRATICIEN MEDECINE GENERALE **24**(847): 650-651.

Cet article nous présente le regard d'un médecin "balintien" sur l'éducation thérapeutique du patient telle qu'elle est aujourd'hui définie par la loi HPST du 21 juillet 2009 et par le programme SOPHIA de l'Assurance maladie. Cette approche institutionnelle de l'ETP questionne le médecin formé aux concepts de Michael Balint et intéresse par la dimension relationnelle avec le malade car elle souffre d'une absence de reconnaissance du róle du médecin généraliste et d'approche personnalisée du malade.

Aulagnier, M., Videau, Y., Combes, J. B., et al. (2007). "Pratiques des médecins généralistes en matière de prévention : les enseignements d'un panel de médecins généralistes en Provence-Alpes-Côtes d'Azur." Pratiques Et Organisation Des Soins **38**(4).
http://www.ameli.fr/fileadmin/user_upload/documents/Medecins_generaliste.pdf

[BDSP. Notice produite par CNAMTS GR0x8n99. Diffusion soumise à autorisation]. Une enquête téléphonique a été réalisée auprès d'un panel de 600 médecins généralistes libéraux exerçant en région PACA pour décrire leurs attitudes et pratiques dans le domaine de la prévention et de l'éducation à la santé et en identifier les déterminants

Aycaguer, S., Vilchien, D., Magar, Y., et al. (2012). "Accompagner l'entrée dans la maladie du "jeune parkinsonien" : place du généraliste." Concours Medical // **134**(4).

[BDSP. Notice produite par ORSRA GpjR0xlq. Diffusion soumise à autorisation]. La maladie de Parkinson concerne aussi les personnes de moins de 60 ans. Le rôle du généraliste est essentiel pour accompagner le patient à modifier sa représentation de la maladie et l'amener à continuer à faire des projets. Dans le programme d'éducation thérapeutique, le médecin se doit, dans un premier temps, d'être un soutien psychologique et/ou d'orienter le patient vers les associations de patients. Dans un second temps il doit informer le patient sur le traitement médicamenteux

Balcou-Debussche, M. (2012). "[Patient education: between complex knowledge, educators, heterogeneous learners and multiple contexts]." Rech Soins Infirm(110): 45-59.

Therapeutic patient education questions the links between medical and social sciences through epistemological, praxeological, and ethical issues. Its development in France and abroad necessary invites to consider the complexity of the particularities and variations of numerous contexts. The present contribution examines the theoretical foundations and the conditions required for the development of integrative learning situations, which involve both persons with chronic diseases and educators who have beneficiated from diverse socialisations. These learning situations have been worked out across three distinct stages: prerequisite analysis of specific knowledge at stake and of learners' representations preceding the thorough design of procedures that can yield results with heterogeneous individuals of various cultural and social origins. More than ten thousands persons have beneficiated from these learning situations courses. Results underline the development of emerging social dynamics and organisations beyond the learning process. These analysis invite to the reflection on social and contextual dimensions of learning, on the access to knowledge for persons with chronic diseases and the opportunities to develop the approach by diverse educators and trainers from various areas.

Barrier, P. (2009). "Éducation thérapeutique, un enjeu philosophique pour le patient et son médecin." Actualite Et Dossier En Sante Publique(66): 57-58.

[BDSP. Notice produite par EHESP rJ8rrR0x. Diffusion soumise à autorisation]. La réciprocité des apprentissages, qui est l'objet de l'éducation thérapeutique, change la nature des relations entre le patient et le médecin. L'éducation est la meilleure défense contre l'échec thérapeutique, mais ne l'exclut pas mécaniquement : elle permet seulement au soin d'aller jusqu'au bout de ses limites. Pour le médecin, l'éducation thérapeutique lui apporte la possibilité de se libérer du paternalisme et du technicisme, qui occultent souvent la dimension réellement éducative du soin. Elle lui permet également de retrouver le sens le plus profond de la clinique, sans laquelle la médecine perd son caractère essentiel d'humanisme et d' "art de la vie".

Beauvais, C., Rodère, M., Pereira, B., et al. (2019). "Essential knowledge for patients with rheumatoid arthritis or spondyloarthritis: Results of a multicentric survey in France among health professionals and patients." Joint Bone Spine **86**(6): 747-752.

OBJECTIVE: Information and education are recommended for patients with inflammatory arthritis including rheumatoid arthritis (RA) and spondyloarthritis (SpA). However, there is no consensus on which knowledge is essential to enhance patients' self-management. The aim of this study was to determine such knowledge. METHODS: Based on published knowledge questionnaires (KQs) collected by a systematic literature review, a list of items was elaborated, classified in domains and sub domains. A Delphi process was performed with rheumatologists, healthcare professionals and patients in 2014-2015, selecting the items considered useful. RESULTS: Three published KQs were analysed: 2 for RA; 1 for SpA and 5 unpublished KQs were collected. In the KQs, 90 knowledge items were mentioned for RA and 67 for SpA. The 1(st) Delphi round enlarged the list to 322 items for RA and 265 items for SpA. The second round selected 69 and 59 knowledge items for RA and SpA respectively, of which 36 (52%) and 34 (57%) were not present or modified from the published KQs. Key domains included treatment strategies, managing cDMARDs and bDMARDs, managing symptomatic medications. Knowledge on non-pharmacological treatment concerned pain and fatigue, physical activity, adaptative skills to personal and professional environment, patient-HP communication and shared decision-making. CONCLUSION: The present study provides a corpus of knowledge considered essential for patients in the self-management of their arthritis. The selection of many items reflects recent emphasis on professional recommendations and the patients' perspective. Future work should lead to the development of new updated KQs for patients with inflammatory arthritis.

Ben, A. A., Soltane, I., Gaha, K., et al. (2006). "Facteurs déterminants du contrôle glycémique des patients diabétiques de type 2 suivis en première ligne." Revue D'Epidemiologie et de Sante Publique **54**(5).

[BDSP. Notice produite par ORSRA UOR0xxY3. Diffusion soumise à autorisation]. L'objectif de cette étude est d'identifier les facteurs déterminants du contrôle glycémique chez les patients diabétiques de type 2 suivis en première ligne dans la région sanitaire de Sousse. Méthodes : Il s'agit d'une étude épidémiologique descriptive transversale menée auprès d'un échantillon représentatif des patients diabétiques de type 2 et suivis depuis deux ans au moins. Les données ont été collectées à partir d'une compilation de trois sources de données : un questionnaire des patients, une grille d'analyse des

> dossiers médicaux et un dosage de l'hémoglobine glyquée (HbA1c) par immunoturbidimétrie. Le contrôle glycémique a été mesuré en se référant aux recommandations de l'American Diabetes Association (ADA) : "bon contrôle" si HbA1c=7%. Résultats : Cette étude a porté sur un échantillon de 404 patients diabétiques de type 2, ayant un âge moyen de 60,5 ans+/-10,89 et un sex-ratio de 0,5. L'ancienneté moyenne de la maladie diabétique était de 8,7 ans+/-6,10. Seulement 16,7% de l'ensemble de la population à l'étude avaient atteint l'objectif recommandé par l'ADA. L'étude multivariée par régression logistique contrôlant un ensemble de variables en rapport avec le patient, la famille, la maladie, le traitement et la structure de soins, a identifié seulement deux facteurs associés d'une manière indépendante et statistiquement significative à un mauvais contrôle glycémique : la mauvaise accessibilité géographique de la structure de soins (OR ajusté : 1,89, p=0,009) et un indice de masse corporelle (IMC)=30 kg/m2 (OR ajusté : 2,2, p=0,034). Conclusion : Le contrôle glycémique des patients diabétiques de type 2, d'une part, est insuffisant et, d'autre part, dépend de l'accessibilité géographique de la structure de soins, certes meilleure dans les centres de santé. D'où l'importance d'adresser les patients diabétiques de type 2 à leur centre de santé le plus proche lorsque cela est possible

Ben Nasr, N., Rouault, A., Cornillet, N., et al. (2018). "Evaluation of a hypertension-based patient education program in a stroke center." Int J Clin Pharm **40**(6): 1490-1500.

> Background The benefits of educational programs are recognized in chronic diseases. An education program was designed in our hospital, for hypertensive patients after an acute episode of stroke to prevent stroke recurrence. Objective Evaluate the effects of such program on patient knowledge and blood pressure management. Setting The 12-bed stroke center of the Groupe Hospitalier Paris Saint-Joseph, France. Method An individual educational session was provided to all the patients by the pharmacist a few days after admission. The effectiveness of the session was evaluated using a questionnaire completed by each patient before and after education. The patients had to identify the correct responses and to judge their answer's self-confidence. The answers were ranked based on their accuracy and the surety of the respondent. Reported medication adherence and self-measurement of blood pressure were analyzed as part of the survey. Patient satisfaction with the intervention was also measured by means of a separate questionnaire. Main outcome measure Evolution of response correctness and self-confidence as well as medication adherence and blood pressure self-measurement practice. Results 64 patients were enrolled. Correct response rate increased from 77.9 to 94.1% and the absolutely sure response rate raised from 52.9 to 80.8%. Patient self-confidence was improved mainly for correct responses. Patients reported a better medication adherence and a more frequent practice of blood pressure self-measurement. They were highly satisfied. A negative correlation was found between knowledge evolution and baseline knowledge. Conclusion Education can improve stroke patient knowledge, which may enhance medication adherence and blood pressure control. Such programs should be developed even early after a stroke.

Bourgueil, Y. (2009). "Collaboration médecin-infirmière au cabinet de médecine générale : un plus pour le suivi des patients diabétiques de type 2." Reseaux Diabete(39).

Bourgueil, Y., Le Fur, P., Mousques, J., et al. (2008). La coopération entre médecins généralistes et infirmières pour le suivi des patients diabétiques de type 2. Evaluation médico-économique de l'expérimentation ASALEE. Rapport Irdes ; 1733. Paris : Irdes
http://www.irdes.fr/Publications/Rapports2008/rap1733.pdf

> Cette recherche évalue l'efficacité et les coûts d'une expérimentation de coopération entre généralistes et infirmières dans la prise en charge des patients diabétiques de type 2. Les infirmières ont pour rôle principal de gérer les données informatisées (dossier patient et rappels informatiques) et de dispenser des consultations d'éducation thérapeutique. La méthode d'évaluation est rétrospective, avant/après, contrôlée. L'évaluation de l'efficacité repose sur la mesure de l'amélioration, sur une année, des taux de réalisation des examens recommandés et du contrôle de l'équilibre glycémique (HbA1c). L'évaluation des coûts repose sur la comparaison de l'évolution sur deux années consécutives des coûts directs. Cette expérimentation de coopération s'avère être efficace sans dépense significativement majorée pour l'Assurance Maladie. L'apport bénéfique de

l'action des infirmières est également clairement démontré tant pour l'amélioration de l'équilibre glycémique (éducation thérapeutique) que pour celui de la qualité du suivi (gestion des dossiers patients et rappels informatiques).

Bourgueil, Y., Le, f. P., Mousques, J., et al. (2008). "La coopération médecins généralistes/infirmières améliore le suivi des patients diabétiques de type 2. principaux résultats de l'expérimentation ASALEE." Questions D'economie De La Sante (Irdes)(136).
http://www.irdes.fr/Publications/Qes/Qes136.pdf

ASALEE, Action de Santé Libérale En Equipe, associe, dans le département des Deux-Sèvres, 41 médecins généralistes et 8 infirmières afin d'améliorer la qualité des soins, notamment des patients atteints de maladies chroniques. Lancée en 2004, elle représente la seule expérimentation de coopération entre professionnels de santé portant sur les soins de premiers recours. Les infirmières se voient confier par les médecins la gestion informatique de certaines données du patient et des consultations d'éducation thérapeutique, selon un protocole bien défini. Une évaluation médico-économique du dispositif ASALEE a été menée par l'IRDES. Centrée sur les patients atteints de diabète de type 2, qui représentent un tiers de l'activité des infirmières, l'étude montre que les patients inclus dans le dispositif voient leur équilibre glycémique s'améliorer davantage que dans le groupe témoin. Ils réalisent également plus systématiquement les examens de suivi et cela sans coût supplémentaire significatif pour l'assurance maladie. Les modalités de l'étude imposent toutefois que ces résultats soient confirmés par des analyses complémentaires

Bourit, O. et Drahi, E. (2007). "Education thérapeutique du patient en médecine générale : une enquête dans les departements de l'Indre et du Loiret." Medecine : De La Medecine Factuelle a Nos Pratiques **3**(5): 229-234.

L'éducation thérapeutique occupe une place importante dans le suivi et la prise en charge du patient diabétique de type 2, et doit lui permettre d'acquérir une réelle autonomie. La plupart des médecins généralistes disent pratiquer l'éducation thérapeutique, définie essentiellement comme un enseignement portant sur les connaissances, c'est-à-dire un transfert d'informations dans le cadre d'une relation du type "dépendance/expertise". Les deux objectifs principalement cités portent sur les données biomédicales et comportementales (changements "contraints"). Pour cette pratique éducative, ils citent très peu les techniques pédagogiques. Il semble donc exister la fois un problème de formation spécifique de l'éducation thérapeutique et de reconnaissance et valorisation du temps nécessaire ces pratiques. Les médecins peuvent s'appuyer sur des structures existantes (qu'ils semblent cependant mal connaître) qui supposent le développement de nouvelles coordinations des tâches autour de l'autonomie des patients.

Bournot, M. C., Cercier, E., Goupil, M. C., et al. (2011). Education thérapeutique, hospitalisation à domicile et loi Léonetti : perception des médecins généralistes des Pays de la Loire. Loire. Nantes : ORS.
http://www.urml-paysdelaloire.fr/upload/pdf/2010panel1_V4_rapport.pdf

Ce document présente les résultats d'une enquête menée en 2009 auprès de 450 praticiens de la région faisant partie du panel d'observation des pratiques et des conditions d'exercice en médecine générale. Il décrit leurs connaissances et perceptions en matière d'hospitalisation à domicile. Il analyse leur intérêt pour l'éducation thérapeutique et sa mise en oeuvre en médecine ambulatoire. Il apporte enfin des informations sur les pratiques concernant l'accès au dossier médical et l'utilisation des directives anticipées.

Bras, P. L. (2011). "Peut-on réformer l'organisation des soins de premier recours ?" Seve : les Tribunes de la Sante //(30).

Le système de soins de premier recours est confronté, en France, à un double défi : d4une part la diminution prévisible du temps médical, d4autre part la nécessité d4enrichir le contenu des prises en charge, notamment des patients chroniques. L4externalisation de certaines fonctions (éducation thérapeutique, accompagnement des patients) en dehors des cabinets de médecine générale en constituant en leur sein des équipes composées de médecins et d'infirmières. Les conditions en matière de définition des fonctions, de formation ou de modes de rémunération sont loin d'être réunies pour que ce mode d'organisation puisse s'implanter en France. Il faut donc envisager une action volontariste des pouvoirs publics : financer les infirmières qui souhaiteraient travailler au sein des cabinets de médecine générale volontaires pour ce nouveau mode d'exercice.

Bros, B., Fontan, G., Fostier, P., et al. (2010). "Pratique de l'éducation thérapeutique des médecins généralistes en Midi-Pyrénées." INFO DES GENERALISTES - URML MIDI-PYRENEES(3): 2-3.

L'URML Midi-Pyrénées a souhait� interroger les médecins généralistes de la région Midi-Pyrénées es sur leur pratique d'éducation thérapeutique (ET) pour identifier leurs difficultés et leurs attentes vis-à-vis de l'ET et pour mieux l'intégrer dans leur exercice. Une enquête a été mise en place, elle s'est appuyée sur un questionnaire explorant quatre thèmes : les conditions d'exercice et les caractéristiques de la patientèle ; le bilan sur les connaissances et pratiques d'ET ; les principales difficultés entraînant des freins à la mise en oeuvre de l'ET ; les principales attentes vis-à-vis de l'ET et les facteurs d'intégration dans la pratique. L'analyse des résultats a été réalisée par l'Observatoire Régional de la Santé de Midi-Pyrénées.

Bucher, S. (2018). Type 2 Diabetes Mellitus and non Institutionnalized Patients Aged 65 and Over : Primary Care Management - The S.AGES Cohort, Université Paris Saclay (COmUE).
https://tel.archives-ouvertes.fr/tel-01842146

La prévalence du diabète de type 2 augmente à travers le monde du fait de l'obésité et du vieillissement de la population. En France, cette prévalence est estimée à 14 % chez les plus de 65 ans et à 25 % pour les plus de 75 ans. Les médecins généralistes sont les médecins de premier recours dans la prise en charge du diabète. Les récentes recommandations de prise en charge du diabète de type 2 chez les sujets âgés préconisent d'ajuster la cible thérapeutique (niveau d'HbA1c) à l'état de santé du patient. Cependant, il peut s'avérer difficile pour les médecins généralistes d'estimer cet état de santé dans leur pratique courante. Une façon de faire est d'estimer l'âge apparent des patients par rapport à leur âge chronologique (font-ils plus vieux ou plus jeunes que leur âge, font-ils leur âge ?).Les objectifs de ce travail étaient 1) d'analyser la prise en charge médicale en soins primaires de sujets âgés diabétiques, en particulier l'association entre l'atteinte de la cible d'HbA1C personnalisée recommandée et la survenue d'événements cliniques majeurs ; 2) de déterminer si l'estimation de l'âge apparent est prédictive de la mortalité sur 3 ans de suivi.La cohorte S. AGES est une étude prospective multicentrique de patients de plus de 65 ans non institutionnalisés ayant une fibrillation auriculaire, un diabète de type 2 ou des douleurs chroniques. Trois ans de suivi étaient prévus. Des modèles logistiques mixtes ont été utilisés pour la plupart des analyses. D'avril 2009 à juin 2011, 760 médecins généralistes ont inclus 3434 patients : 1379, 983, 1072 dans la sous-cohorte douleurs chroniques, diabète et fibrillation auriculaire respectivement. Leur âge moyen était de 77,6 ± 6,2 ans et 56,6 % étaient des femmes. La plupart étaient autonomes, 70% n'avaient pas de troubles cognitifs et 20% des patients avaient un niveau d'études supérieur au baccalauréat. Dans la sous-cohorte diabète, la durée du diabète était de 11,3 ± 8,7 ans avec un taux d'HbA1c moyen de 6,9± 1,0% ; 20 % des patients avaient une complication macrovasculaire, 33 % une insuffisance rénale. La metformine était le premier traitement antidiabétique utilisé et 18 % des patients étaient sous insuline.Parmi les 747 patients analysés à l'inclusion, 551 (76,8 %) atteignaient leur cible d'HbA1C personnalisée recommandée. Au cours du suivi, 391 (52,3%) ont présenté un événement majeur. Parmi les patients qui n'ont pas atteint leur cible d'HbA1C personnalisée (par rapport à ceux qui l'ont atteint), le risque (OR) d'un événement clinique majeur était de 0,95 [IC 95% 0,69 - 1,31], p = 0,76. Les risques de décès, d'événements artériels et d'hospitalisations étaient respectivement de 0,88 [IC à 95% 0,40-1,94], p = 0,75, 1,14 [IC à 95% 0,71-1,83], p = 0,59 et 0,84 [IC à 95% 0,60 - 1,18], p = 0,32.Nos résultats n'ont montré aucune différence, de risque d'événement clinique majeur au cours du suivi entre les patients, qu'ils aient ou non atteint leur cible d'HbA1c recommandée. Parmi les 3434 patients inclus dans les 3 sous-cohortes, 3427 ont été classés en 3 catégories : faire leur âge, faire plus âgés ou plus jeunes. La dépression, la perte d'autonomie, l'insuffisance cardiaque et l'obésité était associés à un risque plus élevé de faire plus âgé, alors que l'absence de dépression, une autonomie conservée et un niveau d'études élevé était associé à un risque plus élevé de faire plus jeune. L'âge apparent était associé au risque de décès au cours du suivi de trois ans : les patients faisant leur âge ou plus âgés avaient un risque de décès plus élevé que ceux faisant plus jeunes : HR=1,27 (0,93-1,73) et 1,79 (1,16-2,76), respectivement (p = 0,008). Nos résultats soutiennent l'hypothèse qu'une stratégie plus permissive pour traiter le diabète de type 2 chez les patients âgés peut être mise en œuvre sans augmenter le risque d'événement clinique majeur. L'âge apparent peut-être considéré comme un marqueur de l'état de santé rapide et facile en soins primaires.

Cadiot, F. et Verdoux, H. (2013). "[Patient therapeutic education in psychiatry. A survey of practice in Aquitaine public hospitals]." Encephale **39**(3): 205-211.

OBJECTIVE: The aims of this study were to assess the characteristics of therapeutic education practice in French public psychiatric hospitals and to describe the ongoing patient education programs. METHODS: We conducted an online survey. Adult and child psychiatrists (n=264) of Aquitaine's public hospitals (n=9) were asked to describe their daily educational practice using an internet questionnaire. Coordinators of patient education programs were invited to complete a specific questionnaire describing these programs. RESULTS: Of the 264 psychiatrists contacted, 95 participated in the only survey (participation rate 36%), 85.7% were adult psychiatrists and 14.3% child psychiatrists. Most psychiatrists (85% or more) "always or often" educated their patients on the disease (name, etiology, symptoms), its treatment and the prevention of relapses and complications. Other mental health professionals, such as nurses, were rarely involved in this educational process. Less than a quarter of the psychiatrists "always or often" invited their patients to participate in a structured patient education program. Twelve education programs were described by their coordinators (13.6% of the participants). Compared to non-coordinators, coordinators had graduated significantly more frequently less than 10years before (92% vs. 49%) but did not differ regarding other characteristics. Bipolar disorder (n=4) and schizophrenia (n=7) were the most frequent indications of these programs. Half of the programs were distributed by pharmaceutical companies. Almost half (45%) of the programs were opened to patient's carers and relatives. Increase in knowledge and competence were evaluated in 73% of the programs, and satisfaction in 64% of the programs. These findings have to be interpretated in the light of a possible selection bias favouring the participation of practitioners supporting or actively implicated in patient education, contributing to inflated estimates of the real frequency of educational practice in public psychiatric hospitals. CONCLUSION: On the one hand, our study shows a strong involvement of psychiatrists in patient therapeutic education in daily practice. On the other hand, very few structured programs were ongoing, mostly concerning bipolar disorder and schizophrenia, i.e. disorders for which evidence of efficiency of patient education has been demonstrated. These findings suggest that implementation of further patient education programs should be encouraged and that formation of further professionals is a priority.

Cnam (2013). Action Assurance Maladie 2013. Éducation à la santé et prévention primaire, une culture pour l'Assurance maladie ?. Paris : Cnam ; Ciss.
http://www.unaf.fr/IMG/pdf/dossier_preventionv5.pdf

Convaincus que l'amélioration de l'état de santé des usagers résidents en France peut être obtenue grâce à un investissement sur l'éducation à la santé et la prévention, l'UNAF, le CISS et la FNATH souhaitaient situer le débat sur un champ marginal en termes de dépenses de santé et pourtant crucial pour éviter leur inflation et améliorer notre qualité de vie : la prévention primaire, qui comprend tous les actes destinés à diminuer l'incidence d'une maladie dans une population, donc à réduire le risque d'apparition de cas nouveaux. L'UNAF, le CISS et la FNATH ont ainsi enquêté sur les actions menées par l'Assurance maladie, qu'elles résultent de la déclinaison de programmes nationaux ou qu'elles émanent d'initiatives locales

l'observance thérapeutique, Paris : Dunod

L'observance est le fait pour un patient de suivre les recommandations faites par son médecin : prendre un traitement, suivre un régime spécifique, arrêter de fumer… Mais nombreux sont ceux qui ne suivent pas l'ordonnance prescrite : la non-observance est devenue un enjeu majeur de santé publique, avec des conséquences graves sur l'efficacité thérapeutique, la guérison des malades et les coûts de santé. Elle impacte aussi la qualité de vie du patient et de ses proches. Et si les techniques de négociation étaient un outil efficace pour améliorer l'observance ? En tant que négociateurs professionnels, les auteurs de cet ouvrage transmettent leur expertise. Médecins, équipes soignantes, pharmaciens, proches de patient… ils vous livrent leurs techniques à travers 12 histoires vraies. Des histoires de vie autour de la relation médecin-patient, dans lesquelles vous vous reconnaitrez peut-être, pour agir contre la non-observance.

Corbeau, C., Boegner, C., Fassier, M., et al. (2013). "Solidarité diabète : patients et professionnels, partenaires dans l'éducation thérapeutique de personnes diabétiques en situation de précarité." Santé Publique **25**: 225-233, tabl.

[BDSP. Notice produite par EHESP R0x9q9r8. Diffusion soumise à autorisation]. Des rencontres de patients et de professionnels ont été organisées pour expérimenter et proposer des recommandations d'éducation thérapeutique. Ce groupe a rassemblé une dizaine de personnes confrontées à des difficultés socioéconomiques et d'équilibre du diabète, une dizaine de professionnels de santé confrontés aux difficultés d'éducation du patient avec le public en précarité et un membre d'association de patients. Ils ont mis en exergue l'importance des liens entre patients, entre professionnels et patients et entre professionnels pour leur mobilisation et la pérennité d'un programme.

Cornet, P. (2013). "Education thérapeutique au cabinet du médecin généraliste : place et limites de l'entretien motivationnel." Medecine : Revue de L'Unaformec/ **9**(7).

L'entretien motivationnel est un outil et une étape majeure dans le processus d'éducation thérapeutique, à la fois continu et discontinu. Continu et soumis à une triple temporalité : celle de l'évolution de la maladie, celle du patient qui en souffre et celle du médecin impliqué dans la relation de soin ; discontinu au rythme des consulttations mais aussi des phase de progression/régression. L'entretien motivationnel s'appuie s'appuie sur l'authenticité du médecin et de son empathie, une même authenticité et un désir de changement de la part du patient. Il ne prend pas en compte le préalable des représentations sociales qui conduisent pour l'essentiel celles du patient et celles du médecin

Deau, X. (2007). "[The doctor-patient-internet relationship: the point of view of a general practitioner]." Bull Acad. Natl Med **191**(8): 1497-1502.
http://www.ncbi.nlm.nih.gov/pubmed/18666450

The doctor-patient relationship is evolving with the advent of new technologies and new legal obligations. In particular, it is now stipulated in France that "Information has to be trustworthy, clear and tailored to the patient... the doctor's explanations must be understandable and take the patient's individuality into account. "In this respect, is the web a plus or a minus in the doctor-patient relationship?

Devineau, V. (2012). "[Patient education and regional healthcare requirements]." Soins(764): 35-36.

In the Pays de la Loire, only 3% of patients suffering from a long-term condition have access to a therapeutic education programme (TEP), mainly implemented in hospitals. A campaign is underway to promote the development of therapeutic education programmes on a regional level, notably by raising awareness of its benefits and coordinating the offer in cooperation with primary care workers and those working in the social sector. The aim is to improve patients' quality of life and to reduce repeated hospitalisations by providing "keys" for the preservation of patients' health status.

D'Ivernois, J.-F. et Gagnayre, R. (2017). "L'éducation thérapeutique. Une pédagogie au service de la santé publique." Actualite Et Dossier En Sante Publique(100): 76-79.

[BDSP. Notice produite par EHESP JktCR0x9. Diffusion soumise à autorisation]. En 2001, ADSP publiait son premier article sur l'éducation thérapeutique, huit ans avant son organisation par la loi HPST. En 2009, un dossier complet de la revue lui était consacré, abordant le sujet de l'éducation thérapeutique sous plusieurs angles, conceptuel, méthodologique, organisationnel, politique, économique. Depuis, nous avons assisté à un développement spectaculaire de l'éducation thérapeutique du patient.

Fantino, B., Wainsten, J. et Bungener, M. (2007). "Représentations par les médecins généralistes du rôle de l'entourage accompagnant le patient." Sante Publique //(3).

[BDSP. Notice produite par ENSP R0x28nuJ. Diffusion soumise à autorisation]. L'objectif de cette étude est de décrire la perception des médecins généralistes du rôle et de la place de l'entourage accompagnant le patient en consultation. 435 médecins représentatifs de leur profession ont rempli deux questionnaires, l'un auto-administré déclaratif, l'autre décrivant trois situations cliniques réelles et la place des accompagnants en cas de maladie d'Alzheimer, de maladie de Parkinson, de dépression, d'épilepsie, d'asthme, d'insuffisance cardiaque ou de diabète de type 2. Les médecins pensent répondre de façon globalement satisfaisante aux attentes de l'entourage concernant la maladie et son traitement mais s'estiment peu compétents pour les questions administratives et sociales. Le rôle de l'accompagnant est majoritairement perçu comme positif et contributif à l'efficacité des soins. Cette étude correspond à la nouvelle donne de l'exercice médical moderne, dominé par le poids des pathologies chroniques et invalidantes impliquant la présence d'un tiers

Fayard, J. L., Tyrawski, S. et Bourgeois, O. (2012). "Éducation thérapeutique du patient obèse : Quelle place pour le médecin généraliste ?" Concours Medical // **134**(2).

[BDSP. Notice produite par ORSRA GEpFR0x8. Diffusion soumise à autorisation]. Les recommandations de la Haute Autorité de Santé (HAS) pour la prise en charge du patient obèse ou en surpoids vise à changer les habitudes alimentaires et augmenter l'activité physique. L'obésité étant une maladie chronique multifactorielle, le médecin généraliste se trouve donc au premier plan pour effectuer un suivi programmé et établir démarche éducative pour modifier le comportement du patient

Fayn, P. G., Des Garets, V. et Bura-Riviere, A. (2017). "Mieux comprendre le processus d'empowerment du patient." Recherches En Sciences De Gestion(119): 55-73.

Co-décideur de son traitement, co-rédacteur des lois, le patient est sorti du silence et de l'invisibilité. Sa prise de pouvoir s'étend à la production de connaissances et de solutions nouvelles. Cet article propose une meilleure compréhension du processus d'empowerment du patient chronique. Après une revue de littérature multidisciplinaire autour des concepts d'empowerment et de Patient-Centered-Care, une étude exploratoire a été réalisée auprès de quatre experts. Elle conduit à l'identification de quatre phases structurant le processus d'empowerment du patient : individuel, collectif, collaboratif et productif. Phénomène social, l'empowerment des patients transforme la relation de soin en une nouvelle alliance plus symétrique.

Foucaud, J. (2012). "[Coordination and promotion of policies favoring patient education]." Soins(764): 32-34.

In the framework of therapeutic patient education (TPE), the definition of the actors' skills is an issue of growing importance. Work in this area has recently been carried out by the French national institute for prevention and health education (INPES).This work highlights a function which is seldom documented in literature: the coordination of TPE policies.

Foucaud, J., Bury, J. A. et Balcou-Debussche, M. (2010). Éducation thérapeutique du patient : modèles, pratiques et évaluation, St Denis : INPES

Issu d'une collaboration entre l'INPES et des acteurs de l'éducation thérapeutique du patient, cet ouvrage rassemble des analyses d'interventions d'éducation thérapeutique mises en place en France et au Québec, dans le cadre de huit maladies chroniques : diabète, obésité, maladies cardio-vasculaires, VIH/sida, asthme, cancer, polyarthrite rhumatoïde et lombalgie. En rendant compte des modèles théoriques qui sous-tendent l'éducation thérapeutique et des démarches mises en oeuvre, les contributions mettent au jour une large diversité de pratiques. Qu'il soit professionnel de santé, formateur ou chercheur, le lecteur trouvera ainsi des pistes pour démarrer, développer et évaluer ses actions éducatives. Il trouvera aussi matière à éprouver ses conceptions de la santé et de l'éducation, notamment à travers la découverte de pratiques qui produisent des résultats très encourageants alors qu'elles se réfèrent à des cadres théoriques diversifiés et à des voies différenciées pour penser l'action éducative. Parce qu'elles ne montrent pas l'excellence d'une voie plutôt qu'une autre, ces analyses invitent au développement de nouvelles perspectives d'action et de recherche. L'ouvrage offre ainsi une ouverture précieuse dans un contexte général où l'éducation thérapeutique s'inscrit, en France, dans le code de santé publique, notamment à travers la loi Hôpital, patients, santé et territoires du 21 juillet 2009, qui en reconnaît l'importance pour l'amélioration de l'état de santé des personnes, en particulier de celles atteintes d'une maladie chronique.

Fourcade, A., Houzard, S., Dubot, C., et al. (2012). "[Breast cancer follow-up by primary care physician: patient satisfaction in the Metropolitan Paris region]." Bull Cancer **99**(10): 915-925.

Because of increasing breast cancer incidence and improvement in long-term prognosis, follow-up of patients cannot be carried out entirely in specialized cancer centres. The Reseau Gynecomed was created to transfer the follow-up of patients to primary care physicians (PCP). In 2009, to evaluate the quality of PCP follow-up, a satisfaction study was performed for the 1,245 women followed after breast cancer. Sixty-four percent of the women participate in the study. Before starting follow-up, 87% were informed about its purpose and 93% about its schedule. The satisfaction score was excellent (91%). Old age, perception of a good health status, a high quality of information about and a confident relationship with their PCP were associated with a better satisfaction level. Forty-eight percent of patients thought easy to accept the PCP follow-up. Considering this data, PCP monitoring seems to provide a good follow-up and may be developed. Nonetheless, conditions of patients' choice should be improved and particularly exclude patients with financial difficulties. It would facilitate the growing transfer of follow-up to the PCP.

Fournier, C., Naiditch, M. et Frattini, M. O. (2018). "Comment les médecins généralistes peuvent-ils contribuer à un accès plus équitable à l'éducation thérapeutique ?" Medecine : De La Medecine Factuelle a Nos Pratiques **14**(6): 268-272.

En France, le droit à bénéficier d'une éducation thérapeutique du patient (ETP) est inscrit dans le Code de la santé publique depuis 2009. Le système d'autorisation des programmes d'ETP instauré par la loi Hôpital, patients, santé et territoires (HPST) a abouti à la constitution d'une offre essentiellement hospitalière et l'accès aux programmes d'ETP reste globalement faible : en 2015, 3 736 programmes étaient autorisés pour environ 15 millions de personnes atteintes de maladies chroniques. Dans cet article, nous qualifions d'« ETP » les pratiques mises en oeuvre dans le cadre de programmes autorisés et nous appelons « pratiques éducatives » celles développées au sein de consultations médicales. La dimension éducative est repérée lorsque les médecins déclarent s'appuyer sur le vécu et l'expérience du patient pour l'aider à développer des compétences d'auto-soin et d'adaptation, en construisant des objectifs personnalisés réévalués d'une consultation à l'autre. Au-delà de quelques travaux sur l'ETP en ambulatoire et sur son intégration aux soins, les pratiques éducatives individuelles restent peu étudiées et leur formalisation n'a été envisagée que récemment. En parallèle, dans la continuité de la loi HPST, la Loi de santé de 2016 énonce l'objectif de « garantir un accès aux soins équitable ». Or on sait que les personnes appartenant aux catégories les moins favorisées de la population, et qui supportent la plus grande part du fardeau lié aux maladies chroniques, ont un accès moindre à la fois aux soins et à la prévention Considérant que l'ETP serait à même de contribuer à réduire les inégalités sociales de santé, on peut donc se demander s'il existe des inégalités d'accès à une prise en charge éducative, et si oui, si les médecins généralistes sont en mesure de contribuer à réduire ces inégalités d'accès, comme cela a été montré pour d'autres interventions de santé publique. Cet article synthétise les résultats d'une recherche dans laquelle des médecins ont été interrogés successivement sur : leurs pratiques éducatives ; l'accès donné à d'autres ressources éducatives ; la façon dont ils appréhendent les caractéristiques sociales de leurs patients et l'influence des inégalités sociales sur leur travail éducatif ; les solutions qu'ils développent ou envisagent pour contribuer à plus d'équité d'accès à une démarche éducative ou d'ETP.

Fournier, C. et Attali, C. (2012). "Education (thérapeutique) du patient en médecine générale." Medecine : Revue de L'Unaformec // **8**(3).

Ce texte résume les éléments présentés dans une keynote au 5e Congrès de médecine générale de Nice, le 25 juin 2011, en introduction de la session « Réaliser l'éducation thérapeutique du patient en médecine générale » co-organisée par Éric Drahi et Yves le Noc (SFDRMG) et Isabelle Cibois-Honnorat (MG-Form). Il s'agissait dans un premier temps de décrire à partir de données quantitatives et qualitatives récentes les pratiques et souhaits des médecins généralistes en matière d'éducation thérapeutique patient (ETP), ainsi que les attentes des patients. Le second objectif était de présenter les recommandations du Haut conseil de la santé publique (HCSP) pour développer une ETP intégrée aux soins de premier recours, afin d'ouvrir la discussion sur la compatibilité de ces recommandations avec les fonctions de la médecine générale et avec les tâches que les médecins généralistes doivent effectuer pour remplir le rôle que la société attend d'eux.

Fournier, C., Bourgeois, I. et Naiditch, M. (2018). "Action de santé libérale en équipe (Asalée) : un espace de transformation des pratiques en soins primaires." Questions D'economie De La Sante (Irdes)(232): 1-8.
http://www.irdes.fr/recherche/questions-d-economie-de-la-sante/232-action-de-sante-liberale-en-equipe-asalee.pdf

Le dispositif expérimental Asalée (Action de santé libérale en équipe) a été créé en 2004 afin d'améliorer la prise en charge des maladies chroniques en médecine de ville. Un protocole de coopération permet des délégations d'actes ou d'activités des médecins généralistes vers des infirmières comprenant des dépistages et des suivis de pathologies chroniques. Dans le cadre du programme d'évaluation Daphnee, une recherche sociologique fondée sur une approche qualitative a été menée entre 2015 et 2017. Elle s'est intéressée d'une part au déploiement et à l'organisation du dispositif Asalée et, d'autre part, aux pratiques et interactions entre patients et professionnels. D'autres aspects de cette évaluation donneront lieu à des publications de l'Irdes, notamment une typologie de la coopération entre médecins et infi rmières et des résultats concernant l'effet du dispositif Asalée sur l'activité des médecins, le suivi et les parcours de soins de leurs patients.

Fournier, C., Gautier, A., Attali, C., et al. (2009). "Besoins d'information et d'éducation des personnes diabétiques, pratiques éducatives des médecins, étude Entred, France, 2007." Bulletin Epidemiologique Hebdomadaire(42-43): 460-464.
http://www.invs.sante.fr/beh/2009/42_43/beh_42_43_2009.pdf

[BDSP. Notice produite par InVS mR0xC8Fr. Diffusion soumise à autorisation]. Introduction - L'information et l'éducation des personnes diabétiques et la démarche éducative de leurs médecins ont été explorées à partir de l'étude Entred 2007. Méthodes - Après enquête par auto-questionnaire postal auprès d'un échantillon représentatif de 8 926 patients diabétiques en métropole, les médecins dont les patients avaient fourni les coordonnées ont reçu un auto-questionnaire postal. Résultats - Ont répondu à l'enquête sur la "démarche éducative" 4 296 personnes diabétiques de type 1 (DT1) et 2 (DT2) (taux de réponse 48%) et 2 232 médecins. Pour les patients : 80% se disent bien informés sur leur maladie, la principale source d'information étant leur médecin (83%) ; 77% souhaiteraient des informations supplémentaires, principalement sur l'alimentation (DT2) et sur les droits et remboursements (DT1). Trente-six pour cent des DT1 et 17% des DT2 ont reçu un complément éducatif en plus de la prise en charge médicale habituelle, parfois des entretiens individuels approfondis, rarement des séances collectives, exceptionnellement un accompagnement téléphonique. À l'avenir, 45% des DT1 et 33% des DT2 souhaiteraient bénéficier d'un complément éducatif, principalement individuel. Pour les médecins (échantillon non représentatif) : la principale difficulté rencontrée est l'adhésion des patients aux recommandations concernant l'alimentation (65%) et l'activité physique (64%). Deux tiers des médecins souhaitent coordonner l'éducation de leurs patients, 23% des spécialistes et seulement 5% des généralistes déclarent assurer pour la majorité de leurs patients diabétiques des consultations dédiées à l'éducation thérapeutique. Discussion - Alors que les besoins d'information exprimés sont importants, le souhait de démarches "éducatives" concerne moins de la moitié des personnes diabétiques. Ces résultats plaident pour une sensibilisation accrue des patients et des médecins à l'importance de la démarche éducative. (R.A.)

Fournier, C. et Kerzanet, S. (2007). "Communication médecin-malade et éducation du patient, des notions à rapprocher : apports croisés de la littérature." Sante Publique (5).

> [BDSP. Notice produite par ENSP 8R0xcIma. Diffusion soumise à autorisation]. Depuis 30 ans, les publications internationales s'accordent pour dire qu'une meilleure communication entre le médecin et le patient améliore leur satisfaction respective, la qualité de vie du patient, le suivi du traitement, et les résultats cliniques. De plus, une participation accrue du patient aux décisions médicales qui le concernent diminue son anxiété et améliore sa santé. Que recouvre cette notion de communication et quelle place y est faite à la participation du patient ? Quelles sont les similitudes et les différences entre les approches visant à améliorer la communication d'une part et les approches promues en éducation du patient d'autre part ? L'article explore ces questions à travers trois parties. Premièrement, il présente les résultats d'une recherche documentaire sur la communication dans la relation de soins et sur les modèles de relation issus de différents champs disciplinaires. Deuxièmement, les modèles qui favorisent la participation du patient aux décisions sont rapprochés des modèles d'intervention, des objectifs et des valeurs promus dans des activités d'éducation du patient et d'éducation pour la santé. Troisièmement, les compétences requises de la part des professionnels pour une communication médecin-consultant adéquate sont comparées aux compétences prônées dans la pratique de l'éducation du patient et de l'éducation pou la santé

Fournier, C. et Murphy, M. (2016). "L'autogestion des maladies chroniques, l'état de santé et l'utilisation des services hospitaliers : exploration de données d'enquêtes populationnelles." Zoom Sante(55): c, 19 , tabl., fig.
http://www.stat.gouv.qc.ca/statistiques/sante/bulletins/zoom-sante-201602.pdf

> Ce numéro du bulletin Zoom santé de l'Institut de la statistique du Québec (ISQ) s'intéresse à l'autogestion des maladies chroniques d'après l'expérience vécue de personnes aux prises avec l'une des cinq maladies chroniques faisant l'objet d'une surveillance particulière par le ministère de la Santé et des Services sociaux, soit : l'arthrite, le diabète, la bronchite chronique, l'hypertension et les maladies cardiaques. Les éléments d'autogestion examinés par l'étude concernent : l'acquisition d'informations et de compétences pour maintenir un bon état de santé, le renforcement de l'autonomie de la personne afin qu'elle reconnaisse les signes avant-coureurs de la maladie et agisse adéquatement et le soutien à l'adoption de saines habitudes.

Fournier, C. (2015). Les maisons de santé pluriprofessionnelles, une opportunité pour transformer les pratiques de soins de premier recours : place et rôle des pratiques préventives et éducatives dans des organisations innovantes. Paris Université Paris 11, Université de Paris 11. Orsay. FRA. **Thèse de doctorat Santé Publique - sociologie:** 337.
https://tel.archives-ouvertes.fr/tel-01149605/

> L'exercice des soins de premier recours en maisons et pôles de santé pluriprofessionnels (MSP) connaît depuis quelques années un développement croissant. Ces modalités d'exercice sont présentées comme une solution aux défis que représentent le vieillissement de la population, l'augmentation de la prévalence des maladies chroniques, l'accentuation des inégalités sociales de santé et l'irrésistible croissance des dépenses de santé. Elles s'inscrivent dans une remise en cause du système de santé français, construit historiquement sur un modèle curatif hospitalo-centré et sur une médecine de ville d'exercice libéral et isolé. L'impératif d'un recentrage du système sur les soins de premier recours devient un objectif partagé par l'Etat et certains professionnels libéraux, associé à celui de leur réorganisation pour en accroître la dimension préventive et éducative, dans une approche de santé publique collective, populationnelle et mieux coordonnée au niveau d'un territoire. Comment les soins primaires se transforment-ils dans les MSP ? Dans les dynamiques observées, quels places et rôles jouent les pratiques préventives et éducatives ? Ces questions sont abordées avec une posture de recherche engagée, inscrite dans une réflexion méthodologique et politique, articulant des approches médicale, de santé publique et sociologique (extrait du résumé de l'auteur).

Fournier, C. (2018). "Éduquer les patients, transformer les soignants." Les Grands Dossiers Des Sciences Humaines(53): 48-49.
https://www.scienceshumaines.com/eduquer-les-patients-transformer-les-soignants_fr_40183.html#achat_article

Les maladies chroniques sont en forte augmentation. Pour les patients qui en sont atteints, il est essentiel d'apprendre à vivre avec. C'est tout l'objectif des activités d'éducation thérapeutique.

Fournier, C. (2019). ETP : travailler en partenariat
https://poletp.fr/synthese-journee-annuelle-pole-de-ressources-etp-idf-22-novembre-2018/

Pour Cécile Fournier, Maître de recherche à l'Irdes, l'Education thérapeutique du patient (ETP) crée des espaces d'expression, de besoins, d'envie. Des acteurs, en partant d'un objectif commun, créent, expérimentent des actions ensemble. Le Pôle de ressources a une connaissance fine du réseau d'acteurs et un savoir-faire, une méthodologie pour accompagner et capitaliser les expériences de partenariat. Interview de Cécile Fournier dans la vidéo : //www.youtube.com/watch?v=diVhkLlP0qo

Fournier, C., Cittee, J., Brugerolles, H., et al. (2018). "Améliorer la complémentarité des offres d'éducation thérapeutique du patient : retour d'expérience et recommandations." Santé Publique **30**(3): 307-311.
https://www.cairn.info/revue-sante-publique-2018-3-p-307.htm

La promotion de l'ETP sur les territoires demande à être réfléchie dans une approche communautaire, suivant une logique de complémentarité pour atténuer les risques de rupture de suivi dans les moments de transition. Le Pôle de ressources Île-de-France en ETP a réuni un échantillon pluri professionnel, pluridisciplinaire et plurisectoriel de 45 participants, afin de définir les modalités d'une complémentarité des offres d'ETP partant des besoins des patients et contribuant au changement de paradigmes professionnels. Trois entretiens collectifs ont abordé successivement les trois thématiques de la complémentarité entre les offres d'ETP, des parcours des patients, et de la pluridisciplinarité, en prenant en compte les éléments structurels, les processus et les résultats. Constatant le manque de visibilité, les cloisonnements, les difficultés d'accès et le cadrage contraint des offres, les participants soulignent des éléments favorables issus de leur expérience, fondée sur un socle culturel commun. Les recommandations portent sur : le décloisonnement des structures, en développant la communication et les formations pluri-professionnelles, et en assouplissant les formats de programme ; la mise en lien des acteurs, en promouvant une offre de proximité, et en facilitant les analyses de pratiques et le développement d'une coordination exemplaire de la démarche d'ETP ; la diversification et l'articulation des approches évaluatives, en valorisant le caractère multidimensionnel des apports de l'ETP, non seulement pour les patients mais aussi pour les professionnels et le système de santé. Les Pôles de ressources en ETP peuvent contribuer à la mise en œuvre de ces recommandations en soutenant une approche collective fédératrice, à même de contribuer à une réduction des inégalités sociales d'accès à l'ETP.

Fournier, C., Frattini, M. O., Naiditch, M., et al. (2018). "[How do general practitioners promote a more equitable access for patient education?]." Santé Publique **30**(1 Suppl): 69-80.

Our research is designed to understand how and under what conditions general practitioners contribute to equitable access to patient education (PE).We conducted a survey based on interactionist sociology in a sample of 32 doctors. These practitioners worked in the context of health networks and health care centres and were also involved in the PE resource centre for the Île-de-France region, thereby providing a favourable setting for our study, also reflected by the fact that one-half of practitioners were aware of the importance of or had been trained in PE.Doctors stress that their engagement in the patient-doctor relationship does not depend on the patient's psycho-social characteristics. Their educational practice nevertheless appears to be influenced by their a priori judgement of these characteristics. Based on their judgement, some clinicians develop practices that seem to promote better access for their socially underprivileged patients. This process is facilitated by several dynamics described in this article.The results of this research open up opportunities for office-based physicians and PE development structures to facilitate better access to PE for all patients.

Fournier, C. et Mousques, J. (2019). "Construction et impact d'une coopération entre médecins généralistes et infirmières : le dispositif Asalée." Actualite Et Dossier En Sante Publique(107): 31-33.

La coopération entre médecins généralistes et infirmières est considérée comme un levier pour améliorer les conditions, l'organisation et la qualité du travail en soins de premier recours, voire la performance. En France, le dispositif action de santé libérale en équipe (Asalée) expérimente depuis 2004 la coopération entre médecins généralistes et infirmières Asalée. Il offre un cadre pour le développement de pratiques avancées infirmières, comprenant notamment des tâches de dépistage, de suivi et d'éducation thérapeutique. À travers une synthèse des enseignements tirés des travaux de recherche évaluative conduits sur le dispositif, cet article a pour objet de discuter de l'opportunité et des conditions de développement de telles pratiques dans un contexte prévoyant en 2019, suite à la reconnaissance en 2018 d'un métier et d'un diplôme d'infirmier en pratiques avancées, de nouvelles mesures relatives à leurs rémunérations et à la modalité d'exercice en maisons et centres de santé pluriprofessionnels.

Gallois, P., Vallee, J. P. et Le, N. Y. (2009). "Education thérapeutique du patient. Le médecin est il -aussi- un éducateur ?" Medecine : Revue de L'Unaformec **5**(5).

En France, selon les estimations actuelles, 15 millions de personnes, près de 20 % de la population, sont atteintes de maladies chroniques avec un retentissement sur la vie quotidienne considérable [1]. Le « plan santé 2007-2011 », le rapport 2008 sur ce sujet [2], les innombrables publications de la presse médicale ou grand public, pourraient faire croire à une opération de communication sur des sujets artificiellement « innovants ». Pourtant, les notions sous-jacentes sont presque aussi anciennes que notre médecine : Hippocrate en témoignait déjà. Les seules vraies « nouveautés » sont l'augmentation du nombre et l'allongement de la durée de vie des malades chroniques, mais aussi l'augmentation des conditions chroniques liées à la nouvelle approche de la prévention. Soins et accompagnement à réaliser par les médecins en sont d'autant multipliés et leur prise en charge individuelle de tous les instants devient hors de portée. Il apparaît par ailleurs que l'observance au quotidien des prescriptions médicales passe par l'adhésion des patients aux principes qui en sont le fondement. Cette constatation rejoint le souhait, voire la revendication des patients, d'une médecine qui leur apporte les moyens d'être pleinement responsables de leur santé et de décider en toute connaissance de cause. Il devient ainsi plus clairement admis que la prise en charge « médicale » d'une maladie est d'autant plus efficace que le patient y est impliqué. Tout cela va peut-être sans dire il s'agit de placer le malade au coeur du système de soins mais n'est pas si évident au quotidien

Garbacz, L., Juilliere, Y., Alla, F., et al. (2015). "Perception of therapeutic patient education in heart failure by healthcare providers." Arch Cardiovasc Dis **108**(8-9): 446-452.

BACKGROUND: Care provider support for therapeutic patient education (TPE), its results and relationships with patients are factors in the setting up and sustainability of this practice. AIM: With a view to understanding the factors determining TPE care provider participation and favouring its development, the aim of this study was to describe the perception healthcare providers have of TPE in heart failure. METHODS: A national survey by self-administered questionnaire was performed in 2013 in 61 Observatoire de l'INsuffisance cardiaque (ODIN; Heart Failure Observatory) centres participating in the I-CARE programme. The cardiologist in charge of each centre received five questionnaires: one for him/herself and four for other healthcare providers working with him/her. RESULTS: We received 116 responses out of the 305 questionnaires sent (38.0%). Almost all of the responders stated that the patients were more observant after TPE sessions (91.4%). According to the responders, patients were better informed thanks to TPE (53.9%); they stated that TPE had changed their relationships with patients (81.9%); they also felt that they were educating the patient's close family/friends at the same time as the patients (86.2%). CONCLUSION: The survey showed that TPE improves care relationships. Healthcare providers recognize that they have been working differently since the programme was set up, and want the patient's close family/friends to be involved in treatment.

Garcia, G. (2014). "Parcours de soin : Asthme de l'adulte, le contrôle optimal fondé sur une médecine personnalisée." Concours Medical // **136**(5).

> [BDSP. Notice produite par ORSRA 788skR0x. Diffusion soumise à autorisation]. Ce dossier s'intéresse au contrôle optimal de l'asthme chez l'adulte : en effet, l'asthme touche plus de 3,5 millions de personnes en France. Le dossier démontre que même si la prise en charge s'améliore, de nombreux traitements sont inadaptés. La question du diagnostic est évoquée puisque l'asthme reste sous-diagnostiqué et sous-traité. L'enquête allergologique reste alors primordiale. Un focus est ensuite fait sur l'asthme professionnel et le rôle du médecin du travail. Le dossier évoque ensuite l'intégration dans le bilan de la recherche d'une pathologie ORL, l'évaluation du contrôle de l'asthme pour ajuster le traitement, la prévention des récidives après une exacerbation, la grossesse comme raison supplémentaire de contrôler l'asthme, l'éducation thérapeutique et la formation des soignants à l'ETP, les particularités du suivi sur le long terme de l'asthme difficile. Le dossier conclut sur la médecine personnalisée qui doit avoir pour objectif "zéro exacerbation" ; en effet, le médecin généraliste doit nécessairement dialoguer avec le pneumologue et doit avoir conscience de son rôle clé dans l'éducation thérapeutique afin d'anticiper les exacerbations. La recherche médicale pour contrôler l'asthme sévère est aussi évoquée

Gautier, A., Fournier, C. et Beck, F. (2011). "Pratiques et opinions des médecins généralistes en matière de prévention." Actualite Et Dossier En Sante Publique(77): 6-10, fig.

> [BDSP. Notice produite par EHESP A8HqsR0x. Diffusion soumise à autorisation]. La sixième enquête "Baromètre santé médecins généralistes" menée par l'Inpes de novembre 2008 à janvier 2009 a permis de recueillir des informations sur le rôle des généralistes en matière de prévention et dépistage. Les praticiens se sont exprimés sur leur rôle, sur leurs pratiques et sur les éléments qui leur permettraient de mieux remplir leur mission de prévention. Si leur implication est particulièrement forte dans certains domaines tels que le tabagisme, en revanche, ils soulignent leurs difficultés à aborder avec leurs patients des sujets tels que la vie affective et sexuelle ou l'usage de drogues illicites.

Gay, B., Demeaux, J. L. et Marty, M. L. (2009). "Education thérapeutique du patient en médecine générale. L'étude Ethiccar : faisabilité et évaluation chez le patient à risque cardiovasculaire." Medecine : Revue de L'Unaformec **5**(1).

> Les maladies cardiovasculaires représentent la première cause de mortalité en France. L'éducation thérapeutique fait du patient un acteur de sa maladie et permet un meilleur suivi des pathologies chroniques. Les objectifs sont donc de mettre en place une action d'éducation thérapeutique auprès de patients à risque cardiovasculaire en pratique de médecine générale et d'évaluer son impact. Une étude d'intervention randomisée et stratifiée chez des patients à risque cardiovasculaire a été réalisée pour cela. Dans le premier groupe, les médecins déterminent avec le patient les objectifs éducatifs prioritaires et assurent les séances éducatives individuelles. Dans le deuxième groupe, les médecins réalisent le diagnostic éducatif et les patients participent à des ateliers collectifs. Le troisième groupe (témoin) bénéficie du suivi médical usuel. Résultats : Parmi les médecins tirés au sort, 102 ont donné leur accord de participation (taux moyen d'acceptation 31 %). Les médecins ont été formés à la démarche éducative et le matériel éducatif élaboré spécifiquement pour cette action. Les séances éducatives ont été mises en place dans une démarche de proximité, sous forme de consultations individuelles dédiées assurées par le médecin ou d'ateliers de groupes de patients animés par des éducateurs. Discussion : Le rôle du médecin généraliste est essentiel dans une perspective de proximité, ce qui nécessite à la fois une formation adaptée et des évolutions structurelles et conceptuelles pour développer l'éducation thérapeutique en ambulatoire

Genolini, J. P., Roca, R., Rolland, C., et al. (2011). ""L'éducation" du patient en médecine générale : une activité périphérique ou spécifique de la relation de soin ?" Sciences Sociales et Sante // **29**(3).

> [BDSP. Notice produite par ORSMIP oR0xlkEt. Diffusion soumise à autorisation]. L'éducation du patient concernant les habitudes hygiénodiététiques est officiellement intégrée à la spécialisation de la

médecine générale mais faiblement objectivée par les travaux sur le recensement des activités médicales. La recherche analyse, dans la pratique ordinaire des médecins, la façon dont se déploient les recommandations d'hygiène. les interactions médecin-patient sont décryptées sur 50 consultations de suivi (risques cardiovasculaires). Elles montrent que les échanges sur les habitudes de vie sont plutôt périphériques et peu influencées par le niveau de l'atteinte mais aussi, pour une partie des consultations, qu'ils déterminent un contexte spécifique à l'éducation du patient. Le travail entrepris par le médecin sur le changement comportemental est une "négociation" qui oscille entre le registre d'une médicalisation du style de vie et celui d'une communication ordinaire. (R.A.)

Girardot, L., Boumedien, D., Magar, Y., et al. (2011). "Aide au sevrage tabagique en médecine générale." Concours Medical // **133**(8).

[BDSP. Notice produite par ORSRA sqR0xEDB. Diffusion soumise à autorisation]. La dépendance au tabac, avec les rechutes fréquentes qu'elle engendre, est considérée par beaucoup comme une véritable maladie chronique, voire l'une des plus fréquentes. C'est à ce titre que l'éducation thérapeutique du patient (ETP) peut contribuer au succès de la démarche de sevrage tabagique. Elle permet au médecin généraliste de structurer une prise en charge le plus souvent complexe

Girardot, L., Boumedien, D. et Roche, N. (2012). "BPCO en médecine générale." Concours Medical // **134**.

[BDSP. Notice produite par ORSRA 7lR0xF9F. Diffusion soumise à autorisation]. L'impact de la bronchopneumopathie obstructive chronique (BPCO) sur la santé est majeur. De même que les traitements médicamenteux, la kinésithérapie ou la réhabilitation respiratoire, l'éducation thérapeutique fait partie intégrante de la prise en charge des patients atteints de BPCO. Le médecin généraliste peut avoir une approche de sensibilisation, de motivation ou d'éducation

Giraud, V., Allaert, F. A. et Roche, N. (2011). "Inhaler technique and asthma: feasability and acceptability of training by pharmacists." Respir Med **105**(12): 1815-1822.

Poor inhaler technique is frequent in asthma, but its long-term consequences have been seldom assessed. Pharmacists are ideally positioned to teach inhaler technique. This prospective observational study evaluated the feasibility of inhaler training by pharmacists in patients receiving inhaled corticosteroids by pressurised metered-dose inhaler (pMDI) or breath-actuated MDI. In parallel, the relationships between inhaler technique, adherence, and asthma control, and their modulation one month after training were assessed. Of 727 patients receiving training at pharmacies (n=123), 61% were prescribed a pMDI; 35%, an Autohaler((R)); and 5%, an Easi-Breathe((R)) inhaler. Poor asthma control (Asthma Control Questionnaire score >/= 1.5) at baseline was significantly (p<0.05) and independently associated with poor inhaler technique and poor self-reported adherence (Morisky score >/= 3). The percentage of patients with optimal inhaler technique rose from 24% before to 79% after training (p<0.001). Median training session length was 6 min. At 1 month, mean (SD) ACQ score had improved from a baseline score of 1.8 (1.2) to 1.4 (1.1), (p<0.001). Importantly, greater change was observed in patients with improved inhaler technique versus those without. Similar results were observed for Morisky score. Inhaler technique is associated with adherence and influences asthma control. Inhaler training by pharmacists is feasible and seams to improve inhaler technique, asthma control and adherence.

Godard, C., Chevalier, A., Siret, B., et al. (2007). "[A strategy for therapy of depressive disorders and anxiety disorders by a health education intervention in medical consultations: the results of the APRAND program]." Rev Epidemiol Sante Publique **55**(2): 113-121.
http://www.ncbi.nlm.nih.gov/pubmed/17446023

BACKGROUND: Studies devoted to the detection and treatment of anxiety and depression in adult populations show that at least 10% meet ICD10 criteria for an anxiety or a depressive disorder, but only half are diagnosed as such and only one third of those receive appropriate treatment. The goal of the APRAND program was to explore the possibility of improving management strategies via health education during doctors' visits. METHODS: In 2001, EDF-GDF conducted an experimental program in

which 21 physicians from its in-house health insurance program used the MINI mental state examination to screen for ICD10 criteria for anxiety and depressive disorders in 9743 employees on sick leave. A "here-elsewhere" epidemiologic study evaluated the program, recording the initial diagnoses and studying a year later the outcome of the persons identified with these disorders in 8 active centers (with prevention activities) and in 13 control centers (without prevention activities). The activities consisted of explanations of the disorders identified, delivery of the test results, delivery of leaflets based on the WHO guidelines, and strong recommendations to see a general practitioner, or a psychiatrist, or the occupational physician, if necessary. Logistic regressions compared the two groups, taking into account sex, age, geographic region, comorbidity, and medical care at screening. RESULTS: Preventive activities were significantly associated with the disappearance at 1 year of depressive episodes (OR=1.93; CI 95%; 1.3-2.84) and of phobic or panic disorders (OR=1.98; CI 95%; 1.14-3.44). The only other variables affecting prognosis were age and sex. The probability of recovery or remission increased by 10 to 20% at active centers, according to age, sex and disorder. Moreover, the physicians reported that they learned a great deal from the program, which thus also improved their practices. CONCLUSION: Diagnosis and prognosis of depressive episodes and phobic and panic disorders in adult populations can be improved by a preventive diagnostic and educational approach of the type used by APRAND during doctor's visits

Grimaldi, A., Caille, Y., Pierru, F., et al. (2017). Les maladies chroniques : vers la 3e médecine. Paris, Odile Jacob

Vingt millions de Français souffrent de maladies chroniques, soit un tiers de la population - une véritable épidémie. Hier encore, on mourait de ces maladies, aujourd'hui, elles nous accompagnent toute notre vie. Diabète, cancers, hypertension artérielle, sida, insuffisance respiratoire, mucoviscidose, myopathies, maladies inflammatoires de l'intestin, polyarthrite rhumatoïde, asthme, lupus, insuffisance rénale, cirrhoses hépatiques, séquelles d'accidents vasculaires cérébraux, insuffisance cardiaque, sclérose en plaques, maladie de Parkinson, maladies psychiatriques, maladie d'Alzheimer, obésité. La France doit à présent se doter de tous les moyens pour améliorer la vie de tous les patients atteints de ces maladies. Nous sommes entrés dans l'ère de la 3e médecine, véritable médecine de la personne, aux côtés de la médecine des maladies aiguës bénignes et de la médecine des maladies graves. Pour le patient, une nouvelle façon de vivre ; pour le médecin, une nouvelle façon d'exercer son métier, à l'heure des grandes avancées médicales et techno-logiques. Soixante-quatorze médecins, patients et experts se sont associés ici pour relever le défi des maladies chroniques.

Groff, M. A. (2011). "[Initial training and therapeutic patient education]." Soins Pediatr Pueric(259): 19.

Hada, F. et Ricardo, C. (2009). L'éducation thérapeutique intégrée aux soins de premier recours. Publique., Paris : HCSP
http://www.hcsp.fr/docspdf/avisrapports/hcspr20091112_edthsoprre.pdf

L'éducation thérapeutique aide les personnes atteintes de maladie chronique et leur entourage à comprendre la maladie et le traitement, à coopérer avec les soignants et à maintenir ou améliorer leur qualité de vie. Pour bon nombre de pathologies, il est démontré que l4éducation thérapeutique des patients améliore l'efficacité des soins et permet de réduire la fréquence et la gravité des complications. Compte tenu du nombre croissant de personnes atteintes de maladie chronique en France (environ 15 millions actuellement), les besoins en la matière sont très importants. L'éducation thérapeutique ne peut pas être assurée par les seuls établissements hospitaliers. Elle devrait s'exercer au plus près des lieux de vie et de soins des patients. Le travail mené par le HCSP a permis d'identifier plusieurs facteurs susceptibles de favoriser ou de freiner l'implication des médecins traitants et autres professionnels de santé de premier recours dans la mise en oeuvre d'une éducation thérapeutique de proximité. L'analyse de ces facteurs l'amène à proposer quatre orientations stratégiques qui se déclinent en cinq mesures et quatorze recommandations.

Helle, P. et Clavagnier, I. (2015). "[A patient-expert in patient education. The story of practice]." Rev Infirm(214): 21-22.

The notion of patient-expert has existed in France since the years 2000 and has been used by patients' associations, notably the Association Francois Aupetit (AFA). Patrick Helle, who suffers from a chronic inflammatory disease, holds a degree in therapeutic education. He organizes and hosts workshops on this topic, alone or in cooperation with healthcare professionals at three public hospitals. This patient-expert serves as a bridge between caregivers and patients, sharing his experience as a patient and transmitting experiential knowledge. He shares his story with us.

Huge, S., Pommier, J., Chapron, A., et al. (2017). "Quels sont les facteurs prioritaires à mettre en oeuvre pour développer une démarche éducative en médecine générale." Santé Publique **29**(1): 21-29.

[BDSP. Notice produite par EHESP BBFqCR0x. Diffusion soumise à autorisation]. Renforcer la formation et les coopérations des MG avec d'autres professionnels peut permettre aux MG de développer lors de leurs consultations une démarche éducative structurée. Ces résultats peuvent éclairer les orientations de la politique régionale de santé publique concernant le déploiement de l'éducation thérapeutique en soins primaires.

Hullar, J., Vespignani, H., Fay, R., et al. (2010). "Impact d'une démarche d'éducation thérapeutique de groupe dans la prise en charge des troubles du sommeil de l'adulte. étude prospective réalisée de septembre 2007 à mars 2008 par un groupe de médecins généralistes." LA REVUE DU PRATICIEN **60**(6): 21-26.

La prescription d'hypnotiques dans la prise en charge des insomnies de l'adulte est un problème de santé publique. La mise en oeuvre d'une approche thérapeutique non pharmacologique est une difficulté au quotidien pour les médecins de famille. Objectif. L'objectif de cette étude était d'évaluer l'impact d'une action d'éducation thérapeutique de groupe dans la prise en charge non pharmacologique des insomnies de l'adulte par des médecins généralistes. Méthode. étude prospective réalisée de septembre 2007 à mars 2008. Deux conférences ont été animées sur une période de 2 mois par 5 médecins généralistes de Laxou, Meurthe-et-Moselle, France. Les volontaires ont été recrutés par invitation des médecins généralistes, par voie de presse régionale, affichage dans les pharmacies, remise de dépliants et annonce sur la radio locale. Un questionnaire a été proposé en début et en fin de conférence. Un entretien téléphonique a éTé réalisé 1 mois puis 3 mois après les conférences, permettant de mesurer leur impact. Résultats. 76 participants ont complété les questionnaires lors des 2 conférences et 55 adultes ont été suivis à 1 mois et 3 mois ; 58% (n=43) étaient âgés de plus de 60 ans, et les femmes représentaient 65% (n=48) des participants ; 63% (n=46) des participants déclaraient souffrir d'insomnie, dont 89% d'insomnie chronique (26% d'insomnie légère, 40% modérée et 34% sévère). A 3 mois, 20% des participants avaient complété l'agenda du sommeil et avaient consulté spécifiquement leur médecin traitant ; 56% des consommateurs de somnifères avaient entrepris une réduction ou un arrêt de leur traitement ; 84% des participants ayant appliqué les conseils et les thérapies cognitives et comportementales avaient constaté une amélioration partielle ou totale de leur trouble du sommeil. Conclusion. Une éducation thérapeutique de groupe de type thérapie cognitivo-comportementale réalisée lors d'une conférence permet d'obtenir un changement des comportements et une amélioration de la qualité du sommeil chez les participants à moyen terme.

Idier, L., Larroumet, N., Trolonge, S., et al. (2012). "[Interest of a specific programme in patient education for dialysis in out-center patients]." Nephrol Ther **8**(2): 87-91.

The development of therapeutic patient education for dialysis patients is recent and concerns mainly out-center patients. To our knowledge, only two papers centred on therapeutic education with out-center patients have been published. The particularities of this dialysis modality (unit close to the home, more autonomy, a nurse for six patients, organisation of unit, better quality of life and psychological status) highlight the interest to develop specific educational programs for patients treated in out-center sitting. The example of a program in Aquitaine (France) composed of mainly collective sessions (representations of the disease, dietetic recommendations, hygiene and protection of the vascular access, drugs compliance...) allows to propose several practical implications to initiate the development of specific programs in therapeutic education for out-center dialysis: educative sessions during the sessions of dialysis, group patients, multidisciplinary team, evaluation of the program from a medical and psychosocial point of view...

Inpes (2005). Baromètre Santé Médecins/Pharmaciens 2003, Saint-Denis : Inpes

Médecins et pharmaciens perçoivent-ils la prévention de manière identique ? Quels obstacles considèrent-ils comme les plus importants à une démarche éducative ou préventive ? Leurs comportements ont-ils évolué depuis 1998 ? Pour la première fois, l'étude des médecins généralistes a été effectuée conjointement à celle des pharmaciens d'officine et a donné lieu à l'édition d'un unique ouvrage. Cette enquête, réalisée auprès de 2 057 médecins généralistes exerçant en mode libéral et 1 062 pharmaciens titulaires d'officine, décrit les opinions, comportements et pratiques de ces professionnels de santé. Les questionnaires portent entre autres sur leurs comportements personnels de santé, leurs opinions et attitudes vis-à-vis de la prévention, la vaccination, le dépistage des cancers, le VIH, l'hépatite C, le traitement et la prise en charge des problèmes d'addiction. Le Baromètre santé médecins/pharmaciens 2003 est destiné à tous ceux qui s'intéressent à l'implication des médecins généralistes et des pharmaciens d'officine dans le domaine de la prévention

Inpes (2011). Baromètre santé médecins généralistes 2009, Saint-Denis : Inpes

Ce Baromètre santé décrit les perceptions et les comportements des généralistes en matière de vaccination, de dépistage des hépatites virales et du VIH, de prise en charge des problèmes d'addiction. Pour la première fois, il aborde la prise en charge des patients souffrant de la maladie d'Alzheimer, ou encore la formation en éducation pour la santé ou en éducation thérapeutique du patient. Il permet ainsi de mieux connaître les attentes des médecins, mais aussi les freins à certaines pratiques. Outre une analyse des données chiffrées et de leur évolution dans le temps, l'ouvrage fournit des clés pour comprendre l'implication des médecins généralistes dans le domaine de la prévention

Iresp (2020). Continuité de l'éducation thérapeutique du patient et Covid-19. Sélection de ressources actualisée au 1er décembre 2020 2020, Nantes : Iresp ; Nantes : ORS
https://ireps-ors-paysdelaloire.centredoc.fr/index.php?lvl=cmspage&pageid=4&id_article=270#.XwR9xigzZPZ

Cette sélection de ressources partage les récentes productions et innovations des acteurs de l'éducation thérapeutique du patient (ETP) pour s'adapter au contexte post-épidémie de Covid-19. Elle propose des supports pour permettre la poursuite des démarches d'ETP à distance ou en présentiel, des exemples de programmes, d'ateliers ou de séances mis en place pendant l'épidémie, mais aussi des documents d'information et de prévention pour aborder avec les patients et leur entourage l'impact de l'épidémie sur la santé psychique et mentale, le déconfinement, l'importance des gestes barrières pour se protéger et protéger les autres.

Jaffiol, C. (2014). L'éducation thérapeutique du patient (ETP), une pièce maîtresse pour répondre aux nouveaux besoins de la médecine. Paris : Académie nationale de médecine
http://www.academie-medecine.fr/wp-content/uploads/2014/01/jaffiolRapport-ETP-voté-10-XII-13-3.pdf

Reconnue déjà par la loi comme une obligation pour la prise en charge des patients, l'éducation thérapeutique du patient (ETP) fait partie des priorités de la nouvelle stratégie nationale de santé, identifiée comme un outil majeur de réussite de la prise en charge globale avec une participation entière et éclairée des patients acteurs de leur santé. Ce rapport de l'Académie nationale de médecine propose, sur l'ETP, des solutions pragmatiques compatibles avec les possibilités financières de la France. Le groupe de travail a réussi à fédérer l'ensemble des acteurs concernés, en particulier les sociétés savantes jusque là peu impliquées dans l'ETP et à confronter leur expérience hospitalière avec les besoins en médecine de ville. Dans l'esprit des recommandations de l'Académie, l'objectif du groupe a été de faire des propositions concrètes, pragmatiques, voire expérimentales, pour trouver des solutions et des réponses consensuelles au nécessaire développement de l'ETP en ville. La méthode de travail a donc consisté, dans un premier temps, à identifier les obstacles culturels et structurels s'opposant à la mise en œuvre de l'ETP, depuis la formation médicale, trop déconnectée du patient, l'absence de travail d'équipe entre les divers intervenants des soins, le manque de coordination territoriale, une tarification inadaptée

Jaffiol, C., Godeau, P. et Grosbois, B. (2016). Prise en charge des maladies chroniques. Redéfinir et valoriser le rôle du médecin généraliste. Paris Académie Nationale de Médecine**:** 15.
http://www.academie-medecine.fr/articles-du-bulletin/publication/?idpublication=100568

Les maladies chroniques sont la première cause de décès et la source principale des dépenses de santé. Leur dépistage précoce permet de limiter leur gravité évolutive et de réduire sensiblement leur coût. Mais, leur suivi thérapeutique se heurte à deux obstacles : le défaut fréquent d'observance du traitement par le patient et aussi, plus rarement, l'inadaptation thérapeutique à l'évolution clinique par le médecin. C'est pourquoi, il faut revoir fondamentalement la prise en charge du patient chronique pour le rendre autonome dans la gestion de sa maladie tout en donnant au praticien les moyens de gérer et de coordonner les diverses étapes de son parcours de soin. Cela exige de changer les mentalités de part et d'autre, mais aussi de donner au praticien les moyens financiers lui permettant de consacrer à ses patients plus de temps, au centre d'une nouvelle organisation interprofessionnelle. La prévention et l'éducation thérapeutique du patient (ETP) sont les clés de cette révolution thérapeutique, fondée aussi sur l'éducation à la santé, une meilleure formation des professionnels de santé, un accès accru au numérique, mais aussi et surtout la reconnaissance, par des mesures concrètes, de la place du médecin généraliste dans un nouveau parcours de soins où il doit avoir un rôle central de coordination (résumé d'auteur).

Jakovenko, D. (2016). "[Doctor-nurse cooperation in a therapeutic education pathway at home]." Soins **61**(809): 23-26.

A therapeutic education programme comprising individual sessions in the patient's home has been tried out with patients with diabetes. It enables them to gain a better understanding of the disease and become players in their own health care. This initiative strengthens the doctor-nurse partnership within a coordinated care pathway.

Jenhani, M. T., Ben, A. A., Guedira, A., et al. (2004). "Efficacité d'un programme d'éducation thérapeutique sur l'équilibre glycémique des diabétiques insulino-traités en médecine générale." Archives of Public Health // **62**(5).

[BDSP. Notice produite par INIST-CNRS npR0x4OW. Diffusion soumise à autorisation]. Le diabète sucré constitue de plus en plus un problème de santé publique en Tunisie, dont la gestion est confrontée à une difficulté majeure : l'absence d'un programme d'éducation thérapeutique, pierre angulaire de tout traitement des diabétiques. Ce travail a pour objectif d'étudier l'efficacité d'un programme d'éducation pour la santé sur l'équilibre glycémique des patients traités par des médecins généralistes aux consultations externes dans la région de Kélibia (Nabeul, Tunisie). Il s'agit d'une étude préexpérimentale (avant/après) ayant porté sur 87 diabétiques âgés de 25 à 70 ans mis sous insuline, diagnostiqués et suivis dans l'unité des maladies chroniques de l'hôpital de Kélibia. Les données ont été collectées au moyen du dosage de l'hémoglobine glyquée et une appréciation du degré de l'anxiété selon l'échelle de Hamilton, avant et après l'administration de six séances d'éducation thérapeutique à raison d'une séance par mois. Parmi les principaux résultats de cette étude : le taux de l'hémoglobine glyquée a chuté de 8.8%+/-1.23 à 7.6+/-1.43 (p<10-6), avec une augmentation de la prévalence d'hémoglobine glyquée satisfaisante ($ 8%) de 33.0% à 68.2% (p<10p<10-3). La prévalence de l'anxiété sévère a diminué de 39.8% à 12.5% (p<0.001). Les résultats de cette se prononcent en faveur de l'efficacité de l'administration d'un programme d'éducation thérapeutique pour les patients diabétiques insulino-traités et suivis dans les structures ambulatoires de première ligne. Le programme national de contrôle du diabète devrait, par conséquent, accorder plus d'intérêt aux activités éducatives et promotionnelles dans les structures ambulatoires de proximité

Jourdain, A., Juilliere, Y., Desnos, M., et al. (2011). "Insuffisance cardiaque en médecine générale." Concours Medical // **133**(2).

[BDSP. Notice produite par ORSRA B78R0xnt. Diffusion soumise à autorisation]. Cet article est consacré à l'éducation thérapeutique des patients insuffisants cardiaques. Sont présentés les objectifs éducatifs, les composantes prioritaires d'un programme éducatif, le programme national Icare et les autres initiatives, ainsi que les outils et moyens pédagogiques

Jourdan, D. (2012). "La prévention : Une priorité de santé publique, un enjeu éthique, un défi pour la pratique en médecine de ville." Concours Medical // **134**(6).

[BDSP. Notice produite par ORSRA mmIR0x8k. Diffusion soumise à autorisation]. En santé publique, la prévention joue un rôle primordial. Les médecins généralistes sont en première ligne pour adopter et mettre en place une démarche de prévention et d'éducation. Cet article est une réflexion concernant les questionnements et dilemmes éthiques posés par les pratiques de prévention

Karrer, M., Buttet, P. et Vincent, I. (2008). "Comment pratiquer l'éducation pour la santé en médecine générale ou en pharmacie ? Résultats d'une expérimentation auprès de femmes enceintes, d'adolescents et de personnes âgées." Santé Publique **20**(1): 69-80.

[BDSP. Notice produite par EHESP IkD7R0xp. Diffusion soumise à autorisation]. Cette expérimentation a évalué l'élaboration et la mise en oeuvre de cinq actions pilotes d'éducation pour la santé en médecine générale et en pharmacie, fondée sur une approche "globale" et "par population". Ces actions ont été conçues et mises en oeuvre par 35 médecins généralistes et pharmaciens sur cinq sites en France entre 2001 et 2004, incluant 185 patients. Les professionnels ont fait preuve le plus souvent d'une approche globale de la santé : vision positive de la santé, non cloisonnement de ses différents aspects, effort de personnalisation. Les femmes enceintes, les adolescents et les personnes âgées ont présenté des spécificités à prendre en compte dans une approche par population. Les actions se sont appuyées sur des techniques simples faisant appel à des guides d'entretien et des documents d'aide à l'expression et à la relation professionnel-patient.

Karrer, M., Buttet, P., Vincent, I., et al. (2004). "Comment pratiquer l'éducation pour la santé en médecine générale ou en pharmacie ? Modalités de mise en oeuvre d'une expérimentation auprès des femmes enceintes, d'adolescents ou de personnes âgées." Sante Publique //(3).

[BDSP. Notice produite par ENSP ZR0xsA2I. Diffusion soumise à autorisation]. Sous l'impulsion de l'INPES et de la CNAMTS, 5 démarches d'éducation pour la santé ont été conçues et expérimentées par 61 médecins généralistes et pharmaciens dans 5 sites pilotes en France auprès de 185 personnes âgées, adolescents ou femmes enceintes. L'élaboration de ces démarches a nécessité un encadrement d'un an des professionnels de santé dans une démarche de projet organisée. Les interventions éducatives élaborées répondent au critères de l'éducation pour la santé : approche globale et personnalisée du patient, participation active au processus d'apprentissage. Les démarches éducatives ne sont pas centrées sur une approche thématique de santé, mais sur la personne, appartenant à une catégorie de population. Il s'agit d'une approche populationnelle d'éducation pour la santé

Keriel-Gascou Maud, B.-P. A., Le Pogam Marie-Annick, et Al. (2013). "Information et participation active des patients à l'aide d'une brochure interactive lors de la prescription d'antihypertenseurs en soins primaires." Sante Publique // **25**(2).

[BDSP. Notice produite par EHESP EpR0xsqo. Diffusion soumise à autorisation]. La prescription médicamenteuse en soins primaires serait responsable d'effets indésirables chez 25% des patients avec des conséquences graves dans 13% des cas. L'objectif des auteurs a été d'élaborer une brochure interactive permettant d'informer et d'impliquer le patient en vue de prévenir les effets indésirables médicamenteux

Lacroix, A., Haxaire, C., Pelicand, J., et al. (2009). "Théories et concepts." Actualite Et Dossier En Sante Publique(66): 16-25.

[BDSP. Notice produite par EHESP E9mR0xEH. Diffusion soumise à autorisation]. L'éducation thérapeutique se construit autour de la rencontre des sciences médicales, humaines et sociales. Complémentaires ou en opposition, les concepts et modèles théoriques sur lesquels elle se fonde font l'objet d'un débat aussi vif qu'intéressant. Les premières tentatives d'éducation thérapeutique consistaient à diffuser des savoirs médicaux relatifs à la maladie alors qu'il s'agissait surtout, pour les patients concernés, d'être entraînés à gérer leur traitement. Or, s'agissant de la maladie, s'approprier des savoirs ne garantit pas leur mise en oeuvre en comportements pertinents. Pour le malade et son entourage, la maladie est expérience vécue, ancrée dans leur histoire, dans leur culture, dans leur milieu social et économique, expérience cadrée ou contrainte par les modes de prise en charge accessibles, expérience de bouleversement du quotidien et de limitation durable de la vie parfois. Dans sa pratique soignante et éducative avec des personnes atteintes de maladies chroniques, le soignant est confronté à deux lieux d'ambivalence. Le premier tient à l'évolution du partage de pouvoir et de responsabilité technique entre patient et soignant. Le second est lié au fait d'accepter que le patient définisse ses propres normes de santé et de prise en charge, même lorsque celles-ci l'exposent à un risque accru de souffrir de complications de sa maladie. En matière de maladies chroniques, cependant, la guérison est par définition exclue et le mieux que le soignant puisse faire est de soulager le patient. Seulement soulager, en sachant renoncer au phantasme de l'éradication du mal et de l'atteinte du bonheur.

Lambert, T., Sannie, T., Bourgeois, O., et al. (2011). "Éducation thérapeutique dans l'hémophilie : quelle place pour le médecin généraliste ?" Concours Medical // **133**(5).

[BDSP. Notice produite par ORSRA pR0xnFrF. Diffusion soumise à autorisation]. Les parents d'enfants hémophiles et les adultes hémophiles attendent un accompagnement et une prise en charge globale de la part de leur médecin généraliste. Le rôle du généraliste est d'une part d'informer le patient sur l'existence des centres spécialisés qui l'aide à acquérir l'autonomie et les compétences nécessaires pour mieux vivre avec sa maladie, et d'autre part de l'accompagner dans sa maladie tout au long de sa vie

Lang, J. P., Jurado, N., Herdt, C., et al. (2019). "[Education care in patients with psychiatric disorders in France: Psychoeducation or therapeutic patient education?]." Rev Epidemiol Sante Publique **67**(1): 59-64.

CONTEXT: Psychoeducation and therapeutic patient education can be effectively included in treatments for patients with psychiatric disorders. These two effective educational therapies have the common purpose of improving disorder-related morbidity, compliance with treatment and patients' quality of life. While they have different methods of application, both teach patients to play an active role in their own care. However, it is still critical to combine them for care of patients with psychiatric and addiction disorders in a manner that allows for specificity. To do this, the differences between psychoeducation and therapeutic patient education must be considered, and their potential for the management of patients with psychiatric and addiction disorders must be determined. METHODS: In our article, we review the literature concerning therapeutic education programs for patients and discuss the literature based on the experiences of psychiatrists trained in these therapies. RESULTS: Despite rather nonrestrictive guidelines, and after reviewing numerous studies, we found that psychoeducation seems to be rarely used in psychiatry. The use of therapeutic patient education programs for psychiatric patients has doubled in four years but still accounts for less than 4% of validated programs in France. Only 154 programs were developed in 1175 public psychiatric facilities in 2016. Therapeutic patient education has a legal framework and recommendations, which make it suitable for inclusion in care and in the training of care providers. The rigor in the development of therapeutic patient education programs and the requirement for training and financial support reinforce the need for their establishment in healthcare institutions. As such, they could help to modify professional practices and the culture of care in mental health fields. CONCLUSION: There is a place for therapeutic patient education in psychiatry as it provides a real benefit for patients. It could modify care practices and costs, and is suitable for patients with psychiatric or addiction disorders by helping them play an active role in their care, thereby improving treatment outcomes and quality of life.

Lasserre Moutet, A., Dupuis, J., Chambouleyron, M., et al. (2008). "Transformer son identité professionnelle : impact d'un programme de formation continue de soignants en éducation thérapeutique du patient." PEDAGOGIE MEDICALE **9**(2): 83-93.

> Le Diplôme de formation continue en éducation thérapeutique du patient (DiFEP) décerné par la Faculté de Médecine de l'Université de Genève a été créé en 1998 pour encourager la développement des compétences des soignants dans l'accompagnement des personnes vivant avec une maladie chronique. Selon nous, l'Education Thérapeutique du Patient (ETP) remet profondément en question le rapport soignant-soigné et incite le soignant à faire évoluer son identité professionnelle. But : Cette étude a pour objectif d'évaluer l'impact du DiFEP sur la transformation de l'identité professionnelle des soignants. Méthode : Un questionnaire a été adressé aux 49 soignants diplômés ; 28 questionnaires nous ont été retournés (57 %). Résultats : Les résultats montrent que 65 % des soignants ont tout à fait évolué dans leur perception du rôle du patient dans son traitement : de profane, celui-ci devient partenaire de soin ; 53 % des soignants témoignent d'une importante évolution de leur perception de leur rôle : la relation thérapeutique est maintenant considérée comme un soin à part entière. Enfin, 44 % des soignants occupent de nouvelles responsabilités en lien direct avec l'éducation thérapeutique du patient au sein de leurs institutions. Conclusion : La formation continue est donc l'occasion de transformations qui ont une portée identitaire. Les formateurs doivent se préoccuper non seulement des connaissances qu'ils transmettent mais aussi d'accompagner ces transformations identitaires.

Le Boeuf, D. (2012). "[Patient education, from implicit nursing practice to structured programs]." Soins(764): 26-28.

> Therapeutic patient education, which with the "Hospital, patients, health and territories" law became a priority of the healthcare system, notably for chronic diseases, has been rooted in nursing training and practice since the 1960s. Following in the steps of the World Health Organisation and the International Council of Nurses, successive laws relating to the profession have continuously emphasised it. Now that it has an official and general framework in France, it should develop within nursing practice.

Le Collen, L., Douillard, A., Pontal, D., et al. (2019). "[Roles of the general practitioner and the vascular medicine physician for patient education concerning venous thromboembolism: The patient's perspective]." J Med Vasc **44**(4): 266-273.

> INTRODUCTION: Venous thromboembolism (pulmonary embolism and deep-vein thrombosis) is a frequent, serious but also chronic disease. Studies reported that both general practitioners (GPs) and vascular medicine physicians (VMPs) report participating in patient education concerning venous thromboembolic disease. OBJECTIVE: To assess the role of GPs and VMPs in venous thromboembolic disease patient education, examining the patient's perspective. METHOD: Phone survey of the French patients recruited in the CACTUS trial assessing anticoagulant treatment in case of first distal deep-vein thrombosis. RESULTS: Among the 103 participating patients, 92% (n=95) reported being satisfied by information provided by the GP and VMP. Information was considered as necessary in 96% of cases (n=99). Eighty-five percent of patients (n=88) felt they did not need complementary information. The VMP would have spent more time on education as compared with the GP (an entire consultation in 93.2% vs. 38.8% of cases respectively) the information provided by the VMP being also clearer and more complete. More than 75% of patients reported that no physician warned them about risks of anticoagulants, long-term complications of venous thromboembolic disease or its prevention. CONCLUSION: In CACTUS, patients reported being satisfied by information provided by their managing physicians and information provided by the VMP was clearer and more complete. Important education messages may not have been delivered suggesting the need for a standardization of venous thromboembolic disease patient's education.

Le Fur. P. (2013). "Education thérapeutique : quelles qualités pour l'accompagnant ? Pratique en santé mentale." Medecine : Revue de L'Unaformec **9**(7).

La pratique de l'éducation thérapeutique est nouvelle en santé mentale. Elle soulève la question de l'analogie de la pathologie mentale à la santé physique. En effet, l'association des deux champs, éducatif et thérapeutique, pose en santé mentale des problèmes de compatibilité de ces deux domaines et de leur champ commun [1]. Le terme « thérapeutique » associe deux significations que différencie la langue anglaise : care et cure. En psychiatrie notamment, le « thérapeutique » se fonde non seulement sur le soin technique (cure) mais aussi sur la rencontre singulière soignant/soigné dans laquelle les soignants ne sont pas interchangeables ni prestataires de service mais créent un lien avec le patient (care). Le care prendre soin, mais aussi attacher de l'importance à la personne, la reconnaître comme sujet dans la pratique de soin classique en santé mentale souligne la notion de relation d'aide, de soutien, d'étayage, la notion d'alliance thérapeutique. Plus récemment, dans une perspective plus cognitive, a été développé dans la littérature anglo-saxonne le concept de care manager dans la réhabilitation psychosociale et le rétablissement (recovery)

Legrand, K., Gendarme, S., Coyard, H., et al. (2012). "[Therapeutic patient education in health centers in the Lorraine region of France - an EPATEL study]." Santé Publique **24**(2): 93-104.

The purpose of this paper is to map out the Therapeutic Patient Education activities of health centers in the Lorraine region of France in the months leading up to the promulgation of the HPST law (reform of the French Public Hospital system) defining and regulating TPE. A self-administered survey and interviews were conducted to identify the educational activities offered by the program (structure, training of professionals, links with general practitioners, etc.) and to quantify them (number of patients, classes, etc.). All health centers in Lorraine were contacted (193 centers in total). 93 centers responded and 48?reported TPE activities, with 131 functional TPE courses (or structured activities) and 40 projects. An analysis based on 8 quality criteria was carried out. The study found that 49 centers met at least 6 quality criteria and were close to the required quality standards. The study also found that the geographical distribution of TPE provision is unbalanced. The number of TPE beneficiaries in a given semester varies between 0 and 24 patients per 1,000 inhabitants (according to the health area), which amounts to 5% of chronically ill people in the Lorraine region.

Lelorain, S., Bachelet, A., Bertin, N., et al. (2017). "French healthcare professionals' perceived barriers to and motivation for therapeutic patient education: A qualitative study." Nurs Health Sci **19**(3): 331-339.

Therapeutic patient education is effective for various patient outcomes; however, healthcare professionals sometimes lack the motivation to carry out patient education. Surprisingly, this issue has rarely been addressed in research. Therefore, this study explores healthcare professionals' perceived barriers to and motivation for therapeutic patient education. Healthcare professionals, mainly nurses, working in different French hospitals were interviewed. Thematic content analysis was performed. Findings included a lack of skills, knowledge, and disillusionment of the effectiveness of therapeutic patient education were features of a demotivated attitude. In contrast, a positive attitude was observed when therapeutic patient education met a need to work differently and more effectively. A key factor motivating professionals was the integration of therapeutic patient education in routine care within a multidisciplinary team. To keep healthcare professionals motivated, managers should ensure that therapeutic patient education is implemented in accordance with its core principles: a patient-centered approach within a trained multidisciplinary team. In the latter case, therapeutic patient education is viewed as an efficient and rewarding way to work with patients, which significantly motivates healthcare professionals.

Lemoine S., F. (2014). "Parcours de soin : Hypertension artérielle, un parcours optimisé pour contrôler 7 hypertendus sur 10 en 2015." Concours Medical // **136**(4).

[BDSP. Notice produite par ORSRA rR0xlCkE. Diffusion soumise à autorisation]. Ce dossier s'intéresse à un parcours optimisé pour contrôler 7 hypertendus sur 10 en 2015 : il expose la qualité du dépistage comme première condition de la prévention, la place des mesures ambulatoires dans la confirmation du diagnostic, l'annonce du diagnostic comme prérequis indispensable, la gestion de l'urgence hypertensive, l'initiation du traitement, les particularités du sujet âgé, le suivi à court terme comme investissement pour l'avenir, comment motiver le patient par une Education Thérapeutique du Patient de proximité, le rôle clé du médecin généraliste dans le combat contre l'inertie médicale, la nécessité du contrôle tensionnel en prévention secondaire, la place des infirmières spécialisées dans le suivi éducatif sur le long terme, le télésuivi comme effet actif possible sur le contrôle tensionnel. On fait alors le constat suivant : il existe deux philosophies différentes, celle de la Société française d'hypertension artérielle (SFHTA), et celle des Sociétés européennes d'hypertension et de cardiologie (ESH/ESC). Le dossier se termine sur Le Comité français de lutte contre l'hypertension artérielle comme relais d'information, les centres d'excellence européens en HTA, la Fédération française de Cardiologie et les associations dans leur combat pour un plan coeur

Liou, A., Nahmiash, A., Lebray, P., et al. (2011). "Hépatite virale C chronique : Contribution du médecin généraliste à l'éducation thérapeutique." Concours Medical **133**(10).

[BDSP. Notice produite par ORSRA 9IA9AR0x. Diffusion soumise à autorisation]. L'hépatite C chronique est une maladie contagieuse, souvent asymptomatique, dont la guérison définitive est possible sous un traitement bien conduit. Mais ces possibilités de guérir peuvent être remises en cause par des effets secondaires majorés et invalidants. L'éducation thérapeutique du patient prend donc une place importante en vue de la guérison définitive, et au niveau du coût lié à la prise en charge des complications de l'hépatite virale C chronique en l'absence de traitement adapté. Une bonne coordination entre l'équipe spécialisée, le médecin traitant et le patient est nécessaire

Magar, Y. (2011). "[Professional training in therapeutic education]." Soins Pediatr Pueric(259): 20-22.

The educational approach differs from the traditional clinical approach and requires specific skills. Which skills are used in patient therapeutic education? How can caregivers be effectively trained to fulfill this mission?

Magar, Y., Delavaud, J. M. et Girardot, L. (2012). "Le contrôle de l'asthme : Un défi pour le médecin généraliste." Concours Medical **134**(6).

[BDSP. Notice produite par ORSRA kER0xI9H. Diffusion soumise à autorisation]. L'asthme devrait, avec un traitement associant anti-inflammatoires et bronchodilatateurs, pouvoir être contrôlé. Or, le contrôle de l'asthme reste encore insuffisant et entraîne des répercussions importantes sur le plan clinique, la qualité de vie et les coûts directs et indirects de la maladie. L'éducation thérapeutique pour cette maladie chronique prend alors toute son importance

Magar, Y., Girardot, L., Dressen, C., et al. (2011). "Éducation thérapeutique des aidants de patients souffrant de la maladie d'Alzheimer. Rôle du médecin généraliste." Concours Medical **133**(7).

[BDSP. Notice produite par ORSRA 89R0xsko. Diffusion soumise à autorisation]. Comme pour toute maladie chronique, l'éducation thérapeutique constitue une dimension importante de la prise en charge de la maladie d'Alzheimer. Cette éducation doit impliquer le patient le plus longtemps possible durant l'évolution de la maladie, mais aussi les aidants. L'éducation thérapeutique peut apporter une contribution importante pour faciliter la prise en charge par l'aidant et prévenir l'évolution de ce dernier vers l'épuisement. Des programmes éducatifs existes mais le rôle du médecin généraliste est également important. Il doit accompagner l'aidant et lui proposer certains apprentissages concrets, lui permettant de gérer les difficultés quotidiennes

Margat, A. (2017). ETP : étude de l'évaluation quadriennale des programmes d'éducation thérapeutique autorisés en Ile de France : 2010-2011. Paris : ARS. **29**.
https://www.iledefrance.ars.sante.fr/etp-etude-de-levaluation-quadriennale-des-programmes-autorises-en-ile-de-france-entre-2010-et-debut

Margat, A. et Morsa, M. (2018). "Le médecin généraliste, un acteur central dans l'accompagnement des patients atteints de maladies chroniques faiblement alphabétisés." Medecine : De La Medecine Factuelle a Nos Pratiques(14): 365.

Parmi les réponses apportées aux malades chroniques, l'éducation thérapeutique du patient tient une place importante. Cependant, un faible niveau de littératie en santé (LS) constitue un obstacle majeur pour accéder à cette éducation. Ceci est particulièrement déterminant chez les patients faiblement ou non alphabétisés qui bénéficient moins des actions d'éducation en santé et ne possèdent pas les compétences pour recourir aux ressources existantes. La LS est au carrefour de l'éducation, de la santé et de la culture et, en ce sens, elle nécessite une approche pluridisciplinaire et pluriprofessionnelle. À ce titre, le médecin généraliste peut jouer un rôle central que ce soit par le repérage des patients avec un faible niveau de littératie ou la mise en œuvre d'interventions éducatives.

Marquillier, T., Trentesaux, T. et Gagnayre, R. (2017). "[Therapeutic education in pediatric dentistry: analysis of obstacles and levers to the development of programmes in France in 2016]." Santé Publique **29**(6): 781-792.

OBJECTIVE: Over recent years, therapeutic patient education has become part of dental medicine. Management of early childhood caries, known to be a very common chronic disease, has evolved to include an educational dimension. The objective of this study was to identify the levers and barriers to the development of formalized therapeutic education programmes and alternatives. METHODS: A comprehensive exploratory qualitative study was conducted between November 2015 and June 2016 on a targeted sample of 15 people aware of the problem of TPE in dentistry. RESULTS: The study showed that TPE training in dentistry is underdeveloped, despite its numerous benefits: change of the healthcare professional's approach, implementation of structured educational programmes, development of research, etc. There are many obstacles to the development of TPE programmes: insufficient resources, rigid legislation or lack of knowledge of TPE practices. The dental profession is an obstacle itself because of its lack of understanding and variable degrees of integration the medical community. There are multiple levers, but the main ones are changing attitudes of the profession and the provision of resources to develop TPE. Although alternatives to TPE programmes exist (accompanying measures, short educational strategies, connected health), they cannot replace TPE. CONCLUSION: More educational strategies must be developed in the field of dentistry. However, the framework of TPE must be adapted to the profession to ensure good uptake.

Meillet, L., Combes, J. et Penfornis, A. (2013). "[Management of type 2 diabetes: Patient education]." Presse Med **42**(5): 880-885.
PM:23523080

Patient education emerged initially as an essential component of the management of type 1 diabetes. Patient education has also been for long an integral part of the recommendations for managing type 2 diabetes. Studies about patient education and type 2 diabetes have demonstrated the effectiveness of patient education by studying the evolution of bioclinic markers including HbA1c. However, if we return to the foundations of patient education definition, we cannot summarize the effectiveness of patient education on the only decrease of HbA1c. So, if the aim of patient education is to support patients to take better care of themselves, it might be interesting to use other types of evaluation methodology, including qualitative studies, to reflect the different dimensions of patient education, especially psychosocial

Mendyk, A. M., Duhamel, A., Bejot, Y., et al. (2018). "Controlled Education of patients after Stroke (CEOPS)- nurse-led multimodal and long-term interventional program involving a patient's caregiver to optimize secondary prevention of stroke: study protocol for a randomized controlled trial." Trials **19**(1): 137.

BACKGROUND: Setting up a follow-up secondary prevention program after stroke is difficult due to motor and cognitive impairment, but necessary to prevent recurrence and improve patients' quality of life. To involve a referent nurse and a caregiver from the patient's social circle in nurse-led multimodal and long-term management of risk factors after stroke could be an advantage due to their easier access to the patient and family. The aim of this study is to compare the benefit of optimized follow up by nursing personnel from the vascular neurology department including therapeutic follow up, and an interventional program directed to the patient and a caregiving member of their social circle, as compared with typical follow up in order to develop a specific follow-up program of secondary prevention of stroke. METHODS/DESIGN: The design is a randomized, controlled, clinical trial conducted in the French Stroke Unit of the Strokavenir network. In total, 410 patients will be recruited and randomized in optimized follow up or usual follow up for 2 years. In both group, patients will be seen by a neurologist at 6, 12 and 24 months. The optimized follow up will include follow up by a nurse from the vascular neurology department, including therapeutic follow up, and a training program on secondary prevention directed to the patient and a caregiving member of their social circle. After discharge, a monthly telephone interview, in the first year and every 3 months in the second year, will be performed by the nurse. At 6, 12 and 24 month, the nurse will give the patient and caregiver another training session. Usual follow up is only done by the patient's general practitioner, after classical information on secondary prevention of risk factors during hospitalization. The primary outcome measure is blood pressure measured after the first year of follow up. Blood pressure will be measured by nursing personnel who do not know the group into which the patient has been randomized. Secondary endpoints are associated mortality, morbidity, recurrence, drug side-effects and medico-economic analysis. DISCUSSION: The result of this trial is expected to provide the benefit of a nurse-led optimized multimodal and long-term interventional program for management of risk factors after stroke, personalizing the role of the nurse and including the patient's caregiver. TRIAL REGISTRATION: ClinicalTrials.gov, NCT 02132364. Registered on 7 May 2014. EUDRACT, A 00473-40.

Mosnier-Pudar, H., Hochberg, G., Reach, G., et al. (2010). "Information and therapeutic education of diabetic patients in French hospitals: the OBSIDIA survey." Diabetes Metab **36**(6 Pt 1): 491-498.

AIM: Although several studies have evaluated the efficacy of therapeutic education (TE) programmes in patients with diabetes and demonstrated the benefits of such interventions, operational aspects are rarely described. For this reason, this national survey was conducted to investigate TE in France, and to identify its obstacles and needs. METHODS: A preliminary qualitative phase was extended to include a quantitative survey through face-to-face interviews, followed by a web-based self-administered questionnaire sent out to every healthcare professional dealing with diabetic patients. RESULTS: From the expanded web-based survey, 272 questionnaires were analyzed (39% from academic hospitals, 54% from general hospitals and 7% from private clinics); 85% of these sites provided TE for inpatients. Overall, TE was offered to 66% of patients (84% new patients) and was individualized in 55% of cases, and involved 9.4 healthcare professionals on average, with physicians, nurses and dietitians making up the core team. The TE offered encompassed a wide range of diabetes topics. However, of every 10 healthcare professionals, only 35% received specific training, while 45% received coaching from their colleagues and 10% received no training at all. Evaluation of TE was carried out in 60% of teams by questionnaires or interviews. CONCLUSION: TE is well implemented in French hospitals, but lacks homogeneity and standardization. Training is inadequate from both qualitative and quantitative points of view, and evaluation of TE procedures needs to be developed. There is also a need for more funding and dedicated qualified staff, a lack of which is partly due to the fact that TE is not a recognized medical activity in hospitals.

Moumjid, N., Christine, D.-B., Denois-Regnier, V., et al. (2011). "Shared decision making in the physician-patient encounter in France: a general overview in 2011." Z Evid Fortbild Qual Gesundhwes **105**(4): 259-262.

WHAT ABOUT POLICY REGARDING SDM? There is a social demand in France for more healthcare user information and greater patient participation in the decision making process, as reflected by the law of March 4(th) 2002 pertaining to patients' rights and the quality of the healthcare system known as the Law on Democracy in healthcare. WHAT ABOUT TOOLS - DECISION SUPPORT FOR PATIENTS? At the micro level, some research projects are being developed, some of them using decision aids. Preliminary results show that patients want to be informed but that the concept of shared decision making needs to be analysed and refined from both the patients' and the physicians' points of views. WHAT ABOUT PROFESSIONAL INTEREST AND IMPLEMENTATION? However, the relationship between physicians/healthcare professionals and patients/healthcare users is very complex and progress in this field takes time. Only ten years after enactment of the Law on Democracy in healthcare, it might be premature to try and determine the state of the art of shared medical decision making at the macro and meso levels in France. WHAT DOES THE FUTURE LOOK LIKE? There is room in France for further studies on shared decision making in the medical encounter. Researchers, decision makers, healthcare users and healthcare professionals need a place to meet and exchange. An observatory dedicated to shared decision making will be launched in the coming months, both at the national level and in collaboration with several other French-speaking areas like Switzerland and the province of Quebec.

Mousques, J., Bourgueil, Y., Le, Fur. P., et al. (2010). Effect of a french experiment of team work between general practitioners and nurses on efficacy and cost of type 2 diabetes patients care, Paris : Irdes
http://www.irdes.fr/EspaceAnglais/Publications/WorkingPapers/DT29EffectExperGenePractiNursesDiabetPatientsCare.pdf

Cette étude a pour objectif d'évaluer l'efficacité et les coûts d'une expérimentation de travail en équipe entre des infirmières et des généralistes (l'expérimentation ASALEE), dans le cas de la prise en charge des patients souffrant de diabète de type 2. Elle s?appuie sur un design cas/témoin dans lequel nous comparons l'évolution des résultats de soins en termes de processus (procédures standards de suivi) et de résultat final (le contrôle glycémique), ainsi qu'en termes de coûts. Cette comparaison est réalisée entre deux périodes consécutives et entre des patients diabétiques de type 2 suivis dans l'expérimentation (le groupe d'intervention) ou dans le groupe témoin (le groupe contrôle). Nous montrons qu'après onze mois de suivi, les patients ASALEE, comparés à ceux du groupe témoin, ont une plus grande probabilité de rester ou devenir bien suivis en termes d'indicateurs de processus (OR compris entre 2.1 à 6.8, p < 5 %), ainsi qu'en termes de contrôle glycémique (OR compris entre 1.8 à 2.7, p < 5 %). Ces derniers résultats sont obtenus uniquement lorsque les patients ont bénéficié d'au moins une consultation infirmière d'éducation et de conseils hygiéno-diététiques en complément du rôle classique des infirmières dans le cadre de l'expérimentation ASALEE, c'est-à-dire la mise à jour des dossiers médicaux informatisés avec l'inscription éventuelle de rappels informatiques à destination des généralistes.

Mousquès, J., Sermet, C. (2003). Évaluation des rappels informatiques dans l'instauration et le suivi de l'éducation diététique de patients diabétiques de type 2, obèses ou en surpoids: rapport d'étude. Rapport Irdes ; 1494bis. Paris : Credes
http://www.irdes.fr/Publications/Rapports2003/doc1494bisEvaluationRappelsInfos

Nahon, S. et Girardot, L. (2012). "Maladies inflammatoires chroniques de l'intestin : interventions éducatives du médecins généraliste." Concours Medical **134**(1): 52-56.

[BDSP. Notice produite par ORSRA 9mR0x998. Diffusion soumise à autorisation]. La rectocolite hémorragique (RCH) et la maladie de Crohn sont des maladies inflammatoires chroniques de l'intestin (MICI) de cause mal connue, évoluant par poussées espacées par des périodes de rémission ; l'évolution est imprévisible. Les MICI nécessitent un traitement lors des poussés et un traitement de fond visant à prévenir les rechutes. Les patients atteints de MICI souffrent de symptômes digestifs (et parfois extradigestifs) nécessitant un recours fréquent aux soins et altérant sévèrement leur qualité de vie. L'éducation thérapeutique constitue donc une approche importante dans la prise en charge des MICI.

Nemirovsky, B. (2013). "Asalée : un continuum de soins, du dépistage précoce au suivi." Concours Medical (Le) // **135**(9).

Avec bientôt dix années d'existence, le dispositif Asalée (Action de santé libérale en équipe) a évolué et progressé . Pour le docteur Jean Gautier, président de l'association, Asalée reste particulièrement adapté au dépistage précoce et au suivi des personnes ayant un diabète de type 2 avéré mais aussi à risque de diabète de type 2

Nicoulaud-Franchi, J. A., Balzani, C. et Vion-Dury, J. (2012). "L'entretien en "explicitation" en médecine : pour explorer les vécus subjectifs." Medecine : Revue de L'Unaformec // **8**(8).

L?apprentissage et la pratique de la médecine posent des questions qui ne relèvent pas uniquement du savoir médical biopsychosocial et de la pratique réglée sur ce savoir. Ces questions impliquent en effet le vécu subjectif et des expériences du patient comme du médecin. Du côté du patient, on peut notamment soulever les questions importantes du sentiment de bonne santé, comme de l?acceptation et de l?engagement dans les thérapeutiques ne correspondant pas forcément à ses représentations et pouvant n?être pas comprises voire s?avérer angoissantes. Du côté du médecin, on peut soulever les questions de l?apprentissage du diagnostic, de l?évaluation du pronostic et de la décision thérapeutique, mais également de la conduite pratique des thérapeutiques et de l?accompagnement du patient

Orfanos, S., Carsin, A., Baravalle, M., et al. (2017). "[Health care providers' knowledge and abilities to use inhalation devices and spacers]." Rev Mal Respir **34**(5): 561-570.

INTRODUCTION: Inhaled therapy is the mainstay of asthma treatment due to its local and rapid action. However, its efficiency relies on the teaching of a good inhalation technique by health care providers. We assessed health care providers' knowledge and practical skills in the use of inhalation devices. METHODS: An observational multicenter study was conducted in the pulmonology and paediatric wards in Marseille. The departments' common practices, theoretical knowledge and practical skills were assessed through a questionnaire and a demonstration using a spacer device. RESULTS: Forty health care providers were interviewed (9 attending physicians, 14 residents, 16 nurses and 1 physiotherapist), in 8 different pulmonology and paediatric wards. A total of 42.5% reported previous training in inhalation device technique. When evaluating theoretical knowledge, we found a mean of 54% correct answers. Attending physicians did significantly better than residents and nurses. With regard to practical skills, we found a mean of 1.12 failed steps out of 7. Here again attending physicians did significantly better than residents and nurses. CONCLUSION: Based on the results of our study, we recommend that attending physicians provide training of inhalation technique to nurses and residents, as they did significantly better theoretically and practically.

Panot, S., Mispelblom-Beyer, F. et Girardot, L. (2019). "Quand l'éducation thérapeutique interroge le "coeur de métier" des médecins généralistes." Medecine : De La Medecine Factuelle a Nos Pratiques **15**(7): 318-323.

L’éducation thérapeutique des patients (ETP), souvent dispensée sous forme de programmes dans le cadre de réseaux de santé, met en lien le Médecin généraliste (MG) avec de nombreux autres professionnels de santé. Elle suggère des modifications dans la façon d’exercer au quotidien, d’adopter une posture éducative plutôt que prescriptive, d’interagir différemment et plus étroitement avec les autres professionnels de santé, de se familiariser avec de nouveaux outils de communication entre professionnels. Cet article s’intéresse aux interrogations et doutes des MG lors de cette mise en pratique de l’ETP au sein d’un dispositif dédié à la prise en charge de patients diabétiques ou, plus généralement, présentant des facteurs de risques cardiovasculaires. Globalement l’ETP questionne les pratiques, interpelle les MG dans l’idée qu’ils se font de leur métier, de ce qui leur est légitime de faire ou non, amène des changements effectifs de postures, et modifie en « mieux » les rapports avec les autres professionnels de santé.

Paraponaris, A., Ventelou, B. et Verger, P. (2011). La médecine générale vue par les médecins généralistes libéraux : résultat d'enquête. Revue Francaise des Affaires Sociales (4)

[BDSP. Notice produite par MIN-SANTE IAqsR0xI. Diffusion soumise à autorisation]. Les systèmes de santé évoluent. Ainsi, au sein des professions médicales, les médecins libéraux de ville se sentent certainement parmi les plus directement sollicités par le changement. Ils sont donc plus exposés aux mutations de l'environnement externe : mutations politiques, économiques et sociales. Les dispositifs d'observation répétée à grande échelle de la population de médecins généralistes sont relativement rares en France. À l'initiative de la Direction de la recherche, des études, de l'évaluation et des statistiques (DREES) du ministère de la Santé, de la Fédération nationale des observatoires régionaux de la santé (FNORS), des unions régionales des médecins libéraux (URML), des observatoires régionaux de la santé (ORS) et des unions régionales des caisses d'assurance maladie (URCAM) de cinq régions françaises (Basse-Normandie, Bourgogne, Bretagne, Pays de la Loire, Provence-Alpes-Côte d'Azur), la création d'un dispositif d'observation des pratiques et des conditions d'exercice en médecine générale a pris, en 2007, la forme d'un panel. Trois objectifs ont été visés : l'observation des pratiques de prise en charge en médecine générale et leurs déterminants, l'observation du cadre d'activité, de

> l'environnement professionnel et du rythme de travail des médecins, et la réponse aux attentes spécifiques d'acteurs régionaux

Pellet, F. et Picard, J. M. (2012). Place d'une consultation infirmière de suivi de patients atteints de maladie chronique dans les maisons et pôles de santé en France. Quelques éléments de réflexion et perspectives tirés d'une enquête (09/2011). Les Vans Unité transversale d'éducation et de promotion de la santé du Pays des Vans.**:** 96 + annexes, tabl., fig.

> Cette étude avait pour but de connaître, par le biais d'une enquête comment les médecins généralistes et les infirmier(e)s se représentaient la consultation infirmière dans les maisons et pôles de santé. Elle s'est surtout centrée sur les consultations en lien avec la prévention, la santé publique, l'éducation thérapeutique et l'éducation pour la santé qui s'appuient sur le rôle propre de l'infirmier(e). Cet état des lieux comportait, entre autres, une évaluation de la place accordée à une démarche de soins basée sur la classification internationale des diagnostics, interventions et résultats de soins infirmiers, aux représentations de l'éducation et de la santé, mais aussi à la place attribuée aux concepts de santé, d'éducation et aux théories infirmières.

Pernin, T., Sahier, C., Monotuka, S., et al. (2018). "Savoir reconnaître le savoir expérientiel des patients : une humilité et une force pour le médecin généraliste." Medecine : De La Medecine Factuelle a Nos Pratiques **14**(1): 19-22.

> Bien que formulée par les textes réglementaires, l'implication de patients dans les activités d'éducation thérapeutique du patient (ETP) reste faible en France. De nombreuses publications internationales soulignent le savoir expérientiel des patients-ressources, la construction de partenariats avec les soignants et l'amélioration de l'état de santé de patients ciblés grâce à leur intervention. Le réseau Paris Diabète (RPD) intègre des patients dans sa gouvernance et cherche à les impliquer dans l'animation de ses programmes d'ETP.

Petre, B., Ketterer, F., Vanmeerbeek, M., et al. (2016). "[Cross-border evaluation of needs for training in therapeutic education of the patient for the management in type 2 diabetes and obesity: Survey by method of nominal group with healthcare professionals]." Presse Med **45**(10): e351-e361.

> INTRODUCTION: The design of continuous training programs in therapeutic patient education (ETP) should be inspired by needs shown by the professionals concerned in terms of mobilization or acquisition of skills in this domain. The objective of this study is to analyze needs expressed by healthcare professionals (HP) involved in patients' management presenting a type 2 diabetes (T2D) and/or obesity and to compare them with the existing recommendations. METHODS: One hundred and five PS (general practitioners, dietitians and nurses) of 3 frontier regions of French-speaking European countries (France, Belgium and Grand duchy of Luxembourg) were questioned in 12 monodisciplinary groups according to the technique of the nominal group. Needs expressed by the participants were classified in the categories of the reference table of skills to dispense TPE (National Institute for Health Prevention and Education [INPES], 2013). RESULTS/DISCUSSION: Among needs expressed by HP, 52 % of the votes targeted relational skills, 10 % of the skills relative to the biomedical techniques, 20 % of the skills relative to the educational techniques and 11 %, those of organization and the coordination. Seven percent of the proposals were out of the categories of the INPES. Results do not allow to establish profiles of skills according to the studied region or profession. The recognition of the TPE by the French legislation does not seem to influence in a major way the data. CONCLUSION: The needs expressed by PS in the context of this study are focused on the relation HP/patient that is the heart of the TPE. It would however be necessary to raise awareness among HP in the acquisition of the other skills which concern in particular the animation of group, the interprofessional coordination, the consideration of the environment or more generally the procedures.

Petre, B. O., Degrange, S., Tittaferante, S., et al. (2016). "[Hospital and general therapeutic patient education practices: example of diabetes and obesity in Belgium]." Santé Publique **28**(3): 287-298.

Introduction/Objectives: Therapeutic Patient Education (TPE) is now part of the new medical landscape, including for the prevention and treatment of diabetes and obesity. While some countries, such as France, have decided to give priority to TPE in public health policy by means of legal recognition, no such framework has been developed in Belgium. The purpose of this article is to describe the actual TPE practices of health professionals (HP) in this environment.Methods: 82 face-to-face interviews (20 GPs and 62 hospital healthcare professionals) were conducted according to a semi-structured interview guide developed from the French Health Authority guidelines. Qualitative content analysis was performed on the data collected.Results/Discussion: For the majority of respondents, TPE is limited to brief information about the disease, its risk factors and complications. This representation of TPE determines the practical modalities of the educational activity right from the educational diagnosis. The possibilities for developing the patient's capacities are limited. Practices reflect a lack of pedagogical structuring and do not correspond to a real multidisciplinary approach.Conclusion: Healthcare professionals must develop a clear vision of the implications of the concept of TPE and must therefore receive adequate training to ensure good quality development and implementation.

Piperini, M. (2012). "L'effet paradoxal de la communication persuasive en sessions d'éducation pour la santé." Sante Publique **24**(6).

[BDSP. Notice produite par EHESP AtCR0x9C. Diffusion soumise à autorisation]. Notre objectif était de comprendre la dynamique interlocutoire favorable à l'adoption de nouvelles cognitions et attitudes, en session d'éducation pour la santé. Nous avons étudié les échanges langagiers en jeu dans la communication persuasive développée au sein de 16 sessions d'éducation pour la santé. Nous avons constaté un effet positif de l'expertise médicale des animateurs et de l'engagement préalable des participants sur l'adhésion aux préconisations. Cependant cette communication persuasive en session d'éducation pour la santé semble initier un processus paradoxal où la critique du message peut aller de pair avec l'expression de l'intention de mettre en oeuvre de nouveaux comportements pour réduire les risques

Porcher, V. (2012). "[The health education nurse in a diabetology network]." Rev Infirm(183): 24-25.

By providing global, multi-disciplinary and coordinated care, the Resodia67 network in the Bas-Rhin department aims to improve the quality of life of patients and their family and to reduce the complications and morbidity linked to type 2 diabetes. Nurses can implement their skills in therapeutic patient education.

Puymirat, E., Teixeira, N., Simon, T., et al. (2015). "Patient education after acute myocardial infarction: cardiologists should adapt their message--French registry of acute ST-elevation or non-ST-elevation myocardial infarction 2010 registry." J Cardiovasc Med (Hagerstown) **16**(11): 761-767.

AIMS: A shorter time delay between onset of symptoms and first call for medical attention would be expected in patients with a history of ischemic heart disease (IHD). We aimed to determine whether time to first call for an ST-elevation myocardial infarction (STEMI) differed between patients with or without history of coronary artery disease from the French registry of acute ST-elevation or non-ST-elevation myocardial infarction (FAST-MI) 2010 registry. METHODS: FAST-MI 2010 is a nationwide French registry that included 4169 patients with acute myocardial infarction (AMI, 2193 STEMI) at the end of 2010 in 213 centers. Factors correlated with time to first call were assessed, with a specific emphasis on previous history of IHD (IHD+; n = 402), compared with patients without history of IHD (IHD-; n = 1791). RESULTS: Time from onset to first call was 222 +/- 420 min (median time 68 min) in IHD+ patients versus 240 +/- 4423 min (median time 75 min) in IHD- patients (P = 0.28). In multivariate analysis, only a few factors were significantly related to a shorter time from onset to first call (</=75min); time of onset during the day (7:00 a.m. to 11:00 p.m.), upper socioeconomic class, anterior MI, cardiac arrest as the initial symptom, whereas history of IHD was not associated with a shorter time delay (odds ratio 0.86; 95% confidence interval 0.70-1.05). Similar results were found between patients with previous AMI and IHD- patients. CONCLUSION: Patients with a history of IHD do not call earlier than IHD-naive patients when they are confronted with symptoms of AMI. Cardiologists

should spend more time educating their coronary patients to recognize symptoms of AMI.Clinicaltrials.gov identifier: NCT01237418.

Rat, C., Quereux, G., Grimault, C., et al. (2016). "Inclusion of populations at risk of advanced melanoma in an opportunistic targeted screening project involving general practitioners." Scand J Prim Health Care **34**(3): 286-294.

OBJECTIVE: The study objective was to measure the rates of inclusion of populations at risk of advanced melanoma in a pilot targeted screening project involving general practitioners. DESIGN: This cross-sectional database study compared the inclusion rates of patients who signed inclusion in a targeted screening project with those of patients who did not, during a period in which both groups of patients consulted investigators. SETTING: Data were extracted from the national healthcare insurance records in western France from 11 April to 30 October 2011. PATIENTS: Patients, older than 18, considered for the data extraction had consulted one of the 78 participating GPs during the study period, and were affiliated with the national healthcare insurance. MAIN OUTCOME MEASURES: Inclusion in the screening was the main outcome measure. Patients at risk of advanced melanoma were characterized by male gender, age over 50, low income, rural residence, farmer, and presence of chronic disease. RESULTS: A total of 57,279 patients consulted GPs during the inclusion period and 2711 (4.73%) were included in the targeted screening. Populations at risk of advanced melanoma were less included: men (OR = 0.67; 95%CI [0.61-0.73]; p < 0.001), older than 50 (OR = 0.67; 95%CI [0.60-0.74]; p < 0.001), low income (OR = 0.65; 95%CI [0.55-0.77]; p < 0.001), farmer (OR = 0.23; 95%CI [0.17-0.30]; p < 0.001) and presence of a chronic disease (OR = 0.87; 95%CI [0.77-0.98]; p < 0.028). CONCLUSION: This study demonstrated inequalities in the inclusion of patients in a melanoma screening. Patients at risk of advanced cancer were screened less often. Further studies should focus on GPs ability to identify and screen these patients. KEY POINTS Advanced melanoma is more frequently diagnosed in men, older patients and socioeconomically disadvantaged populations, which leads to survival inequalities. * Despite the involvement of general practitioners, the implementation of targeted melanoma screening did not avoid inclusion inequalities. * Men, older patients, patients suffering from chronic diseases, and low-income patients were less likely to benefit from screening. * The display of a conventional or an alarmist poster in the waiting room did not statistically reduce these inclusion inequalities.

Reach, R. (2006). "La non-observance thérapeutique : une question complexe. Un problème crucial de la médecine contemporaine." Medecine : Revue de L'Unaformec // **2**(9).

On définit la non-observance thérapeutique comme l'absence d'adéquation entre les comportements des patients et les prescriptions médicales. Le problème est important du fait de sa fréquence et de ses conséquences médicales et économiques. Il est en fait révélateur de la relation médecin-malade. Il a de nombreux déterminants et mécanismes qu'il est essentiel de connaître pour améliorer l'observance thérapeutique en particulier dans le traitement des maladies chroniques (tiré de l'introduction)

Roux, F., Girardot, L. et Rousiere, M. (2011). "Ostéoporose postménopausique. Nécessité et possibilité de l'ETP en médecine générale." Concours Medical **133**(3).

[BDSP. Notice produite par ORSRA jlpFrR0x. Diffusion soumise à autorisation]. Cet article est consacré à l'éducation thérapeutique des patientes (ETP) ostéoporotiques. Pour cette pathologie, les besoins en ETP des patientes sont plus latents qu'exprimés, et le défaut d'observance est parfaitement démontré, défaut associé à une augmentation du risque de fracture. Cet article présente plusieurs études d'évaluation de programmes d'ETP et de programmes de prévention (primaire ou secondaire)

Saout, C. et Chiche, L. (2012). "[Therapeutic education and internal medicine]." Rev Med Interne **33**(11): 646-649.

Therapeutic education is not a recent idea. It arouses renewed interest thanks to the article 84 of French law no. 2009-879 from July 21, 2009 reforming the hospital and concerning patients, health and territory. This article inserts in the public health code no less than five articles devoting patient therapeutic education. Nevertheless, the conditions imposed by the legislator raise questions, which should be outstripped in favor of a widespread implementation of integrated care pathways in which therapeutic education is enclosed. In France, internists should be involved in the development of new programs of therapeutic education in the field of rare diseases, especially systemic autoimmune diseases. A pilot project for systemic lupus erythematosus is ongoing, before an expected geographic extension through referent centers, as well as the progressive development of additional programs aiming all rare diseases. Content, funding and evaluation are key points that remain to be defined.

Schieber, A. C., Kelly-Irving, M., Rolland, C., et al. (2011). "Do doctors and patients agree on cardiovascular-risk management recommandations post-consultation ? The Intermede study." British Journal of General Practice **61**(584).

Comprendre les interactions entre les patients et les médecins généralistes peuvent être importantes pour optimiser la communication au cours des consultations et l'amélioration de promotion de la santé, notamment dans la gestion des facteurs de risque cardio-vasculaire

Sustersic, M., Tissot, M., Tyrant, J., et al. (2019). "Impact of patient information leaflets on doctor-patient communication in the context of acute conditions: a prospective, controlled, before-after study in two French emergency departments." BMJ Open **9**(2): e024184.

OBJECTIVE: In the context of acute conditions seen in an emergency department, where communication may be difficult, patient information leaflets (PILs) could improve doctor-patient communication (DPC) and may have an impact on other outcomes of the consultation. Our objective was to assess the impact of PILs on DPC, patient satisfaction and adherence, and on patient and doctor behaviours. DESIGN: Prospective, controlled, before-after trial between November 2013 and June 2015. SETTING: Two French emergency departments. PARTICIPANTS: Adults and adolescents >15 years diagnosed with ankle sprain or an infection (diverticulitis, infectious colitis, pyelonephritis, pneumonia or prostatitis). INTERVENTION: Physicians in the intervention group gave patients a PIL about their condition along with an oral explanation. MAIN OUTCOME MEASURES: 7-10 days later, patients were contacted by phone to answer questionnaires. Results were derived from questions scored using a 4-point Likert scale. MAIN FINDINGS: Analysis of the 324 patients showed that PILs improved the mean DPC score (range: 13-52), with 46 (42-49) for 168 patients with PILs vs 44 (38-48) for 156 patients without PILs (p<0.01). The adjusted OR for good communication (having a score >35/52) was 2.54 (1.27 to 5.06). The overall satisfaction and adherence scores did not show significant differences. In contrast, satisfaction with healthcare professionals and timing of medication intake were improved with PILs. The overall satisfaction score improved significantly on per-protocol analysis. When using PILs, doctors prescribed fewer drugs and more examinations (radiology, biology, appointment with a specialist); the need for a new medical consultation for the same pathology was reduced from 32.1% to 17.9% (OR 0.46 [0.27 to 0.77]), particularly revisiting the emergency department. CONCLUSION: In emergency departments, PILs given by doctors improve DPC, increase patients' satisfaction with healthcare professionals, reduce the number of emergency reconsultations for the same pathology and modify the doctor's behaviour. TRIAL REGISTRATION NUMBER: NCT02246361.

Taille, C. (2014). "Parcours de soins : Asthme de l'adulte. Le contrôle optimal fondé sur une médecine personnalisée." Concours Medical **136**(5).

La prise en charge de l'asthme de l'adulte en France est presque un paradoxe : alors que l'on dispose d'un panel très large de molécules, de dosages et de dispositifs d'inhalation, la proportion de patients dont le traitement est adapté (permettant de contrôler les symptômes) est de seulement 40 %. À l'inverse, la baisse continue de la mortalité et des hospitalisations pour asthme depuis quinze ans démontre que la prise en charge s'améliore et que ces traitements sont très efficaces pour l'immense majorité des asthmatiques

Thariat, J., Creisson, A., Chamignon, B., et al. (2016). "[Integrating patient education in your oncology practice]." Bull Cancer **103**(7-8): 674-690.

> BACKGROUND: Patient education is the process by which health professionals impart information to patients and their caregivers that will alter their health behaviors; improve their health status to better manage their lives with a chronic disease. Patient education implies a profound paradigm shift in the conception of care among health professionals, and should result in structural care changes. Patient education has been promoted by the French Health system for 30years, including in the 2009 HPST law and Cancer Plan 2014-2019. A patient education program was designed in our hospital for breast cancer patients. MATERIAL AND METHODS: A multidisciplinary and transversal team of health professionals and resource patients was trained before grant application for funding of the program by the regional health care agency. Management of the project required that a functional unit be built for recording of all patient education related activities. A customized patient education program process was built under the leadership of a coordinator and several patient education project managers during bimonthly meetings, using an accurate timeline and a communication strategy to ensure full institutional support and team engagement. RESULTS: The grant was prepared in four months and the program started within the next four months with the aim to include 120 patients during year 1. The program includes a diagnosis of patient abilities and well-being resources, followed by collective and individual workshops undertaken in 4months for each patient. DISCUSSION: Patient education is positively evaluated by all participants and may contribute to better health care management in the long term but the financial and human resources allocated to such programs currently underestimate the needs. Sustainability of patient education programs requires that specific tools and more commitment be developed to support health care professionals and to promote patient coping and empowerment in the long term.

Traynard, P. Y. (2013). Education thérapeutique du patient en ville et sur le territoire, Paris : Maloine

> L'éducation thérapeutique du patient, pratique indissociable des soins reconnue par la loi Hôpital, Patients, Santé et Territoires en 2009, vise à aider le patient à acquérir les compétences utiles pour vivre au mieux avec sa maladie et ses traitements. En reconnaissant à la personne malade sa place d'acteur dans les prises de décisions qui concernent sa santé, elle transforme durablement la relation soignant/patient. Initialement expérimentée et mise en oeuvre en milieu hospitalier, son déploiement, en ville et sur les territoires de santé pour le plus grand nombre des personnes atteintes de maladie chronique, constitue un véritable enjeu de santé publique. Pour partager leurs réflexions sur les particularités de 'éducation thérapeutique en ville et sur le territoire, Pierre-Yves Traynard, médecin praticien, et Rémi Gagnayre, professeur des Universités, ont sollicité la réflexion et le témoignage de professionnels de santé, d'acteurs associatifs et d'universitaires, tous experts investis dans cette éducation.En alternant les descriptions de pratiques individuelles et collectives, les enseignements tirés d'expériences originales et les exposés sur l'état actuel des recherches, cet ouvrage apporte des éléments de réponse aux questions portant sur la place, l'organisation et l'évaluation de l'éducation thérapeutique réalisée hors des murs de l'hôpital. Il propose aussi une vision plus globale de l'éducation thérapeutique, partant de l'individu jusqu'à l'organisation territoriale, et montre comment l'inscrire désormais de manière durable dans les parcours de soins des personnes (4e de couverture)

Vallee, J. P. (2010). "Éducation thérapeutique et soins de premier recours. Les points clés du rapport du Haut Conseil de la santé publique, novembre 2009." Medecine : Revue De L'unaformec **6**(3): 118-121.

> Cet article examine les trois points clés du rapport du Haut comité de santé publique concernant l'éducation thérapeutique et les soins de premier recours. L'approche du patient doit être globale, au plus près des lieux de vie et de soins, le médecin traitant étant le premier acteur et principal coordonnateur de l'éduction thérapeutique.

Vallee, J. P., Drahi, E. et Le Noc, Y. (2008). "Médecine générale aujourd'hui domaine d'expertise ? (1ere partie)." Medecine : De La Medecine Factuelle a Nos Pratiques **4**(1): 35-40.

Que représentent les "soins primaires" dans les systèmes de soins d'aujourd'hui ? Les définitions proposéees pour la médecine générale depuis déjà quelques décennies restent généralement admises, bien que l'on commence ici ou là à en redessiner les contours. Vers la fin des années 60, la terminologie primary care s'est progressivement imposée dans les écrits anglo-saxons. En désignant le médecin généraliste comme élément central de ce premier cercle de soins, on en décrivait les rôles spécifiques, bien diférents de ceux des spécialistes en nombre croissant. Le praticien de soins primaires était appelé à jouer un rôle essentiel comme premier contact des patients avec le système de santé, mais aussi comme médiateur nécessaire entre la personne en demande de soins ete un système de plus en plus complexe et fragmenté.

Varroud Vial, D. (2011). "Le parcours de soiná: une solution ou une contrainte supplémentaireá?" MEDECINE DES MALADIES METABOLIQUES SUPPLEMENT **5**(2): S81-S85.

La loi a instauré un parcours de soins pour les patients atteints de maladie chronique, qui doit être organisé sous la responsabilité des médecins traitants. De nombreux dispositifs incitent les médecins à prescrire un parcours de soins approprié aux diabétiquesá: recommandations, guides ALD, programme SOPHIA, CAPI, tableau de bord informatisés, formation continue, programmes de "disease management". L'effet de ces actions porte principalement sur l'amélioration du suivi et paraît modeste sur l'inertie clinique qui reste importante. Une des raisons est que l'application du modèle bio-médical au parcours de soins peut générer une mauvaise observance du patient qui renforce l'inertie clinique du médecin. Le modèle bio-psycho-social centré sur le patient est probablement plus adapté à obtenir une réduction de l'inertie clinique, en favorisant le dialogue avec le patient et la coopération pluridisciplinaire. Le Plan Personnalisé de Santé, issu des réseaux et expérimenté par la HAS, est un outil pour appliquer cette démarche.

Varroud, V. M. (2013). "Parcours de soins : Diabète de type 2. Promouvoir le suivi personnalisé par une équipe pluriprofessionnelle de santé primaire." Concours Medical // **135**(9).

[BDSP. Notice produite par ORSRA 8HtR0xmH. Diffusion soumise à autorisation]. Plusieurs articles composent ce dossier sur le parcours de soins de la personne diabétique de type 2. Ils s'intéressent au dépistage ciblé, à l'éducation à l'activité physique, à l'évaluation globale de chaque patient, aux réseaux de santé, aux centres du pied, aux différents modèles d'organisation des soins

Verger, P., Flicoteaux, R. et Pauvif, L. (2011). "Attitudes et pratiques des médecins généralistes de ville relatives à la vaccination en général et à celle contre la grippe A/H1N1 en 2009 : une étude auprès d'un panel national et dans trois régions " Etudes Et Resultats (Drees)(770).
http://www.drees.sante.gouv.fr/IMG/pdf/er770.pdf //

[BDSP. Notice produite par MIN-SANTE 9JqElR0x. Diffusion soumise à autorisation]. Un panel de médecins généralistes de ville composé d'un échantillon national et de trois échantillons régionaux a été mis en place en juin 2010. La première enquête a porté sur les attitudes et pratiques des médecins relatives à la vaccination, notamment celle contre la grippe pandémique A/H1N1 en 2009. Plus de 95% des médecins se déclarent favorables à la vaccination dans leur pratique quotidienne et huit sur dix discutent de ses bénéfices et de ses risques avec leurs patients. La vaccination contre la grippe saisonnière fait l'objet d'une large adhésion et sept médecins généralistes sur dix se sont fait vacciner ces trois dernières années. Concernant la vaccination contre la grippe pandémique A/H1N1, six médecins sur dix se sont fait vacciner et 71% ont conseillé cette vaccination aux adultes jeunes à risque. Les médecins étaient plus enclins à recommander cette vaccination à leurs patients lorsqu'ils s'étaient eux-mêmes vaccinés. Ils ont jugé plutôt favorablement l'information reçue sur la grippe pandémique, le virus et les moyens de prévention, mais ils ont un avis plus mitigé sur le niveau d'information des patients

Viard, D., Netillard, C., Cheraitia, E., et al. (2016). "[Patient education in psychiatry: Representations of caregivers, patients and their families]." Encephale **42**(1): 4-13.

INTRODUCTION: Why do caregivers working in psychiatry seem to wonder about their practices, in front of the recent mediatisation of patient education in France? Do our educational practices meet the needs and the expectations of patients and their families? These questions led us to carry out this qualitative and prospective study concerning the representations of patient education of the main actors in psychiatry. OBJECTIVE: This work aims to assess the representations of patient education of the main actors in psychiatry, in particular to assess convergences and divergences. METHODS: This is a qualitative and prospective study. Qualitative data are speeches from caregivers working in psychiatry, patients suffering from a psychiatric pathology and their families. The three populations studied were defined by precise characteristics. The sample was diversified by a variable related to the study theme: experience or not in patient education. Speeches were collected during interviews, which were carried out by the same person. Interviews were semi-structured by a thematic guide, which defined the themes to be explored. The three main themes are: the concept of patient education, the objectives of patient education, and the caregiver/patient relationship. We analysed the content of the speeches with a lexical reference table that we elaborated from the literature of experts in patient education. We also realised a transverse analysis in order to assess convergences and divergences between the different speeches. RESULTS: Thirty-two interviews were realised with fifteen caregivers (six psychiatrists and nine nurses), ten patients and seven families. In the speeches of the different populations, we found the expected element of language for all the themes explored. Unexpected ideas were also found in the speeches of the various groups. We could find convergences and divergences concerning these unexpected ideas between and within each group. Regarding convergences, all the groups mentioned the unexpected idea of the problem of social representations of psychiatric diseases. The three groups also approached the need to develop the work with families. Patients and families entrusted their feeling that there would be a lack of exchange with some caregivers. Patients and caregivers evoked the paternalistic attitude of some caregivers. Finally, both caregivers and family approached their questions regarding the caregiver/patient relationship during care without the patient's consent. We found several divergences in the caregivers' speeches. These divergences seemed to be correlated with the experience in patient education in psychiatry. They concerned the scope of patient education in psychiatry, the differences perceived between patient education in psychiatry or in somatic cares, and the diagnostic announcement to the patient. This last unexpected idea was the main point of divergence between caregivers and patients. DISCUSSION: Results of this study showed that the representations of caregivers, patients and their families correlate with the experts' ideas regarding patient education. The analysis of the different speeches highlighted several unexpected ideas, which constitute themes of reflection about patient education. Some of these themes concern in particular the medical domain of psychiatry such as the questions about caregiver/patient relationship during care without the patient's consent and restraint. Another theme of psychiatry specific reflection is the differences perceived by some caregivers between their practices and the patient education in somatic care. Others themes of reflection highlighted all the medical specialities: the need to develop the work with families, the problem of the social representations of diseases, the scopes of patient education and the diagnostic announcement to the patient. CONCLUSION: This study highlighted several themes of reflection about patient education in psychiatry. We should include this theme of reflection in our practices in order to respond more precisely to the needs and the expectations of the patients and their families.

Vincent, I., Loaec, A. et Fournier, C. (2010). Modèles et pratiques en éducation du patient : apports internationaux. 5èmes journées de la prévention. Paris, 2-3 avril 2009. Collection Séminaires. St Denis INPES**:** 167.

La session « Modèles et pratiques en éducation du patient : apports internationaux », qui s?est tenue aux Journées de la prévention 2009, a produit des contributions et des éléments de débats pouvant nourrir la réflexion sur les pratiques françaises. Cet ouvrage, qui restitue ce temps d?échanges, souligne la complémentarité des différentes approches mises en oeuvre en éducation du patient. La première partie de l?ouvrage s?intéresse aux besoins des patients. La deuxième s?articule autour de deux notions fondamentales : les transformations du patient liées à la maladie chronique et au processus éducatif, ainsi que le type de compétences que le patient va devoir acquérir ou renforcer tout au long de sa vie avec la maladie. La troisième partie est davantage centrée sur le rôle et les pratiques des professionnels. La quatrième partie restitue les éléments de discussion de la table ronde qui concluait cette session : les questions de systématisation, de standardisation de l?éducation du patient versus sa personnalisation et son adaptation auprès de certains publics ont été abordées, de même que le rôle des patients dans l?éducation.

Walger, O. (2011). "Similitudes, différences, complémentarités entre médecins et infirmières en interaction avec le patient dans le cadre de programmes en éducation du patient diabétique : une revue de la littérature." Education Therapeutique Du Patient **3**(1): 45-55.
http://www.etp-journal.org/articles/tpe/abs/2011/01/tpe110009/tpe110009.html

La répartition des rôles et des tâches entre infirmières et médecins en éducation du patient diabétique reste très peu décrite dans la littérature professionnelle. En Suisse Romande, comme probablement dans bien d'autres régions en Europe, l'éducation du patient se développe sans que l'on sache vraiment qui fait quoi. Face au développement des compétences infirmières en éducation du patient et la pénurie annoncée de médecins généralistes, ce flou suscite des frustrations de la part des infirmières cliniciennes qui se sentent peu reconnues à travers leurs compétences éducatives et des craintes de la part de certains médecins qui se sentent menacés dans leur territoire (résumé d'auteur).

Zendjidjian, X. Y., Boyer, L., Magalon, D., et al. (2014). "[Therapeutic patient education of depressive disorder in primary care]." Presse Med **43**(9): 883-885.
PM:24935685

Ziegler, O., Bertin, E., Jouret, B., et al. (2015). "Éducation thérapeutique et parcours de soins de la personne obèse. Référentiel et organisation. Rapport à la Direction générale de la santé et à la Direction générale de l'offre de soins 4 octobre 2014." Médecine des Maladies Métaboliques **9**(4): 423-446.

L'obésité est une maladie chronique évolutive dont le développement est fortement associé au mode de vie, et donc au comportement de la personne dans son environnement. Ce sont là, précisément, les cibles de l'éducation thérapeutique du patient (ETP), qui est considérée comme la pierre angulaire de la prise en charge de l'obésité dans le plan Obésité. L'analyse de la situation en France nous a conduit à proposer un référentiel de bonnes pratiques, dont le but est de renforcer l'autonomie des personnes obèses et leur capacité à se prendre en charge (notion de "self-management" et d' "empowerment"), en prenant en compte l'activité physique, l'alimentation, et la dimension psychologique, tel que le demande le plan Obésité (Mesure 1-4 du plan). L'ETP donne aux professionnels de santé l'opportunité de changer ou d'adapter leurs connaissances, leurs attitudes, et leurs pratiques, envers les patients obèses. Les patients sont amenés à modifier leurs croyances et leurs représentations vis-à-vis de la maladie et de son traitement. Sont concernés le contrôle du poids, mais aussi les conséquences sur l'image corporelle, l'estime de soi et la qualité de vie. L'approche est globale, centrée sur le patient, à qui l'on propose de changer "par lui-même" les habitudes de vie qui ont un impact sur cette maladie (Modifications thérapeutiques du mode de vie, ou MTMV). La personne apprend aussi "à faire face" en mobilisant ses propres ressources (capacité d'exercer un contrôle sur sa vie personnelle, sentiment d'efficacité, démarche de résolution de problème, prise de décision), mais aussi en s'appuyant sur l'équipe de soignants pour mettre en place des actions. La démarche éducative tient le plus grand compte des besoins, des objectifs, et du vécu du patient, tout en restant conforme à un référentiel de bonnes pratiques. Certes, l'objectif est la perte de poids et/ou la stabilisation pondérale, mais le principal est bien d'améliorer l'état de santé (risque de complications inclus), le bien-être, et la qualité de vie. Les programmes multi-cibles et pluri-professionnels, adaptés à la typologie des patients (âge, sexe, contexte socio-culturel et économique, sévérité et complications de la maladie) constituent la référence. L'enjeu immédiat est de permettre le développement de l'ETP pour la médecine de proximité, comme l'ont souligné la Haute Autorité de Santé (HAS) et le plan Obésité. Il paraît nécessaire de créer de nouveaux formats dans le cadre des parcours autorisés, adaptés aux soins de niveau 1, pour les enfants, comme pour les adultes. Cela implique une certaine adaptation du système de santé français. Le plan Obésité a mis en place la gradation des soins et les principes de "clarté, accessibilité, qualité et cohérence" de la chaîne de soins. Des solutions ou des pistes pour améliorer l'offre d'ETP sont présentées comme, par exemple, la gradation en deux niveaux des programmes éducatifs : ETP de proximité et ETP de recours. [résumé éditeur].

ÉTUDES INTERNATIONALES

Adams, R., Price, K., Tucker, G., et al. (2012). "The doctor and the patient--how is a clinical encounter perceived?" Patient Educ Couns **86**(1): 127-133.

> OBJECTIVE: To examine the population distribution of different types of relationships between people with chronic conditions and their doctors that influence decisions being made from a shared-decision making perspective. METHODS: A survey questionnaire based on recurring themes about the doctor/patient relationship identified from qualitative in-depth interviews with people with chronic conditions and doctors was administered to a national population sample (n=999) of people with chronic conditions. RESULTS: Three factors explained the doctor/patient relationship. Factor 1 identified a positive partnership characteristic of involvement and shared decision-making; Factor 2 doctor-controlled relationship; Factor 3 relationship with negative dimensions. Cluster analysis identified four population groups. Cluster 1 doctor is in control (9.7% of the population); Cluster 2 ambivalent (27.6%); Cluster 3 positive long-term relationship (58.6%); Cluster 4 unhappy relationship (4.4%). The proportion of 18-34 year olds is significantly higher than expected in Cluster 4. The proportion of 65+ year olds is significantly higher than expected in Cluster 1, and significantly lower than expected in Cluster 4. CONCLUSION: This study adds to shared decision-making literature in that it shows in a representative sample of people with chronic illnesses how their perceptions of their experiences of the doctor-patient relationship are distributed across the population. PRACTICE IMPLICATIONS: Consideration needs to be given as to whether it is better to help doctors to alter their styles of interactions to suit the preferences of different patients or if it is feasible to match patients with doctors by style of decision-making and patient preference.

Babinec, P. M., Rock, M. J., Lorenzetti, D. L., et al. (2010). "Do researchers use pharmacists' communication as an outcome measure? A scoping review of pharmacist involvement in diabetes care." Int J Pharm Pract **18**(4): 183-193.

> OBJECTIVES: Pharmacy practice increasingly revolves around obtaining and interpreting information. We investigated whether and how pharmacy practice researchers design their studies in ways that acknowledge verbal communication between pharmacists and patients with diabetes. METHODS: We conducted a scoping review of pharmacists' interventions with patients previously diagnosed as having diabetes with the aim of assessing how many used communication (quality and quantity) as an outcome measure. A scoping review identifies gaps in the literature and draws conclusions regarding the overall state of a research programme, but does not necessarily identify gaps in the quality of the studies reviewed. Quality assessment, therefore, was not conducted. MEDLINE, EMBASE, the Cochrane Library and International Pharmaceutical Abstracts were searched from 2003 to 2008 to identify relevant studies published in English. Reference lists of key studies were also scanned to identify additional studies. Randomized controlled trials and related studies of pharmacists verbal communication with diabetic patients were included. KEY FINDINGS: Some 413 abstracts were identified through database and reference searching. Of these, 65 studies met abstract inclusion criteria and 16 studies met full-text inclusion criteria necessary for this review. The majority of included studies report on patients' health outcomes, beliefs about drugs, self-reported health-related quality-of-life scales or some combination of these measures as indicators of pharmacists' interventions. Nine studies included information on the duration of the initial interaction between pharmacists and patients with diabetes; 13 reported on the number of follow-up contacts with pharmacists, and seven studies indicated that pharmacists participating in interventions had received training in diabetes management or in patient-centred care. No studies included or evaluated transcripts of pharmacist-patient interactions. SUMMARY: Results reveal a gap in the existing literature. In studies of diabetes, pharmacy practice researchers do not appear to consider the influence of pharmacists' communication skills on health outcomes. Future studies should be designed to incorporate a communication research component.

Ball, L., Johnson, C., Desbrow, B., et al. (2013). "General practitioners can offer effective nutrition care to patients with lifestyle-related chronic disease." J Prim Health Care **5**(1): 59-69.

> INTRODUCTION: Nutrition is a key priority for the management of lifestyle-related chronic disease, and the demand on general practitioners (GPs) to provide nutrition care is increasing. AIM: The aim of this systematic review was to investigate the effectiveness of nutrition care provided by GPs in improving the nutrition-related behaviour and subsequent health outcomes of individuals with lifestyle-related chronic disease. METHODS: A systematic literature review was conducted using the Cochrane Library, MEDLINE and ISI Web of Knowledge databases. Randomised controlled trials that investigated a nutrition care intervention feasible within general practice consultations, and that utilised outcome measures relevant to nutritionrelated behaviour or indicators of health, were included in the review. RESULTS: Of the 131 articles screened for inclusion, nine studies, totalling 9564 participants, were included in the review. Five interventions observed improvements in the nutrition behaviour of participants, such as a reduction of energy consumption, reduction of meat consumption, increase in fruit and vegetable intake, increase in fish intake and increase in fibre intake. Seven interventions observed improvements in risk factors, including in weight, serum lipid levels and blood pressure. Some inconsistencies in findings were observed in the reviewed studies. DISCUSSION: This systematic review demonstrates that GPs have the potential to provide nutrition care that improves the nutrition behaviour and risk factors in individuals with lifestyle-related chronic disease. However, the consistency and clinical significance of the intervention outcomes are unclear. Further investigation regarding the development of nutrition care protocols and the attributes of nutrition care that result in improved outcomes are required.

Balogh, E. P., Ganz, P. A., Murphy, S. B., et al. (2011). "Patient-centered cancer treatment planning: improving the quality of oncology care. Summary of an Institute of Medicine workshop." Oncologist **16**(12): 1800-1805.
http://www.ncbi.nlm.nih.gov/pubmed/22128118

> The Institute of Medicine's National Cancer Policy Forum recently convened a workshop on patient-centered cancer treatment planning, with the aim of raising awareness about this important but often overlooked aspect of cancer treatment. A primary goal of patient-centered treatment planning is to engage patients and their families in meaningful, thorough interactions with their health care providers to develop an accurate, well-conceived treatment plan, using all available medical information appropriately while also considering the medical, social, and cultural needs and desires of the patient and family. A cancer treatment plan can be shared among the patient, family, and care team in order to facilitate care coordination and provide a roadmap to help patients navigate the path of cancer treatment. There are numerous obstacles to achieving patient-centered cancer treatment planning in practice. Some of these challenges stem from the patient and include patients' lack of assertiveness, health literacy, and numeracy, and their emotional state and concurrent illnesses. Others are a result of physician limitations, such as a lack of time to explain complex information and a lack of tools to facilitate treatment planning, as well as insensitivity to patients' informational, cultural, and emotional needs. Potential solutions to address these obstacles include better training of health care providers and patients in optimal communication and shared decision making, and greater use of support services and tools such as patient navigation and electronic health records. Other options include greater use of quality metrics and reimbursement for the time it takes to develop, discuss, and document a treatment plan

Banerjee, M., Chakraborty, S. et Pal, R. (2020). "Diabetes self-management amid COVID-19 pandemic." Diabetes Metab Syndr **14**(4): 351-354.

> BACKGROUND AND AIMS: COVID-19 pandemic has challenged the physician-centered approach of diabetes care in India that is primarily based on routine clinic visits. We aim to review the various aspects of patient-centered care via diabetes self-management education based on available literature. METHODS: This is a narrative review using Pubmed, EMBASE and Google Scholar search till March 29, 2020. Search terms were "COVID-19", "diabetes self-care", "diabetes self-management education", "DSME", "diabetes self-management in India", "diabetes self-care in India" and "DSME in India". RESULTS: We have discussed an educational plan on diabetes self-management that can be

adopted for people with diabetes mellitus in our country amid the ongoing pandemic. We have also identified the barriers to diabetes self-management in the current scenario and suggested possible solutions to overcome those. CONCLUSIONS: We have reemphasized the need for a simultaneous patient-centered approach in routine diabetes care that has to be coordinated by a multidisciplinary team amid the ongoing COVID-19 pandemic.

Barley, E. A., Haddad, M., Simmonds, R., et al. (2012). "The UPBEAT depression and coronary heart disease programme: using the UK Medical Research Council framework to design a nurse-led complex intervention for use in primary care." BMC Fam Pract **13**: 119.

BACKGROUND: Depression is common in coronary heart disease (CHD) and increases the incidence of coronary symptoms and death in CHD patients. Interventions feasible for use in primary care are needed to improve both mood and cardiac outcomes. The UPBEAT-UK programme of research has been funded by the NHS National Institute for Health Research (NIHR) to explore the relationship between CHD and depression and to develop a new intervention for use in primary care. METHODS: Using the Medical Research Council (MRC) guidelines for developing and evaluating complex interventions, we conducted a systematic review and qualitative research to develop a primary care-based nurse-led intervention to improve mood and cardiac outcomes in patients with CHD and depression. Iterative literature review was used to synthesise our empirical work and to identify evidence and theory to inform the intervention. RESULTS: We developed a primary care-based nurse-led personalised care intervention which utilises elements of case management to promote self management. Following biopsychosocial assessment, a personalised care plan is devised. Nurses trained in behaviour change techniques facilitate patients to address the problems important to them. Identification and utilisation of existing resources is promoted. Nurse time is conserved through telephone follow up. CONCLUSIONS: Application of the MRC framework for complex interventions has allowed us to develop an evidence based intervention informed by patient and clinician preferences and established theory. The feasibility and acceptability of this intervention is now being tested further in an exploratory trial.

Bengtsson, U., Kjellgren, K., Hallberg, I., et al. (2018). "Patient contributions during primary care consultations for hypertension after self-reporting via a mobile phone self-management support system." Scand J Prim Health Care **36**(1): 70-79.

OBJECTIVE: This paper reports on how the clinical consultation in primary care is performed under the new premises of patients' daily self-reporting and self-generation of data. The aim was to explore and describe the structure, topic initiation and patients' contributions in follow-up consultations after eight weeks of self-reporting through a mobile phone-based hypertension self-management support system. DESIGN: A qualitative, explorative study design was used, examining 20 audio- (n = 10) and video-recorded (n = 10) follow-up consultations in primary care hypertension management, through interaction analysis. Clinical trials registry: ClinicalTrials.gov NCT01510301. SETTING: Four primary health care centers in Sweden. SUBJECTS: Patients with hypertension (n = 20) and their health care professional (n = 7). RESULTS: The consultations comprised three phases: opening, examination and closing. The most common topic was blood pressure (BP) put in relation to self-reported variables, for example, physical activity and stress. Topic initiation was distributed symmetrically between parties and BP talk was lifestyle-centered. The patients' contributed to the interpretation of BP values by connecting them to specific occasions, providing insights to the link between BP measurements and everyday life activities. CONCLUSION: Patients' contribution through interpretations of BP values to specific situations in their own lives brought on consultations where the patient as a person in context became salient. Further, the patients' and health care professionals' equal contribution during the consultations showed actively involved patients. The mobile phone-based self-management support system can thus be used to support patient involvement in consultations with a person-centered approach in primary care hypertension management Key points The clinical consultation is important to provide opportunities for patients to gain understanding of factors affecting high blood pressure, and for health care professionals to motivate and promote changes in life-style. This study shows that self-reporting as base for follow-up consultations in primary care hypertension management can support patients and professionals to equal participation in clinical consultations.

Self-reporting combined with increased patient-health care professional interaction during follow-up consultations can support patients in understanding the blood pressure value in relation to their daily life. These findings implicate that the interactive mobile phone self-management support system has potential to support current transformations of patients as recipients of primary care, to being actively involved in their own health.

Berger, S., Braehler, E. et Ernst, J. (2012). "The health professional-patient-relationship in conventional versus complementary and alternative medicine. A qualitative study comparing the perceived use of medical shared decision-making between two different approaches of medicine." Patient Educ Couns **88**(1): 129-137.

OBJECTIVE: To explore differences between conventional medicine (COM) and complementary and alternative medicine (CAM) regarding the attitude toward and the perceived use of shared decision-making (SDM) from the health professional perspective. METHODS: Thirty guideline-based interviews with German GPs and nonmedical practitioners were conducted using qualitative analysis for interpretation. RESULTS: The health professional-patient-relationship in CAM differs from that in COM, as SDM is perceived more often. Reasons for this include external context variables (e.g., longer consultation time) and internal provider beliefs (e.g., attitude toward SDM). German health care policy was regarded as one of the most critical factors which affected the relationship between GPs and their patients and their practice of SDM. CONCLUSION: Differences between COM and CAM regarding the attitude toward and the perceived use of SDM are attributable to diverse concepts of medicine, practice context variables and internal provider factors. Therefore, the perceived feasibility of SDM depends on the complexity of different occupational socialization processes and thus, different value systems between COM and CAM. PRACTICE IMPLICATIONS: Implementation barriers such as insufficient communication skills, lacking SDM training or obedient patients should be reduced. Especially in COM, contextual variables such as political restrictions need to be eliminated to successfully implement SDM.

Berntsen, G., Høyem, A., Lettrem, I., et al. (2018). "A person-centered integrated care quality framework, based on a qualitative study of patients' evaluation of care in light of chronic care ideals." BMC Health Serv Res **18**(1): 479.

BACKGROUND: Person-Centered Integrated Care (PC-IC) is believed to improve outcomes and experience for persons with multiple long-term and complex conditions. No broad consensus exists regarding how to capture the patient-experienced quality of PC-IC. Most PC-IC evaluation tools focus on care events or care in general. Building on others' and our previous work, we outlined a 4-stage goal-oriented PC-IC process ideal: 1) Personalized goal setting 2) Care planning aligned with goals 3) Care delivery according to plan, and 4) Evaluation of goal attainment. We aimed to explore, apply, refine and operationalize this quality of care framework. METHODS: This paper is a qualitative evaluative review of the individual Patient Pathways (iPP) experiences of 19 strategically chosen persons with multimorbidity in light of ideals for chronic care. The iPP includes all care events, addressing the persons collected health issues, organized by time. We constructed iPPs based on the electronic health record (from general practice, nursing services, and hospital) with patient follow-up interviews. The application of the framework and its refinement were parallel processes. Both were based on analysis of salient themes in the empirical material in light of the PC-IC process ideal and progressively more informed applications of themes and questions. RESULTS: The informants consistently reviewed care quality by how care supported/ threatened their long-term goals. Personal goals were either implicit or identified by "What matters to you?" Informants expected care to address their long-term goals and placed responsibility for care quality and delivery at the system level. The PC-IC process framework exposed system failure in identifying long-term goals, provision of shared long-term multimorbidity care plans, monitoring of care delivery and goal evaluation. The PC-IC framework includes descriptions of ideal care, key questions and literature references for each stage of the PC-IC process. This first version of a PC-IC process framework needs further validation in other settings. CONCLUSION: Gaps in care that are invisible with event-based quality of care frameworks become apparent when evaluated by a long-term goal-driven PC-IC process framework. The framework appears meaningful to persons with multimorbidity.

Beune, E. J., Haafkens, J. A. et Bindels, P. J. (2011). "Barriers and enablers in the implementation of a provider-based intervention to stimulate culturally appropriate hypertension education." Patient Educ Couns **82**(1): 74-80.

> OBJECTIVE: to identify barriers and enablers influencing the implementation of an intervention to stimulate culturally appropriate hypertension education (CAHE) among health care providers in primary care. METHODS: the intervention was piloted in three Dutch health centers. It consists of a toolkit for CAHE, training, and feedback meetings for hypertension educators. Data were collected from 16 hypertension educators (nurse practitioners and general practice assistants) during feedback meetings and analyzed using qualitative content analysis. RESULTS: perceived barriers to the implementation of the intervention fell into three main categories: political context (health care system financing); organizational factors (ongoing organizational changes, work environment, time constraints and staffing) and care provider-related factors (routines, attitudes, computer and educational skills, and cultural background). Few barriers were specifically related to the delivery of CAHE (e.g. resistance to registering ethnicity). Enabling strategies addressing these barriers consisted of reorganizing practice procedures, team coordination, and providing reminders and additional instructions to hypertension educators. CONCLUSION AND PRACTICE IMPLICATIONS: the adoption of a tool for CAHE by care providers can be accomplished if barriers are identified and addressed. The majority of these barriers are commonly associated with the implementation of health care innovations in general and do not indicate resistance to providing culturally appropriate care.

Bieber, C., Gschwendtner, K., Muller, N., et al. (2017). "[Shared Decision Making (SDM) - Patient and Physician as a Team]." Rehabilitation (Stuttg) **56**(3): 198-213.

> The article provides an overview on Shared Decision Making (SDM), which is considered as the ideal form of physician-patient-interaction by many stakeholders of the health care system. SDM is distinguished from other models of physician-patient-interaction such as the paternalistic model and the information model. Besides the degree of acceptance of SDM in the general population and among physicians, barriers for its implementation will be reported. Indications for SDM as well as strategies and support material for its use in individual consultations will be discussed and illustrated by an oncological case study. Effects of SDM for patients as well as for clinicians will be highlighted. After background information on origins of SDM, its significance with regard to health policy in Germany is discussed.

Bhaloo, T., Juma, M. et Criscuolo-Higgins, C. (2018). "A solution-focused approach to understanding patient motivation in diabetes self-management: Gender differences and implications for primary care." Chronic Illn **14**(4): 243-255.

> OBJECTIVE: Healthcare providers often neglect to recognize the role they play in motivating patients with diabetes to perform self-management. Our aims were to understand what motivates patients with diabetes to implement recommended self-management practices and understand the role of the primary care team in patient motivation. METHODS: We use a solution-focused qualitative approach, supplemented with a quantitative scale. We used a purposive sampling strategy to invite patients with uncontrolled diabetes. Semi-structured telephone interviews were conducted and analyzed using content and thematic analysis. RESULTS: Key motivators were strong support systems that included family and friends, the physician's communication style and message, fear of deterioration, and other intrinsic factors. Female family members were described as supportive; not all married women felt supported by their husbands. Women were more influenced by empathy and concern from their doctor, compared to men who were motivated by improved health literacy. Women with few family or friends were more disadvantaged, regardless of race/ethnicity. DISCUSSION: While physicians play a vital role in motivating their patients, female patients may depend on this empathy more than males. The interdisciplinary care team can play an important role in helping patients create a support network where it may not exist.

Bischoff, A. (2011). "[Patient information - tumor after-care - palliative care. What cancer patients need from their family practitioner]." MMW Fortschr Med **153**(18): 14-15.

http://www.ncbi.nlm.nih.gov/pubmed/21608148

Black, R. L. et Duval, C. (2019). "Diabetes Discharge Planning and Transitions of Care: A Focused Review." Curr Diabetes Rev **15**(2): 111-117.

> BACKGROUND: Diabetes is a growing problem in the United States. Increasing hospital admissions for diabetes patients demonstrate the need for evidence-based care of diabetes patients by inpatient providers, as well as the importance of continuity of care when transitioning patients from inpatient to outpatient providers. METHODS: A focused literature review of discharge planning and transitions of care in diabetes, conducted in PubMed is presented. Studies were selected for inclusion based on content focusing on transitions of care in diabetes, risk factors for readmission, the impact of inpatient diabetes education on patient outcomes, and optimal medication management of diabetes during care transitions. American Diabetes Association (ADA) guidelines for care of patients during the discharge process are presented, as well as considerations for designing treatment regimens for a hospitalized patient transitioning to various care settings. RESULTS: Multiple factors may make transitions of care difficult, including poor communication, poor patient education, inappropriate follow-up, and clinically complex patients. ADA recommendations provide guidance, but an individualized approach for medication management is needed. Use of scoring systems may help identify patients at higher risk for readmission. Good communication with patients and outpatient providers is needed to prevent patient harm. A team-based approach is needed, utilizing the skills of inpatient and outpatient providers, diabetes educators, nurses, and pharmacists. CONCLUSION: Structured discharge planning per guideline recommendations can help improve transitions in care for patients with diabetes. A team based, patient-centered approach can help improve patient outcomes by reducing medication errors, delay of care, and hospital readmissions.

Blakeman, T., Chew-Graham, C., Reeves, D., et al. (2011). "The Quality and Outcomes Framework and self-management dialogue in primary care consultations: a qualitative study." Br J Gen Pract **61**(591): e666-673.

> BACKGROUND: Two key elements to improve the quality of care for people with long-term conditions in primary care are improved clinical information systems to support delivery of evidence-based care, and enhanced self-management support. Although both elements are viewed as necessary, their interaction is not well understood. AIM: To explore the use of computer-based 'disease management' templates and their relevance to self-management dialogue within clinical encounters. DESIGN AND SETTING: Qualitative study of general practices located in three primary care trusts in the north of England. METHOD: A qualitative mixed methods study was conducted that included comparative analysis of (1) observations of general practice consultations (n = 86); and (2) interviews with health professionals in general practice (n = 17). RESULTS: The analysis suggested that use of the computer templates reinforced a checklist approach to consultations, which included professionals working through several self-management topics framed as discrete behaviours. As a consequence, conversation tended to become focused on the maintenance of the professional-patient relationship at the expense of expansion in self-management dialogue. The computer templates also shaped how patient-initiated self-management dialogue was managed when it arose, with a shift towards discussion around medical agendas. CONCLUSION: In order to enhance the management of long-term conditions in primary care, the design and implementation of clinical information systems to improve evidence-based care need to take into account their potential impact on supporting self-management.

Bosnic-Anticevich, S. Z., Stuart, M., Mackson, J., et al. (2014). "Development and evaluation of an innovative model of inter-professional education focused on asthma medication use." BMC Med Educ **14**: 72.

> BACKGROUND: Inter-professional learning has been promoted as the solution to many clinical management issues. One such issue is the correct use of asthma inhaler devices. Up to 80% of people with asthma use their inhaler device incorrectly. The implications of this are poor asthma control and quality of life. Correct inhaler technique can be taught, however these educational instructions need to be repeated if correct technique is to be maintained. It is important to maximise the opportunities to deliver this education in primary care. In light of this, it is important to explore how health care providers, in particular pharmacists and general medical practitioners, can work together in delivering

inhaler technique education to patients, over time. Therefore, there is a need to develop and evaluate effective inter-professional education, which will address the need to educate patients in the correct use of their inhalers as well as equip health care professionals with skills to engage in collaborative relationships with each other. METHODS: This mixed methods study involves the development and evaluation of three modules of continuing education, Model 1, Model 2 and Model 3. A fourth group, Model 4, acting as a control.Model 1 consists of face-to-face continuing professional education on asthma inhaler technique, aimed at pharmacists, general medical practitioners and their practice nurses.Model 2 is an electronic online continuing education module based on Model 1 principles.Model 3 is also based on asthma inhaler technique education but employs a learning intervention targeting health care professional relationships and is based on sociocultural theory.This study took the form of a parallel group, repeated measure design. Following the completion of continuing professional education, health care professionals recruited people with asthma and followed them up for 6 months. During this period, inhaler device technique training was delivered and data on patient inhaler technique, clinical and humanistic outcomes were collected. Outcomes related to professional collaborative relationships were also measured. DISCUSSION: Challenges presented included the requirement of significant financial resources for development of study materials and limited availability of validated tools to measure health care professional collaboration over time.

Bossy, D., Knutsen, I. R., Rogers, A., et al. (2016). "Institutional logic in self-management support: coexistence and diversity." Health Soc Care Community **24**(6): e191-e200.

The prevalence of chronic conditions in Europe has been the subject of health-political reforms that have increasingly targeted collaboration between public, private and voluntary organisations for the purpose of supporting self-management of long-term diseases. The international literature describes collaboration across sectors as challenging, which implies that their respective logics are conflicting or incompatible. In line with the European context, recent Norwegian health policy advocates inter-sectorial partnerships. The aim of this policy is to create networks supporting better self-management for people with chronic conditions. The purpose of our qualitative study was to map different understandings of self-management support in private for-profit, volunteer and public organisations. These organisations are seen as potential self-management support networks for individuals with chronic conditions in Norway. From December 2012 to April 2013, we conducted 50 semi-structured interviews with representatives from relevant health and well-being organisations in different parts of Norway. According to the theoretical framework of institutional logic, representatives' statements are embedded with organisational understandings. In the analysis, we systematically assessed the representatives' different understandings of self-management support. The institutional logic we identified revealed traits of organisational historical backgrounds, and transitions in understanding. We found that the merging of individualism and fellowship in contemporary health policy generates different types of logic in different organisational contexts. The private for-profit organisations were concerned with the logic of a healthy appearance and mindset, whereas the private non-profit organisations emphasised fellowship and moral responsibility. Finally, the public, illness-oriented organisations tended to highlight individual conditions for illness management. Different types of logic may attract different users, and simultaneously, a diversity of logic types may challenge collaboration at the user's expense. Moral implications embed institutional logic implying a change towards individual responsibility for disease. Policy makers ought to consider complexities of logic in order to tailor the different needs of users.

Bostrom, E., Isaksson, U., Lundman, B., et al. (2014). "Interaction between diabetes specialist nurses and patients during group sessions about self-management in type 2 diabetes." Patient Educ Couns **94**(2): 187-192.

OBJECTIVE: The aim of this study was to explore the interaction between diabetes specialist nurses (DSNs) and patients with type 2 diabetes (T2D) during group sessions about self-management. METHODS: Ten DSNs and 44 patients were observed during group sessions about self-management, and thereafter the observations were analyzed using qualitative content analysis. RESULTS: The interaction was characterized by three themes: becoming empowered, approaching each other from different perspectives, and struggling for authority. The interaction was not a linear process, but rather a dynamic process with distinct episodes that characterized the content of the sessions. CONCLUSION: It is important to achieve an interaction that is patient-centered, where the DSN is aware of each patient's individual needs and avoids responding to patients in a normative way. A satisfying interaction may strengthen patients' self-management, and also may strengthen the DSNs in their professional performance. PRACTICE IMPLICATIONS: Authority struggles between patients and DSNs could be a prerequisite for patients to become autonomous and decisive in self-management. DSNs might benefit from an increased awareness about this issue, because they can better support patients if they do not perceive authority struggles as threats to their professional role.

Bourbeau, J. et Saad, N. (2013). "Integrated care model with self-management in chronic obstructive pulmonary disease: from family physicians to specialists." Chron Respir Dis **10**(2): 99-105.

Patient with chronic obstructive pulmonary disease (COPD) has to become a partner and an active participant in his own care, that is, disease self-management. The goal of this article is to present successful and unsuccessful interventions using patient self-management and to propose a model of integrated care more suitable to the needs of COPD patients. This is a narrative review and an opinion article. Many systematic reviews have shown positive outcomes for patients with COPD. These studies have in common a self-management intervention including an action plan in the event of an exacerbation embedded in an integrated health-care system coordinated by a case manager for educational sessions and regular communication. Recently published trials have brought controversy with respect to the effectiveness of self-management programmes, especially in patients with high burden of disease and co-morbidities. It may be more challenging to make the patient with high burden of disease a partner and not without risk of serious adverse events. Finally, our health-care delivery has to be well integrated and more coherent, that is, strategic alliance between primary and secondary care, and supported by interdisciplinary teams for patients with high-risk and complex COPD. Clinical practice has to be structured to address COPD throughout the disease spectrum, that is, secondary versus primary, team work, partnership, self-management and continuity of care.

Bowen, D. J., Hannon, P. A., Harris, J. R., et al. (2011). "Prostate cancer screening and informed decision-making: provider and patient perspectives." Prostate Cancer Prostatic Dis **14**(2): 155-161.
http://www.ncbi.nlm.nih.gov/pubmed/21243007

The objective was to determine the extent of informed decision making for prostate cancer screening in a defined population. A state-wide population based survey of men aged 50 and above (Behavioral Risk Factor Surveillance System, 2004, Washington state) and a simple random sample of primary care physicians, were conducted in the same geographic area. We examined prostate cancer screening rates among the men (defined as either PSA or digital rectal examination within the past year) and prostate cancer screening practices among the physicians. Screening rates were 56% at ages 50-64, 68% at ages 65-79 and 64% among men age 80 and older. Adjusted analyses indicated that age, income, marital status, possessing health insurance and a personal health care provider, and talking with a provider about prostate cancer screening tests were all positively associated with screening status. In the physician survey, most physicians recommend screening to their average-risk male patients. Three-fourths (74%) of physicians discussed benefits and risks of PSA testing with their patients; but few used educational tools. Only 35% discussed the side effects of prostate cancer treatment with their patients. The rates of screening reported by men were relatively high, given that current recommendations promote informed decision making rather than universal screening. The majority of physicians recommend prostate cancer screening to their patients, with few decision-making tools used. All relevant information may not be provided in the discussion. These results point to the need for increasing informed decision making about prostate cancer screening

Bowes, P., Stevenson, F., Ahluwalia, S., et al. (2012). "'I need her to be a doctor': patients' experiences of presenting health information from the internet in GP consultations." Br J Gen Pract **62**(604): e732-738.

BACKGROUND: Patients are increasingly using the internet for health-related information and may bring this to a GP consultation. There is scant information about why patients do this and what they expect from their GP. AIM: The aim was to explore patients' motivation in presenting information, their perception of the GP's response and what they wanted from their doctor. DESIGN AND SETTING: Qualitative study based in North London involving patients with experience of bringing health information from the internet to their GP. METHOD: Semi-structured face-to-face and telephone interviews using a critical incident technique, recorded, transcribed verbatim, and subjected to thematic analysis by a multidisciplinary team of researchers. RESULTS: Twenty-six interviews were completed. Participants reported using the internet to become better informed about their health and hence make best use of the limited time available with the GP and to enable the GP to take their problem more seriously. Patients expected their GP to acknowledge the information; discuss, explain, or contextualise it; and offer a professional opinion. Patients tended to prioritise the GP opinion over the internet information. However, if the GP appeared disinterested, dismissive or patronising patients reported damage to the doctor-patient relationship, occasionally to the extent of seeking a second opinion or changing their doctor. CONCLUSION: This is the first in-depth qualitative study to explore why patients present internet information to their GP within the consultation and what they want when they do this. This information should help GPs respond appropriately in such circumstances.

Boylan, P., Joseph, T., Hale, G., et al. (2018). "Chronic Obstructive Pulmonary Disease and Heart Failure Self-Management Kits for Outpatient Transitions of Care." Consult Pharm **33**(3): 152-158.

OBJECTIVE: To develop heart failure (HF) and chronic obstructive pulmonary disease (COPD) self-management kits in an accountable care organization (ACO) to facilitate patients' self-care and prevent hospital readmissions. SETTING: Pharmacists practice in an outpatient-based ACO. They participate in interprofessional office visits with providers and independently manage maintenance pharmacotherapies. PRACTICE DESCRIPTION: Pharmacists collaborate with an interprofessional team within the ACO including physicians, nurses, case managers, and paramedics. Two commonly encountered diseases are chronic COPD and HF. Reducing preventable readmissions for these conditions are important quality benchmarks and cost-saving strategies. PRACTICE INNOVATION: Pharmacists were responsible for developing HF and COPD self-management kits containing patient education materials and prescriptions to facilitate self-care. Prior to kit development, pharmacists performed a literature review to determine the presence of previously published findings on these topics. MAIN OUTCOME MEASUREMENTS: The interprofessional team continually evaluates the successes and limitations of this initiative. Pharmacists developed training and instructions for ACO allied health professionals in an effort to incorporate the self-management kits in clinical practice. RESULTS: The initial literature search revealed no studies describing the intervention of interest. Innovative programs designed to help reduce preventable readmissions are lacking in primary care. Implementation of the self-management kits was accepted by interprofessional ACO leadership and is currently being integrated into allied health workflow. CONCLUSION: Patients at risk for having an exacerbation of COPD or HF should receive self-management strategies. Prompt therapy prior to exacerbations reduces hospital admissions and readmissions, speeds recovery, and slows disease progression. Pharmacist-facilitated implementation of self-management kits may be developed by interprofessional health care teams.

Braillard, O., Slama-Chaudhry, A., Joly, C., et al. (2018). "The impact of chronic disease management on primary care doctors in Switzerland: a qualitative study." BMC Fam Pract **19**(1): 159.

BACKGROUND: Patient-centeredness and therapeutic relationship are widely explored as a means to address the challenge of chronic disease and multi-morbidity management, however research focusing on the perspective of doctors is still rare. In this study, we aimed to explore the impact of the patient's chronic disease(s) on their healthcare provider. METHODS: A qualitative approach was taken using semi-structured interviews with general practitioners working in outpatient clinics either in individual practices or in a hospital setting in Geneva, Switzerland. Codes were developed through an iterative process and using grounded theory an inductive coding scheme was performed to identify the key themes. Throughout the analysis process the research team reviewed the analysis and refined the coding scheme. RESULTS: Twenty interviews, 10 in each practice type, allowed for saturation to be reached. The following themes relevant to the impact of managing chronic diseases emerge around the issue of feeling powerless as a doctor; facing the patient's socio-economic context; guidelines versus the reality of the patient; time; and taking on the patient's burden. Primary care practitioners face an emotional burden linked with their powerlessness and work conditions, but also with the empathetic bond with their patients and their circumstances. Doctors seem poorly prepared for this emotional strain. The health system is also not facilitating this with time constraints and guidelines unsuitable for the patient's reality. CONCLUSIONS: Chronic disease and multi-morbidity management is a challenge for healthcare providers. This has its roots in patient characteristics, the overall health system and healthcare providers themselves. Structural changes need to be implemented at different levels: medical education; health systems; adapted guidelines; leading to an overall environment that favors the development of the therapeutic relationship.

Brazil, K., Scott, D., Wallace, E., et al. (2020). "Anticipatory care planning intervention for older adults at risk of functional decline: study protocol for a primary care cluster feasibility randomised trial." Trials **21**(1): 168.

> BACKGROUND: The treatment and management of long-term health conditions is the greatest challenge facing health systems around the world today. Innovative approaches to patient care in the community such as Anticipatory Care Planning (ACP), which seek to help with the provision of high-quality comprehensive care to older adults at risk of functional decline, require evaluation. This study will evaluate one approach that will include primary care as the setting for ACP. METHODS/DESIGN: This study will help to determine the feasibility for a definitive randomised trial to evaluate the implementation and outcomes of an ACP intervention. The intervention will be delivered by specially trained registered nurses in a primary care setting with older adults identified as at risk of functional decline. The intervention will comprise: (a) information collection via patient assessment; (b) facilitated informed dialogue between the patient, family carer, general practitioner and other healthcare practitioners; and, (c) documentation of the agreed support plan and follow-up review dates. Through a structured consultation with patients and their family carers, the nurses will complete a mutually agreed personalised support plan. DISCUSSION: This study will determine the feasibility for a full trial protocol to evaluate the implementation and outcomes of an (ACP) intervention in primary care to assist older adults aged 70 years of age or older and assessed as being at risk of functional decline. The study will be implemented in two jurisdictions on the island of Ireland which employ different health systems but which face similar health challenges. This study will allow us to examine important issues, such as the impact of two different healthcare systems on the health of older people and the influence of different legislative interpretations on undertaking cross jurisdictional research in Ireland. PROTOCOL VERSION: Version 1, 17 September 2019. TRIAL REGISTRATION: Clinicaltrials.gov, ID: NCT03902743. Registered on 4 April 2019.

Broderick, M. C. et Coffey, A. (2013). "Person-centred care in nursing documentation." Int J Older People Nurs **8**(4): 309-318.

> AIMS AND OBJECTIVES: To explore nursing documentation in long-term care, to determine whether it reflected a person-centred approach to care and to describe aspects of PCC as they appeared in nursing records. BACKGROUND: Documentation is an essential part of nursing. It provides evidence that care has been carried out and contains important information to enhance the quality and continuity of care. Person-centred care (PCC) is an approach to care that is underpinned by mutual respect and the development of a therapeutic relationship between the patient and nurse. It is a core principle in standards for residential care settings for older people and is beneficial for both patients and staff (International Practice Development in Nursing and Healthcare, Chichester, Blackwell, 2008 and The Implementation of a Model of Person-Centred Practice in Older Person Settings, Dublin, Health Service Executive, 2010a). However, the literature suggests a lack of person-centredness within nursing documentation (International Journal of Older People Nursing 2, 2007, 263 and The Implementation of a Model of Person-Centred Practice in Older Person Settings, Dublin, Health Service Executive, 2010a). METHOD: A qualitative descriptive study using the PCN framework (Person-centred Nursing; Theory and Practice, Oxford, Wiley-Blackwell, 2010) as the context through which nursing assessments and care plans were explored. RESULTS: Findings indicated that many nursing records were incomplete, and information regarding psychosocial aspects of care was infrequent. There was evidence that nurses engaged with residents and worked with their beliefs and values. However, nursing documentation was not completed in consultation with the patient, and there was little to

suggest that patients were involved in decisions relating to their care. IMPLICATIONS FOR PRACTICE: The structure of nursing documentation can be a major obstacle to the recording of PCC and appropriate care planning. Documentation that is focused on the 'person' will contribute to a more meaningful relationship between nurses and residents.

Brom, L., De Snoo-Trimp, J. C., Onwuteaka-Philipsen, B. D., et al. (2017). "Challenges in shared decision making in advanced cancer care: a qualitative longitudinal observational and interview study." Health Expect **20**(1): 69-84.

BACKGROUND: Patients' preferences and expectations should be taken into account in treatment decision making in the last phase of life. Shared decision making (SDM) is regarded as a way to give the patient a central role in decision making. Little is known about how SDM is used in clinical practice in advanced cancer care. OBJECTIVE: To examine whether and how the steps of SDM can be recognized in decision making about second- and third-line chemotherapy. METHODS: Fourteen advanced cancer patients were followed over time using face-to-face in-depth interviews and observations of the patients' out-clinic visits. Interviews and outpatient clinic visits in which treatment options were discussed or decisions made were transcribed verbatim and analysed using open coding. RESULTS: Patients were satisfied with the decision-making process, but the steps of SDM were barely seen in daily practice. The creation of awareness about available treatment options by physicians was limited and not discussed in an equal way. Patients' wishes and concerns were not explicitly assessed, which led to different expectations about improved survival from subsequent lines of chemotherapy. CONCLUSION: To reach SDM in daily practice, physicians should create awareness of all treatment options, including forgoing treatment, and communicate the risk of benefit and harm. Open and honest communication is needed in which patients' expectations and concerns are discussed. Through this, the difficult process of decision making in the last phase of life can be facilitated and the focus on the best care for the specific patient is strengthened.

Brooke, B. S., Slager, S. L., Swords, D. S., et al. (2018). "Patient and caregiver perspectives on care coordination during transitions of surgical care." Transl Behav Med **8**(3): 429-438.

Care coordination for patients with chronic disease commonly involves multiple transitions between primary care and surgical providers. These transitions often cross healthcare settings, providers, and information systems. We performed a cross-sectional qualitative study to gain a better understanding of the factors that influence how patients and caregivers perceive care coordination during transitions of surgical care. Eight focus groups were conducted among individuals from three different U.S. states who had experienced an episode of surgical care within the past year. We included patients who had undergone major surgery for a chronic condition, as well as caregivers. We used Atlas.ti qualitative software and engaged in an iterative process of thematic analysis of focus group transcripts. After five-rounds of review, five main themes emerged that define chronic care coordination for surgical patients and caregivers: (a) Care coordination is embedded in the unwritten social con tract patients share with their surgical providers; (b) Patients expect all surgical and nonsurgical healthcare providers to be "on the same page"; (c) Patients are frightened and vulnerable during surgical care transitions; (d) Patients need to have accurate expectations of the processes associated with care coordination; and (e) Care coordination relies upon establishing patient trust with their surgical team and needs to be continually reaffirmed. Surgical patients and caregivers expect care coordination processes to involve informatics infrastructure, patient education, and information exchange between providers. Unfortunately, these aspects of care coordination are often lacking during transitions. These findings have implications for designing patient-centered interventions to improve coordination of chronic care.

Brown, C. E., Roberts, N. J. et Partridge, M. R. (2007). "Does the use of a glossary aid patient understanding of the letters sent to their general practitioner?" Clin Med **7**(5): 457-460.
http://www.ncbi.nlm.nih.gov/pubmed/17990712

The NHS Plan suggests that all patients should be offered copies of letters regarding their treatment which are currently sent from a specialist clinic to their general practitioner (GP). Previous work has suggested that this enhances patient satisfaction, but medical letters can be difficult to understand. This report concerns the production and evaluation of a lung disease glossary to enhance patient understanding of terms used within the letter sent to their GP. Non-clinical staff reviewed 219 letters sent to GPs and words not likely to be understood by patients were listed and used to produce a glossary of 133 terms. One hundred and thirty-one participants from nine respiratory outpatient clinics in a London teaching hospital were sent the glossary and a questionnaire with their copy of the letter also sent to their GP Of the 131 participants, 93 patients (71%) returned the questionnaire. Eighty-three (89%) found the glossary useful and the number of words checked ranged from 0 to 14 with a median of three words. Those who did not find the glossary useful explained that their understanding was already optimal or that the words they did not understand were not contained within the glossary. This was usually because the words related to non-respiratory comorbidities. This study confirms that the inclusion of a specialty specific glossary with the patients' copy of the letter being sent to their GP is appreciated by patients and appears to aid their understanding

Brundisini, F., Vanstone, M., Hulan, D., et al. (2015). "Type 2 diabetes patients' and providers' differing perspectives on medication nonadherence: a qualitative meta-synthesis." BMC Health Serv Res **15**: 516.

BACKGROUND: Poor adherence to medication regimens increases adverse outcomes for patients with Type 2 diabetes. Improving medication adherence is a growing priority for clinicians and health care systems. We examine the differences between patient and provider understandings of barriers to medication adherence for Type 2 diabetes patients. METHODS: We searched systematically for empirical qualitative studies on the topic of barriers to medication adherence among Type 2 diabetes patients published between 2002-2013; 86 empirical qualitative studies qualified for inclusion. Following qualitative meta-synthesis methods, we coded and analyzed thematically the findings from studies, integrating and comparing findings across studies to yield a synthetic interpretation and new insights from this body of research. RESULTS: We identify 7 categories of barriers: (1) emotional experiences as positive and negative motivators to adherence, (2) intentional non-compliance, (3) patient-provider relationship and communication, (4) information and knowledge, (5) medication administration, (6) social and cultural beliefs, and (7) financial issues. Patients and providers express different understandings of what patients require to improve adherence. Health beliefs, life context and lay understandings all inform patients' accounts. They describe barriers in terms of difficulties adapting medication regimens to their lifestyles and daily routines. In contrast, providers' understandings of patients poor medication adherence behaviors focus on patients' presumed needs for more information about the physiological and biomedical aspect of diabetes. CONCLUSIONS: This study highlights key discrepancies between patients' and providers' understandings of barriers to medication adherence. These misunderstandings span the many cultural and care contexts represented by 86 qualitative studies. Counseling and interventions aimed at improving medication adherence among Type 2 diabetes might become more effective through better integration of the patient's perspective and values concerning adherence difficulties and solutions.

Buchanan, A. H., Skinner, C. S., Rawl, S. M., et al. (2005). "Patients' interest in discussing cancer risk and risk management with primary care physicians." Patient Educ Couns **57**(1): 77-87.
http://www.ncbi.nlm.nih.gov/pubmed/15797155

Little is known about patients' preferences for discussing cancer risks and risk management with primary care physicians. We sought to determine whether patients want to discuss such topics and what factors are associated with this interest. Participants (375 patients ages 40-85, of diverse race and education level) completed a telephone survey prior to scheduled physician visits. Survey included items on perceived health, perceived cancer risk, education level, and whether participants would like to discuss with a physician their breast, ovarian or colon cancer risk, tamoxifen, cancer genetic counseling, and colon cancer screening. Greater proportions were interested in discussing risks for each cancer, compared with those who were not (P < 0.0001). More participants were interested in discussing mammograms (80%) and cancer genetic counseling (60%) than tamoxifen (49%) or colon cancer screening modalities (43-53%). For many topics, poorer perceived health was associated with greater interest in future discussion; higher education level was associated with less interest

Burke, M., Carey, P., Haines, L., et al. (2010). "Implementing the information prescription protocol in a family medicine practice: a case study." J Med Libr. Assoc **98**(3): 228-234.
http://www.ncbi.nlm.nih.gov/pubmed/20648257

> QUESTION: Can an information prescription protocol be successfully integrated into a family medicine practice seeking to enhance patient education and self-management? SETTING: Milton Family Practice, an outpatient clinic and resident teaching site of the University of Vermont and Fletcher Allen Health Care, is located in a semirural area fifteen miles from main campus. OBJECTIVES: The objectives were to increase physicians' knowledge and use of information prescriptions, sustain integration of information prescription use, and increase physicians' ability to provide patient education information. METHODS: Methods used were promotion of the National Library of Medicine's Information Rx, physician instruction, installation of patient and provider workstations, and a collaborative approach to practice integration. MAIN RESULTS: A post-intervention survey showed increased physician knowledge and use of the Information Rx protocol. Support procedures were integrated at the practice. CONCLUSIONS: Sustainable integration of Information Rx in a primary care clinic requires not only promotion and education, but also attention to clinic organization and procedures

Butalid, L., Verhaak, P. F., Boeije, H. R., et al. (2012). "Patients' views on changes in doctor-patient communication between 1982 and 2001: a mixed-methods study." BMC Fam Pract **13**: 80.

> BACKGROUND: Doctor-patient communication has been influenced over time by factors such as the rise of evidence-based medicine and a growing emphasis on patient-centred care. Despite disputes in the literature on the tension between evidence-based medicine and patient-centered medicine, patients' views on what constitutes high quality of doctor-patient communication are seldom an explicit topic for research. The aim of this study is to examine whether analogue patients (lay people judging videotaped consultations) perceive shifts in the quality of doctor-patient communication over a twenty-year period. METHODS: Analogue patients (N = 108) assessed 189 videotaped general practice consultations from two periods (1982-1984 and 2000-2001). They provided ratings on three dimensions (scale 1-10) and gave written feedback. With a mixed-methods research design, we examined these assessments quantitatively (in relation to observed communication coded with RIAS) and qualitatively. RESULTS: 1) The quantitative analyses showed that biomedical communication and rapport building were positively associated with the quality assessments of videotaped consultations from the first period, but not from the second. Psychosocial communication and personal remarks were related to positive quality assessments of both periods; 2) the qualitative analyses showed that in both periods, participants provided the same balance between positive and negative comments. Listening, giving support, and showing respect were considered equally important in both periods. We identified shifts in the participants' observations on how GPs explained things to the patient, the division of roles and responsibilities, and the emphasis on problem-focused communication (first period) versus solution-focused communication (last period). CONCLUSION: Analogue patients recognize shifts in the quality of doctor-patient communication from two different periods, including a shift from problem-focused communication to solution-focused communication, and they value an egalitarian doctor-patient relationship. The two research methods were complementary; based on the quantitative analyses we found shifts in communication, which we confirmed and specified in our qualitative analyses.

Butenko, S., Lockwood, C. et McArthur, A. (2017). "Patient experiences of partnering with healthcare professionals for hand hygiene compliance: a systematic review." JBI Database System Rev Implement Rep **15**(6): 1645-1670.

> BACKGROUND: Healthcare-associated infections pose a significant risk to patients in acute healthcare settings such as hospitals. Increasingly, patients are encouraged to be active participants and partner with healthcare professionals to positively influence their own safety and overall experience throughout their healthcare journey. Patient-focused safety initiatives include the empowerment of patients to be active partners with healthcare professionals in order to influence the hand hygiene behaviors and compliance of the healthcare professionals providing care to them. Partnering within the context of healthcare, and between the patient and healthcare professional, can be considered as

a general concept that involves the empowerment of patients to participate in their care. Terms used to describe patient partnering within healthcare vary and include patient participation, patient-centeredness, patient empowerment and patient engagement. Although patients appear generally to have positive attitudes and intentions about engaging in their safety and partnering in the healthcare setting, their intentions and actual behaviors vary considerably. Patients appear less likely to engage in behaviors that require questioning of the perceived or real authority of healthcare professionals. A patient's intention and subsequent act of partnering with healthcare professionals for hand hygiene compliance by the healthcare professional are influenced by complex internal, external and social factors as well as cultural, behavioral and systematic factors. OBJECTIVES: To determine the best available evidence in relation to the experiences of the patient partnering with healthcare professionals for hand hygiene compliance. INCLUSION CRITERIA TYPES OF PARTICIPANTS: The current review considered qualitative (critical or interpretive) papers that included adult in-patients and healthcare professionals (medical and nursing staff), in the acute hospital-care setting. Adult was considered to be any person aged 18 years or over. It should be noted that consumers in this context were patients and vice versa; the term patient is therefore used throughout this report for consistency. PHENOMENA OF INTEREST: The current review considered studies that investigated the experience of partnership between patients and healthcare professionals in relation to hand hygiene compliance. This review investigated the phenomena of partnering from both the perspectives of the patient and the healthcare professional. TYPES OF STUDIES: The current review considered studies that focused on qualitative data including, but not limited to, designs such as phenomenology, grounded theory, ethnography, action research and feminist research. As qualitative studies were identified and on appraisal found to be of sufficient quality for inclusion, this review did not seek alternate forms of evidence such as text and opinion. SEARCH STRATEGY: The search strategy aimed to find both published and unpublished studies from 1990 to May 2015. Studies published in English were considered for inclusion in this review. METHODOLOGICAL QUALITY: Qualitative papers selected for retrieval were assessed by two independent reviewers for methodological validity prior to inclusion in the review using standardized critical appraisal instruments from the Joanna Briggs Institute Qualitative Assessment and Review Instrument (JBI-QARI). DATA EXTRACTION: Qualitative data were extracted from papers included in the review using the standardized data extraction tool from JBI-QARI. DATA SYNTHESIS: Qualitative research findings were pooled using JBI-QARI. RESULTS: Following the systematic search and critical appraisal process, three studies were included in the review for data extraction and synthesis of findings. The review process resulted in 29 study findings that were aggregated into seven categories. The categories generated two meta-synthesized findings. The two final synthesized findings were as follows. Synthesized finding 1: Organizational structures enable partnering between healthcare professionals and patients for hand hygiene compliance; however, the culture, beliefs and behaviors of healthcare professionals and patients do not fully support this partnership. Synthesized finding 2: Patients have differing levels of knowledge and balance partnering in hand hygiene against possible detrimental impacts on the caring relationship provided by healthcare professionals, out of concern for their own wellbeing, health outcomes, treatment and/or recovery. CONCLUSION: The current review highlights the complexity of the patient's experience of partnering with healthcare professionals for hand hygiene compliance. The experiences reported indicated that there is a possible disparity between the healthcare facility and healthcare professionals' promotion and intention of partnering for hand hygiene compliance, and the actual patient's acceptance, participation, partnership, experience and implementation of this initiative. This disconnect between intent and action appears to be influenced by a number of factors including organizational structures as well as drivers such as cultural beliefs and behavior.

Carey, M. E., Agarwal, S., Horne, R., et al. (2019). "Exploring organizational support for the provision of structured self-management education for people with Type 2 diabetes: findings from a qualitative study." Diabet Med **36**(6): 761-770.

AIM: To explore the organizational context in which Type 2 diabetes structured group education is provided. METHODS: Four Clinical Commissioning Groups in England providing Type 2 diabetes structured self-management education participated in a qualitative study exploring the context for provision of that education. Using UK National Diabetes Audit returns, two Clinical Commissioning Groups were selected that had non-attendance rates of ≤25%, and two that had non-attendance rates of ≥50%. Between May 2016 and August 2017, 20 interviews were conducted with Clinical Commissioning Group staff including: commissioners, healthcare professionals, managers, general practitioners and diabetes educators. Data gathering was prolonged as it proved challenging to engage with healthcare staff as a result of frequent local restructuring and service disruption. RESULTS: Local audits revealed discrepancies in basic data such as referral and attendance numbers compared with national audit data. There was a commonality in the themes identified from interviews: diabetes education was rarely embedded in service structure; where education uptake was poor, a lack of central support to delivery teams was noticeable; and where education uptake was positive, delivery teams were actively engaged, sometimes relying on enthusiastic individuals. Both situations put the local sustainability of diabetes education at risk. CONCLUSIONS: There appears to be a link between attendance rates and organizational issues, therefore, when considering how to increase attendance rates, the state of the diabetes education infrastructure should be reviewed. Good uptake of diabetes education can be too reliant on the enthusiastic commitment of small teams or individuals delivering the education.

Carlsen, B., Aakvik, A. et Norheim, O. F. (2008). "Variation in practice: a questionnaire survey of how congruence in attitudes between doctors and patients influences referral decisions." Med Decis. Making **28**(2): 262-268.
http://www.ncbi.nlm.nih.gov/pubmed/18349435

BACKGROUND: There is a well-known and partly unexplained variation in referral rates among general practitioners (GPs). GPs who are positive toward shared decision making refer less to secondary care, but how congruence in attitudes between doctors and patients influences referral rates has not been investigated. In this study, the authors analyze whether congruence in attitudes between the GP and patients toward shared decision making affects the GP's referral rate. METHODS: Questionnaire survey was distributed by 56 Norwegian GPs, each to 50 consulting patients. The level of congruence in attitudes toward shared decision making of GPs and corresponding patients was measured by the Patient-Practitioner Orientation Scale. The survey also included self-reported referral rates. RESULTS: In total, 1268 patients (45%) returned the questionnaires. Respondents were eliminated if they did not fully answer the questionnaire, resulting in a working sample of 835 patients. The authors found that congruence of attitudes toward shared decision making between the GP and patients had a negative effect on referral rate. CONCLUSION: In this study, congruence of attitudes toward shared decision making between GPs and patients influences referral decisions, indicating that matching attitudes may enhance the effort to solve the medical problem within the GPs' practice (i.e., doctor-patient interaction explains some of the variation in practice). The study supports the policy argument that, if possible, health authorities should enhance the possibilities for patients to choose a GP of matching attitudes

Cegala, D. J., Chisolm, D. J. et Nwomeh, B. C. (2012). "Further examination of the impact of patient participation on physicians' communication style." Patient Educ Couns **89**(1): 25-30.
http://www.ncbi.nlm.nih.gov/pubmed/22560252

OBJECTIVE: Previous research in primary care has shown that physicians are more informative and/or patient-centered when they interact with high participation patients (e.g., those who ask questions, express preferences and concerns). This study contributes to this literature by examining parents' participation and physicians' discourse in a pediatric surgery context. METHODS: The audiotapes of 7 pediatric surgeons and 68 of their patients' parents/guardians were coded and examined for physicians' information exchange and support utterances as they interacted with parents/guardians with varying degrees of participation. RESULTS: The results of a multilevel regression analysis showed, consistent with related research, that the same physicians were more informative overall and provided more information in response to parents' questions when interacting with high participation parents. However, participation was not associated with physicians' volunteered information, general explanations, or support utterances. DISCUSSION AND CONCLUSION: The results are discussed with respect to the impact of participation on physicians' information provision and implications for future research, particularly with respect to general explanations, volunteered information, and medical context. PRACTICE IMPLICATIONS: This study suggests that surgeons may provide more detailed information to patients who are active participants in the preoperative interview, thereby improving the adequacy and validity of informed consent for surgical procedures

Chandak, A. et Joshi, A. (2015). "Self-management of hypertension using technology enabled interventions in primary care settings." Technol Health Care **23**(2): 119-128.

BACKGROUND: Self-management of hypertension by controlling Blood Pressure (BP) through technology-based interventions can effectively reduce the burden of high BP, which affects one out of every three adults in the United States. OBJECTIVE: The primary aim of this study is to explore the role of technology enabled interventions to improve or enhance self-management among individuals with hypertension. METHODS: We conducted a systematic review of the literature published between July 2008 and June 2013 on the MEDLINE database (via PubMed interface) during July 2013. The search words were "hypertension" and "primary care" in combination with each of the terms of "technology", "internet", "computer" and "cell phone". Our inclusion criteria consisted of: (a) Randomized Controlled Trials (RCTs) (b) conducted on human subjects; (c) technology-based interventions (d) to improve self-management (e) of hypertension and if the (f) final results of the study were published in the study. Our exclusion criteria included (a) management of other conditions and (b) literature reviews. RESULTS: The initial search resulted in 108 results. After applying the inclusion and exclusion criteria, a total of 12 studies were analyzed. Various technologies implemented in the studies included internet-based telemonitoring and education, telephone-based telemonitoring and education, internet-based education, telemedicine via videoconferencing, telehealth kiosks and automated modem device. Some studies also involved a physician intervention, in addition to patient intervention. The outcomes of proportion of subjects with BP control and change in mean SBP and DBP were better for the group of subjects who received combined physician and patient interventions. CONCLUSION: Interventions to improve BP control for self-management of hypertension should be aimed at both physicians as well as the patients. More interventions should utilize the JNC-7 guidelines and cost-effectiveness of the intervention should also be assessed.

Chen, C. S., Chan, S. W., Chan, M. F., et al. (2017). "Nurses' Perceptions of Psychosocial Care and Barriers to Its Provision: A Qualitative Study." J Nurs Res **25**(6): 411-418.

BACKGROUND: Psychosocial care is the culturally sensitive provision of psychological, social, and spiritual care through therapeutic communication. Current evidence suggests that effective psychosocial care improves patients' health outcomes and quality of life. PURPOSE: The aim of this study was to explore nurses' perceptions and experiences in providing psychosocial care to patients and to identify the related barriers and challenges. METHODS: An exploratory qualitative design using semistructured, individual, face-to-face interviews was adopted. A purposive sample of 18 registered nurses was recruited from the geriatric, medical, and surgical wards in an acute general hospital in Singapore. Interviews were audio-recorded, transcribed, and analyzed thematically. RESULTS: Four major themes emerged: patient-centered care, communication, interprofessional care, and barriers to psychosocial care. Nurses perceived that psychosocial care consists of providing holistic care, spiritual care, support to the patient and family members, and showing empathy. Furthermore, psychosocial care is composed of communication between nurses and the patient and family members as well as communication among nurses. In addition, psychosocial care involves collaboration between healthcare professionals as well as multidisciplinary care. Barriers that are perceived by nurses include lack of time, language barriers, being task-oriented, excessive documentation, lack of family involvement, and fear of complaints. CONCLUSIONS: This study highlighted the perceptions of nurses regarding psychosocial care and the challenges in providing this care. Future studies are needed to explore ways to overcome these barriers and to enhance nurses' competencies in providing psychosocial care. The findings indicate a need to plan future interventions to provide nurses with both skill development and support to improve their ability to integrate psychosocial care, which will improve patient outcomes.

Chiang, C. Y., Choi, K. C., Ho, K. M., et al. (2018). "Effectiveness of nurse-led patient-centered care behavioral risk modification on secondary prevention of coronary heart disease: A systematic review." Int J Nurs Stud **84**: 28-39.

BACKGROUND: Despite establishment of advocacies centered on using patient-centered care to improve disease-related behavioral changes and health outcomes, studies have seldom discussed incorporation of patient-centered care concept in the design of secondary cardiac prevention. OBJECTIVES: This review aimed to identify, appraise, and examine existing evidence on the effectiveness of nurse-led patient-centered care for secondary cardiac prevention in patients with coronary heart disease. DESIGN: A systematic review of randomized controlled trials focusing on nurse-led patient-centered care for secondary cardiac prevention was conducted. Primary outcomes were behavioral risks (e.g. smoking, physical activity), secondary outcomes were clinically relevant physiological parameters (e.g. body weight, blood pressure, blood glucose, blood lipoproteins), health-related quality of life, mortality, and self efficacy. DATA SOURCES: Twenty-three English and seven Chinese electronic databases were searched to identify the trials. REVIEW METHODS: The studies' eligibility and methodological quality were assessed by two reviewers independently according to the Joanna Briggs Institute guidelines. Statistical heterogeneities of the included studies were assessed by Higgins I2 and quantitative pooling was performed when studies showed sufficient comparability. RESULTS: 15 articles on 12 randomized controlled trials were included in this review. Methodological quality of the included studies was fair. Based on the Joanna Briggs Institute critical appraisal tool for experimental studies, the included studies had met a mean of six criteria out the ten in this appraisal tool. The meta-analyses of the included studies revealed that nurse-led patient-centered care had significantly improved patients' smoking habits, adherence toward physical activity advices, and total cholesterol level with medical regime optimization, in short- to medium-term. The intervention was also favorable in improving the patients' health-related quality of life in several domains of SF-36. Furthermore, from single-study results, the intervention was favorable in improving the patients' weight management and alcohol consumption. However, it did not show significant effects on improving the patient's dietary habits, certain cardiac physiological parameters, mortality and self-efficacy. Currently, no addition long-term benefit of the intervention on secondary cardiac prevention was identified. CONCLUSION: This review has systematically analyzed the effects of nurse-led patient-centered care on patients' behavioral risks, cardiac physiological parameters, mortality, health-related quality of life and self-efficacy. Given limited quantity of existing evidence regarding certain outcomes and long-term follow-up period; cross-trial heterogeneity of the interventions, measurement methods and statistical results; high or unclear risk of bias in some quality dimensions, the effectiveness of the intervention on secondary cardiac prevention remains inconclusive and subject to additional trials and evidences.

Chiswell, E., Hampton, D. et Okoli, C. T. C. (2019). "Effect of Patient and Provider Education on Antibiotic Overuse for Respiratory Tract Infections." J Healthc Qual **41**(3): e13-e20.

Antibiotic overuse for respiratory tract infections (RTIs) in primary care (PC) is a known important contributor to the serious health threat of antibiotic resistance, yet remains a difficult problem to improve. The purpose of the study was to assess the effects of a combination patient and provider education program on antibiotic prescribing in RTIs in a rural primary care clinic. Utilizing a quasi-experimental pretest-posttest design, a retrospective electronic medical record review was conducted to determine if a patient and provider education program changed the rates of antibiotics being prescribed (immediate or delayed) during a visit for RTI for 207 randomly selected patients during the established evaluation time periods. The antibiotic prescription rate for the preintervention group was 56.3% compared to 28.8% for the postintervention group ($p < .01$). Immediate antibiotics were ordered in the preintervention group 31.1% of the time compared to 13.5% for the postintervention group ($p < .05$). The results of this study demonstrate that educational interventions can be effective in rural settings and that changes in antibiotic prescribing are possible.

Chung, G. S., Lawrence, R. E., Curlin, F. A., et al. (2012). "Predictors of hospitalised patients' preferences for physician-directed medical decision-making." J Med Ethics **38**(2): 77-82.
http://www.ncbi.nlm.nih.gov/pubmed/21697296

BACKGROUND: Although medical ethicists and educators emphasise patient-centred decision-making, previous studies suggest that patients often prefer their doctors to make the clinical decisions.

OBJECTIVE: To examine the associations between a preference for physician-directed decision-making and patient health status and sociodemographic characteristics. METHODS: Sociodemographic and clinical information from all consenting general internal medicine patients at the University of Chicago Medical Center were examined. The primary objectives were to (1) assess the extent to which patients prefer an active role in clinical decision-making, and (2) determine whether religious service attendance, the importance of religion, self-rated spirituality, Charlson Comorbidity Index, self-reported health, Vulnerable Elder Score and several demographic characteristics were associated with these preferences. RESULTS: Data were collected from 8308 of 11,620 possible participants. Ninety-seven per cent of respondents wanted doctors to offer them choices and to consider their opinions. However, two out of three (67%) preferred to leave medical decisions to the doctor. In multiple regression analyses, preferring to leave decisions to the doctor was associated with older age (per year, OR=1.019, 95% CI 1.003 to 1.036) and frequently attending religious services (OR=1.5, 95% CI 1.1 to 2.1, compared with never), and it was inversely associated with female sex (OR=0.6, 95% CI 0.5 to 0.8), university education (OR=0.6, 95% CI 0.4 to 0.9, compared with no high school diploma) and poor health (OR=0.6, 95% CI 0.3 to 0.9). CONCLUSIONS: Almost all patients want doctors to offer them choices and to consider their opinions, but most prefer to leave medical decisions to the doctor. Patients who are male, less educated, more religious and healthier are more likely to want to leave decisions to their doctors, but effects are small

Claramita, M., Arininta, N., Fathonah, Y., et al. (2020). "A partnership-oriented and culturally-sensitive communication style of doctors can impact the health outcomes of patients with chronic illnesses in Indonesia." Patient Educ Couns **103**(2): 292-300.

OBJECTIVES: A partnership-oriented communication style is globally recommended for medical practice. A culturally-sensitive doctor-patient communication guideline is also needed for Southeast Asia. The 'Greet-Invite-Discuss' guideline was established and tested with primary care doctors and their patients in Indonesia. METHODS: In this mixed-methods study, doctors were trained according to the 'Greet-Invite-Discuss' guideline, while patients received standard treatment. Two groups of fifteen doctors were assigned to have consultations with 45 patients with hypertension or 51 patients with type-2 diabetes mellitus. Doctors' self-assessment and patients' perceptions and their clinical outcomes were longitudinally measured. Six focus group discussions were conducted to explore doctors' and patients' experiences. RESULTS: Doctors' self-assessments and patients' perceptions of doctors' communication skills increased significantly ($p < 0.05$). Moreover, patients' blood pressure or fasting blood glucose levels decreased significantly ($p < 0.05$), except the two-hour blood glucose levels (NS). Qualitatively, doctors demonstrated more partnership and culturally-sensitive communication, and patients expressed more satisfaction, increased comprehension and self-management, of their chronic illnesses. CONCLUSIONS: The 'Greet-Invite-Discuss' guideline was useful for primary care doctors for a more partnership-oriented and culturally-sensitive communication with patients in chronic care management. PRACTICE IMPLICATIONS: Using a partnership-oriented and culturally-sensitive communication guideline, doctors can improve their communication skills with their patients towards optimum health outcomes.

Clayman, M. L., Bylund, C. L., Chewning, B., et al. (2016). "The Impact of Patient Participation in Health Decisions Within Medical Encounters: A Systematic Review." Med Decis Making **36**(4): 427-452.

BACKGROUND: Although there are compelling moral arguments for patient participation in medical decisions, the link to health outcomes has not been systematically explored. OBJECTIVE: Assess the extent to which patient participation in decision making within medical encounters is associated with measured patient outcomes. METHODS: We conducted a primary search in PubMed-excluding non-English and animal studies-for articles on decision making in the context of the physician-patient relationship published through the end of February 2015, using the MeSH headings (Physician-Patient Relations [MeSH] OR Patient Participation [MeSH]) and the terms (decision OR decisions OR option OR options OR choice OR choices OR alternative OR alternatives) in the title or abstract. We also conducted a secondary search of references in all articles that met the inclusion criteria. RESULTS: A thorough search process yielded 116 articles for final analysis. There was wide variation in study design, as well as measurement of patient participation and outcomes, among the studies. Eleven of

> the 116 studies were randomized controlled trials (RCTs). Interventions increased patient involvement in 10 (91%) of the 11 RCTs. At least one positive outcome was detected in 5 (50%) of the 10 RCTs reporting increased participation; the ratio of positive results among all outcome variables measured in these studies was much smaller. Although proportions differed, similar patterns were found across the 105 nonrandomized studies. CONCLUSIONS: Very few RCTs in the field have measures of participation in decision making and at least one health outcome. Moreover, extant studies exhibit little consistency in measurement of these variables, and results are mixed. There is a great need for well-designed, reproducible research on clinically relevant outcomes of patient participation in medical decisions.

Clemente, D., Leon, L., Foster, H., et al. (2016). "Systematic review and critical appraisal of transitional care programmes in rheumatology." Semin Arthritis Rheum **46**(3): 372-379.

> OBJECTIVES: Identify existing models of transitional care in rheumatic and musculoskeletal diseases (RMD), describe their strengths and weaknesses, and provide support to a consensus initiative to develop recommendations for transitional care. METHODS: A systematic review was conducted to identify publications describing transition programmes in RMD. Eligibility for inclusion required detailed description of the programme. Descriptive information was collected, including country of the programme, target diseases and ages of the patients, resources, elements of the transition process and, when described, outcomes and quality indicators. Quality assessment of the programmes included: level of definition and the evidence base for the programme, availability of quality indicators and evidence of effectiveness. RESULTS: Overall, 27 articles were identified and evaluated, related to 8 programmes in 6 countries: 4 covered all RMDs, 3 specific for patients with juvenile idiopathic arthritis (JIA) and 1 programme generic for chronic diseases and adapted for RMD. Core elements of these transition programmes included the following: a written transition policy; patient individualised planning and flexibility of transitional care; designation of transition coordinator role; acquisition of knowledge and skills in self-management of care; decision making, shared care and communication between paediatric and adult health care provider teams and a planned transfer to adult rheumatology. Only 2 provided evidence of effectiveness according to previously specified outcome measures. CONCLUSIONS: Transitional care programmes in RMDs are variable in their structures, staffing and processes. There are no standardised measures of outcome or effectiveness. This information provides important valuable insights and strategies to develop transitional care in RMD.

Clever, S. L., Ford, D. E., Rubenstein, L. V., et al. (2006). "Primary care patients' involvement in decision-making is associated with improvement in depression." Med Care **44**(5): 398-405.
http://www.ncbi.nlm.nih.gov/pubmed/16641657

> BACKGROUND: Depression is undertreated in primary care settings. Little research investigates the impact of patient involvement in decisions on guideline-concordant treatment and depression outcomes. OBJECTIVE: The objective of this study was to determine whether patient involvement in decision-making is associated with guideline-concordant care and improvement in depression symptoms. DESIGN: Prospective cohort study. SETTING: Multisite, nationwide randomized clinical trial of quality improvement strategies for depression in primary care. SUBJECTS: Primary care patients with current symptoms and probable depressive disorder. MEASUREMENTS: Patients rated their involvement in decision-making (IDM) about their care on a 5-point scale from poor to excellent 6 months after entry into the study. Depressive symptoms were measured every 6 months for 2 years using a modified version of the Center for Epidemiologic Studies-Depression (CES-D) scale. We examined probabilities (Pr) of receipt of guideline-concordant care and resolution of depression across IDM groups using multivariate logistic regression models controlling for patient and provider factors. RESULTS: For each 1-point increase in IDM ratings, the probability of patients' report of receiving guideline-concordant care increased 4% to 5% (adjusted Pr 0.31 vs. 0.50 for the lowest and highest IDM ratings, respectively, $P < 0.001$). Similarly, for each 1-point increase in IDM ratings, the probability of depression resolution increased 2% to 3% (adjusted Pr 0.10 vs. 0.19 for the lowest and highest IDM ratings respectively, $P = 0.004$). CONCLUSIONS: Depressed patients with higher ratings of involvement in medical decisions have a higher probability of receiving guideline-concordant care and improving

their symptoms over an 18-month period. Interventions to increase patient involvement in decision-making may be an important means of improving care for and outcomes of depression

Cleveringa, F. G., Gorter, K. J., van den Donk, M., et al. (2013). "Computerized decision support systems in primary care for type 2 diabetes patients only improve patients' outcomes when combined with feedback on performance and case management: a systematic review." Diabetes Technol Ther **15**(2): 180-192.

PURPOSE: Computerized decision support systems (CDSSs) are often part of a multifaceted intervention to improve diabetes care. We reviewed the effects of CDSSs alone or in combination with other supportive tools in primary care for type 2 diabetes mellitus (T2DM). MATERIALS AND METHODS: A systematic literature search was conducted for January 1990-July 2011 in PubMed, Embase, and the Cochrane Database and by consulting reference lists. Randomized controlled trials (RCTs) in general practice were selected if the interventions consisted of a CDSS alone or combined with a reminder system and/or feedback on performance and/or case management. The intervention had to be compared with usual care. Two pairs of reviewers independently abstracted all available data. The data were categorized by process of care and patient outcome measures. RESULTS: Twenty RCTs met inclusion criteria. In 14 studies a CDSS was combined with another intervention. Two studies were left out of the analysis because of low quality. Four studies with a CDSS alone and four studies with a CDSS and reminders showed improvements of the process of care. CDSS with feedback on performance with or without reminders improved the process of care (one study) and patient outcome (two studies). CDSS with case management improved patient outcome (two studies). CDSS with reminders, feedback on performance, and case management improved both patient outcome and the process of care (two studies). CONCLUSIONS: CDSSs used by healthcare providers in primary T2DM care are effective in improving the process of care; adding feedback on performance and/or case management may also improve patient outcome.

Clinch, M. et Benson, J. (2013). "Making information 'relevant': general practitioner judgments and the production of patient involvement." Soc Sci Med **96**: 104-111.
http://www.ncbi.nlm.nih.gov/pubmed/24034957

Sociological work that has engaged with the issue of patient involvement in health care suggests it needs to be recognised that decision-making is not simply an individual cognitive act contained in a single consultation, but a process that is distributed across multiple encounters in relation to a range of agents and non-human actors. Drawing on such conceptualisations of decision-making, and based on semi-structured interviews with 24 General Practitioners (GPs) in the United Kingdom about the prescription of statins for the primary prevention of cardiovascular disease, this paper explores the preemptive work that GPs perform when attempting to achieve patient involvement in healthcare decisions. The paper identifies a set of repertoires through which they evaluate and coordinate often contradictory forms of knowledge, transforming them into information that they think is relevant to patients, and which will potentially facilitate meaningful involvement in healthcare decisions. The study concludes by suggesting that such fluid and context sensitive practices are a necessary strategy for navigating complex health environments, which can be justified and underpinned by a relational model of autonomy. However, work needs to be done to explore how such judgments can be calibrated to mesh with the decision-making preferences of patients and what new approaches and standards for practice this would require

CommonwealthFund (2019). Quick Reference Guide to Promising Care Models for Patients with Complex Needs. New York The Commonwealth Fund**:** 9 , tabl.
https://www.commonwealthfund.org/publications/2019/feb/care-models-patients-complex-needs

Many pioneering programs have reduced avoidable utilization of care and lowered costs while improving health outcomes for adults with complex needs. The most promising models target high-risk populations and provide key elements of person-centered care, including individualized care plans, interdisciplinary care teams, active care coordination, and continuous information-sharing with providers and patients. The Quick Reference Guide to Promising Care Models offers summary information on 28 programs for adults with complex needs, specifically: target population and subpopulations served by the model; Key features of the model associated with person-centered care; Outcomes and impact.

Cooper, L. A., Ghods Dinoso, B. K., Ford, D. E., et al. (2013). "Comparative effectiveness of standard versus patient-centered collaborative care interventions for depression among African Americans in primary care settings: the BRIDGE Study." Health Serv Res **48**(1): 150-174.
http://www.ncbi.nlm.nih.gov/pubmed/22716199

OBJECTIVE: To compare the effectiveness of standard and patient-centered, culturally tailored collaborative care (CC) interventions for African American patients with major depressive disorder (MDD) over 12 months of follow-up. DATA SOURCES/STUDY SETTING: Twenty-seven primary care clinicians and 132 African American patients with MDD in urban community-based practices in Maryland and Delaware. STUDY DESIGN: Cluster randomized trial with patient-level, intent-to-treat analyses. DATA COLLECTION/EXTRACTION METHODS: Patients completed screener and baseline, 6-, 12-, and 18-month interviews to assess depression severity, mental health functioning, health service utilization, and patient ratings of care. PRINCIPAL FINDINGS: Patients in both interventions showed statistically significant improvements over 12 months. Compared with standard, patient-centered CC patients had similar reductions in depression symptom levels (-2.41 points; 95 percent confidence interval (CI), -7.7, 2.9), improvement in mental health functioning scores (+3.0 points; 95 percent CI, -2.2, 8.3), and odds of rating their clinician as participatory (OR, 1.48, 95 percent CI, 0.53, 4.17). Treatment rates increased among standard (OR = 1.8, 95 percent CI 1.0, 3.2), but not patient-centered (OR = 1.0, 95 percent CI 0.6, 1.8) CC patients. However, patient-centered CC patients rated their care manager as more helpful at identifying their concerns (OR, 3.00; 95 percent CI, 1.23, 7.30) and helping them adhere to treatment (OR, 2.60; 95 percent CI, 1.11, 6.08). CONCLUSIONS: Patient-centered and standard CC approaches to depression care showed similar improvements in clinical outcomes for African Americans with depression; standard CC resulted in higher rates of treatment, and patient-centered CC resulted in better ratings of care

Couet, N., Desroches, S., Robitaille, H., et al. (2015). "Assessments of the extent to which health-care providers involve patients in decision making: a systematic review of studies using the OPTION instrument." Health Expect **18**(4): 542-561.

BACKGROUND: We have no clear overview of the extent to which health-care providers involve patients in the decision-making process during consultations. The Observing Patient Involvement in Decision Making instrument (OPTION) was designed to assess this. OBJECTIVE: To systematically review studies that used the OPTION instrument to observe the extent to which health-care providers involve patients in decision making across a range of clinical contexts, including different health professions and lengths of consultation. SEARCH STRATEGY: We conducted online literature searches in multiple databases (2001-12) and gathered further data through networking. INCLUSION CRITERIA: (i) OPTION scores as reported outcomes and (ii) health-care providers and patients as study participants. For analysis, we only included studies using the revised scale. DATA EXTRACTION: Extracted data included: (i) study and participant characteristics and (ii) OPTION outcomes (scores, statistical associations and reported psychometric results). We also assessed the quality of OPTION outcomes reporting. MAIN RESULTS: We found 33 eligible studies, 29 of which used the revised scale. Overall, we found low levels of patient-involving behaviours: in cases where no intervention was used to implement shared decision making (SDM), the mean OPTION score was 23 +/- 14 (0-100 scale). When assessed, the variables most consistently associated with higher OPTION scores were interventions to implement SDM (n = 8/9) and duration of consultations (n = 8/15). CONCLUSIONS: Whatever the clinical context, few health-care providers consistently attempt to facilitate patient involvement, and even fewer adjust care to patient preferences. However, both SDM interventions and longer consultations could improve this.

Coulter, A. (2013). Delivering better services for people with long-term conditions. Building the house of care. Institute.Londres.GBR, K. s. F.
http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/delivering-better-services-for-people-with-long-term-conditions.pdf

As of 1 April 2013, clinical commissioning groups (CCGs) are responsible for the majority of the NHS budget ? more than £65 billion of public money. At the same time, public health budgets of £2.7 billion are transferring to local authorities, while NHS England (formerly the NHS Commissioning Board), through its 27 area teams, takes responsibility for commissioning primary care (£13 billion) and specialised services (£12 billion). It is hoped that the new health and wellbeing boards, convened by local authorities, will play a key role in co-ordinating the activities of these different groups of commissioners, while commissioning support units ? also new ? will provide a range of services to clinical commissioning groups and NHS England to help them to perform their functions effectively. The new commissioning landscape is summarised in the figure below. Collectively, the task of this new set of commissioners is to deliver a sustainable health care system in the face of one of the most challenging financial and organisational environments the NHS has ever experienced. The task is especially daunting in the context of a population in which the burden of disease is growing and medical advances offer increasing opportunities to treat disease, but at a cost. The result, if nothing else changes in the NHS, will be significant unmet need and threats to the quality of care

Covi-Crochet, A., Cittee, J. C. et Letrilliart, L. (2010). "[Frequency, modes, and determinants of patients' nutritional education in family medicine: the Nutrimege study]." Rev Prat **60**(6 Suppl): 4-8.
http://www.ncbi.nlm.nih.gov/pubmed/20623914

BACKGROUND: Nutritional education is one of the tasks of the family physicians. The aims of the Nutrimege study were to describe the frequency and modes of patients' nutritional education in family medicine, the characteristics of family physicians and patients involved, and its impact on the consultation length. METHODS: Cross-sectional study, performed with questionnaires mailed to sixty family physicians from the Val-de-Marne in December 2007. Each physician had to include the first ten patients seen during a given day. RESULTS: 45 family physicians participated, allowing the inclusion of 410 patients. The sample of family physicians was representative of the physicians in Val-de-Marne and in France. Nutritional counseling was delivered in 42.4% of consultations (95% CI: 37.6-47.2%). It mainly consisted in a dietary advice (90.2%), delivered orally (80.5%), at the initiative of the physician (81.6%). Collaborating with other healthcare professionals for nutritional purposes was rare (5.4%). Nutritional counseling was especially delivered for secondary prevention, to patients either aged 40 or older, obese, having one or more chronic conditions. The physicians who delivered nutritional counseling most were aged 45 and over, were practicing with free fees agreement, and had a specific practice. When nutritional counseling was delivered, the consultation lasted one minute more on average. CONCLUSION: The use of written tailored media (edited with appropriate computer tools), a better collaboration with other healthcare professionals, and the strengthening of the medical training on preventive medicine may help to improve the quality of patients' nutritional education process

Cramm, J. M. et Nieboer, A. P. (2015). "Chronically ill patients' self-management abilities to maintain overall well-being: what is needed to take the next step in the primary care setting?" BMC Fam Pract **16**: 123.

BACKGROUND: Although widespread problems in patient-professional interaction and insufficient support of patients' self-management abilities have been recognized, research investigating the relationships among care quality, productive interaction, and self-management abilities to maintain overall well-being is lacking. Furthermore, studies have revealed differences in these characteristics among certain groups (e.g., less-educated and older patients). This longitudinal study thus aimed to identify relationships among background characteristics, quality of care, productivity of patient-professional interaction, and self-management abilities to maintain overall well-being in chronically ill patients participating in 18 Dutch disease management programs. METHODS: This longitudinal study included patients participating in 18 Dutch disease management programs. Surveys were administered in 2011 (T1; n = 2191 (out of 4693), 47 % response rate) and 2012 (T2: n = 1722 (out of 4350), 40 % response rate). A total of 1279 patients completed questionnaires at both timepoints (T1 and T2) (27 % response rate). Self-management abilities to maintain well-being were measured using the short (18-item) version of the Self-Management Ability Scale (SMAS-S), patients' perceptions of the productivity of interactions with health care professionals were assessed with the relational coordination instrument and the short (11-item) version of the Patient Assessment of Chronic Illness

Care (PACIC-S) was used to assess patients' perceptions of the quality of chronic care delivery. RESULTS: Perceived and objective quality of care and the productivity of patient-professional interaction were found to be related to patients' self-management abilities to maintain overall well-being. These abilities were related negatively to and significantly predicted by low educational level, single status, and older age, despite the mediating role of productive interaction in their relationship with patients' perceptions of care quality. CONCLUSIONS: These findings suggest that patient-professional interaction is not yet sufficiently productive to successfully protect against the deterioration of self-management abilities in some groups of chronically ill patients, although such interaction and high-quality care are important factors in such protection. Improvement of the quality of chronic care delivery should thus always be accompanied by investment in high-quality communication and patient-professional relationships.

Dambha-Miller, H., Silarova, B., Irving, G., et al. (2018). "Patients' views on interactions with practitioners for type 2 diabetes: a longitudinal qualitative study in primary care over 10 years." Br J Gen Pract **68**(666): e36-e43.

BACKGROUND: It has been suggested that interactions between patients and practitioners in primary care have the potential to delay progression of complications in type 2 diabetes. However, as primary care faces greater pressures, patient experiences of patient-practitioner interactions might be changing. AIM: To explore the views of patients with type 2 diabetes on factors that are of significance to them in patient-practitioner interactions in primary care after diagnosis, and over the last 10 years of living with the disease. DESIGN AND SETTING: A longitudinal qualitative analysis over 10 years in UK primary care. METHOD: The study was part of a qualitative and quantitative examination of patient experience within the existing ADDITION-Cambridge and ADDITION-Plus trials from 2002 to 2016. The researchers conducted a qualitative descriptive analysis of free-text comments to an open-ended question within the CARE measure questionnaire at 1 and 10 years after diagnosis with diabetes. Data were analysed cross-sectionally at each time point, and at an individual level moving both backwards and forwards between time points to describe emergent topics. RESULTS: At the 1-year follow-up, 311 out of 1106 (28%) participants had commented; 101 out of 380 (27%) participants commented at 10-year follow-up; and 46 participants commented at both times. Comments on preferences for face-to-face contact, more time with practitioners, and relational continuity of care were more common over time. CONCLUSION: This study highlights issues related to the wider context of interactions between patients and practitioners in the healthcare system over the last 10 years since diagnosis. Paradoxically, these same aspects of care that are valued over time from diagnosis are also increasingly unprotected in UK primary care.

Davies, F., Risor, M. B., Melbye, H., et al. (2014). "Primary and secondary care clinicians' views on self-treatment of COPD exacerbations: a multinational qualitative study." Patient Educ Couns **96**(2): 256-263.

OBJECTIVE: To explore clinicians' views on antibiotic and/or steroid 'rescue packs' used as self-treatment for patients with exacerbations of COPD. METHODS: 21 focus groups conducted in 7 countries--Netherlands, Russia, Norway, China (Hong Kong), Wales, Germany and Poland involving 142 primary care clinicians and pulmonologists. RESULTS: We found wide variation in reported use of and attitudes to self-treatment among GPs and pulmonologists in the participating countries. Clinicians highlighted the importance of identifying patients who were most likely to benefit (those with more severe disease) and most likely to use the treatment appropriately (demonstrated by previous behaviour), and the importance of adequate patient education and ongoing communication in regard to use of self-treatment packs. Clinicians recognised patient empowerment and facilitating prompt treatment as potential benefits of self-treatment. However, many felt they did not have the time or resources for appropriate patient selection and education. CONCLUSION: Clinicians do not feel it is appropriate to offer self-treatment rescue packs to all patients routinely without careful consideration of patient understanding of their illness and their capacity for self-management. PRACTICE IMPLICATIONS: Adequate resources and continuity of patient care are required for clinicians to feel confident in the safe and effective implementation of this strategy.

de Belvis, A. G., Pelone, F., Biasco, A., et al. (2009). "Can primary care professionals' adherence to Evidence Based Medicine tools improve quality of care in type 2 diabetes mellitus? A systematic review." Diabetes Res Clin Pract **85**(2): 119-131.

> BACKGROUND: Our aim is to review the effectiveness of EBM tools available to primary care professionals to improve the quality of Type 2 diabetes disease management. METHODS: A systematic review of RCT was performed according to the Cochrane methods. RESULTS: Starting from an overall number of 1737 references found, a total of 13 studies met all the inclusion criteria. CONCLUSIONS: The adherence to EBM instruments is likely to improve process of care, rather than patient outcomes. In addition, our review outlines that feedback reports and use of ICT devices are likely to be effective in diabetes disease management.

de Figueiredo, R. C., Snoek, F. J. et Barreto, S. M. (2013). "Do patients and physicians agree on diabetes management? A study conducted in public healthcare centres in Brazil." Patient Educ Couns **92**(1): 107-113.

> OBJECTIVE: To explore to what extent patients with diabetes agree with their physicians on diabetes management and whether the agreement varies according to patients' socio-demographic characteristics. METHODS: A cross-sectional study was conducted among patients with diabetes and their Family Health physicians in 108 healthcare centres in Belo Horizonte, Brazil. Patients and physicians were interviewed face-to-face using standard questionnaires. Physicians were unaware of which of their patients would be interviewed. Their responses were compared using descriptive statistics and Cohen's weighted kappa. RESULTS: 282 patient-physician pairs were included. Kappa coefficients were often low, the highest was found for presence of diabetic foot and the lowest for kidney disease. Physicians tended to overestimate patients' risk of diabetes complications and underestimate patients' adherence to all diabetes self-management activities as well as diabetes control. Moreover, the agreement rate regarding adherence to diet, foot care and medicine prescriptions was significantly higher among male, younger and higher educated patients. CONCLUSION: Results indicate that physicians' recommendations are generally poorly apprehended by their patients, especially by the lower educated, compromising the goal of patient-centred care. PRACTICE IMPLICATIONS: Educational programmes need to incorporate strategies to improve the comprehension and effectiveness of physician-patient communication, especially with the most socially vulnerable groups.

Debyser, B., Grypdonck, M. H., Defloor, T., et al. (2011). "Involvement of inpatient mental health clients in the practical training and assessment of mental health nursing students: Can it benefit clients and students?" Nurse Educ Today **31**(2): 198-203.

> Even though the central position of the client has been recognized in psychiatric nursing education, the client is seldom formally involved in the feedback provided to students during practical training. This research paper focuses on three questions: (1) What conditions support the gathering of meaningful client feedback to enhance the student's learning process and client's wellbeing? (2) Does the use of the practical model for client feedback lead to positive experiences, and if so, under what conditions? (3) To what extent is a client's feedback on the student's work performance, consistent with feedback from the mentor (nurse from the ward), the teacher and the student? Based on a literature review, participatory observation and contacts with experts, a practical model was developed to elicit client feedback. Using this model in two psychiatric inpatient services, clients were actively and formally involved in providing feedback to four, final year psychiatric nursing students. Clients, nurses, teachers and students were interviewed and data were analysed using a qualitative explorative research approach. Analyses revealed that client feedback becomes meaningful in a safe environment created by the psychiatric nurse. Client feedback generates a learning effect for the student and supports the student's recognition of the value and vulnerability of the psychiatric client.

Dhillon, A. K., Hattingh, H. L., Stafford, A., et al. (2015). "General practitioners' perceptions on home medicines reviews: a qualitative analysis." BMC Fam Pract **16**: 16.

BACKGROUND: Home Medicines Review (HMR) is an Australian initiative introduced in 2001 to improve quality use of medicines. Medication management services such as HMRs have the potential to reduce medication related problems. In 2011, changes to the HMR program were introduced to allow for referrals directly to accredited pharmacists in addition to the community pharmacy referral model. These changes were introduced to improve efficiency of the process. This study explored the perceptions of Western Australian general practitioners (GPs) on benefits and barriers of the HMR service and process, including their insights into the direct referral model. METHODS: Purposive sampling of GPs who had experience ensured that participants had a working knowledge of the HMR service. Semi structured interviews with 24 GPs from 14 metropolitan Western Australian medical centres between March and May 2013. Transcribing and thematic analysis of data were performed. RESULTS: Most GPs had positive attitudes towards the HMR service. Main perceived benefits of the service were poly-pharmacy reduction and education for both the GP and patient. Strategies identified to improve the service were introduction of a standard HMR report template for pharmacists and better use of technology. Whilst reliability and GPs' familiarity were the main perceived benefits of the direct referral model, a number of GPs agreed that patient unfamiliarity with the HMR pharmacist was a barrier. CONCLUSIONS: Despite recognition of the value of the HMR service participating GPs were of the opinion that there are aspects of the HMR service that could be improved. As one of the success factors of HMRs is relying on GPs to utilise this service, this study provides valuable insight into issues that need to be addressed to improve HMR uptake.

Dickfos, M., King, D., Parekh, S., et al. (2015). "General practitioners' perceptions of and involvement in health behaviour change: can computer-tailored interventions help?" Prim Health Care Res Dev **16**(3): 316-321.

AIM: To explore GPs' perceptions of their role in primary prevention, barriers experienced and willingness to accommodate an automated, computer-tailored intervention. BACKGROUND: General practice is an attractive setting for primary prevention of chronic disease. Due to constraints in time and knowledge it is underutilised. METHODS: Telephone interviews of 13 GPs in Brisbane, Australia, whose patients were previously involved in a lifestyle change research project. Qualitative responses were grouped into themes. FINDINGS: GPs perceived their role in lifestyle change as 'educators', 'supporters' and 'prompters'. Smoking and physical activity were addressed more often than alcohol and salt intake. Longer lifestyle-focussed consultations and computer-generated reminders were suggested to overcome barriers. A computer-tailored approach was appreciated due to its minimal impact on practice routine. GPs understand their role in primary prevention but need help to overcome barriers. GP initiated consultations focusing on lifestyle and prevention along with computer support systems could improve capability for prevention in general practice.

Dickson, V. V. et Riegel, B. (2009). "Are we teaching what patients need to know? Building skills in heart failure self-care." Heart Lung **38**(3): 253-261.

OBJECTIVE: Heart failure (HF) self-care requires both knowledge and skill, but little attention has been given to identify how to improve skill in HF self-care. The objective was to assess what self-care skills patients with HF perceive that they need and how they developed the skills needed to perform self-care. METHODS: Data from 85 adults with chronic HF enrolled in 3 prior studies were analyzed using qualitative descriptive meta-analysis techniques. Themes were reexamined using within study and across-study analyses and translated to create a broader and more complete understanding of the development of skill in HF self-care. RESULTS: Tactical and situational skills are needed to perform adequate self-care. Skill in self-care evolves over time and with practice as patients learn how to make self-care practices fit into their daily lives. Proficiency in these skills was acquired primarily through input from family and friends. Health care professionals rarely made significant contributions to the learning of essential skills. CONCLUSION: Traditional patient education does not support self-care skill development in patients with HF. New patient teaching strategies are needed that support the development of tactical and situational skills, foster coherence, and use trusted resources. Research testing coaching interventions that target skill-building tactics, such as role-playing in specific situations, are needed.

Doumont, D. et Libion, F. (2008). Quelle est la place de l’éducation pour la santé dans les pratiques de médecine générale ? Université Catholique de Louvain.
http://www.uclouvain.be/cps/ucl/doc/reso/documents/Dossier51.pdf

> Cette revue de littérature, certes, loin d’être exhaustive, s’intéresse principalement aux pratiques de promotion pour la santé en médecine générale et surtout à l’évolution de celles ci. Quelques exemples d’activités mises en place seront également développés dans le cadre de ce travail ainsi que des propositions de pistes permettant de favoriser, voire de consolider l’existant.

Driscoll, A., Beauchamp, A., Lyubomirsky, G., et al. (2011). "Suboptimal management of cardiovascular risk factors in coronary heart disease patients in primary care occurs particularly in women." Intern Med J **41**(10): 730-736.
http://www.ncbi.nlm.nih.gov/pubmed/21627740

> BACKGROUND: Patients with established coronary heart disease (CHD) are at the highest risk of further events. Despite proven therapies, secondary prevention is often suboptimal. General practitioners (GPs) are in an ideal position to improve secondary prevention. AIM: To contrast management of cardiovascular risk factors in patients with established CHD in primary care to those in clinical guidelines and according to gender. METHODS: GPs throughout Australia were approached to participate in a programme incorporating a disease management software (mdCare) program. Participating practitioners (1258 GPs) recruited individual patients whose cardiovascular risk factor levels were measured. RESULTS: The mdCare programme included 12,509 patients (58% male) diagnosed with CHD. Their mean age was 71.7years (intra-quartile range 66-78) for men and 74years (intra-quartile range 68-80) for women. Low-density-lipoprotein cholesterol was above target levels in 69% (2032) of women compared with 58% (2487) in men (P < 0.0001). There was also a higher proportion of women with total cholesterol above target levels (76%, 3592) compared with men (57%, 3787) (P < 0.0001). In patients who were prescribed lipid-lowering medication, 53% (2504) of men and 72% (2285) of women continued to have a total cholesterol higher than recommended target levels (P < 0.0001). Overall, over half (52%, 6538) had at least five cardiovascular risk factors (55% (2914) in women and 50% (3624) in men, P < 0.0001). CONCLUSION: This study found less intensive management of cardiovascular risk factors in CHD patients, particularly among women, despite equivalent cardiovascular risk. This study has shown that these patients have multiple risk factors where gender also plays a role

Dowell, A., Stubbe, M., Macdonald, L., et al. (2018). "A Longitudinal Study of Interactions Between Health Professionals and People With Newly Diagnosed Diabetes." Ann Fam Med **16**(1): 37-44.

> PURPOSE: We undertook a study to observe in detail the primary care interactions and communications of patients with newly diagnosed diabetes over time. In addition, we sought to identify key points in the process where miscommunication might occur. METHODS: All health interactions of 32 patients with newly diagnosed type 2 diabetes were recorded and tracked as they moved through the New Zealand health care system for a period of approximately 6 months. Data included video recordings of patient interactions with the health professionals involved in their care (eg, general practitioners, nurses, dietitians). We analyzed data with ethnography and interaction analysis. RESULTS: Challenges to effective communication in diabetes care were identified. Although clinicians showed high levels of technical knowledge and general communication skill, initial consultations were often driven by biomedical explanations out of context from patient experience. There was a perception of time pressure, but considerable time was spent with patients by health professionals repeating information that may not be relevant to patient need. Health professionals had little knowledge of what disciplines other than their own do and how their contributions to patient care may differ. CONCLUSIONS: Despite current high skill levels of primary care professionals, opportunities exist to increase the effectiveness of communication and consultation in diabetes care. The various health professionals involved in patient care should agree on the length and focus of each consultation.

du Pon, E., Wildeboer, A. T., van Dooren, A. A., et al. (2019). "Active participation of patients with type 2 diabetes in consultations with their primary care practice nurses - what helps and what hinders: a qualitative study." BMC Health Serv Res **19**(1): 814.

> BACKGROUND: Patients with type 2 diabetes mellitus (T2DM) receiving primary care regularly visit their practice nurses (PNs). By actively participating during medical consultations, patients can better manage their disease, improving clinical outcomes and their quality of life. However, many patients with T2DM do not actively participate during medical consultations. To understand the factors affecting engagement of patients with T2DM, this study aimed to identify factors that help or hinder them from actively participating in consultations with their primary care PNs. METHODS: Two semi-structured focus groups and 12 semi-structured individual interviews were conducted with patients with T2DM (n = 20) who were undergoing treatment by primary care PNs. All interviews were transcribed verbatim and analyzed using a two-step approach derived from the context-mapping framework. RESULTS: Four factors were found to help encourage patients to actively participate in their consultation: developing trusting relationships with their PNs, having enough time in the appointment, deliberately preparing for consultations, and allowing for the presence of a spouse. Conversely, four factors were found to hinder patients from participating during consultations: lacking the need or motivation to participate, readjusting to a new PN, forgetting to ask questions, and ineffectively expressing their thoughts. CONCLUSION: Patients lacked the skills necessary to adequately prepare for a consultation and achieve an active role. In addition, patients' keen involvement appeared to benefit from a trusting relationship with their PNs. When active participation is impeded by barriers such as a lack of patient's skills, facilitators should be introduced at an early stage. TRIAL REGISTRATION: Current Controlled Trials NTR4693 (July 16, 2014).

Duineveld, L. A., Wieldraaijer, T., Wind, J., et al. (2016). "Primary care-led survivorship care for patients with colon cancer and the use of eHealth: a qualitative study on perspectives of general practitioners." BMJ Open **6**(4): e010777.

> OBJECTIVES: The aim of this study was to explore the perspectives of general practitioners (GPs) regarding their current and future role in survivorship care of patients with colon cancer, and to assess their perspectives on patients' self-management capacities and the value of the eHealth application Oncokompas(2.0) used by patients. SETTING: GPs from the central part of the Netherlands were interviewed at their location of preference. PARTICIPANTS: 20 GPs participated (10 men, 10 women, age range 34-65 years, median age 49.5 years). The median years of experience as a GP was 14.5 years (range 3-34 years). RESULTS: GPs indicated attempting to keep in contact with patients after colon cancer treatment and mentioned being aware of symptoms of recurrent disease. Most participants would have liked to be more involved and expected to be able to provide survivorship care of colon cancer. Requirements mentioned were agreements with secondary care and a protocol. GPs considered Oncokompas(2.0), which stimulates patients to structure their own survivorship care, as a useful additional tool for a specific group of patients (ie, young and highly-educated patients). CONCLUSIONS: Based on the perspectives of the GPs, survivorship care of colon cancer in primary care is deemed feasible and the use of an eHealth application such as Oncokompas(2.0) is expected to benefit specific groups of patients after colon cancer treatment.

Duprez, V., Vandecasteele, T., Verhaeghe, S., et al. (2017). "The effectiveness of interventions to enhance self-management support competencies in the nursing profession: a systematic review." J Adv Nurs **73**(8): 1807-1824.

> AIM: The aim of this study was to explore the effectiveness and effective components of training interventions to enhance nurses' competencies in self-management support in chronic care. BACKGROUND: The growing burden of chronic diseases puts an increasing focus on nurses' self-management support of people living with a chronic illness. The most effective method to train nurses' competencies in self-management support remains unclear. DESIGN: Systematic literature review. DATA SOURCES: PubMed, CINAHL, Cochrane CENTRAL, EMBASE, Web of Science, ERIC and PsycARTICLES databases were searched up to August 2015. REVIEW METHOD: Eligible studies reported on training interventions to enhance chronic care self-management support competencies in nurses.

Outcomes were defined as trainees' reactions to the training (level 1), changes in trainees' competencies (level 2) or changes in trainees' performance in practice (level 3) concerning self-management support. Risk of bias was assessed. Level 1 outcomes were synthesized narratively. Standardized mean differences were calculated per study for level 2 and 3 outcomes. RESULTS: In total, 25 studies were included. Twelve of these studies included level 1 outcomes, eight studies included level 2 outcomes and 10 studies included level 3 outcomes. Effect sizes in favour of training ranged from -0.36 - 1.56 (level 2) and from 0.06 - 5.56 (level 3). Theory-driven training interventions with time to practice, (video) feedback and follow-up generated the most training effects. Caution is needed due to the inconsistent study quality. CONCLUSION: To date, there is a knowledge gap concerning the most effective method to train nurses' competencies in self-management support. More well-designed, longitudinal studies are needed.

Dures, E., Hewlett, S., Ambler, N., et al. (2014). "Rheumatology clinicians' experiences of brief training and implementation of skills to support patient self-management." BMC Musculoskelet Disord **15**: 108.

BACKGROUND: Self-management of arthritis requires informed, activated patients to manage its physical and psychosocial consequences. Patient activation and self-management can be enhanced through the use of cognitive-behavioural approaches, which have a strong evidence base and provide insight into the variation in outcome of patients with ostensibly the same degree of disease activity. However, training for rheumatology health professionals in theory and skills underpinning the facilitation of self-management is not widely available. To develop such training, this study explored rheumatology clinicians' experiences of a variety of brief skills training courses to understand which aspects were helpful or unhelpful, and to identify the barriers and facilitators of applying the skills in clinical practice. METHODS: 16 clinicians who had previously attended communication and self-management skills training participated in semi-structured interviews: 3 physicians, 3 physiotherapists, 4 nurses, 6 occupational therapists. Transcripts were analysed (ED) using a hybrid inductive and deductive thematic approach, with a subset independently analysed (SH, RG-H, RJ). RESULTS: 3 overarching themes captured views about training undertaken and subsequent use of approaches to facilitate self-management. In 'putting theory into practice', clinicians felt that generic training was not as relevant as rheumatology-specific training. They wanted a balance between theory and skills practice, and identified the importance of access to ongoing support. In 'challenging professional identity', models of care and working cultures influenced learning and implementation. Training often challenged a tendency to problem-solve on behalf of patients and broadened clinicians' remit from a primary focus on physical symptoms to the mind and body interaction. In 'enhanced practice', clinicians viewed consultations as enhanced after training. Focus had shifted from clinicians' agendas to those of patients, and clinicians reported eliciting patients' priorities and the use of theoretically-driven strategies such as goal-setting. CONCLUSIONS: To varying extents, clinicians were able to learn and implement new approaches to support patient self-management after brief training. They believed that cognitive behavioural and communication skills to facilitate self-management enhanced their practice. To optimise self-management support in routine care brief, skills-based, rheumatology-specific training needs to be developed, alongside ongoing clinical supervision. Further research should examine patients' perspectives of care based on these approaches.

Dures, E., Hewlett, S., Ambler, N., et al. (2016). "A qualitative study of patients' perspectives on collaboration to support self-management in routine rheumatology consultations." BMC Musculoskelet Disord **17**: 129.

BACKGROUND: Self-management of inflammatory arthritis (IA) requires patients to address the impact of symptoms, treatment, and the psychosocial consequences of a long term condition. There are several possible mechanisms for facilitating self-management, including patient-clinician interactions in routine consultations. This requires patients to collaborate in their healthcare, and clinicians to specifically encourage and help patients to do so. To design training that enables clinicians to support patients to be actively involved and self-manage requires understanding both patients' and clinicians' perspectives about what is important and feasible. Previous research explored the perspectives of clinicians who had undertaken brief training which they were putting into practice in their routine consultations. This study explored the perspectives of patients attending those routine consultations to identify aspects of the interaction that influenced collaboration and self-management. METHODS:

Nineteen patients with IA who had attended a routine consultation with a rheumatology clinician at one of four hospitals in England took part in semi-structured interviews. Interviews were transcribed, anonymised and analysed using inductive thematic analysis. RESULTS: Three themes encompass participants' thoughts about interactions that facilitated collaboration in consultations and their ability to self-manage their IA: first, patients and clinicians viewing care as a shared endeavour, including patients responding actively to their IA and clinicians exploring and negotiating with patients; second, the need for clinicians to understand the challenges faced by patients, appreciate the impact of IA and focus on patients' priorities; and third, clinicians using an open communication style, including the use of non-didactic, patient-centred approaches. A fourth theme was perceived benefits of actively engaging in consultations, including increased confidence to deal with the impact of IA and greater acceptance of a long term condition. CONCLUSIONS: Patients perceive that self-management can be facilitated when clinicians and patients view healthcare as a shared responsibility, underpinned by clinicians as experts in the disease and patients as experts in living with it. Clinicians can support patients' self-management by using non-didactic communication skills to identify patients' priorities, and to prompt patients to problem-solve and share in setting the consultation agenda. This should inform skills-training for rheumatology clinicians.

Eikelenboom, N., van Lieshout, J., Jacobs, A., et al. (2016). "Effectiveness of personalised support for self-management in primary care: a cluster randomised controlled trial." Br J Gen Pract **66**(646): e354-361.

BACKGROUND: Self-management support is an important component of the clinical management of many chronic conditions. The validated Self-Management Screening questionnaire (SeMaS) assesses individual characteristics that influence a patient's ability to self-manage. AIM: To assess the effect of providing personalised self-management support in clinical practice on patients' activation and health-related behaviours. DESIGN AND SETTING: A cluster randomised controlled trial was conducted in 15 primary care group practices in the south of the Netherlands. METHOD: After attending a dedicated self-management support training session, practice nurses in the intervention arm discussed the results of SeMaS with the patient at baseline, and tailored the self-management support. Participants completed a 13-item Patient Activation Measure (PAM-13) and validated lifestyle questionnaires at baseline and after 6 months. Data, including individual care plans, referrals to self-management interventions, self-monitoring, and healthcare use, were extracted from patients' medical records. Multilevel multiple regression was used to assess the effect on outcomes. RESULTS: The PAM-13 score did not differ significantly between the control (n = 348) and intervention (n = 296) arms at 6 months. In the intervention arm, 29.4% of the patients performed self-monitoring, versus 15.2% in the control arm (effect size r = 0.9, P = 0.01). In the per protocol analysis (control n = 348; intervention n = 136), the effect of the intervention was significant on the number of individual care plans (effect size r = 1.3, P = 0.04) and on self-monitoring (effect size r = 1.0, P = 0.01). CONCLUSION: This study showed that discussing SeMaS and offering tailored support did not affect patient activation or lifestyle, but did stimulate patients to self-monitor and use individual care plans.

El, F. F., Hoes, A. W., Uitewaal, P. J., et al. (2008). "Process evaluation of an intensified preventive intervention to reduce cardiovascular risk in general practices in deprived neighbourhoods." Eur J Cardiovasc. Nurs **7**(4): 296-302.
http://www.ncbi.nlm.nih.gov/pubmed/18296125

BACKGROUND: A RCT, conducted to examine the effectiveness of a structured collaboration in general practice to provide intensified preventive care in patients at high cardiovascular risk yielded no effect in the total group but differences across healthcare centres and ethnic groups become apparent. We conducted a process evaluation to explain these differences. METHODS: We assessed the reach of the target group and whether key intervention components (individual educational sessions, structured team meetings, and risk assessments) were performed as planned (maximum score for protocol completion is 11). RESULTS: The reach was initially 91%, but only a minority of patients completed the intervention activities as planned. The average score of the number of intervention components was low (5.66 out of 11 (sd 2.8)) and varied between centres (4.84 to 7.40) and ethnic groups (4.89 to 7.38), with team meetings as the least implemented activity conform plan. CONCLUSION: This study indicates that adding a practice nurse and a peer health educator to the general practice did not seem to result in the desired collaboration between the healthcare personnel. Further research is needed to investigate the reasons behind the low participation rate of the patients in the intervention

Elder, C. R., Debar, L. L., Ritenbaugh, C., et al. (2017). "Health Care Systems Support to Enhance Patient-Centered Care: Lessons from a Primary Care-Based Chronic Pain Management Initiative." Perm J **21**.

BACKGROUND: Supporting day-to-day self-care activities has emerged as a best practice when caring for patients with chronic pain, yet providing this support may introduce challenges for both patients and primary care physicians. It is essential to develop tools that help patients identify the issues and outcomes that are most important to them and to communicate this information to primary care physicians at the point of care. OBJECTIVE: We describe our process to engage patients, primary care physicians, and other stakeholders in the context of a pilot randomized controlled trial of a patient-centered assessment process implemented in an everyday practice setting. We identify lessons on how to engage stakeholders and improve patient-centered care for those with chronic conditions within the primary care setting. METHODS: A qualitative analysis of project minutes, interviews, and focus groups was conducted to evaluate stakeholder experiences. Stakeholders included patients, caregivers, clinicians, medical office support staff, health plan administrators, an information technology consultant, and a patient advocate. RESULTS: Our stakeholders included many patients with no prior experience with research. This approach enriched the applicability of feedback but necessitated extra time for stakeholder training and meeting preparation. Types of stakeholders varied over the course of the project, and more involvement of medical assistants and Information Technology staff was required than originally anticipated. CONCLUSION: Meaningful engagement of patient and physician stakeholders must be solicited in a well-coordinated manner with broad health care system supports in place to ensure full execution of patient-centered processes.

Ellen, M., Perlman, S., Horowitz, E., et al. (2020). "Understanding Physicians' Perceptions of Overuse of Health Services in Oncology." Medical Care Research and Review(Ahead of pub): 1077558720915112.
https://doi.org/10.1177/1077558720915112

Overuse rates in oncology are high, but areas of possible improvement exist for reducing it and improving quality of care. This study explores perceptions and experiences of oncologists in Israel regarding overuse of health services within oncology. In-depth, semistructured interviews were conducted focusing on causes of overuse, facilitators for reduction, and suggestions for improvement. Interviews were audio recorded, transcribed, coded, and thematically analyzed. Physicians reported patient-level causes including ?well-informed? and ?demanding? patients; physician-level causes including desire to satisfy patients, lack of confidence, time, and skills; and system-level causes like ease of access, and lack of alignment and coordination. Physicians can reduce overuse through patient dialogue, building trust and solidifying patient?physician relationships, and further reduce overuse with better teamwork. Improvements can be made through educational initiatives, and bottom-up solutions. Policy makers and decision makers should develop appropriate interventions addressing health service overuse, including improving patient education and instilling confidence and knowledge in physicians.

Elliott, A. M., McAteer, A. et Hannaford, P. C. (2011). "Revisiting the symptom iceberg in today's primary care: results from a UK population survey." BMC Fam Pract **12**: 16.
http://www.ncbi.nlm.nih.gov/pubmed/21473756

BACKGROUND: Recent changes in UK primary care have increased the range of services and healthcare professionals available for advice. Furthermore, the UK government has promoted greater use of both self-care and the wider primary care team for managing symptoms indicative of self-limiting illness. We do not know how the public has been responding to these strategies. The aim of this study was to describe the current use of different management strategies in the UK for a range of symptoms and identify the demographic, socio-economic and symptom characteristics associated with these different approaches. METHODS: An age and sex stratified random sample of 8,000 adults (aged 18-60), drawn from twenty general practices across the UK, were sent a postal questionnaire. The questionnaire collected detailed information on 25 physical and psychological symptoms ranging from those usually indicative of minor illness to those which could be indicative of serious conditions. Information on symptom characteristics, actions taken to manage the symptoms and demographic/socio-economic details were also collected. RESULTS: Just under half of all symptoms reported resulted in respondents doing nothing at all. Lay-care was used for 35% of symptoms and primary care health professionals were consulted for 12% of symptoms. OTC medicine use was the most common lay-care strategy (used for 25% of all symptom episodes). The GP was the most common health professional consulted (consulted for 8% of all symptom episodes) while use of other primary care health professionals was very small (each consulted for less than 2% of symptom episodes). The actions taken for individual symptoms varied substantially although some broad patterns emerged. Symptom characteristics (in particular severity, duration and interference with daily life) were more commonly associated with actions taken than demographic or socio-economic characteristics. CONCLUSION: While the use of lay-care was widespread, use of the primary care team other than the GP was low. Further research is needed to examine the public's knowledge and opinions of different primary care services to investigate why certain services are not being used to inform the future development of primary care services in the UK

Entwistle, V. A., Cribb, A. et Owens, J. (2018). "Why Health and Social Care Support for People with Long-Term Conditions Should be Oriented Towards Enabling Them to Live Well." Health Care Anal **26**(1): 48-65.

There are various reasons why efforts to promote "support for self-management" have rarely delivered the kinds of sustainable improvements in healthcare experiences, health and wellbeing that policy leaders internationally have hoped for. This paper explains how the basis of failure is in some respects built into the ideas that underpin many of these efforts. When (the promotion of) support for self-management is narrowly oriented towards educating and motivating patients to adopt the behaviours recommended for disease control, it implicitly reflects and perpetuates limited and somewhat instrumental views of patients. It tends to: restrict the pursuit of respectful and enabling 'partnership working'; run the risk of undermining patients' self-evaluative attitudes (and then of failing to notice that as harmful); limit recognition of the supportive value of clinician-patient relationships; and obscure the practical and ethical tensions that clinicians face in the delivery of support for self-management. We suggest that a focus on enabling people to live (and die) well with their long-term conditions is a promising starting point for a more adequate conception of support for self-management. We then outline the theoretical advantages that a capabilities approach to thinking about living well can bring to the development of an account of support for self-management, explaining, for example, how it can accommodate the range of what matters to people (both generally and more specifically) for living well, help keep the importance of disease control in perspective, recognize social influences on people's values, behaviours and wellbeing, and illuminate more of the rich potential and practical and ethical challenges of supporting self-management in practice.

Entwistle, V. A., Cribb, A., Watt, I. S., et al. (2018). ""The more you know, the more you realise it is really challenging to do": Tensions and uncertainties in person-centred support for people with long-term conditions." Patient Educ Couns **101**(8): 1460-1467.

OBJECTIVE: To identify and examine tensions and uncertainties in person-centred approaches to self-management support - approaches that take patients seriously as moral agents and orient support to enable them to live (and die) well on their own terms. METHODS: Interviews with 26 UK clinicians about working with people with diabetes or Parkinson's disease, conducted within a broader interdisciplinary project on self-management support. The analysis reported here was informed by philosophical reasoning and discussions with stakeholders. RESULTS: Person-centred approaches require clinicians to balance tensions between the many things that can matter in life, and their own and each patient's perspectives on these. Clinicians must ensure that their supportive efforts do not inadvertently disempower people. When attending to someone's particular circumstances and perspectives, they sometimes face intractable uncertainties, including about what is most important to the person and what, realistically, the person can or could do and achieve. The kinds of professional judgement that person-centred working necessitates are not always acknowledged and supported. CONCLUSION: Practical and ethical tensions are inherent in person-centred support and need to be better understood and addressed. PRACTICE IMPLICATIONS: Professional development and service improvement initiatives should recognise these tensions and uncertainties and support clinicians to navigate them well.

Ewbank, L., Hitchcock, A., Sasse, T., et al. (2016). Who cares ? The future of general practice. Londres, Reform**:** 71p.

This report examines the current model of general practice in relation to advances in culture, society and technology and argues that the model needs to change to adapt to future needs. It highlights the need for providers to operate at a larger scale in order to deliver primary care services more effectively. It also considers different approaches to providing primary care services such as utilising a more diverse workforce to deliver these services, such as using nurses or pharmacists to administer some general practice appointments.

Fall, E., Chakroun, N., Dalle, N., et al. (2013). "Is patient education helpful in providing care for patients with rheumatoid arthritis? A qualitative study involving French nurses." Nurs Health Sci **15**(3): 346-352.

This French study explored nurses' involvement in patient education for patients with rheumatoid arthritis. The study design was qualitative. Semistructured interviews were conducted with 16 hospital nurses. Data analysis was performed according to Giorgi's descriptive phenomenological method, and supported by specific qualitative analysis software (Sphinx). The results showed the important role of hospital nurses in rheumatoid arthritis care. Patient education is a core part of nurses' work, allowing them to give patients information and emotional support. The interviewees displayed skills in helping patients learn to care for themselves. However, patient education mostly concerned patients who are already committed to their health care. Non-adherent patients warrant special attention; their acceptance of their disease, perceptions about disease and treatment, motivation, and autonomy should be specifically addressed. French nurses could benefit from more training, and could be aided by psychologists. Ambulatory services could also be developed for patient education in France, based on examples from other countries.

Farmer, S. A., Magasi, S., Block, P., et al. (2016). "Patient, Caregiver, and Physician Work in Heart Failure Disease Management: A Qualitative Study of Issues That Undermine Wellness." Mayo Clin Proc **91**(8): 1056-1065.

OBJECTIVE: To identify factors underlying heart failure hospitalization. METHODS: Between January 1, 2012, and May 31, 2012, we combined medical record reviews and cross-sectional qualitative interviews of multiple patients with heart failure, their clinicians, and their caregivers from a large academic medical center in the Midwestern United States. The interview data were analyzed using a 3-step grounded theory-informed process and constant comparative methods. Qualitative data were compared and contrasted with results from the medical record review. RESULTS: Patient nonadherence to the care plan was the most important contributor to hospital admission; however, reasons for nonadherence were complex and multifactorial. The data highlight the importance of patient education for the purposes of condition management, timeliness of care, and effective communication between providers and patients. CONCLUSION: To improve the consistency and quality of care for patients with heart failure, more effective relationships among patients, providers, and caregivers are needed. Providers must be pragmatic when educating patients and their caregivers about heart failure, its treatment, and its prognosis.

Femdal, I. et Knutsen, I. R. (2017). "Dependence and resistance in community mental health care-Negotiations of user participation between staff and users." J Psychiatr Ment Health Nurs **24**(8): 600-609.

WHAT IS KNOWN ON THE SUBJECT?: Implementation of user participation is described as a change from a paternalistic healthcare system to ideals of democratization where users' voices are heard in relational interplays with health professionals. The ideological shift involves a transition from welfare dependency and professional control towards more active service-user roles with associated rights and responsibilities. A collaborative relationship between users and professionals in mental health services is seen as important by both parties. Nevertheless, the health professionals find it challenging in practice to reorient their roles and to find productive ways to cooperate. WHAT THIS PAPER ADDS TO EXISTING KNOWLEDGE?: This study illuminates how user participation is negotiated and involves multiple and shifting subject positions in the collaboration between users and professionals in community mental health care. By taking different positions, the relationship between users and professionals develops through dynamic interaction. This study challenges understandings of equality and implicit "truths" in user participation by illuminating subtle forms of power and dilemmas that arise in user-professional negotiations. WHAT ARE THE IMPLICATIONS FOR PRACTICE?: Instead of denying the appearance of power, it is important to question the execution of power in the interplay between users and professionals. Focusing on the negotiation processes between users and professionals is important for increasing reflection on and improving understanding of the dynamic in collaboration and speech. By focusing on negotiations, power can be used in productive ways in user-professional relationships. ABSTRACT: Introduction Implementation of user participation is considered important in today's mental health care. Research shows, however, that user participation lacks clarity and provokes uncertainty regarding shifting roles. Aim To investigate negotiation of user participation in a microstudy of interplay between users and health professionals in community mental health care. Method This qualitative study is based on semi-structured in-depth interviews, involving ten service users and ten professionals in community mental health care in Norway. The analysis is inspired by Willig's model for Foucauldian discourse analysis. Results The study illuminates the dynamic nature of user participation that arises through negotiation between users' and professionals' positions as change enablers, dependents, resisters, persuaders and knowledge holders. Discussion Discourses of user participation allow for different subject positions in mental health care. User participation also involves government and questions of power, as well as ambitions of change and control. Professionals act in different ways to make and keep users active, participating, enterprising and self-governing, and users respond and take part within the same discursive framework. Implications for practice Awareness of subjects' positions in discourses is important to increase reflection on the dynamic interplay in user-professional collaboration.

Ferguson, L. M., Ward, H., Card, S., et al. (2013). "Putting the 'patient' back into patient-centred care: an education perspective." Nurse Educ Pract **13**(4): 283-287.

Patient-centred care is a value espoused by most healthcare systems and a concept taught in nursing education programs as a fundamental concept of patient care. In this study, we focused on the patient's experience of patient-centredness, interviewing eighteen patients and eight family members about their experiences as patients on an in-patient acute care medical unit in a large hospital in Canada. Approximately half of the patients expressed satisfaction with their experiences and their involvement in decisions about their healthcare. The remainder expressed concerns about their care that jeopardized their experiences of patient-centredness. These areas concerned issues of communication with and among healthcare professionals, relationships with these care providers, trust and respect in the professional relationships, and general satisfaction with care. Participants provided advice to professional students about ways to interact more effectively with their patients to establish caring, empathetic, patient-centred relationships as the basis for care. We address patient recommendations to support learner understanding of the patient experience both in classrooms and clinical experiences throughout educational programs as a means to enhance their patient-centredness.

Ferguson, S., Swan, M. et Smaldone, A. (2015). "Does diabetes self-management education in conjunction with primary care improve glycemic control in Hispanic patients? A systematic review and meta-analysis." Diabetes Educ **41**(4): 472-484.

PURPOSE: The purpose of this systematic review and meta-analysis is to evaluate the effectiveness of diabetes self-management education (DSME) interventions delivered in conjunction with primary care among Hispanic adults with type 2 diabetes mellitus (T2DM). METHODS: A systematic search of PubMed, Cochrane Library, and the Cumulative Index to Nursing and Allied Health Literature identified randomized controlled trials (RCT) that tested the effect of DSME interventions in Hispanic adults with T2DM. Studies reporting hemoglobin A1C (A1C) pre and post intervention or change in A1C were eligible for inclusion in the meta-analysis. RESULTS: Of 625 studies identified, 13 RCTs met criteria for inclusion in the systematic review; of these, 11 studies were included in the meta-analysis. The 13 RCTs represent data from 2784 adult Hispanic subjects. DSME interventions (individual, group, telephone/electronic, and multimodal sessions) varied in intensity from 1-time DSME sessions with phone follow-up to contact every 4 to 6 weeks over 5 years. At >/=6 months following intervention, pooled A1C reduction was -0.25 (95% CI, -0.42 to -0.07), favoring the intervention group. CONCLUSIONS: DSME in conjunction with primary care is effective in improving glycemic control in Hispanic adults with T2DM. Future comparative effectiveness research is needed to identify best delivery methods to optimize effectiveness of DSME delivered to the Hispanic population.

Ferguson, W. J., Lemay, C. A., Hargraves, J. L., et al. (2012). "Developing community health worker diabetes training." Health Educ Res **27**(4): 755-765.

We designed, implemented and evaluated a 48-hour training program for community health workers (CHWs) deployed to diabetes care teams in community health centers (CHCs). The curriculum included core knowledge/skills with diabetes content to assist CHWs in developing patient self-management goals. Our qualitative evaluation included pre/post-knowledge outcomes and encounter data from the field. CHWs and their supervisors were interviewed providing qualitative outcome data of the training process and program implementation. There were statistically significant increases in the scores of CHWs' self-reported knowledge in 8 of 15 curricular domains. Qualitative analysis revealed that CHWs preferred skill-based and case-based teaching, shorter training days but more contact hours. CHWs reported that pre-deployment training alone is insufficient for successful integration into care teams. CHW supervisors reported that CHC's readiness to accept CHWs as members of the care team was as important to successful deployment as training. With respect to implementation, supervision by social workers was deemed more successful than nursing supervision. Field data showed that patient encounters lasted less than 30 min and self-management goals focused on appointment keeping, diet, exercise and glucose testing. Integration and analysis of qualitative and descriptive field data provide an opportunity to continuously evaluate the effectiveness of implementation.

Fichera, E., Banks, J., Siciliani, L., et al. (2017). Does Patient Health Behaviour respond to Doctor's Effort? Bath Economics Research Papers; No. 62 /17. Bath University of Bath**:** 34 , fig., tabl.
http://opus.bath.ac.uk/58124/1/does_patient_health_behaviour_respond_to_doctors_effort.pdf

Incentive pay systems have been introduced in public sectors such as education and healthcare. In these organisations where the outcome (health or education) is a joint product between different agents, it is unclear what the effects of these incentives are onto the behaviour of untargeted agents. We focus on patient health as a joint product of patient effort, through lifestyle and behaviour, and doctor effort, through diagnosis and treatment. Patient response to doctor effort is a priori ambiguous and depends on the degree of complementarity or substitution between doctor and patient effort. We use data on the physical activity, drinking and smoking behaviours of over 2,000 patients aged over 50 with cardiovascular diseases in England. Through a new data linkage and an instrumental variable approach, we test whether changes in doctors' treatment efforts triggered by changes in their payment system between 2004 and 2006 had an impact on patient behaviour. Doctors working in primary care practices increased the proportion of patients with controlled disease from 76% to 83% in response to the payment change. Patients responded by reducing the frequency of drinking alcohol and their cigarette consumption. This suggests that patient efforts are complements to doctor effort. The results have implications for the effectiveness of pay-for-performance schemes which encourage higher doctor effort, and the design of such incentive schemes.

Fiscella, K., Yosha, A., Hendren, S. K., et al. (2010). "Get screened: a pragmatic randomized controlled trial to increase mammography and colorectal cancer screening in a large, safety net practice." BMC Health Serv Res **10**: 280.
http://www.ncbi.nlm.nih.gov/pubmed/20863395

BACKGROUND: Most randomized controlled trials of interventions designed to promote cancer screening, particularly those targeting poor and minority patients, enroll selected patients. Relatively little is known about the benefits of these interventions among unselected patients.

> METHODS/DESIGN: "Get Screened" is an American Cancer Society-sponsored randomized controlled trial designed to promote mammography and colorectal cancer screening in a primary care practice serving low-income patients. Eligible patients who are past due for mammography or colorectal cancer screening are entered into a tracking registry and randomly assigned to early or delayed intervention. This 6-month intervention is multimodal, involving patient prompts, clinician prompts, and outreach. At the time of the patient visit, eligible patients receive a low-literacy patient education tool. At the same time, clinicians receive a prompt to remind them to order the test and, when appropriate, a tool designed to simplify colorectal cancer screening decision-making. Patient outreach consists of personalized letters, automated telephone reminders, assistance with scheduling, and linkage of uninsured patients to the local National Breast and Cervical Cancer Early Detection program. Interventions are repeated for patients who fail to respond to early interventions. We will compare rates of screening between randomized groups, as well as planned secondary analyses of minority patients and uninsured patients. Data from the pilot phase show that this multimodal intervention triples rates of cancer screening (adjusted odds ratio 3.63; 95% CI 2.35 - 5.61). DISCUSSION: This study protocol is designed to assess a multimodal approach to promotion of breast and colorectal cancer screening among underserved patients. We hypothesize that a multimodal approach will significantly improve cancer screening rates.The trial was registered at Clinical Trials.gov NCT00818857

Fleury, M. J., Imboua, A., Aube, D., et al. (2012). "General practitioners' management of mental disorders: a rewarding practice with considerable obstacles." BMC Fam Pract **13**: 19.
http://www.ncbi.nlm.nih.gov/pubmed/22423592

> BACKGROUND: Primary care improvement is the cornerstone of current reforms. Mental disorders (MDs) are a leading cause of morbidity worldwide and widespread in industrialised countries. MDs are treated mainly in primary care by general practitioners (GPs), even though the latter ability to detect, diagnose, and treat patients with MDs is often considered unsatisfactory. This article examines GPs' management of MDs in an effort to acquire more information regarding means by which GPs deal with MD cases, impact of such cases on their practices, factors that enable or hinder MD management, and patient-management strategies. METHODS: This study employs a mixed-method approach with emphasis on qualitative investigation. Based on a previous survey of 398 GPs in Quebec, Canada, 60 GPs representing a variety of practice settings were selected for further study. A 10-minute-long questionnaire comprising 27 items was administered, and 70-minute-long interviews were conducted. Quantitative (SPSS) and qualitative (NVivo) analyses were performed. RESULTS: At least 20% of GP visits were MD-related. GPs were comfortable managing common MDs, but not serious MDs. GPs' based their treatment of MDs on pharmacotherapy, support therapy, and psycho-education. They used clinical intuition with few clinical tools, and closely followed their patients with MDs. Practice features (salary or hourly fees payment; psycho-social teams on-site; strong informal networks), and GPs' individual characteristics (continuing medical education; exposure and interest in MDs; traits like empathy) favoured MD management. Collaboration with psychologists and psychiatrists was considered key to good MD management. Limited access to specialists, system fragmentation, and underdeveloped group practice and shared-care models were impediments. MD management was seen as burdensome because it required more time, flexibility, and emotional investment. Strategies exist to reduce the burden (one-problem-per-visit rule; longer time slots). GPs found MD practice rewarding as patients were seen as grateful and more complying with medical recommendations compared to other patients, generally leading to positive outcomes. CONCLUSIONS: To improve MD management, this study highlights the importance of extending multidisciplinary GP practice settings with salary or hourly fee payment; access to psychotherapeutic and psychiatric expertise; and case-discussion training involving local networks of GPs and MD specialists that encourage both knowledge transfer and shared care

Flink, M., Hesselink, G., Pijnenborg, L., et al. (2012). "The key actor: a qualitative study of patient participation in the handover process in Europe." BMJ Qual Saf **21 Suppl 1**: i89-96.

> BACKGROUND: Patient safety experts have postulated that increasing patient participation in communications during patient handovers will improve the quality of patient transitions, and that this may reduce hospital readmissions. Choosing strategies that enhance patient safety through improved

handovers requires better understanding of patient experiences and preferences for participation. OBJECTIVE: The aim of this paper is to explore the patients' experiences and perspectives related to the handovers between their primary care providers and the inpatient hospital. METHODS: A qualitative secondary analysis was performed, based on individual and focus group patient interviews with 90 patients in five European countries. RESULTS: The analysis revealed three themes: patient positioning in the handover process; prerequisites for patient participation and patient preferences for the handover process. Patients' participation ranged from being the key actor, to sharing the responsibility with healthcare professional(s), to being passive participants. For active participation patients required both personal and social resources as well as prerequisites such as information and respect. Some patients preferred to be the key actor in charge; others preferred their healthcare professionals to be the key actors in the handover. CONCLUSIONS: Patients' participation is related to the healthcare system, the activity of healthcare professionals' and patients' capacity for participation. Patients prefer a handover process where the responsibility is clear and unambiguous. Healthcare organisations need a clear and well-considered system of responsibility for handover processes, that takes into account the individual patient's need of clarity, and support in relation to his/hers own recourses.

Fong, S., Tan, A., Czupryn, J., et al. (2019). "Patient-centred education: How do learners' perceptions change as they experience clinical training?" Adv Health Sci Educ Theory Pract **24**(1): 15-32.

The use of patient educators is one of many teaching strategies meant to foster principles of patient-centred care. We previously found that early patient educator exposure helped to shape the understanding of patient-centredness in pre-clerkship learners. We now expand on this work to evaluate whether there is persistence of initial perceptions and to explore general reflections on longer-term impacts of early patient educator exposures once learners are immersed in the clinical phase of their training. In this follow-up study, we conducted group interviews with a sample of learners who wrote reflections as part of their pre-clerkship patient educator experience. We explored how perspectives on patient educators changed over time, and determined which themes identified during pre-clerkship remained relevant to clinical trainees. Audio recordings were transcribed and analyzed thematically using a hybrid inductive and deductive analysis to construct a thematic framework derived through a method of constant comparison. We identified three new themes: "value of early clinical experience", "change in learners' perspectives", and "valuing and applying CanMEDS roles other than Medical Expert". Themes from pre-clerkship that remained relevant included: "patients' perspective humanizes disease", "patients' experiences with navigating the healthcare system", "learners' perceptions of the learning strategy", and "inaccuracies and inconsistencies in the learning experience." Many themes identified in pre-clerkship learners remain relevant in early clinical trainees. Further, insights from pre-clerkship experiences with patient educators evolve as learners experience clerkship with definite shifts in emphasis and new perspectives. This work illuminates the utility of patient educators for those considering this strategy for supporting the development of patient-centredness in undergraduate medical education.

Fortin, M., Chouinard, M. C., Bouhali, T., et al. (2013). "Evaluating the integration of chronic disease prevention and management services into primary health care." BMC Health Serv Res **13**: 132.

BACKGROUND: The increasing number of patients with chronic diseases represents a challenge for health care systems. The Chronic Care Model suggests a multi-component remodelling of chronic disease services to improve patient outcomes. To meet the complex and ongoing needs of patients, chronic disease prevention and management (CDPM) has been advocated as a key feature of primary care producing better outcomes, greater effectiveness and improved access to services compared to other sectors. The objective of this study is to evaluate the adaptation and implementation of an intervention involving the integration of chronic disease prevention and management (CDPM) services into primary health care. METHODS/DESIGN: The implementation of the intervention will be evaluated using descriptive qualitative methods to collect data from various stakeholders (decision-makers, primary care professionals, CDPM professionals and patients) before, during and after the implementation. The evaluation of the effects will be based on a combination of experimental designs: a randomized trial using a delayed intervention arm (n = 326), a before-and-after design with repeated measures (n = 163), and a quasi-experimental design using a comparative cohort (n = 326). This evaluation will utilize self-report questionnaires measuring self-efficacy, empowerment, comorbidity, health behaviour, functional health status, quality of life, psychological well-being, patient characteristics and co-interventions. The study will take place in eight primary care practices of the Saguenay region of Quebec (Canada). To be included, patients will have to be referred by their primary care provider and present at least one of the following conditions (or their risk factors): diabetes, cardiovascular diseases, chronic obstructive pulmonary disease, asthma. Patients presenting serious cognitive problems will be excluded. DISCUSSION: In the short-term, improved patient self-efficacy and empowerment are expected. In the mid-term, we expect to observe an improvement in health behaviour, functional health status, quality of life and psychological well-being. At the organizational level, the project should lead to coordinated service delivery, improved patient follow-up mechanisms and enhanced interprofessional collaboration. Integration of CDPM services at the point of care in primary care practices is a promising innovation in care delivery that needs to be thoroughly evaluated. TRIAL REGISTRATION: ClinicalTrials.gov Identifier: NCT01319656.

Franklin, M., Lewis, S., Willis, K., et al. (2018). "Patients' and healthcare professionals' perceptions of self-management support interactions: Systematic review and qualitative synthesis." Chronic Illn **14**(2): 79-103.

Objective To review studies examining the experience of self-management support in patient-provider interactions and the shaping of goals through interactions. Methods We undertook a systematic review and thematic synthesis of the qualitative literature. We searched six databases (2004-2015) for published studies on the provision of self-management support in one-to-one, face-to-face, patient-provider interactions for obesity, type 2 diabetes mellitus and chronic obstructive pulmonary disease, with 14 articles meeting inclusion criteria. Results Themes identified from studies were (1) dominance of a traditional model of care, encompassing the provision of generic information, exclusion of the psychosocial and temporal nature of interactions and (2) a context of individual responsibility and accountability, encompassing self-management as patients' responsibility and adherence, accountability and the attribution of blame. Interactions were constrained by consultation times, patient self-blame and guilt, desire for autonomy and beliefs about what constitutes 'effective' self-management. Discussion Encounters were oriented towards a traditional model of care delivery and this limited opportunity for collaboration. These findings suggest that healthcare professionals remain in a position of authority, limiting opportunities for control to be shared with patients and shared understandings of social context to be developed.

Freeman, E., Howell-Jones, R., Oliver, I., et al. (2009). "Promoting chlamydia screening with posters and leaflets in general practice--a qualitative study." BMC Public Health **9**: 383.
http://www.ncbi.nlm.nih.gov/pubmed/19821964

BACKGROUND: General practice staff are reluctant to discuss sexual health opportunistically in all consultations. Health promotion materials may help alleviate this barrier. Chlamydia screening promotion posters and leaflets, produced by the English National Chlamydia Screening Programme (NCSP), have been available to general practices, through local chlamydia screening offices, since its launch. In this study we explored the attitudes of general practice staff to these screening promotional materials, how they used them, and explored other promotional strategies to encourage chlamydia screening. METHODS: Twenty-five general practices with a range of screening rates, were purposively selected from six NCSP areas in England. In focus groups doctors, nurses, administrative staff and receptionists were encouraged to discuss candidly their experiences about their use and opinions of posters, leaflets and advertising to promote chlamydia screening. Researchers observed whether posters and leaflets were on display in reception and/or waiting areas. Data were collected and analysed concurrently using a stepwise framework analytical approach. RESULTS: Although two-thirds of screening practices reported that they displayed posters and leaflets, they were not prominently displayed in most practices. Only a minority of practices reported actively using screening promotional materials on an ongoing basis. Most staff in all practices were not following up the advertising in posters and leaflets by routinely offering opportunistic screening to their target population. Some staff in many practices thought posters and leaflets would cause offence or embarrassment to their patients. Distribution of chlamydia leaflets by receptionists was thought to be inappropriate by some practices, as they thought patients would be offended when being offered a leaflet in a public area. Practice staff suggested the development of pocket-sized leaflets. CONCLUSION: The NCSP should consider developing a range of more discrete but eye catching posters and small leaflets specifically to promote chlamydia screening in different scenarios within general practice; coordinators should audit their use. Practice staff need to discuss, with their screening co-ordinator, how different practice staff can promote chlamydia screening most effectively using the NCSP promotional materials, and change them regularly so that they do not loose their impact. Education to change all practice staff's attitudes towards sexual health is needed to reduce their worries about displaying the chlamydia materials, and how they may follow up the advertising up with a verbal offer of screening opportunistically to 15-24 year olds whenever they visit the practice

Frerichs, W., Hahlweg, P., Muller, E., et al. (2016). "Shared Decision-Making in Oncology - A Qualitative Analysis of Healthcare Providers' Views on Current Practice." Plos One **11**(3): e0149789.

BACKGROUND: Despite an increased awareness of shared decision-making (SDM) and its prominent position on the health policy agenda, its implementation in routine care remains a challenge in Germany. In order to overcome this challenge, it is important to understand healthcare providers' views regarding SDM and to take their perspectives and opinions into account in the development of an implementation program. The present study aimed at exploring a) the attitudes of different healthcare providers regarding SDM in oncology and b) their experiences with treatment decisions in daily practice. MATERIAL AND METHODS: A qualitative study was conducted using focus groups and individual interviews with different healthcare providers at the University Cancer Center Hamburg, Germany. Focus groups and interviews were audio-recorded, transcribed and analyzed using conventional content analysis and descriptive statistics. RESULTS: N = 4 focus groups with a total of N = 25 participants and N = 17 individual interviews were conducted. Attitudes regarding SDM varied greatly between the different participants, especially concerning the definition of SDM, the attitude towards the degree of patient involvement in decision-making and assumptions about when SDM should take place. Experiences on how treatment decisions are currently made varied. Negative experiences included time and structural constraints, and a lack of (multidisciplinary) communication. Positive experiences comprised informed patients, involvement of relatives and a good physician-patient relationship. CONCLUSION: The results show that German healthcare providers in oncology have a range of attitudes that currently function as barriers towards the implementation of SDM. Also, their experiences on how decision-making is currently done reveal difficulties in actively involving patients in decision-making processes. It will be crucial to take these attitudes and experiences seriously and to subsequently disentangle existing misconceptions in future implementation programs.

Freund, T., Freund, M., Mahler, C., et al. (2010). "Family practice web sites: new perspectives for patient care and health information?" Fam Med **42**(7): 501-506.

BACKGROUND AND OBJECTIVES: To cater to the needs of informed and proactive patients in family medicine, health care providers could offer access to care and health information via practice Web sites. To determine the content and quality of family medicine Web sites, we performed a cross-sectional study on a large sample of family practices' Web sites in Berlin, Germany. METHODS: After screening of all family medicine practices in Berlin for the provision of their own practice Web site, we determined the content and quality using a predefined checklist based on a review of literature. RESULTS: Among 1,453 family practices in Berlin, only 211 (15%) had an accessible Web site. Online tools for appointment scheduling (17/211, 8%) or prescription ordering (8/211, 4%) were rarely provided. Approximately half of all Web sites (102/211) provided health information on a wide range of topics, with complementary medicine dominating. Transparency about the source and currentness of information and barrier-free design were identified as main areas in which there was a need for quality improvement. CONCLUSIONS: Family physicians should be trained in quality requirements for Web sites and in how to use online solutions for practice reorganization.

Friedberg, M. W., Coltin, K. L., Safran, D. G., et al. (2010). "Medical home capabilities of primary care practices that serve sociodemographically vulnerable neighborhoods." Arch Intern Med **170**(11): 938-944.

http://www.ncbi.nlm.nih.gov/pubmed/20548005

> BACKGROUND: Under current medical home proposals, primary care practices using specific structural capabilities will receive enhanced payments. Some practices disproportionately serve sociodemographically vulnerable neighborhoods. If these practices lack medical home capabilities, their ineligibility for enhanced payments could worsen disparities in care. METHODS: Via survey, 308 Massachusetts primary care practices reported their use of 13 structural capabilities commonly included in medical home proposals. Using geocoded US Census data, we constructed racial/ethnic minority and economic disadvantage indices to describe the neighborhood served by each practice. We compared the structural capabilities of "disproportionate-share" practices (those in the most sociodemographically vulnerable quintile on each index) and others. RESULTS: Racial/ethnic disproportionate-share practices were more likely than others to have staff assisting patient self-management (69% vs 55%; P = .003), on-site language interpreters (54% vs 26%; P < .001), multilingual clinicians (80% vs 51%; P < .001), and multifunctional electronic health records (48% vs 29%; P = .01). Similarly, economic disproportionate-share practices were more likely than others to have physician awareness of patient experience ratings (73% vs 65%; P = .03), on-site language interpreters (56% vs 25%; P < .001), multilingual clinicians (78% vs 51%; P < .001), and multifunctional electronic health records (40% vs 31%; P = .03). Disproportionate-share practices were larger than others. After adjustment for practice size, only language capabilities continued to have statistically significant relationships with disproportionate-share status. CONCLUSIONS: Contrary to expectations, primary care practices serving sociodemographically vulnerable neighborhoods were more likely than other practices to have structural capabilities commonly included in medical home proposals. Payments tied to these capabilities may aid practices serving vulnerable populations

Frosch, D. L., Legare, F. et Mangione, C. M. (2008). "Using decision aids in community-based primary care: a theory-driven evaluation with ethnically diverse patients." Patient Educ Couns **73**(3): 490-496.
http://www.ncbi.nlm.nih.gov/pubmed/18771875

> OBJECTIVE: To assess the effects of informational brochures and video decision aids about cancer screening on patient intention to engage in shared decision-making and its predictors in a racially diverse sample. METHODS: Participants were recruited from 13 community-based primary care practices serving racially and ethnically diverse patients in predominately economically disadvantaged neighborhoods. Participants completed theory-based measures assessing attitudes, perceived social norms, self-efficacy and intentions for working with their physician to make a cancer screening decision after reviewing a brochure or video decision aid, but before seeing the physician. A post-questionnaire assessed screening decisions and participant knowledge. RESULTS: Participants who reviewed a video decision aid had higher knowledge and were more likely to want to be the primary decision-maker. They reported lower perceived social norms, self-efficacy and intentions to work with their physicians than participants who reviewed a brochure. Participants who decided against cancer screening reported lower intentions to work with their physician in making a decision and were less likely to report having spoken with their physician about screening. CONCLUSION: Participants who opted against cancer screening after reviewing a brochure or decision aid were less likely to discuss their decision with their physician. The tendency toward autonomous decision-making was stronger among participants who reviewed a video decision aid

Frosch, D. L., Singer, K. J. et Timmermans, S. (2011). "Conducting implementation research in community-based primary care: a qualitative study on integrating patient decision support interventions for cancer screening into routine practice." Health Expect **14 Suppl 1**: 73-84.
http://www.ncbi.nlm.nih.gov/pubmed/19906215

> BACKGROUND: Despite a growing body of evidence supporting the efficacy of patient decision support interventions (DESI), little is known about their implementation in community-based primary care practices. OBJECTIVE: The goal of this study was to explore the feasibility of integrating the use of DESIs for cancer screening in primary care practices serving patients from diverse backgrounds and learn more about the potential barriers and facilitators of integration. SETTING: 12 community-based primary care practices in metropolitan Los Angeles. MAIN VARIABLES STUDIED: Qualitative field notes

documented the roles played by staff and physicians in accomplishing project goals, the impact of the programmes on the clinical work-flow in the practices and other noteworthy observations. RESULTS: Practices that were better able to integrate the project had adequate clinic infrastructure, a relatively well-matched patient pool, and positive work and patient care environments. The remaining identified components, including staff facilitation and the physician's role accounted for higher level differences between the clinics, acting as barriers and facilitators that distinguished practices that were able to work independently from those that required more assistance and, to a lesser extent, those clinics that did and those that did not meet the project goals. DISCUSSION AND CONCLUSIONS: This study suggests that implementation of DESIs to be used immediately before a consultation is feasible if the practice infrastructure can provide sufficient basic accommodation and physician and staff are dedicated to patient care goals that are implicit in the use of these tools. Overall, the physician's role appeared to be the most important factor in determining whether project integration was successful

Fu, Y., McNichol, E., Marczewski, K., et al. (2016). "Patient-professional partnerships and chronic back pain self-management: a qualitative systematic review and synthesis." Health Soc Care Community **24**(3): 247-259.

Chronic back pain is common, and its self-management may be a lifelong task for many patients. While health professionals can provide a service or support for pain, only patients can actually experience it. It is likely that optimum self-management of chronic back pain may only be achieved when patients and professionals develop effective partnerships which integrate their complementary knowledge and skills. However, at present, there is no evidence to explain how such partnerships can influence patients' self-management ability. This review aimed to explore the influence of patient-professional partnerships on patients' ability to self-manage chronic back pain, and to identify key factors within these partnerships that may influence self-management. A systematic review was undertaken, aiming to retrieve relevant studies using any research method. Five databases were searched for papers published between 1980 and 2014, including Cochrane Library, CINAHL, Medline, EMBASE and PsycINFO. Eligible studies were those reporting on patients being supported by professionals to self-manage chronic back pain; patients being actively involved for self-managing chronic back pain; and the influence of patient-professional partnerships on self-management of chronic back pain. Included studies were critically appraised for quality, and findings were extracted and analysed thematically. A total of 738 studies were screened, producing 10 studies for inclusion, all of which happened to use qualitative methods. Seven themes were identified: communication, mutual understanding, roles of health professionals, information delivery, patients' involvement, individualised care and healthcare service. These themes were developed into a model suggesting how factors within patient-professional partnerships influence self-management. Review findings suggest that a partnership between patients and professionals supports patients' self-management ability, and effective communication is a fundamental factor underpinning their partnerships in care. It also calls for the development of individualised healthcare services offering self-referral or telephone consultation to patients with chronic conditions.

Fu, Y., McNichol, E., Marczewski, K., et al. (2018). "The Management of Chronic Back Pain in Primary Care Settings: Exploring Perceived Facilitators and Barriers to the Development of Patient-Professional Partnerships." Qual Health Res **28**(9): 1462-1473.

Supporting patients in forming partnerships with health professionals is the key of effective self-management. This study aimed to explore the nature of patient-professional partnerships and its related factors that create facilitators and barriers to patients' self-management ability. A constructivist grounded theory approach was undertaken. Three main themes emerged: interaction and communication, integrated care, and service and system. A theoretical model was generated that posits effective communication, individualized integrated care, and high-quality service as key influences on the successful development of patient-professional partnerships and patients' ability to self-manage. Giving attention to these factors helps understand the development, implementation, mechanisms, and evaluation of building a patient-professional partnership and maximizes the opportunities for patient self-management of chronic pain. Future research and practice are needed to move beyond a simplistic focus on health outcomes to address the complex links between partnerships and treatment delivery processes, and interventions, effects, and patients' context.

Furler, J., Stewart, A., Sims, J., et al. (2005). "Patient social and economic circumstances--GP perceptions and their influence on management." Aust. Fam Physician **34**(3): 189-192.
http://www.ncbi.nlm.nih.gov/pubmed/15799673

> BACKGROUND: Socioeconomic status (SES) is a major determinant of health. There is little research on if or how general practitioners assess this in individual patients and use it in their clinical practice. METHODS: An exploratory pilot study was conducted using qualitative methodology. Telephone interviews were conducted with a purposive sample of 11 GPs. RESULTS: The participating GPs commonly assessed SES through observation of patient behaviour and presentation, contextualised with knowledge of the patient's background and the community, rather than direct enquiry. The GPs understood the link between low SES and poor health primarily in terms of a higher prevalence of behavioural risk factors. Participating GPs were generally pessimistic about achieving behaviour change for patients they identified as being of low SES. DISCUSSION: General practitioners' complex understanding of SES is supported by newer theories of health inequalities and social position. However, GP attitudes may potentially play a role in reinforcing inequalities. Further research is needed regarding the relationship between GP perceptions and objective indicators of SES

Furler, J., Walker, C., Blackberry, I., et al. (2008). "The emotional context of self-management in chronic illness: A qualitative study of the role of health professional support in the self-management of type 2 diabetes." BMC Health Serv Res **8**: 214.

> BACKGROUND: Support for patient self-management is an accepted role for health professionals. Little evidence exists on the appropriate basis for the role of health professionals in achieving optimum self-management outcomes. This study explores the perceptions of people with type 2 diabetes about their self-management strategies and how relationships with health professionals may support this. METHODS: Four focus groups were conducted with people with type 2 diabetes: two with English-speaking and one each with Turkish and Arabic-speaking. Transcripts from the groups were analysed drawing on grounded hermeneutics and interpretive description. RESULTS: We describe three conceptually linked categories of text from the focus groups based on emotional context of self management, dominant approaches to self management and support from health professionals for self management. All groups described important emotional contexts to living with and self-managing diabetes and these linked closely with how they approached their diabetes management and what they looked for from health professionals. Culture seemed an important influence in shaping these linkages. CONCLUSION: Our findings suggest people construct their own individual self-management and self-care program, springing from an important emotional base. This is shaped in part by culture and in turn determines the aims each person has in pursuing self-management strategies and the role they make available to health professionals to support them. While health professionals' support for self-care strategies will be more congruent with patients' expectations if they explore each person's social, emotional and cultural circumstances, pursuit of improved health outcomes may involve a careful balance between supporting as well as helping shift the emotional constructs surrounding a patient life with diabetes.

Galliher, J. M., Post, D. M., Weiss, B. D., et al. (2010). "Patients' question-asking behavior during primary care visits: a report from the AAFP National Research Network." Ann Fam Med **8**(2): 151-159.
http://www.ncbi.nlm.nih.gov/pubmed/20212302

> PURPOSE: The Ask Me 3 (AM3) health communication program encourages patients to ask specific questions during office visits with the intention of improving understanding of their health conditions and adherence to treatment recommendations. This study evaluated whether implementing AM3 improves patients' question-asking behavior and increases adherence to prescription medications and lifestyle recommendations. METHODS: This randomized trial involved 20 practices from the American Academy of Family Physicians National Research Network that were assigned to an AM3 intervention group or a control group. Forty-one physicians in the practices were each asked to enroll at least 20 patients. The patients' visits were audio recorded, and recordings were reviewed to determine whether patients asked questions and which questions they asked. Patients were interviewed 1 to 3

weeks after the visit to assess their recall of physicians' recommendations, rates of prescription filling and taking, and attempts at complying with lifestyle recommendations. RESULTS: The study enrolled 834 eligible patients in 20 practices. There were no significant difference between the AM3 and control patients in the rate of asking questions, but this rate was high (92%) in both groups. There also were no differences in rates of either filling or taking prescriptions, although rates of these outcomes were fairly high, too. Control patients were more likely to recall that their physician recommended a lifestyle change, however (68% vs 59%, P = .04). CONCLUSIONS: In a patient population in which asking questions already occurs at a high rate and levels of adherence are fairly high, we found no evidence that the AM3 intervention results in patients asking specific questions or more questions in general, or in better adherence to prescription medications or lifestyle recommendations

Gensichen, J., Von, K. M., Rutter, C. M., et al. (2009). "Physician support for diabetes patients and clinical outcomes." BMC Public Health **9**: 367.
http://www.ncbi.nlm.nih.gov/pubmed/19788726

BACKGROUND: Physician practical support (e.g. setting goals, pro-active follow-up) and communicative support (e.g., empathic listening, eliciting preferences) have been hypothesized to influence diabetes outcomes. METHODS: In a prospective observational study, patients rated physician communicative and practical support using a modified Health Care Climate Questionnaire. We assessed whether physicians' characteristic level of practical and communicative support (mean across patients) and each patients' deviation from their physician's mean level of support was associated with glycemic control outcomes. Glycosylated haemoglobin (HbA1c) levels were measured at baseline and at follow-up, about 2 years after baseline. RESULTS: We analysed 3897 patients with diabetes treated in nine primary care clinics by 106 physicians in an integrated health plan in Western Washington, USA. Physicians' average level of practical support (based on patient ratings of their provider) was associated with significantly lower HbA1c at follow-up, controlling for baseline HbA1c (p = .0401). The percentage of patients with "optimal" and "poor" glycemic control differed significantly across different levels of practical support at follow (p = .022 and p = .028). Communicative support was not associated with differences in HbA1c at follow-up. CONCLUSION: This observational study suggests that, in community practice settings, physician differences in practical support may influence glycemic control outcomes among patients with diabetes

Gill, V. T., Pomerantz, A. et Denvir, P. (2010). "Pre-emptive resistance: patients' participation in diagnostic sense-making activities." Sociol Health Illn **32**(1): 1-20.

In medical clinic visits, patients do more than convey information about their symptoms and problems so doctors can diagnose and treat them. Patients may also show how they have made sense of their health problems and may press doctors to interpret their problems in certain ways. Using conversation analysis, we analyse a practice patients use early in the medical visit to show that relatively benign or commonplace interpretations of their symptoms are implausible. In this practice, which we term pre-emptive resistance, patients raise candidate explanations for their symptoms and then report circumstances that undermine these explanations. By raising candidate explanations on their own and providing evidence against them, patients call for doctors to restrict the range of diagnostic hypotheses they might otherwise consider. However, the practice does not compel doctors to transparently indicate whether they will do so. Patients also display their ability to recognise and weigh the evidence for common, easily remedied causes of their symptoms. By presenting evidence against them, they show doctors the relevance of more serious diagnostic interpretations without pressing for them outright.

Gillespie, H., Kelly, M., Gormley, G., et al. (2018). "How can tomorrow's doctors be more caring? A phenomenological investigation." Med Educ **52**(10): 1052-1063.

CONTEXT: Peabody's maxim 'the secret of the care of the patient is in caring for the patient' inspired generations of doctors to relate humanely to patients. Since then, phrases such as 'managed care' have impersonalised caring. The term 'patient-centred' was introduced to re-personalise caring. Ironically, however, such terms have been defined by professionals' preconceptions rather than patients' experiences. Using patients' experiences of doctors being (un)caring to guide doctors' learning could reinvigorate caring. Interpretive phenomenology provides qualitative research tools with which to do this. METHODS: Ten patients, purposively selected to have broad experiences of primary, secondary and tertiary health care, consented to participate. To stay close to their lived experiences, participants first drew 'Pictor' diagrams to represent relationships between themselves and professionals during remembered experiences of (un)caring. A researcher then used the depictions to structure in-depth, one-to-one explorations of the lived experience of caring. Verbatim transcripts were analysed using template analysis. To remain very close to patients' experiences, the researchers assembled a narrative description of the phenomenon of caring using participants' own words. RESULTS: Caring doctors were genuine. They allowed their own individuality to interact with patients' individuality. This made participants feel recognised as individuals, not just diseases. Caring doctors listened and spoke carefully, encouraged expressions of emotion, were accessible and responsive, and formed relationships. These factors empowered participants to be actively involved in their own care. Little things like smiling, shaking hands, admitting uncertainty, asking a colleague for advice and calling a participant unexpectedly at home showed that doctors were prepared to 'go above and beyond'. This was caring. CONCLUSIONS: These findings provide medical educators with an interpretation of caring that is truly patient-centred. Coupling technical proficiency with human qualities - being genuinely empathic and respectful - within doctor-patient relationships is the essence of caring.

Gillespie, H., Kelly, M., Duggan, S., et al. (2017). "How do patients experience caring? Scoping review." Patient Educ Couns **100**(9): 1622-1633.

OBJECTIVE: Summarise empirical research into patients' experiences of caring in order to promote this as a core condition for the work of health professionals. METHODS: A review team: carried out a scoping review with a phenomenological orientation that did not privilege any profession or context of care; comprehensively searched six databases from inception to the present, including all English language articles that report patients' lived experiences of caring; and identified and contrasted uncaring experiences. RESULTS: 43 articles straddled nursing, medicine, and physiotherapy, and a wide range of care settings. Patients experienced caring when competent professionals displayed positive attitudes, communicated effectively, formed relationships, helped them navigate clinical services, and engaged emotionally. CONCLUSION: This research provides a rich description of caring, which was derived from patients', rather than professionals', experiences. PRACTICE IMPLICATIONS: Whilst publications and basic professional curricula are dominated by the perspectives of single professions, this research describes patients' experiences that can prepare all health professionals to be caring in collaborative, interprofessional practice.

Giordano, L., Webster, P., Anthony, C., et al. (2008). "Improving the quality of communication in organised cervical cancer screening programmes." Patient Educ Couns **72**(1): 130-136.
http://www.ncbi.nlm.nih.gov/pubmed/18538725

OBJECTIVE: To provide health professionals involved in cervical cancer screening with an insight into the complex issues relating to communication about screening and to provide a framework for a more effective communication strategy. METHODS: This paper has been compiled by a multidisciplinary pan-European group of health professionals and cancer advocates from several European screening programmes. European surveys on screening communication, literature reviews and group discussion were used for this purpose. RESULTS: Information on cervical screening must be accessible, relevant, comprehensible, comprehensive, client-centred, phase-specific and multilevel. An effective communication strategy should consider health professionals' screening knowledge and their communication skills, consumers' health literacy skills and the communication needs of specific sub-groups in the target population. Co-operation between screening professionals, advocacy groups and journalists should be promoted. CONCLUSION: To communicate effectively and appropriately is a complex task which can be influenced by a number of factors. Screening workers need better information themselves and must take into account the needs and characteristics of the target population. PRACTICE IMPLICATIONS: This document should provide a useful tool to help screening professionals in designing and developing good quality and effective communication strategies

Glasgow, R. E., Kurz, D., King, D., et al. (2012). "Twelve-month outcomes of an Internet-based diabetes self-management support program." Patient Educ Couns **87**(1): 81-92.

> OBJECTIVE: Internet-based programs offer potential for practical, cost-effective chronic illness self-management programs. METHODS: We report 12-month results of an Internet-based diabetes self-management program, with and without additional support, compared to enhanced usual care in a 3-arm practical randomized trial. Patients (n=463) were randomized: 77.3% completed 12-month follow-up. Primary outcomes were changes in health behaviors of healthy eating, physical activity, and medication taking. Secondary outcomes were hemoglobin A1c, body mass index, lipids, blood pressure, and psychosocial factors. RESULTS: Internet conditions improved health behaviors significantly vs. usual care over the 12-month period (d for effect size=.09-.16). All conditions improved moderately on biological and psychosocial outcomes. Latinos, lower literacy, and higher cardiovascular disease risk patients improved as much as other participants. CONCLUSIONS: The Internet intervention meets the reach and feasibility criteria for a potentially broad public health impact. However, 12-month magnitude of effects was small, suggesting that different or more intensive approaches are necessary to support long-term outcomes. Research is needed to understand the linkages between intervention and maintenance processes and downstream outcomes. PRACTICE IMPLICATIONS: Automated self-management interventions should be tailored and integrated into primary care; maintenance of patient self-management can be enhanced through links to community resources.

Goderis, G., Borgermans, L., Grol, R., et al. (2010). "Start improving the quality of care for people with type 2 diabetes through a general practice support program: a cluster randomized trial." Diabetes Res Clin Pract **88**(1): 56-64.
http://www.ncbi.nlm.nih.gov/pubmed/20047770

> AIMS: To evaluate the effectiveness of a two-arm quality improvement program (QIP) to support general practice with limited tradition in chronic care on type 2 diabetes patient outcomes. METHODS: During 18 months, we performed a cluster randomized trial with randomization of General Practices. The usual QIP (UQIP: 53 GPs, 918 patients) merged standard interventions including evidence-based treatment protocol, annual benchmarking, postgraduate education, case-coaching for GPs and patient education. The advanced QIP (AQIP: 67 GPs, 1577 patients) introduced additional interventions focussing on intensified follow-up, shared care and patient behavioural changes. Main outcomes were HbA1c, systolic blood pressure (SBP), and low density lipoprotein cholesterol (LDL-C), analyzed by generalized estimating equations and linear mixed models. RESULTS: In UQIP, endpoints improved significantly after intervention: HbA1c -0.4%, 95% CI [-0.4; -0. 3]; SBP -3mmHg, 95% CI [-4; -1]; LDL-C -13mg/dl, 95% CI [-15; -11]. In AQIP, there were no significant additional improvements in outcomes: HbA1c -0.4%, 95% CI [-0.4; -0.3]; SBP -4mmHg, 95% CI [-5; -2]; LDL-C -14mg/dl, 95% CI [-15; -11]. CONCLUSIONS: A multifaceted program merging standard interventions in support of general practice induced significant improvements in the quality of diabetes care. Intensified follow-up in AQIP with focus on shared care and patient behaviour changes did not yield additional benefit

Goransson, C., Wengstrom, Y., Ziegert, K., et al. (2017). "Perspectives of health and self-care among older persons-To be implemented in an interactive information and communication technology-platform." J Clin Nurs **26**(23-24): 4745-4755.

> AIM AND OBJECTIVES: To acquire knowledge regarding the contents to be implemented in an interactive information and communication technology-platform perceived to be relevant to health and self-care among older persons based on the literature, healthcare professionals and the older persons themselves. BACKGROUND: The growing ageing population places demands on the healthcare system to promote healthy ageing and to strengthen the older person's self-care ability. This requires innovative approaches to facilitate communication between the older person and healthcare professionals, and to increase the older person's participation in their care. An information and communication technology-platform could be used for this purpose, but the content needs to be relevant to both the older persons and the healthcare professionals. DESIGN: Descriptive qualitative

design. METHODS: This study was based on three samplings: a scoping review of the literature (n = 20 articles), interviews with healthcare professionals (n = 5) and a secondary analysis of interviews with older persons (n = 8) and nursing assistants (n = 7). The data were analysed using qualitative content analysis. RESULTS: Four areas were identified to be of relevance to older persons' perceived health: frame of mind, having relationships and social activities, physical ability and concerns, and maintaining self-care. Self-care was described in the literature and by the healthcare professionals more than by the older persons. CONCLUSIONS: The results show a concordance in the data samplings that give a clear indication of the areas relevant to older persons' health and self-care that can be integrated in an interactive information and communication technology-platform for use in regular daily care assessments. Descriptions of self-care were limited indicating a possible gap in knowledge that requires further research. RELEVANCE TO CLINICAL PRACTICE: Areas relevant to older persons' health and self-care could be used for regular assessment to support and promote healthy ageing.

Gordon, K., Rice, H., Allcock, N., et al. (2017). "Barriers to self-management of chronic pain in primary care: a qualitative focus group study." Br J Gen Pract **67**(656): e209-e217.

BACKGROUND: Supported self-management is a recommended intervention for chronic pain. Effective self-management should enable an individual to reduce the impact of pain on their everyday life. Clinical guidelines suggest primary care services have a role to play in supporting self-management of chronic pain. AIM: To examine the opinions of primary care healthcare professionals (HCPs) and people with chronic pain and their carers, in order to identify possible barriers to the facilitation and adoption of self-management. DESIGN AND SETTING: A qualitative study using focus groups in locations throughout Scotland. METHOD: Eighteen focus groups were held with patients and HCPs. Fifty-four patients, nine carers, and 38 HCPs attended the groups. RESULTS: Four categories of barriers were found. 1) Patient-HCP consultation: some patients felt a discussion about self-management came too late or not at all. Communication and building positive relations were sometimes challenging. 2) Patient experience: the emotional impact of pain was difficult and patients often felt unsupported by HCPs. 3) Limited treatment options: some participants felt there was a tendency for overmedicalisation. 4) Organisational constraints: short appointment times, long waiting lists, and a compartmentalised NHS created challenges. CONCLUSION: This study illustrates some of the barriers faced by HCPs and patients in the facilitation and adoption of self-management of chronic pain. If self-management is to be an important approach to chronic pain, primary care services need to be designed to address the barriers identified.

Goris, J., Komaric, N., Guandalini, A., et al. (2013). "Effectiveness of multicultural health workers in chronic disease prevention and self-management in culturally and linguistically diverse populations: a systematic literature review." Aust J Prim Health **19**(1): 14-37.

With a large and increasing culturally and linguistically diverse (CALD) population, the Australian health care system faces challenges in the provision of accessible culturally competent health care. Communities at higher risk of chronic disease include CALD communities. Overseas, multicultural health workers (MHWs) have been increasingly integrated in the delivery of culturally relevant primary health care to CALD communities. The objective of this systematic review was to examine the effectiveness of MHW interventions in chronic disease prevention and self-management in CALD populations with the aim to inform policy development of effective health care in CALD communities in Australia. A systematic review protocol was developed and computerised searches were conducted of multiple electronic databases from 1 January 1995 until 1 November 2010. Thirty-nine studies were identified including 31 randomised controlled trials. Many of the studies focussed on poor and underserved ethnic minorities. Several studies reported significant improvements in participants' chronic disease prevention and self-management outcomes and meta-analyses identified a positive trend associated with MHW intervention. Australian Government policies express the need for targeted inventions for CALD communities. The broader systemic application of MHWs in Australian primary health care may provide one of the most useful targeted interventions for CALD communities.

Goyder, E., Carlisle, J., Lawton, J., et al. (2009). "Informed choice and diabetes screening in primary care: qualitative study of patient and professional views in deprived areas of England." Prim Care Diabetes **3**(2): 85-90.
http://www.ncbi.nlm.nih.gov/pubmed/19464976

> AIMS: To examine perceived need for, and provision of, information prior to participation in a diabetes screening programme in English general practices. METHODS: Case studies using qualitative semi-structured interviews with patients and practitioners in five participating practices. RESULTS: Participating patients generally demonstrated a lack of understanding of issues in relation to the benefits and disadvantages of diabetes screening or the implications of screening test results. Posted invitation letters provided written information but did not necessarily ensure that patients were better informed than those invited by telephone or opportunistically when attending the practice for another reason. Not all patients interviewed wanted the extent of information that would be required to enable them to give fully informed consent to screening. CONCLUSIONS: The ways in which information is provided to patients requires careful consideration so that a patient has sufficient understanding to make a decision about undergoing a screening test and understands the implications of test results. There is a potential conflict between the ideal of fully informed choice and patient expectations that they can depend on professionals to make the appropriate decision on their behalf

Graves, H., Garrett, C., Amiel, S. A., et al. (2016). "Psychological skills training to support diabetes self-management: Qualitative assessment of nurses' experiences." Prim Care Diabetes **10**(5): 376-382.

> AIM: Evidence for the efficacy of psychological skills training as a method of supporting patients' self-management is growing, but there is a shortage of mental health providers with specialist diabetes knowledge to deliver them. Primary care nurses are now increasingly expected to learn and use these techniques. This study explores nurse experience of training in six psychological skills to support patients' self-management of type 2 diabetes. METHODS: Semi-structured interviews elicited themes relating to nurses' experiences of participating in a trial of a psychological intervention, the Diabetes-6 study (D-6). Nurses were employed in GP surgeries in 5 South London boroughs. Thematic framework analysis was used to compare and contrast themes across participants. Nine nurses delivering the intervention (n=11), and 7 from the control intervention (n=12, no psychological element) were interviewed. RESULTS: Three key themes were identified: (i) positive and negative impact of D6 on nurses' practice: positives included patient empowerment; negatives included patients' capacity to engage; (ii) professional boundaries including concerns about over-stepping role as a nurse and (iii) concerns about degree of support from physicians at participating practices in integrating psychological and diabetes care. CONCLUSION: Primary care nurses report that psychological skills training can have a positive impact on patient care. Significant role adjustment is required, which may be aided by additional support from the practice team. Qualitative evaluation of effectiveness of psychological interventions may reveal processes that hinder or contribute to efficacy and translation. Appropriate support is necessary for primary care nurses to deliver psychological therapies with confidence.

Greene, J. et Yedidia, M. J. (2005). "Provider behaviors contributing to patient self-management of chronic illness among underserved populations." J Health Care Poor Underserved **16**(4): 808-824.
http://www.ncbi.nlm.nih.gov/pubmed/16311500

> Effective treatment of chronic illness requires active engagement of patients in managing their own conditions. This research explores the influence of provider support for self-management on patients' performance of self-care activities, a widely presumed but under-studied relationship, particularly among underserved populations. We surveyed an ethnically diverse, primarily low-income sample of 956 patients (or parents of pediatric patients) with diabetes or asthma in 17 outpatient teaching settings across the country. Multivariate analysis established that patients with strongly positive assessments of their providers were substantially more confident in self-care. Further, among patients with diabetes, high assessments of provider support, in comparison with low, were significantly associated with performance of self-management tasks, amounting to approximately one more day per week. These relationships were significant for patients with either illness and from varied socio-

economic backgrounds. The results provide evidence of the validity of our measure of provider support, its relevance to underserved populations, and its usefulness for evaluating quality of care

Grohmann, B., Espin, S. et Gucciardi, E. (2017). "Patients' experiences of diabetes education teams integrated into primary care." Can Fam Physician **63**(2): e128-e136.

OBJECTIVE: To explore patients' perspectives on care received from diabetes education teams (a registered nurse and a registered dietitian) integrated into primary care. DESIGN: Qualitative study using semistructured, one-on-one interviews. SETTING: Three diabetes education programs operating in 11 primary care sites in one region of Ontario. PARTICIPANTS: Twenty-three patients with diabetes. METHODS: Purposeful sampling was used to recruit participants from each site for interviews. Educator teams invited patients with whom they had met at least once to participate in semistructured interviews. Data were analyzed using thematic analysis with NVivo 11 software. MAIN FINDINGS: The diabetes education teams integrated into primary care exhibited many of the principles of person-centred care, as evidenced by the 2 overarching themes. The first is personalized care, with the subthemes care environment, shared decision making, and patient preference for one-on-one care. Participants described feeling included in partnerships with their health care providers, as they collaborated with physicians and diabetes educators to develop knowledge and set goals in the convenience and comfort of their usual primary care settings. Many participants also expressed a preference for one-on-one sessions. The second theme is patient-provider relationship, with the subthemes respect, supportive interaction, and facilitating patient engagement. Supportive environments created by the educators built trusting relationships, where patients expressed enhanced motivation to improve their self-care. CONCLUSION: Diabetes educators integrated into primary care can serve to enrich the experience of patients, provide key education to improve patient understanding, and support primary care physicians in providing timely and comprehensive clinical care. Diabetes patients appear to benefit from convenient access to interprofessional teams of educators in primary care to support diabetes self-management.

Grünloh, C., Myreteg, G., Cajander, Å., et al. (2018). ""Why Do They Need to Check Me?" Patient Participation Through eHealth and the Doctor-Patient Relationship: Qualitative Study." J Med Internet Res **20**(1): e11.

BACKGROUND: Roles in the doctor-patient relationship are changing and patient participation in health care is increasingly emphasized. Electronic health (eHealth) services such as patient accessible electronic health records (PAEHRs) have been implemented to support patient participation. Little is known about practical use of PAEHR and its effect on roles of doctors and patients. OBJECTIVE: This qualitative study aimed to investigate how physicians view the idea of patient participation, in particular in relation to the PAEHR system. Hereby, the paper aims to contribute to a deeper understanding of physicians' constructions of PAEHR, roles in the doctor-patient relationship, and levels and limits of involvement. METHODS: A total of 12 semistructured interviews were conducted with physicians in different fields. Interviews were transcribed, translated, and a theoretically informed thematic analysis was performed. RESULTS: Two important aspects were identified that are related to the doctor-patient relationship: roles and involvement. The physicians viewed their role as being the ones to take on the responsibility, determining treatment options, and to be someone who should be trusted. In relation to the patient's role, lack of skills (technical or regarding medical jargon), motives to read, and patients' characteristics were aspects identified in the interviews. Patients were often referred to as static entities disregarding their potential to develop skills and knowledge over time. Involvement captures aspects that support or hinder patients to take an active role in their care. CONCLUSIONS: Literature of at least two decades suggests an overall agreement that the paternalistic approach in health care is inappropriate, and a collaborative process with patients should be adopted. Although the physicians in this study stated that they, in principle, were in favor of patient participation, the analysis found little support in their descriptions of their daily practice that participation is actualized. As seen from the results, paternalistic practices are still present, even if professionals might not be aware of this. This can create a conflict between patients who strive to become more informed and their questions being interpreted as signs of critique and mistrust toward the physician. We thus believe that the full potential of PAEHRs is not reached yet and argue that the concept of patient empowerment is problematic as it triggers an interpretation of "power" in health care as a zero-sum, which is not helpful for the maintenance of the relationship between the actors. Patient involvement is often discussed merely in relation to decision making; however, this study emphasizes the need to include also sensemaking and learning activities. This would provide an alternative understanding of patients asking questions, not in terms of "monitoring the doctor" but to make sense of the situation.

Gustafsson, S., Sävenstedt, S., Martinsson, J., et al. (2018). "Need for reassurance in self-care of minor illnesses." J Clin Nurs **27**(5-6): 1183-1191.

AIMS AND OBJECTIVES: This study describes people's need for reassurance in self-care of minor illnesses. BACKGROUND: Self-care and active surveillance are advocated as important strategies to manage minor illnesses. Reassurance influences patient satisfaction and confidence in the practicing of self-care. DESIGN: This study is a descriptive and interpretive qualitative study. METHODS: Twelve persons with experience in self-care and receiving self-care advice were recruited, and data were collected using semi-structured interviews between September-December 2014. Data were analysed using qualitative content analyses. RESULTS: Having previous experience and the ability to actively manage symptoms using self-care interventions was described as reassuring. Participants became stressed and concerned when the symptoms persisted and interventions lacked the desired effect, which often resulted in a decision to consult. Participants wanted to feel that the nurse was an actual person, who was sympathetic, present and understanding, when they received self-care advice. The nurse's assessment and reasoning of the symptoms facilitated care-seekers' assessments of risk, and clear and concrete advice on how to manage the symptoms exerted a calming effect. Patients needed to trust that the nurse understood their situation to embrace the advice, and being invited to return created a feeling that the nurse had listened and taken them seriously. CONCLUSIONS: Reassurance has the potential to allay doubts and fears to build confidence, which influences self-care and consultation behaviour. Personal presence in the encounter, receiving an assessment and an explanation of the symptoms and precise advice are reassuring. RELEVANCE TO CLINICAL PRACTICE: The needs of nursing care may persist despite the absence of medical needs. The encounter between the nurse and care-seeker is a unique possibility for reassurance and confidence that a minor illness is self-limiting in its nature, and self-care interventions provide relief and comfort.

Haafkens, J. A., Beune, E. J., Moll van Charante, E. P., et al. (2009). "A cluster-randomized controlled trial evaluating the effect of culturally-appropriate hypertension education among Afro-Surinamese and Ghanaian patients in Dutch general practice: study protocol." BMC Health Serv Res **9**: 193.
http://www.ncbi.nlm.nih.gov/pubmed/19849857

BACKGROUND: Individuals of African descent living in western countries have increased rates of hypertension and hypertension-related complications. Poor adherence to hypertension treatment (medication and lifestyle changes) has been identified as one of the most important modifiable causes for the observed disparities in hypertension related complications, with patient education being recommended to improve adherence. Despite evidence that culturally-appropriate patient education may improve the overall quality of care for ethnic minority patients, few studies have focused on how hypertensive individuals of African descent respond to this approach. This paper describes the design of a study that compares the effectiveness of culturally-appropriate hypertension education with that of the standard approach among Surinamese and Ghanaian hypertensive patients with an elevated blood pressure in Dutch primary care practices. METHODS/DESIGN: A cluster-randomized controlled trial will be conducted in four primary care practices in Amsterdam, all offering hypertension care according to Dutch clinical guidelines. After randomization, patients in the usual care sites (n = 2) will receive standard hypertension education. Patients in the intervention sites (n = 2) will receive three culturally-appropriate hypertension education sessions, culturally-specific educational materials and targeted lifestyle support. The primary outcome will be the proportion of patients with a reduction in systolic blood pressure >or= 10 mmHg at eight months after the start of the trial. The secondary outcomes will be the proportion of patients with self-reported adherence to (i) medication and (ii) lifestyle recommendations at eight months after the start of the trial. The study will enrol 148 patients (74 per condition, 37 per site). Eligibility criteria for patients of either sex will be: current diagnosis of hypertension, self-identified Afro-Surinamese or Ghanaian, >or= 20 years, and baseline blood pressure

>or= 140/90 mmHg. Primary and secondary outcomes will be measured at baseline and at 3 1/2, 6 1/2, and eight months. Other measurements will be performed at baseline and eight months. DISCUSSION: The findings will provide new knowledge on how to improve blood pressure control and patient adherence in ethnic minority persons with a high risk of negative hypertension-related health outcomes. TRIAL REGISTRATION: ISRCTN35675524

Hammig, B., Ogletree, R. et Wycoff-Horn, M. R. (2011). "The relationship between professional preparation and class structure on health instruction in the secondary classroom." J Sch. Health **81**(9): 513-519.
http://www.ncbi.nlm.nih.gov/pubmed/21831063

BACKGROUND: The aim of the present study was to examine the impact of professional preparation and class structure on health content delivery and time spent delivering content among required health education classes in the United States. METHODS: Data from the classroom-level file of the 2006 School Health Policies and Programs Study were utilized. A series of multivariable logistic regression models were employed to determine if instruction of content was dependent on professional preparation and/or class structure. Years of teaching health topics and size of the school district were included as covariates in the multivariable logistic models. We also conducted a multivariable logistic regression model to examine if time spent teaching each topic area was dependent upon professional preparation and/or class structure. RESULTS: Findings indicated that professionally prepared teachers were significantly more likely to deliver content in 6 of 12 health topic areas when compared to untrained teachers. Class structure was also an important predictor of content delivery among many topic areas. Teachers who taught classes that were devoted to health instruction were significantly more likely to deliver content in the following topic areas: alcohol/drug prevention, tobacco prevention, sexuality, pregnancy, human immuno virus and sexually transmitted disease prevention, emotional/mental health and suicide, and violence prevention. CONCLUSIONS: Research concerning the relationship between professional preparation and teaching outcomes is scant. The present study indicates that health content coverage and time spent on instruction are associated with both professional preparation and class structure for many health content areas

Harris, M. F., Williams, A. M., Dennis, S. M., et al. (2008). "Chronic disease self-management: implementation with and within Australian general practice." Med J Aust **189**(10 Suppl): S17-S20.
http://www.ncbi.nlm.nih.gov/pubmed/19143580

Although there is evidence for the effectiveness of self-management support, there has been limited engagement of Australian general practice staff with self-management support provided by other services. Efforts to integrate self-management support into general practice have also been challenging, largely because of capacity constraints and the difficulties of incorporating it into existing work practices. A broader systemic approach is needed, including a collaborative approach between providers, a range of self-management support options, training of general practice staff, and changes to the organisation of services and the way in which they relate to each other. The expanding role of practice nurses, new models of integrated primary health care and changes to the role of the Divisions of General Practice present an opportunity for this to be incorporated "from the ground up"

Hawley, S. T., Janz, N. K., Lillie, S. E., et al. (2010). "Perceptions of care coordination in a population-based sample of diverse breast cancer patients." Patient Educ Couns **81 Suppl**: S34-S40.
http://www.ncbi.nlm.nih.gov/pubmed/21074963

OBJECTIVE: To identify factors associated with perceptions of care coordination in a diverse sample of breast cancer patients. METHODS: Breast cancer patients reported to the metropolitan SEER registries of Detroit or Los Angeles from 6/05 to 2/07 were surveyed after diagnosis (N=2268, RR=72.4%). Outcomes were two dichotomous measures reflecting patient appraisal of care coordination during their treatment experience. Primary independent variables were race/ethnicity (white, African American, Latina-high acculturated, Latina-low acculturated) and health literacy (low, moderate, high). Logistic regression was used to evaluate factors associated with both measures of care coordination. RESULTS: 2148 subjects were included in the analytic dataset. 16.4% of women perceived low care coordination and 12.5% reported low satisfaction. Race/ethnicity was not significantly associated with care coordination. Women with low subjective health literacy were 3-4 times as likely as those with high health literacy to perceive low care coordination and low satisfaction with care coordination (OR=3.88; 95% CI: 2.78-5.41; OR=3.19 95% CI: 2.25-4.52, respectively). CONCLUSIONS: Many breast cancer patients positively appraised their care coordination, but patients with low health literacy perceived low care coordination. PRACTICE IMPLICATIONS: Providers should be aware of the health literacy deficits that may contribute to their patients' attitudes towards their breast cancer care coordination

Hay-Smith, E. J., Brown, M., Anderson, L., et al. (2016). "Once a clinician, always a clinician: a systematic review to develop a typology of clinician-researcher dual-role experiences in health research with patient-participants." BMC Med Res Methodol **16**: 95.

BACKGROUND: Many health researchers are clinicians. Dual-role experiences are common for clinician-researchers in research involving patient-participants, even if not their own patients. To extend the existing body of literature on why dual-role is experienced, we aimed to develop a typology of common catalysts for dual-role experiences to help clinician-researchers plan and implement methodologically and ethically sound research. METHODS: Systematic searching of Medline, CINAHL, PsycINFO, Embase and Scopus (inception to 28.07.2014) for primary studies or first-person reflexive reports of clinician-researchers' dual-role experiences, supplemented by reference list checking and Google Scholar scoping searches. Included articles were loaded in NVivo for analysis. The coding was focused on how dual-role was evidenced for the clinician-researchers in research involving patients. Procedures were completed by one researcher (MB) and independently cross-checked by another (JHS). All authors contributed to extensive discussions to resolve all disagreements about initial coding and verify the final themes. RESULTS: Database searching located 7135 records, resulting in 29 included studies, with the addition of 7 studies through reference checks and scoping searches. Two overarching themes described the most common catalysts for dual-role experiences - ways a research role can involve patterns of behaviour typical of a clinical role, and the developing connection that starts to resemble a clinician-patient relationship. Five subthemes encapsulated the clinical patterns commonly repeated in research settings (clinical queries, perceived agenda, helping hands, uninvited clinical expert, and research or therapy) and five subthemes described concerns about the researcher-participant relationship (clinical assumptions, suspicion and holding back, revelations, over-identification, and manipulation). Clinician-researchers use their clinical skills in health research in ways that set up a relationship resembling that of clinician-patient. Clinicians' ingrained orientation to patients' needs can be in tension with their research role, and can set up ethical and methodological challenges. CONCLUSION: The typology we developed outlines the common ways dual-role is experienced in research involving clinician-researchers and patient-participants, and perhaps the inevitability of the experience given the primacy accorded to patient well-being. The typology offers clinician-researchers a framework for grappling with the ethical and methodological implications of dual-role throughout the research process, including planning, implementation, monitoring and reporting.

Healy, P. (2019). "Rethinking the doctor-patient relationship: toward a hermeneutically-informed epistemology of medical practice." Med Health Care Philos **22**(2): 287-295.

Although typically implicit, clinicians face an inherent conflict between their roles as medical healers and as providers of technical biomedicine (Scott et al. in Philos Ethics Humanit Med 4:11, 2009). This conflict arises from the tension between the physicalist model which still predominates in medical training and practice and the extra-physicalist dimensions of medical practice as epitomised in the concept of patient-centred care. More specifically, the problem is that, as grounded in a "borrowed" physicalist philosophy, the dominant "applied scientist" model exhibits a number of limitations which severely restrict its ability to underwrite the effective practice of care. Moreover, being structural in character, these problems cannot be resolved by piecemeal modifications of the existing model, nor by an appeal to evidence-based medicine (Miles in J Eval Clin Pract 15(6):887-890, 2009; Miles in Folia Med 55(1):5-24, 2013; Miles et al. in J Eval Clin Pract 14(5):621-649, 2008). Hence, the need for medical theorists to "partner with experts in the humanities to build a sui generis philosophy of medicine" (Whatley in J Eval Clin Pract 20(6):961-964, 2014, p. 961). In response, the present paper seeks to vindicate the merits of hermeneutically-informed template in providing the requisite grounding. While capable of correcting for the limitations of the applied scientist model, a hermeneutically-informed template is a "both/and" approach, which seeks to complement rather than exclude the physicalist dimension, and thereby aspires to reconcile technical mastery with patient-centred care, rather than eschew one in favour of the other. As such, it can provide a cogent philosophical template for current best practice, which does justice to the art as well as the science of medical care.

Heggland, L. H. et Hausken, K. (2013). "A qualitative identification of categories of patient participation in decision-making by health care professionals and patients during surgical treatment." Clin Nurs Res **22**(2): 206-227.

The aim of this article is to identify how health care professionals and patients experience patient participation in decision-making processes in hospitals. Eighteen semi-structured interviews with experts from different disciplines such as medicine and nursing in surgical departments as well as patients who have undergone surgical treatment constitute the data. By content analysis four categories of patient participation were identified: information dissemination, formulation of options, integration of information, and control. To meet the increasing demands of patient participation, this categorization with four identified critical areas for participation in decision-making has important implications in guiding information support for patients prior to surgery and during hospitalization.

Heggland, L. H., Mikkelsen, A. et Hausken, K. (2013). "Models, phases and cases of patient participation in decision-making in surgical treatment in Norway: a qualitative study." Nurs Health Sci **15**(1): 39-44.

This study improves our understanding of patients' participation in hospital treatment-decision processes. We explored the degree of patient participation perceived by both patients and healthcare professionals in four phases of the decision process: information dissemination, formulation of options, integration of information, and control within four models of interactions between healthcare professionals and patients: the paternalistic model, the shared model, the informed model, and the non-paternalistic model. The analysis was based on 18 in-depth, exploratory interviews with patients and healthcare professionals in six surgical units in Norway. Knowledge about how patients and healthcare professionals interact in the surgical-decision process is important for developing systems and arenas for patient participation in practice, and for a climate and culture to further support the implementation.

Henrotin, Y., Moyse, D., Bazin, T., et al. (2011). "Study of the information delivery by general practitioners and rheumatologists to patients with acute low back pain." Eur Spine J **20**(5): 720-730.

Providing information to patients regarding appropriate management of LBP is a crucial component of primary care and treatment of low back pain (LBP). Limited knowledge is available, however, about the information delivered by physicians to patients with low back pain. Hence, this study aimed at evaluating (1) the self-reported practices of French physicians concerning information about patients with acute LBP (2) the consistency of these practices with the COST B13 guidelines, and (3) the effects of the delivery of a leaflet summarizing the COST B13 recommendations on the management of patient information, using the following study design: 528 French physicians [319 general practitioners (GP) and 209 rheumatologists (RH)] were asked to provide demographic information, responses to a Fear Avoidance Beliefs questionnaire adapted for physicians and responses to a questionnaire investigating the consistency of their practice with the COST B13 guidelines. Half of the participants (163 GP and 105 RH) were randomized to receive a summary of the COST B13 guidelines concerning information delivery to patient with low back pain and half (156 GP and 104 RH) were not given this information. The mean age of physicians was 52.1+/-7.6 years, 25.2% were females, 75% work in private practice, 63.1% reported to treat 10-50 patients with LBP per month and 18.2%<10 per month. The majority of the physicians (71.0%) reported personal LBP episode (7.1% with a duration superior to 3 months). Among the 18.4% (97) of the physicians that knew the COST B13 guidelines, 85.6% (83/97) reported that they totally or partially applied these recommendations in their practice. The average work (0-24) and physical activity (0-24) FABQ scores were 21.2+/-8.4 and 10.1+/-6.0, respectively. The consistency scores (11 questions scored 0 to 6, total score was standardized from 0 to 100) were significantly higher in the RH group (75.6+/-11.6) than in GP group (67.2+/-12.6; p<0.001). The delivery of a summary of the COST B13 guidelines significantly improved the consistency score (p=0.018). However, a multivariate analysis indicated that only GP consistency was improved by recommendations' delivery.The results indicated that GP were less consistent with the European COST B13 guidelines on the information of patients with acute LBP than RH. Interestingly, delivery of a summary of these guidelines to GP improved their consistency score, but not that of the RH. This suggests that GP information campaign can modify the message that they deliver to LBP, and subsequently could change patient's beliefs on LBP.

Hepworth, J., Askew, D., Jackson, C., et al. (2013). "'Working with the team': an exploratory study of improved type 2 diabetes management in a new model of integrated primary/secondary care." Aust J Prim Health **19**(3): 207-212.

This study aimed to explore how a new model of integrated primary/secondary care for type 2 diabetes management, the Brisbane South Complex Diabetes Service (BSCDS), related to improved diabetes management in a selected group of patients. We used a qualitative research design to obtain detailed accounts from the BSCDS via semi-structured interviews with 10 patients. The interviews were fully transcribed and systematically coded using a form of thematic analysis. Participants' responses were grouped in relation to: (1) Patient-centred care; (2) Effective multiprofessional teamwork; and (3) Empowering patients. The key features of this integrated primary/secondary care model were accessibility and its delivery within a positive health care environment, clear and supportive interpersonal communication between patients and health care providers, and patients seeing themselves as being part of the team-based care. The BSCDS delivered patient-centred care and achieved patient engagement in ways that may have contributed to improved type 2 diabetes management in these participants.

Hickman, L. (2008). "Product placement in the waiting room." BMJ **336**(7656): 1274-1275.
http://www.ncbi.nlm.nih.gov/pubmed/18535067

Hillen, M. A., de Haes, H. C. et Smets, E. M. (2011). "Cancer patients' trust in their physician-a review." Psychooncology **20**(3): 227-241.
http://www.ncbi.nlm.nih.gov/pubmed/20878840

OBJECTIVE: Patient's trust in their physician is crucial for desirable treatment outcomes such as satisfaction and adherence. In oncology, trust is possibly even more essential, due to the life-threatening nature of cancer. A review was undertaken of the current knowledge of the conceptualization, assessment, correlates, and consequences of cancer patients' trust in their physician. METHODS: The empirical literature published in peer-reviewed journals between October 1988 and October 2008 was searched, employing all combinations and variations of the following keywords: trust, physician-patient relations, and cancer. RESULTS: The search identified 45 relevant papers, only 11 of which drew attention to the conceptualization of trust, and 5 of which focused on trust as the primary subject of interest. Trust in physicians was strong overall. Patients' trust appeared to be enhanced by the physician's perceived technical competence, honesty, and patient-centred behaviour. A trusting relationship between patient and physician resulted in facilitated communication and medical decision making, a decrease of patient fear, and better treatment adherence. CONCLUSIONS: A lack of focus on trust and the conceptualization thereof, strong methodological variations between studies and a possible publication bias lead us to conclude that cancer patients' trust in their physician deserves more systematic, theoretically based, research attention. Consequently, studies are needed aimed at gaining a thorough understanding of the nature and impact of cancer patients' trust in their physician, and how the interaction between physician and patient may contribute to such trust

Hoover, C., Plamann, J. et Beckel, J. (2017). "Outcomes of an Interdisciplinary Transitional Care Quality Improvement Project on Self-Management and Health Care Use in Patients With Heart Failure." J Gerontol Nurs **43**(1): 23-31.

> Heart failure (HF) accounts for most U.S. Medicare hospital admissions. The purpose of the current study was to evaluate the effectiveness of a care transitions quality improvement (QI) intervention on self-management and readmission rates in older adults with HF. A quasi-experimental, descriptive study was conducted with 66 patients with HF in three medical units in a 489-bed Midwestern acute care hospital. The intervention included a nurse coach visit and follow up, pharmacy medication education and reconciliation, and HF clinic referral. Outcomes were assessed within 48 hours of admission and 30 days after discharge using the Self-Care of Heart Failure Index and medical record review. Following implementation, readmission rates decreased from 24% to 13%. Participants demonstrated a greater improvement in use of self-management strategies to control symptoms than the non-intervention group ($p < 0.02$) and more readily identified their symptoms of HF ($p < 0.04$). The evolution of population health, with increasing numbers of older adults living at home with complex chronic conditions, will require establishment of active partnerships among pharmacists, physicians, nurse specialists, home care nurses, and patients. [Journal of Gerontological Nursing, 43(1), 23-31.].

Horwitz, A., Reuther, L. et Andersen, S. E. (2009). "[Patient information leaflets seen through the eyes of patients in a general practice]." Ugeskr. Laeger **171**(8): 599-602.
http://www.ncbi.nlm.nih.gov/pubmed/19284903

> INTRODUCTION: The objective was to investigate patients' perception of patient information leaflets, including their readability, comprehensibility and their impact on adherence. MATERIAL AND METHODS: A 14-item questionnaire was prepared and answered by unselected patients in a general practice in Copenhagen. RESULTS: A total of 111 patients were included. Eighty-eight patients (79%) always or often read the patient information leaflets. Among these, 77% attached importance to adverse effects. A mere 13% attached importance to all leaflet information. In all, 21% never or rarely read patient information leaflets, but relied on the doctor or the pharmacist. 62% of the interviewed had no problems reading or understanding the patient information leaflets. Among the 38% with reading problems, 57% had difficulties due to text-size, and 33% found the written language difficult to understand. Thirty-five patients (32%) stated that they had stopped taking medication due to the information about adverse effects. CONCLUSION: The patient information leaflet is an important source of drug information as most patients read the leaflet and nearly a third of the patients stated that information about the adverse effects had made them stop taking their medicine. Future studies should bring into focus the reason for medication adherence, how written information can be made easier to read, comprehensive and correct without contributing to anxiety and non-adherence

Hoskins, G., Williams, B., Abhyankar, P., et al. (2016). "Achieving Good Outcomes for Asthma Living (GOAL): mixed methods feasibility and pilot cluster randomised controlled trial of a practical intervention for eliciting, setting and achieving goals for adults with asthma." Trials **17**(1): 584.

> BACKGROUND: Despite being a core component of self-management, goal setting is rarely used in routine care. We piloted a primary care, nurse-led intervention called Achieving Good Outcomes for Asthma Living (GOAL) for adults with asthma. Patients were invited to identify and prioritise their goals in preparation for discussing and negotiating an action/coping plan with the nurse at a routine asthma review. METHODS: The 18-month mixed methods feasibility cluster pilot trial stratified and then randomised practices to deliver usual care (UC) or a goal-setting intervention (GOAL). Practice asthma nurses and adult patients with active asthma were invited to participate. The primary outcome was asthma-specific quality of life. Semi-structured interviews with a purposive patient sample (n = 14) and 10 participating nurses explored GOAL perception. The constructs of normalisation process theory (NPT) were used to analyse and interpret data. RESULTS: Ten practices participated (five in each arm), exceeding our target of eight. However, only 48 patients (target 80) were recruited (18 in GOAL practices). At 6 months post-intervention, the difference in mean asthma-related quality of life (mAQLQ) between intervention and control was 0.1 (GOAL 6.20: SD 0.76 (CI 5.76-6.65) versus UC 6.1: SD 0.81 (CI 5.63-6.57)), less than the minimal clinically important difference (MCID) of 0.5. However, change from baseline was stronger in the intervention group: at 6 months the change in the emotions sub-score was 0.8 for intervention versus 0.2 for control. Costs were higher in the intervention group by pound22.17. Routine review with goal setting was considered more holistic, enhancing rapport and

> enabling patients to become active rather than passive participants in healthcare. However, time was a major barrier for nurses, who admitted to screening out patient goals they believed were unrelated to asthma. CONCLUSIONS: The difference in AQLQ score from baseline is larger in the intervention arm than the control, indicating the intervention may have impact if appropriately strengthened. The GOAL intervention changed the review dynamic and was well received by patients, but necessitated additional time, which was problematic in the confines of the traditional nurse appointment. Modification to recruitment methods and further development of the intervention are needed before proceeding to a definitive cluster randomised controlled trial. TRIAL REGISTRATION: ISRCTN18912042 . Registered on 26 June 2012.

Hosseinzadeh, H. et Shnaigat, M. (2019). "Effectiveness of chronic obstructive pulmonary disease self-management interventions in primary care settings: a systematic review." Aust J Prim Health.

> Chronic obstructive pulmonary disease (COPD) is one of the more disabling diseases and the third cause of mortality worldwide. Self-management is considered an effective strategy for controlling and managing COPD. This review aims to summarise the available evidence on the effectiveness of COPD self-management in primary care settings. Social Sciences, Citation Index, MEDLINE, CINAHL, Academic Search Complete and Scopus were searched for randomised controlled trials of COPD self-management in general practice between 2001 and 2018. Ten randomised controlled trials of COPD self-management trials conducted in primary care settings were included in this review. The identified trials have recruited stable patients; a majority having mild to moderate COPD. The trials implemented different types of interventions and measured improvements in knowledge, skills and behaviours of self-management, mental health, self-efficacy and endpoint outcomes such as hospitalisation and quality of life. The findings showed that COPD self-management trials had positive effects on COPD knowledge and improved self-management behaviours such as adherence to medication, physical activities and smoking cessation in some cases; however, the effect of trials on hospitalisation rate, quality of life and healthcare utilisation were not conclusive. There was also not enough evidence to suggest that the trials were efficient in improving self-efficacy, a major driver of self-management behaviours. Primary care COPD self-management trials are efficient in improving surrogate outcomes such as knowledge of and adherence to self-management behaviours; however, such improvements are less likely to be sustainable in the absence of self-efficacy. Future studies should also focus on improving endpoint self-management outcomes like hospitalisation rate and quality of life to benefit both patient and healthcare system.

Hoving, C., Visser, A., Mullen, P. D., et al. (2010). "A history of patient education by health professionals in Europe and North America: from authority to shared decision making education." Patient Educ Couns **78**(3): 275-281.

> OBJECTIVE: This paper describes the development of patient education from the 1960s until now and identifies future challenges to improve patient education. RESULTS: Patient education developed from the health care professional deciding what the patient needed to know to a shared decision making design where physician and patient are equally influential on the decision making process. The development of patient education is described for primary and secondary health care, as well as the impact of biomedical advances, an ageing population and cultural diversity on patient education. Some of the challenges for future patient education are identified: training health professionals as well as patients, involvement of the patient's social environment and application of e-Health techniques to patient education. CONCLUSION: Patient education has made several developmental changes, has spread to different settings in health care and has now finally established itself as a valuable part of health care for patients. Nevertheless, both patients and health professionals still need to be provided with skills to optimize patient education. A good science-practice fit for future interventions to facilitate patient education is paramount. PRACTICE IMPLICATION: Lessons from the past of patient education are important for the growth and future development of patient education.

Hovstadius, B. et Petersson, G. (2012). "Factors leading to excessive polypharmacy." Clin Geriatr. Med **28**(2): 159-172.
http://www.ncbi.nlm.nih.gov/pubmed/22500536

There are numerous risk factors for patients to develop excessive polypharmacy. The most prominent risk factors are associated with sociodemographics and the patients' conditions. Risk factors associated with patient behavior, such as patient's self medication with all types of medications, have not been observed to the same extent but might be at the same level of importance for patients developing excessive polypharmacy. Risk factors related to physicians, and the interaction between patient and physician, are studied to a much lesser extent. The few studies conducted regarding the large variation in physicians' individual prescribing practices, in terms of polypharmacy, add another perspective to the complexity of the area. Interventions aiming to improve communication between GP and hospital specialist, to create support systems for medical reviews that include all patients' medications, and to improve the knowledge of multiple prescribing might have the largest potential to better manage excessive polypharmacy

Howick, J., Steinkopf, L., Ulyte, A., et al. (2017). "How empathic is your healthcare practitioner? A systematic review and meta-analysis of patient surveys." BMC Med Educ **17**(1): 136.

BACKGROUND: A growing body of evidence suggests that healthcare practitioners who enhance how they express empathy can improve patient health, and reduce medico-legal risk. However we do not know how consistently healthcare practitioners express adequate empathy. In this study, we addressed this gap by investigating patient rankings of practitioner empathy. METHODS: We conducted a systematic review and meta-analysis of studies that asked patients to rate their practitioners' empathy using the Consultation and Relational Empathy (CARE) measure. CARE is emerging as the most common and best-validated patient rating of practitioner empathy. We searched: MEDLINE, Embase, PsycINFO, Cinahl, Science & Social Science Citation Indexes, the Cochrane Library and PubMed from database inception to March 2016. We excluded studies that did not use the CARE measure. Two reviewers independently screened titles and extracted data on average CARE scores, demographic data for patients and practitioners, and type of healthcare practitioners. RESULTS: Sixty-four independent studies within 51 publications had sufficient data to pool. The average CARE score was 40.48 (95% CI, 39.24 to 41.72). This rank s in the bottom 5th percentile in comparison with scores collected by CARE developers. Longer consultations (n = 13) scored 15% higher (42.60, 95% CI 40.66 to 44.54) than shorter (n = 9) consultations (34.93, 95% CI 32.63 to 37.24). Studies with mostly (>50%) female practitioners (n = 6) showed 16% higher empathy scores (42.77, 95% CI 38.98 to 46.56) than those with mostly (>50%) male (n = 6) practitioners (34.84, 95% CI 30.98 to 38.71). There were statistically significant (P = 0.032) differences between types of providers (allied health professionals, medical students, physicians, and traditional Chinese doctors). Allied Health Professionals (n = 6) scored the highest (45.29, 95% CI 41.38 to 49.20), and physicians (n = 39) scored the lowest (39.68, 95% CI 38.29 to 41.08). Patients in Australia, the USA, and the UK reported highest empathy ratings (>43 average CARE), with lowest scores (<35 average CARE scores) in Hong Kong. CONCLUSIONS: Patient rankings of practitioner empathy are highly variable, with female practitioners expressing empathy to patients more effectively than male practitioners. The high variability of patient rating of practitioner empathy is likely to be associated with variable patient health outcomes. Limitations included frequent failure to report response rates introducing a risk of response bias. Future work is warranted to investigate ways to reduce the variability in practitioner empathy.

Hsu, C., Gray, M. F., Murray, L., et al. (2019). "Actions and processes that patients, family members, and physicians associate with patient- and family-centered care." BMC Fam Pract **20**(1): 35.

BACKGROUND: Patient- and family-centered care (PFCC) is increasingly linked to improved communication, care quality, and patient decision making. However, in order to consistently implement and study PFCC, health care systems and researchers need a solid evidentiary base. Most current definitions and models of PFCC are broad and conceptual, and difficult to translate into measurable behaviors and actions. This paper provides a brief overview of all actions that focus group respondents associated with PFCC in ambulatory (outpatient) care settings and then explores actions associated with the concept of "dignity and respect" in greater detail. METHODS: We conducted nine focus groups with patients, family members, and physicians in three metropolitan regions across the

United States. Group discussions were transcribed and analyzed using a thematic analysis approach. RESULTS: We identified 14 domains and 47 specific actions that patients, family members, and physicians associate with PFCC. In addition to providing a detailed matrix of these domains and actions, this paper details the actions associated with the "dignity and respect" concept. Key domains identified under "dignity and respect" include: 1) building relationships, 2) providing individualized care, and 3) respecting patients' time. Within these domains we identified specific actions that break down these abstract ideas into explicit and measurable units such as taking time, listening, including family, and minimizing wait times. We identified 9, 6, and 3 specific actions associated, respectively, with building relationships, providing individualized care, and respecting patients' time. CONCLUSIONS: Our work fills a critical gap in our ability to understand and measure PFCC in ambulatory care settings by breaking down abstract concepts about PFCC into specific measurable actions. Our findings can be used to support research on how PFCC affects clinical outcomes and develop innovative tools and policies to support PFCC.

Hsu, K. Y., Contreras, V. M., Vollrath, K., et al. (2019). "Incorporating the Patient Voice Into Practice Improvement: A Role for Medical Trainees." Fam Med **51**(4): 348-352.

BACKGROUND AND OBJECTIVES: Many primary care clinics rely on providers and staff to generate quality improvement (QI) ideas without explicitly including patients. However, without understanding patient perspectives, clinics may miss areas for improvement. We identified practice improvement opportunities using a medical student-driven pilot of QI design that incorporates the patient voice and explored provider/staff perceptions of patient perspectives. METHODS: One medical student interviewed eight patients for their perspectives on QI opportunities at a university-based primary care practice. Two trainees independently coded interview transcripts using directed content analysis (final codebook: 11 themes) and determined frequency of mentions for each theme. We surveyed 11 providers/staff by asking them to select 5 of the 11 themes and place them in rank order based on their perceptions of patient concerns; their surveys were aggregated into one ranked list. RESULTS: Patients most frequently identified the following themes as QI opportunities: relationship (ie, feeling of personal connection with providers/staff), specialty care, convenience, sustainability, and goal follow-up. While patients frequently identified relationship (rank=1) and goal follow-up (rank=3) as QI opportunities, the provider/staff top five list did not include relationship (rank=10) or goal follow-up (rank=7). CONCLUSIONS: Our study demonstrates two things: (1) there are areas of discordance between provider/staff perceptions and patient perspectives regarding practice improvement opportunities; and (2) medical students can participate meaningfully in the QI process. By harnessing patient perspectives with the help of medical trainees, clinics may better understand patient concerns and avoid potential QI blind spots.

Huber, J., Ihrig, A., Huber, C. G., et al. (2011). "[Patient centeredness and decision-making in localised prostate cancer: possible fields of health services research in urology]." Urologe. A **50**(6): 691-696.
http://www.ncbi.nlm.nih.gov/pubmed/21656094

BACKGROUND: Quality of care is essential for health services research. Therefore, our patients' preferences are of major importance and this can be illustrated by decision-making in localised prostate cancer. MATERIAL AND METHODS: A total of 349 patients reported on their preferred mode of decision-making, on their habits of information procurement, and on their feeling of being well informed. Moreover, we tried to objectify their actual knowledge. Their mean age was 63.0 years and mean PSA level 9.4 ng/ml. As 40% had a higher level of education we investigated possible influences of this feature by applying the chi-square test. RESULTS: Half of the patients preferred to share the treatment decision and 39% wanted to choose for themselves considering their physician's recommendation. The most important sources of information were treating physicians (88%) and the Internet (77%). All patients felt well informed and 94% knew their latest PSA count. Patients with a higher level of education had better knowledge of their clinical data and used the Internet more (84 vs 71%; p=0.007). CONCLUSIONS: Our patients actively take part in medical decision-making and thereby contribute significantly to everyday health care. Based on this aspect, the whole scope of urology is developed as a promising field of health services research

Hudson, J. N., Knight, P. J. et Weston, K. M. (2012). "Patient perceptions of innovative longitudinal integrated clerkships based in regional, rural and remote primary care: a qualitative study." BMC Fam Pract **13**: 72.

> BACKGROUND: Medical students at the University of Wollongong experience continuity of patient care and clinical supervision during an innovative year-long integrated (community and hospital) clinical clerkship. In this model of clinical education, students are based in a general practice 'teaching microsystem' and participate in patient care as part of this community of practice (CoP). This study evaluates patients' perceptions of the clerkship initiative, and their perspectives on this approach to training 'much-needed' doctors in their community. METHODS: Semi-structured, face-to-face, interviews with patients provided data on the clerkship model in three contexts: regional, rural and remote health care settings in Australia. Two researchers independently thematically analysed transcribed data and organised emergent categories into themes. RESULTS: The twelve categories that emerged from the analysis of transcribed data were clustered into four themes: learning as doing; learning as shared experience; learning as belonging to a community; and learning as 'becoming'. Patients viewed the clerkship learning environment as patient- and student-centred, emphasising that the patient-student-doctor relationship triad was important in facilitating active participation by patients as well as students. Patients believed that students became central, rather than peripheral, members of the CoP during an extended placement, value-adding and improving access to patient care. CONCLUSIONS: Regional, rural and remote patients valued the long-term engagement of senior medical students in their health care team(s). A supportive CoP such as the general practice 'teaching microsystem' allowed student and patient to experience increasing participation and identity transformation over time. The extended student-patient-doctor relationship was seen as influential in this progression. Patients revealed unique insights into the longitudinal clerkship model, and believed they have an important contribution to make to medical education and new strategies addressing mal-distribution in the medical workforce.

Hullar, J., Vespignani, H., Fay, R., et al. (2010). "[Impact of group therapeutic education in the management of adult sleep disorders. Prospective study conducted from September 2007 to March 2008 by a group of general practitioners]." Rev Prat **60**(6 Suppl): 21-26.
http://www.ncbi.nlm.nih.gov/pubmed/20623917

> The prescription of hypnotic drugs in the management of adult insomnia is a public health issue. The implementation of a non-pharmacological, therapeutic approach is a daily problem for primary physicians. OBJECTIVE: This study aimed at assessing the impact of a group therapeutic education approach in the non-medical management of adult insomnia by general practitioners. METHOD: Prospective study conducted from September 2007 to March 2008. Two conferences were held in a two-month period by 5 general practitioners from Laxou, Meurthe-et-Moselle (France). Volunteers were recruited by general practitioners, through local press, posters displayed in pharmacies, leaflet distribution and local radio announcements. A questionnaire was provided at the beginning and the end of the conferences. A phone interview was conducted 1 month and 3 months after the conferences were held, to assess their impact. RESULTS: Seventy-six participants completed the questionnaire during both conferences, and 55 adults were followed-up at 1 and 3 months; 58% (n = 43) were aged over 60, and women represented 65% (n = 48) of the participants; 63% (n = 46) reported insomnia, out of which 89% complained of chronic insomnia (26%, 40% and 34% reported mild insomnia, moderate insomnia and severe insomnia, respectively). At 3 months, 20% of the participants had completed the sleep diary and specifically seen their general practitioner; 56% of the participants taking hypnotic drugs had initiated a dose reduction or a discontinuation of their treatment; 84% of the participants who followed recommendations and initiated cognitive behavioral therapies noted a partial or complete improvement in their sleep disorder. CONCLUSION: Group therapeutic education in the form of cognitive behavioral therapy performed during a conference results in a change in behaviors and a mid-term improvement in sleep quality in participants

Hung, D. Y., Rundall, T. G., Tallia, A. F., et al. (2007). "Rethinking prevention in primary care: applying the chronic care model to address health risk behaviors." Milbank Q **85**(1): 69-91.

This study examines the Chronic Care Model (CCM) as a framework for preventing health risk behaviors such as tobacco use, risky drinking, unhealthy dietary patterns, and physical inactivity. Data were obtained from primary care practices participating in a national health promotion initiative sponsored by the Robert Wood Johnson Foundation. Practices owned by a hospital health system and exhibiting a culture of quality improvement were more likely to offer recommended services such as health risk assessment, behavioral counseling, and referral to community-based programs. Practices that had a multispecialty physician staff and staff dieticians, decision support in the form of point-of-care reminders and clinical staff meetings, and clinical information systems such as electronic medical records were also more likely to offer recommended services. Adaptation of the CCM for preventive purposes may offer a useful framework for addressing important health risk behaviors.

Iosifescu, A., Halm, E. A., McGinn, T., et al. (2008). "Beliefs about generic drugs among elderly adults in hospital-based primary care practices." Patient Educ Couns **73**(2): 377-383.
http://www.ncbi.nlm.nih.gov/pubmed/18706784

OBJECTIVE: This study aimed to characterize seniors' beliefs about generic drugs, and examine potential correlates of these beliefs, including socioeconomic and health status variables, health literacy, and physician communication skills. METHODS: Older adults (> or = 65 years) were interviewed in two primary care practices of an inner-city, tertiary care hospital (n = 311). Beliefs about generics were measured using a scale that compared generic and brand name drugs across four domains. Beliefs were modeled with multivariable linear regression. RESULTS: Negative beliefs about generics were associated with non-white race (p < 0.0001), lower education (p = 0.008) and income (p = 0.001), and having Medicaid coverage (p = 0.001). Individuals with low health literacy and who reported that their physicians had poor communication skills were more likely to hold negative views (p < 0.0001 and p = 0.003, respectively). In multivariable analysis, black race (beta = -2.30, p = 0.006) and inadequate health literacy (beta = -2.17, p = 0.0004) remained strongly associated with negative views about generic drugs. Poor physician communication skills also predicted negative beliefs about generics but the association was not significant for all levels of communication skill. CONCLUSION: Many low-income seniors mistrust generic medications, especially African-Americans and seniors with low health literacy. PRACTICE IMPLICATIONS: Educational efforts to promote generic medications should account for patients' health literacy and cultural backgrounds

Ihrig, A., Herzog, W., Huber, C. G., et al. (2012). "Multimedia support in preoperative patient education for radical prostatectomy: the physicians' point of view." Patient Educ Couns **87**(2): 239-242.

OBJECTIVE: To systematically assess the physicians' point of view of multimedia support in preoperative patient education for radical prostatectomy. METHODS: We evaluated the view of physicians performing multimedia supported preoperative educations within a randomized controlled trial. Therein 8 physicians educated 203 patients for radical prostatectomy. RESULTS: All physicians rated multimedia supported education better than the standard procedure. Main reasons were better comprehensibility, the visual presentation, and greater ease in explaining complex issues. Objective time measurement showed no difference between both educations. The major disadvantage was the impression, that multimedia supported education lasted longer. Moreover, they had the impression that some details could be further improved. Given the choice, every physician would decide for multimedia support. CONCLUSION: Physicians appreciate multimedia support in preoperative education and contrary to their impression, multimedia support does not prolong patient education. Therefore, patients and physicians likewise profit from multimedia support for education and counseling. PRACTICE IMPLICATIONS: The readiness of physicians is a possible obstacle to this improvement, as their view is a key factor for the transition to everyday routine. Therefore, our results could alleviate this possible barrier for establishing multimedia supported education in clinical routine.

Ireson, C. L., Slavova, S., Steltenkamp, C. L., et al. (2009). "Bridging the care continuum: patient information needs for specialist referrals." BMC Health Serv Res **9**: 163.
http://www.ncbi.nlm.nih.gov/pubmed/19754957

BACKGROUND: Information transfer is critical in the primary care to specialist referral process and has been examined extensively in the US and other countries, yet there has been little attention to the patient's perspective of the information transfer process. This cross-sectional study examined the quality of the information received by patients with a chronic condition from the referring and specialist physician in the specialist referral process and the relationship of the quality of information received to trust in the physicians. METHODS: Structured telephone interviews were conducted with a random sample of 250 patients who had experienced a referral to a specialist for the first visit for a chronic condition within the prior six months. The sample was selected from the patients who visited specialist physicians at any of the 500 hospitals from the National Research Corporation client base. RESULTS: Most patients (85%) received a good explanation about the reason for the specialist visit from the referring physician yet 26% felt unprepared about what to expect. Trust in the referring physician was highly associated with the preparatory information patients received. Specialists gave good explanations about diagnosis and treatment, but 26% of patients got no information about follow-up. Trust in the specialist correlated highly with good explanations of diagnosis, treatment, and self-management. CONCLUSION: Preparatory information from referring physicians influences the quality of the referral process, the subsequent coordination of care, and trust in the physician. Changes in the health care system can improve the information transfer process and improve coordination of care for patients

Jaensch, D., Baker, N. et Gordon, S. (2019). "Contemporaneous patient and health professional views of patient-centred care: a systematic review." Int J Qual Health Care **31**(10): G165-g173.

OBJECTIVE: To understand the domains of agreement and disagreement, related to person-centred care, between the patient and healthcare professional during a shared episode of care. DESIGN: A systematic review following the PRISMA protocol searched PubMed (Medline), CINAHL, PsychInfo and Scopus using keywords for health professionals, patients and patient-centred care. A descriptive-interpretive method was used to identify domains described in the person-centred care framework. SETTING: Research conducted in all healthcare settings (inpatient, outpatient, community) were included. PARTICIPANTS: Research which presented the contemporaneous perspectives of a health professional and the person they were providing services to were included. INTERVENTION(S): Research regarding the delivery of any type of health service was included. MAIN OUTCOME MEASURE(S): The person-centred care framework which includes Structure, Process and Outcome as measures for implementing person-centred care was used to interpret and summarize the data. RESULTS: After title and abstract screening against inclusion and exclusion criteria, 15 of 1,406 studies were critically appraised. High levels of contemporaneous agreement were identified for easily accessible, supportive and accommodating environments, where information sharing occurred. Contemporaneous agreement occurred most often between patients and healthcare professionals in the importance of sharing information across all geographical settings, with greatest disagreement of patient involvement in the European and American hospital environments. CONCLUSIONS: Greater understanding of the context of information sharing and drivers for management preferences may support shared decision-making and increase satisfaction. More information regarding contemporaneous experiences of healthcare episodes is required to further inform patient-centred care practices and optimize health outcomes.

Jangland, E. et Gunningberg, L. (2017). "Improving patient participation in a challenging context: a 2-year evaluation study of an implementation project." J Nurs Manag **25**(4): 266-275.

AIM: To evaluate an implementation project on patient participation. BACKGROUND: Patient participation is one of the cornerstones of person-centred care. A previous intervention study resulted in improved patient participation in a surgical department in a large university hospital in Sweden. A subsequent implementation project was guided by the PARiSH framework and included several strategies over 2 years. METHOD: Patients (n = 198) in five units completed a questionnaire and nurse managers (n = 5) were interviewed. RESULTS: Although the long-term implementation project did not improve patient participation in the units, the nurse managers described a changing culture in which staff grew to accept patients' involvement in their own care. Several barriers to change and sustainability were acknowledged. CONCLUSIONS: Improving patient participation in a busy environment is challenging. The framework was useful in the different steps of the project. In the future, the interrelationship of the core elements needs to be analysed in an ongoing and deeper way to allow both prediction and prevention of barriers to improvement. IMPLICATIONS FOR NURSING MANAGEMENT: A dedicated leadership together with skilled facilitators should encourage and support staff to reflect on their attitudes and ways of working to increase person-centred care.

Johansen, M. L., Holtedahl, K. A., Davidsen, A. S., et al. (2012). "'I deal with the small things': the doctor-patient relationship and professional identity in GPs' stories of cancer care." Health (London) **16**(6): 569-584.

An important part of GPs' work consists of attending to the everyday and existential conditions of human being. In these life world aspects, biomedicine is often not the relevant theory to guide the GP; nevertheless they are a part of GPs' professional domain. In cancer care, previous studies have shown that GPs with a biomedical perspective on medicine could feel subordinate to specialists, and that doctors with a curative focus could see disease progression as a personal failure. The aim of this study was to explore in depth the experiences of being a GP for people with advanced cancer. Fourteen Norwegian GPs were interviewed about accompanying patients through a cancer illness. Their stories were analysed using a narrative approach. The GPs expressed a strong commitment to these patients, a loyalty which in some cases could be weakened due to judgements of distant specialists. In view of the GPs' close knowledge of their patients' background and history this subordination was a paradox, mirroring a hierarchy of medical knowledge. The GPs had an ideal of honesty and openness about death, which they sometimes failed. To reach the ideal of honesty, clinicians would have to abandon the biomedical ideal of mastering human nature through interventions and acknowledge the fundamental uncertainty and finiteness of human life. GPs may learn from being with their patients that bodily and existential suffering are connected, and thus learn implicitly to overlook the body-mind dualism. This practical wisdom lacks a theoretical anchoring, which is a problem not only for general practice.

Johns, T. S., Yee, J., Smith-Jules, T., et al. (2015). "Interdisciplinary care clinics in chronic kidney disease." BMC Nephrol **16**: 161.

The burden of chronic kidney disease (CKD) is substantial, and is associated with high hospitalization rates, premature deaths, and considerable health care costs. These factors provide strong rationale for quality improvement initiatives in CKD care. The interdisciplinary care clinic (IDC) has emerged as one solution to improving CKD care. The IDC team may include other physicians, advanced practice providers, nurses, dietitians, pharmacists, and social workers--all working together to provide effective care to patients with chronic kidney disease. Studies suggest that IDCs may improve patient education and preparedness prior to kidney failure, both of which have been associated with improved health outcomes. Interdisciplinary care may also delay the progression to end-stage renal disease and reduce mortality. While most studies suggest that IDC services are likely cost-effective, financing IDCs is challenging and many insurance providers do not pay for all of the services. There are also no robust long-term studies demonstrating the cost-effectiveness of IDCs. This review discusses IDC models and its potential impact on CKD care as well as some of the challenges that may be associated with implementing these clinics.

Kahn, L. S., Fox, C. H., Carrington, J., et al. (2009). "Telephonic nurse case management for patients with diabetes and mental illnesses: a qualitative perspective." Chronic Illn **5**(4): 257-267.
http://www.ncbi.nlm.nih.gov/pubmed/20156943

OBJECTIVES: Gold Choice, a partially capitated Medicaid managed care programme for individuals with a behavioural health diagnosis, implemented a telephonic nurse case management (TNCM) programme to improve diabetes self-management. We sought to identify issues faced by patients with co-morbid behavioural health diagnoses and diabetes as documented in the telephonic nurse case manager's progress notes. We also explored the role of the TNCM in addressing members' needs. METHODS: We undertook a qualitative analysis of 853 de-identified progress notes from 539 Gold Choice members and conducted a semi-structured interview with the TNCM. RESULTS: Seven major themes emerged reflecting the nurse's perspectives on challenges faced by Gold Choice members and addressed by the TNCM: (1) Transience of the population. (2) Complex needs, involving not only medical and psychiatric conditions but also housing, transportation and survival. (3) Confusion regarding diabetes diagnosis. (4) Mistrust and suspicion. (5) Difficulties with medical care. (6) Need for diabetes self-management education/skills. (7) Marked appreciation that the TNCM would initiate contact and care about the patient. DISCUSSION: Members with co-morbid behavioural health diagnoses and diabetes constitute a complex population with extensive needs. The TNCM's role extends beyond diabetes care and entails social support as well as navigation of the healthcare and social service systems

Khan, A. et Plummer, D. (2008). "Are printed sexually transmissible infection materials for patients appropriate? A physician perspective." Sex Health **5**(3): 307-308.
http://www.ncbi.nlm.nih.gov/pubmed/18771649

The data from a postal survey of 409 general practitioners (GPs) practicing in New South Wales are analysed to explore GPs' concerns, if any, about available printed information materials on sexually transmissible infections (STI) for patients. Just over half (55%) of GPs considered the materials for patients to be inadequate and/or inappropriate with 18% considering the materials as too technical for many patients and 13% considering the materials mostly out of date. Over a fifth reported that either STI materials were not available in their clinic or they did not know where to get those materials

Kim, J. M., Suarez-Cuervo, C., Berger, Z., et al. (2018). "Evaluation of Patient and Family Engagement Strategies to Improve Medication Safety." Patient **11**(2): 193-206.

BACKGROUND: Patient and family engagement (PFE) is critical for patient safety. We systematically reviewed types of PFE strategies implemented and their impact on medication safety. METHODS: We searched MEDLINE, EMBASE, reference lists and websites to August 2016. Two investigators independently reviewed all abstracts and articles, and articles were additionally reviewed by two senior investigators for selection. One investigator abstracted data and two investigators reviewed the data for accuracy. Study quality was determined by consensus. Investigators developed a framework for defining the level of patient engagement: informing patients about medications (Level 1), informing about engagement with health care providers (Level 2), empowering patients with communication tools and skills (Level 3), partnering with patients in their care (Level 4), and integrating patients as full care team members (Level 5). RESULTS: We included 19 studies that mostly targeted older adults taking multiple medications. The median level of engagement was 2, ranging from 2-4. We identified no level 5 studies. Key themes for patient engagement strategies impacting medication safety were patient education and medication reconciliation, with a subtheme of patient portals. Most studies (84%) reported implementation outcomes. The most commonly reported medication safety outcomes were medication errors, including near misses and discrepancies (47%), and medication safety knowledge (37%). Most studies (63%) were of medium to low quality, and risk of bias was generally moderate. Among the 11 studies with control groups, 55% (n = 6) reported statistically significant improvement on at least one medication safety outcome. Further synthesis of medication safety measures was limited due to intervention and outcome heterogeneity. CONCLUSIONS: Key strategies for engaging patients in medication safety are education and medication reconciliation. Patient engagement levels were generally low, as defined by a novel framework for determining levels of patient engagement. As more patient engagement studies are conducted, this framework should be evaluated for associations with patient outcomes.

Kirby, S. E., Dennis, S. M., Bazeley, P., et al. (2012). "What distinguishes clinicians who better support patients for chronic disease self-management?" Aust J Prim Health **18**(3): 220-227.

Many frequent readmissions due to acute exacerbations of chronic disease could be prevented if patients self-managed. This study explored factors involved in patient activation for chronic disease self-management by qualitative analysis of interview data from hospital and community-based clinicians and patients. All clinicians reported that many frequently readmitted patients did not readily take up referral to chronic disease self-management services. This reluctance was compounded by system or access barriers. Clinicians who had a defined role in chronic disease management and patient-centred and behaviour change skills reported that although some patients were more resistant than others, patients could be persuaded to adopt self-management behaviours. Hospital clinicians and GPs were more inclined to attribute blame to clinical, social and personal patient factors, such as difficulty with support at home, social circumstances and reluctance to take responsibility. Investment in extending the skills and role of hospital clinicians and GPs to take a more supportive role in patient uptake of referrals to chronic disease self-management services would reduce hospital readmissions. Improvements in access to chronic disease self-management and GP services are also needed to address failure to take up chronic disease self-management.

Kirk, J. K., Davis, S. W., Hildebrandt, C. A., et al. (2011). "Characteristics associated with glycemic control among family medicine patients with type 2 diabetes." N C Med J **72**(5): 345-350.
http://www.ncbi.nlm.nih.gov/pubmed/22416509

BACKGROUND: As new payment models are developed for chronic diseases such as diabetes, there is a need to understand which patient characteristics impact glycemic control. This study examines the relationship between patient variables and glycemic control, defined as a hemoglobin A1c (A1c) level of <7%, in a cohort of family medicine patients with type 2 diabetes. METHODS: A total of 1,398 medical charts were selected using International Classification of Diseases, Ninth Revision, Clinical Modification codes for diabetes. To gather information not available through chart review, a survey was used to collect data on individual-level characteristics. Information included marital status, education level, income level, insurance status, activity level, receipt of diabetes education, living arrangement, employment status, and annual income. A cross-sectional design was used to obtain, via chart review, data about diabetes outcomes (ie, A1c level, blood pressure, and low-density lipoprotein cholesterol [LDL-C] level). RESULTS: A mailed survey was completed by 669 patients (response rate, 47.9%). Almost half of patients in this sample achieved the goal A1c level, LDL-C level (ie, <100 mg/dL), and/or blood pressure (ie, <130/<80 mm Hg). Medicare insurance (odds ratio [OR], 2.16 [95% confidence interval {CI}{Fournier, 2018 #993}, 1.18-3.96]) and female sex (OR, 1.61 [95% CI, 1.01-2.56]) were associated with glycemic control. Other variables, such as annual income, education level, and receipt of diabetes education, that were expected to impact glycemic control were not significantly associated with an A1c level of <7%. LIMITATIONS: The survey response rate was <50%, the study was conducted at a single site, and the chart data were retrospective. CONCLUSIONS: Our findings indicate that Medicare insurance and female sex were associated with glycemic control. Further evaluation is needed to identify determinants that lead to achievement of optimal glycemic control among individuals with type 2 diabetes

Kirk, J. K., Devoid, H. M. et Strickland, C. G. (2018). "Educational Strategies of Diabetes Group Medical Visits: A Review." Curr Diabetes Rev **14**(3): 227-236.

BACKGROUND: Diabetes is a demanding disease that is growing in prevalence. Improved outcomes for patients with diabetes are highly dependent on self-management skills and the ability to make lifestyle changes. Innovative healthcare approaches are necessary to meet these specific patient needs. A group care medical visit (GMV) combines diabetes check-ups with diabetes education in a supportive and patient centered environment that promotes effective self-management. GMVs are associated with improved diabetes outcomes including hemoglobin A1C, weight, and self-efficacy; however details of the methods by which content is delivered to achieve these outcomes remain vague. INTRODUCTION: Improved GMV diabetes outcomes may be the result of specific processes used in group care models. We seek to describe educational strategies, content, and qualities of facilitators that contribute to successful outcomes associated with diabetes GMVs. METHODS: A review of the literature was conducted focusing on diabetes GMVs, specifically the educational strategies implemented, topics discussed, and facilitator qualities that contribute to successful outcomes. RESULTS: We identified 260 citations containing information about GMVs in patients with diabetes. A total of 7 citations met inclusion criteria and additional 5 were found through reference lists and relevant papers. CONCLUSION: Diabetes GMV educational topics comprise standard themes of disease process, medication, nutrition, and exercise. Several programs, however, target the development and realization of individualized patient goals, giving the patient more involvement in the session. Methods for facilitation may hold the key to successfully activating patients to reach meaningful behavior change goals. In addition to using expert clinical skills in diabetes care, effective facilitators provide support, and empower patients to take ownership of their diabetes. Rigorous evaluation of

> best practices for both the type and methods of delivering content in GMVs is lacking. Translational research to evaluate the relative effectiveness of educational strategies can be leveraged toward the successful scale and spread of this innovative primary care model.

Kochen, M. M. (2007). "[Eight common reasons for counselling. What has changed for family physicians]." MMW Fortschr Med **149**(43): 28.
http://www.ncbi.nlm.nih.gov/pubmed/17992897

Kolasa, K. M. et Rickett, K. (2010). "Barriers to providing nutrition counseling cited by physicians: a survey of primary care practitioners." Nutr. Clin Pract **25**(5): 502-509.
http://www.ncbi.nlm.nih.gov/pubmed/20962310

> In a 1995 pivotal study, Kushner described the attitudes, practice behaviors, and barriers to the delivery of nutrition counseling by primary care physicians. This article recognized nutrition and dietary counseling as key components in the delivery of preventive services by primary care physicians. Kushner called for a multifaceted approach to change physicians' counseling practices. The prevailing belief today is that little has changed. Healthy People 2010 and the U.S. Preventive Task Force identify the need for physicians to address nutrition with patients. The 2010 objective was to increase to 75% the proportion of office visits that included ordering or providing diet counseling for patients with a diagnosis of cardiovascular disease, diabetes, or hypertension. At the midcourse review, the proportion actually declined from 42% to 40%. Primary care physicians continue to believe that providing nutrition counseling is within their realm of responsibility. Yet the gap remains between the proportion of patients who physicians believe would benefit from nutrition counseling and those who receive it from their primary care physician or are referred to dietitians and other healthcare professionals. The barriers cited in recent years continue to be those listed by Kushner: lack of time and compensation and, to a lesser extent, lack of knowledge and resources. The 2010 Surgeon General's Vision for a Healthy and Fit Nation and First Lady Obama's "Let's Move Campaign" spotlight the need for counseling adults and children on diet and physical activity

Koller, D. (2017). "'Kids need to talk too': inclusive practices for children's healthcare education and participation." J Clin Nurs **26**(17-18): 2657-2668.

> AIMS AND OBJECTIVES: To examine how children with chronic medical conditions view healthcare education and decision-making and to propose the application of the universal design for learning in paediatric settings. BACKGROUND: Children and adolescents with chronic medical conditions tend to be excluded from healthcare decision-making. In schools, the universal design for learning promotes access to education and participation in school communities for all children, regardless of their disabilities or medical needs, rendering it an appropriate model for children's participation in healthcare decision-making. DESIGN: This article presents findings from a qualitative study with 26 children and adolescents with chronic medical conditions about their views and experiences with healthcare education and decision-making. METHODS: Twenty-six children and adolescents with chronic medical conditions were interviewed using semi-structured interviews. RESULTS: Findings provide evidence that clinical practices often fail to provide equal opportunities for paediatric patients to understand their condition, share their views and/or participate in decisions regarding their care. CONCLUSIONS: In response to ongoing concerns about paediatric decision-making, we propose that the universal design for learning be adapted in paediatrics. The model presents exemplary programmes as inclusive, accounting for the needs of all children through multiple means of engagement and expression. RELEVANCE TO CLINICAL PRACTICE: A discussion of how the principles of universal design for learning could be applied in paediatric settings is offered for the purpose of advancing ethical and psychosocial care for all children regardless of their age, developmental capacity or condition.

Korwin, A., Black, H., Perez, L., et al. (2017). "Exploring Patient Engagement: A Qualitative Analysis of Low-Income Urban Participants in Asthma Research." J Allergy Clin Immunol Pract **5**(6): 1625-1631.e1622.

BACKGROUND: Uncontrolled asthma is a common highly morbid condition with worse outcomes in low-income and minority patients in part due to barriers accessing and engaging with health care. We developed a patient advocate to educate about and assist with navigating access to care and provider-patient communication. Participants completed an End of Study Questionnaire (ESQ) that was analyzed to assess experience and engagement with the protocol. OBJECTIVE: This study uses qualitative analysis to evaluate participant experience with the patient advocate and control group interventions. METHODS: The ESQ aimed to prompt an open-ended discussion of study experience. Questions were developed from patient focus groups about the patient advocate intervention (PAI), and were revised based on early responses. The questionnaire was administered after 12 months of study participation: 6 months of control or PAI, followed by 6 months of follow-up. Answers were evaluated using qualitative coding and a grounded theory analytical approach. RESULTS: A total of 102 low-income and minority adults with moderate or severe asthma who had completed the study protocol at the time of publication (approximately one-third of total participants) found PAI and control group activities acceptable. Four themes emerged from both groups: (1) appreciation of interpersonal and educational interaction, (2) perception of improved health care adherence, (3) preparedness for physician appointments, (4) improved patient-provider communication. Attention from study personnel and review of asthma-related information was unanimously well received and empowered patients' active health care participation. CONCLUSIONS: Patient engagement and empowerment were elicited by perceived education and personal attention. This study suggests a low-resource, feasible method to improve patient engagement.

Kristiansen, A. M., Svanholm, J. R., Schjodt, I., et al. (2017). "Patients with heart failure as co-designers of an educational website: implications for medical education." Int J Med Educ **8**: 47-58.

Objectives: To identify the learning needs of patients with heart failure between outpatients follow-up visits from their perspective and to ascertain what they emphasize as being important in the design of an educational website for them. Methods: We conducted a two-step qualitative study at Aarhus University Hospital, Denmark. Twenty patients with heart failure participated either in focus group interviews, diary writing, or video-recorded design sessions. Data on learning needs were collected in step 1 and analyses, therefore, helped develop the preliminary prototypes of a website. In step 2, patients worked on the prototypes in video-recorded design sessions, employing a think-aloud method. The interviews were transcribed and a content analysis was performed on the text and video data. Results: Patients' learning needs were multifaceted, driven by anxiety, arising from, and often influenced by, such daily situations and contexts as the medical condition, medication, challenges in daily life, and where to get support and how to manage their self-care. They emphasized different ways of adapting the design to the patient group to enable interaction with peers and professionals and specific interface issues. Conclusions: This study provided insights into the different learning needs of patients with heart failure, how managing daily situations is the starting point for these needs and how emotions play a part in patients' learning. Moreover, it showed how patient co-designers proved to be useful for understanding how to design a website that supports patients' learning: insights, which may become important in designing online learning tools for patients.

Kristensen, M. A. T., Holge-Hazelton, B., Waldorff, F. B., et al. (2017). "How general practitioners perceive and assess self-care in patients with multiple chronic conditions: a qualitative study." BMC Fam Pract **18**(1): 109.

BACKGROUND: It is not known how general practitioners (GPs) perceive the concept of self-care and how they assess self-care ability in patients with multiple chronic conditions. As a part of the strategy to improve the care of people living with chronic conditions, disease management programs in Denmark require GPs and other health care workers to assess and support patients' self-care ability. The aim of the present study was to explore GPs' perceptions and assessment of self-care ability in patients with multiple chronic conditions who have difficulty following a given treatment. METHODS: A qualitative study conducted through in-depth, semi-structured interviews with a purposive sample of 12 GPs in rural areas of Denmark with economically disadvantaged populations. The interviews involved 36 complex patient cases selected by the GPs themselves. Our analysis followed the principles of systematic text condensation. RESULTS: Most GPs in our study had a health-related perception of self-care, but some had a broader perception encompassing the situational context of the patient's life. The GPs' assessments of patients' self-care ability were based on information from the ongoing and often long-term relationships with the patients. GPs identified four major factors that influenced patients' self-care ability, which accumulated and fluctuated over time: multimorbidity, cognitive resources, material resources, and the patients' social contexts. CONCLUSIONS: The GPs in this study had dual perceptions of self-care, related to both the chronic health conditions and to the broader situational contexts of their patients' lives. GPs' assessments of self-care ability depended largely on their experiences from the doctor-patient relationship, and they emphasized that the factors affecting self-care ability were highly dynamic over the patient's lifetime. However, these findings might be resisted by the Danish disease management programs, which tend to have a static and more narrow, health-related view of patient self-care. The Danish programs require GPs to assess self-care ability upfront at the beginning of treatment and do not consider whether a relationship with the patient is established. If GPs' perceptions and assessments of self-care ability are not included in chronic disease management models, there is a risk that they vill be insufficiently implemented in general practice.

Kristiansen, A. M., Svanholm, J. R., Schjodt, I., et al. (2017). "Patients with heart failure as co-designers of an educational website: implications for medical education." Int J Med Educ **8**: 47-58.

Objectives: To identify the learning needs of patients with heart failure between outpatients follow-up visits from their perspective and to ascertain what they emphasize as being important in the design of an educational website for them. Methods: We conducted a two-step qualitative study at Aarhus University Hospital, Denmark. Twenty patients with heart failure participated either in focus group interviews, diary writing, or video-recorded design sessions. Data on learning needs were collected in step 1 and analyses, therefore, helped develop the preliminary prototypes of a website. In step 2, patients worked on the prototypes in video-recorded design sessions, employing a think-aloud method. The interviews were transcribed and a content analysis was performed on the text and video data. Results: Patients' learning needs were multifaceted, driven by anxiety, arising from, and often influenced by, such daily situations and contexts as the medical condition, medication, challenges in daily life, and where to get support and how to manage their self-care. They emphasized different ways of adapting the design to the patient group to enable interaction with peers and professionals and specific interface issues. Conclusions: This study provided insights into the different learning needs of patients with heart failure, how managing daily situations is the starting point for these needs and how emotions play a part in patients' learning. Moreover, it showed how patient co-designers proved to be useful for understanding how to design a website that supports patients' learning: insights, which may become important in designing online learning tools for patients.

Kristensen, M. A. T., Guassora, A. D., Arreskov, A. B., et al. (2018). "'I've put diabetes completely on the shelf till the mental stuff is in place'. How patients with doctor-assessed impaired self-care perceive disease, self-care, and support from general practitioners. A qualitative study." Scand J Prim Health Care **36**(3): 342-351.

OBJECTIVE: This paper investigated patients' experiences of disease and self-care as well as perceptions of the general practitioner's role in supporting patients with impaired self-care ability. DESIGN: Qualitative interviews with 13 patients with type 2 diabetes, concurrent chronic diseases, and impaired self-care ability assessed by a general practitioner. We analyzed our data using systematic text condensation. The shifting perspectives model of chronic illness formed the theoretical background for the study. RESULTS: Although most patients experienced challenges in adhering to recommended self-care activities, many had developed additional, personal self-care routines that increased wellbeing. Some patients were conscious of self-care trade-offs, including patients with concurrent mental disorders who were much more attentive to their mental disorder than their somatic diseases. Patients' perspectives on diseases could shift over time and were dominated by emotional considerations such as insisting on leading a normal life or struggling with limitations caused by disease. Most patients found support in the ongoing relationship with the same general practitioner, who was valued as a companion or appreciated as a trustworthy health informant. CONCLUSION: Patient experiences of self-care may collide with what general practitioners find appropriate in a medical regimen. Health professionals should be aware of patients' prominent and shifting considerations about the emotional aspects of disease. Patients valued the general practitioner's role in self-care support, primarily through the long-term doctor-patient relationship. Therefore, relational continuity should be prioritized in chronic care, especially for patients with impaired self-care ability who often have a highly complex disease burden and situational context. Key points Little is known about the perspectives of disease and self-care in patients with a doctor-assessed impaired ability of self-care. • Although patients knew the prescribed regimen they often prioritized self-care routines that increased well-being at the cost of medical recommendations. • Shifting emotional aspects were prominent in patients' considerations of disease and sustained GPs' use of a patient-centred clinical method when discussing self-care. • Relational continuity with general practitioners was a highly valued support and should be prioritized for patients with impaired self-care.

Krska, J., Allison, K., Delargy, M., et al. (2012). "Implementing a statin switching programme in primary care: patients' views and experiences." Br J Clin Pharmacol **74**(1): 147-153.
http://www.ncbi.nlm.nih.gov/pubmed/22257274

WHAT IS ALREADY KNOWN ABOUT THIS SUBJECT: * Switching of patients' prescribed medicines within a therapeutic class is a common strategy to reduce prescribing costs, and in England a standard methodology has been promoted for switching processes. * Previous work to date suggests many patients are sceptical of generic products and switching may reduce compliance. * Patients' views on switching in general and the processes used have not been widely sought. WHAT THIS STUDY ADDS: * Patients may be less accepting of therapeutic switching programmes than is currently assumed. * Patients lacked understanding of the reason for the switch, despite standard letters and information leaflets being used, and few sought consultations. * Greater explanation of switching, possibly with involvement of community pharmacists, could lead to improved patient understanding and acceptance. INTRODUCTION Estimates suggest pound200 million could be saved on prescribing costs in England by implementing medication switches. Few studies have evaluated patients' views or understanding of therapeutic switches. AIM: To obtain patient and pharmacist perspectives on switching from atorvastatin to simvastatin within an English Primary Care Trust (PCT). METHOD: All patients undergoing this switch, in seven self-selected East Lancashire practices, were sent postal questionnaires covering demographics, experiences and views regarding switching, with no reminder. Practice pharmacists implementing switches in these practices were interviewed about processes and their views on these. RESULTS: Pharmacists' switching process involved a standard letter offering a telephone consultation or appointment, plus an information leaflet. They considered most patients accepted switches, with few requesting consultations. Four hundred and ninety-four patients were identified and a response rate of 48.6% (240) obtained. The majority of respondents were happy with the switch (53.7%) and how they were informed (60.1%), with these findings being positively correlated. However over half (52.9%) did not understand the reason for the switch, particularly those with lower educational qualifications. Patients unhappy about switching perceived they had experienced side effects, or only learned of the switch on collecting a prescription or did not recall the consultation offer. Respondents indicated a preference for future switches to involve a face-to-face consultation (59.8%), with two-thirds (65.2%) agreeing that community pharmacists should explain medication switches. CONCLUSION: The standard process used, in line with nationally-designed templates, resulted in many patients being unhappy with or lacking understanding of switching statins, suggesting that improvements may be needed

Laidsaar-Powell, R. C., Butow, P. N., Bu, S., et al. (2013). "Physician-patient-companion communication and decision-making: a systematic review of triadic medical consultations." Patient Educ Couns **91**(1): 3-13.

OBJECTIVE: To systematically review quantitative and qualitative studies exploring physician-adult patient-adult companion (triadic) communication and/or decision-making within all medical encounters. METHODS: Studies were identified via database searches and reference lists. One author assessed eligibility of studies, verified by two co-authors. Data were extracted by one author and cross-checked for accuracy. Two authors assessed the quality of included articles using standardized criteria. RESULTS: Of the 8409 titles identified, 52 studies were included. Summary statements and tables were developed for each of five identified themes. Results indicated companions regularly attended consultations, were frequently perceived as helpful, and assumed a variety of roles.

However, their involvement often raised challenges. Patients with increased need were more often accompanied. Some companion behaviours were felt to be more helpful (e.g. informational support) and less helpful (e.g. dominating/demanding behaviours), and preferences for involvement varied widely. CONCLUSION: Triadic communication in medical encounters can be helpful but challenging. Based on analysis of included studies, preliminary strategies for health professionals are proposed. PRACTICE IMPLICATIONS: Preliminary strategies for health professionals include (i) encourage/involve companions, (ii) highlight helpful companion behaviours, (iii) clarify and agree upon role preferences of patient/companions. Future studies should develop and evaluate specific strategies for optimizing triadic consultations.

Lall, D. et Prabhakaran, D. (2014). "Organization of primary health care for diabetes and hypertension in high, low and middle income countries." Expert Rev Cardiovasc Ther **12**(8): 987-995.

Chronic non-communicable diseases, predominantly diabetes and cardiovascular disease are a major public health problem globally. The chronicity of these diseases necessitates a restructuring of healthcare to address the multidisciplinary, sustained care including psychosocial support and development of self-management skills. Primary healthcare with elements of the chronic-care model provides the best opportunity for engagement with the health system. In this review, the authors discuss aspects of primary healthcare for management of diabetes and hypertension and innovations such as mobile-phone messaging, web-based registries, computer-based decision support systems and multifaceted health professionals in the care team among others that are being tested to improve the quality of care for these diseases in high, middle and low-income countries. The goal of quality care for diabetes and hypertension demands innovation within the realities of health systems both in high as well as low and middle-income countries.

Lamiani, G. et Furey, A. (2009). "Teaching nurses how to teach: an evaluation of a workshop on patient education." Patient Educ Couns **75**(2): 270-273.

OBJECTIVE: To evaluate the effects of a patient education workshop on nurses: (1) communication skills; (2) Knowledge of patient-centered model, patient education process, and sense of preparedness to provide patient education. METHODS: Fourteen nurses attended a 2-day workshop on patient education based on a patient-centered model. Data on communication skills were collected by means of pre-/post-written dialogues and analyzed with the Roter Interaction Analysis System (RIAS). Data of nurses' knowledge and sense of preparedness were collected through a post questionnaire comprised of 5-point Likert scale items. RESULTS: Post-dialogues showed an increase in patient talking (P<0.001) and in patient-centered communication as indicated by the increase in Psychosocial exchanges (P=0.003) and Process exchanges (P=0.001). Nurses reported that the workshop increased "very much" their knowledge of the patient-centered model (mean=4.19) and patient education process (mean=4.69), and their sense of preparedness to provide patient education (P=0.001). CONCLUSIONS: Data suggest the efficacy of the workshop in developing patient-centered communication skills and improving nurses' knowledge and preparedness to deliver patient education. PRACTICE IMPLICATIONS: Training based on a patient-centered model and interactive learning methods should be implemented for nurses to improve their ability to deliver effective patient education.

Land, V., Parry, R. et Seymour, J. (2017). "Communication practices that encourage and constrain shared decision making in health-care encounters: Systematic review of conversation analytic research." Health Expect **20**(6): 1228-1247.

BACKGROUND: Shared decision making (SDM) is generally treated as good practice in health-care interactions. Conversation analytic research has yielded detailed findings about decision making in health-care encounters. OBJECTIVE: To map decision making communication practices relevant to health-care outcomes in face-to-face interactions yielded by prior conversation analyses, and to examine their function in relation to SDM. SEARCH STRATEGY: We searched nine electronic databases (last search November 2016) and our own and other academics' collections. INCLUSION CRITERIA: Published conversation analyses (no restriction on publication dates) using recordings of health-care encounters in English where the patient (and/or companion) was present and where the data and analysis focused on health/illness-related decision making. DATA EXTRACTION AND SYNTHESIS: We extracted study characteristics, aims, findings relating to communication practices, how these functioned in relation to SDM, and internal/external validity issues. We synthesised findings aggregatively. RESULTS: Twenty-eight publications met the inclusion criteria. We sorted findings into 13 types of communication practices and organized these in relation to four elements of decision-making sequences: (i) broaching decision making; (ii) putting forward a course of action; (iii) committing or not (to the action put forward); and (iv) HCPs' responses to patients' resistance or withholding of commitment. Patients have limited opportunities to influence decision making. HCPs' practices may constrain or encourage this participation. CONCLUSIONS: Patients, companions and HCPs together treat and undertake decision making as shared, though to varying degrees. Even for non-negotiable treatment trajectories, the spirit of SDM can be invoked through practices that encourage participation (eg by bringing the patient towards shared understanding of the decision's rationale).

Landmark, A. M. D., Ofstad, E. H. et Svennevig, J. (2017). "Eliciting patient preferences in shared decision-making (SDM): Comparing conversation analysis and SDM measurements." Patient Educ Couns **100**(11): 2081-2087.

OBJECTIVE: To explore how physicians bring up patient preferences, and how it aligns with assessments of shared decision-making. METHODS: Qualitative conversation analysis of physicians formulating hypotheses about the patient's treatment preference was compared with quantitative scores on SDM and 'patient preferences' using OPTION(5) and MAPPIN'SDM. RESULTS: Physicians occasionally formulate hypotheses about patients' preferences and then present a treatment option on the basis of that ("if you think X+we can do Y"). This practice may promote SDM in that the decisions are treated as contingent on patient preferences. However, the way these hypotheses are formulated, simultaneously constrains the patient's freedom of choice and exerts a pressure to accept the physician's recommendation. These opposing effects may in part explain cases where different assessment instruments yield large variations in SDM measures. CONCLUSION: Eliciting patient preferences is a complex phenomenon that can be difficult to reduce into an accurate number. Detailed analysis can shed light on how patient preferences are elicited, and its consequences for patient involvement. Comparing CA and SDM measurements can contribute to specifying communicative actions that SDM scores are based on. PRACTICE IMPLICATIONS: Our findings have implications for SDM communication skills training and further development of SDM measurements.

Larson, A., Ward, J., Ross, L., et al. (2010). "Impact of structured education and self management on rural asthma outcomes." Aust Fam Physician **39**(3): 141-144.

BACKGROUND: This study trialled the outcome for asthma patients of a brief, nurse led, patient education session with general practice review of an Asthma Action Plan. METHODS: Prospective cohort with before-after measures conducted in six rural general practices. Outcome measures were changes over 12 months in self reported asthma control, quality of life, device use, and unscheduled general practice and emergency department visits for asthma exacerbation. RESULTS: Eighty-three patients participated. Mean asthma control score decreased but did not reach statistical significance (p=0.124). Quality of life improved for adults (Wilcoxon rank signed test for two related samples p<0.001). The proportion of patients who had one or more unscheduled visits to their general practitioner over 12 months decreased from 23% to 13% (p=0.178) and emergency department presentations decreased from 9% to 4% (p=0.102). DISCUSSION: Structured general practice based education appears to be an effective preventive health care program, with the potential to reduce expensive unscheduled use of health services.

Le Faou, A.-L. (2007). La prise en charge des maladies chroniques à l'étranger. Actualite et Dossier en Sante Publique //
Les affections de longue durée.

[BDSP. Notice produite par ENSP VR0xMx3g. Diffusion soumise à autorisation]. Le disease management, ou organisation coordonnée des soins, est appliqué aux maladies chroniques dans de nombreux pays (États-Unis, Allemagne, Royaume-Uni). Cette méthode est-elle adaptable au système de santé français ? Cet article tente de répondre à cette interrogation

Lee, A., Siu, C. F., Leung, K. T., et al. (2011). "General practice and social service partnership for better clinical outcomes, patient self efficacy and lifestyle behaviours of diabetic care: randomised control trial of a chronic care model." Postgrad. Med J **87**(1032): 688-693.
http://www.ncbi.nlm.nih.gov/pubmed/21693570

BACKGROUND: The International Diabetes Attitudes, Wishes, and Needs (DAWN) programmes have shown the existence of a critical gap in self management support and access to the support system. This study aims to evaluate the effectiveness of the diabetes mellitus (DM) self management programme, with partnership between general practice and social work, on clinical outcomes, patient self efficacy and lifestyle behaviours. METHODS: In this is single blind randomised controlled trial, subjects were recruited from patients attending general outpatient clinics in the Hospital Authority New Territory East Cluster of Hong Kong. 157 subjects meeting the inclusion criteria completed the study and were randomly assigned to the experimental or control group. The experimental group underwent the six sessions of weekly DM self management course with emphasis on self efficacy and participatory approach. The outcome measurements included HbA1c concentration, DM self efficacy scale, dietary behaviours, body mass index (BMI), and waist: hip ratio. RESULTS: Baseline assessment observed no significant differences between experimental and control groups for the variables related to outcomes. For the experimental group, the proportion of subjects with normal HbA1c increased from 4.5% (3/66) at baseline to 28.6% (19/66) at week 28 (p<0.001), but there was insignificant improvement in the control group (3.9% to 11.8%, p=0.13). Repeated measure of analysis of variance showed pronounced improvement in DM self efficacy scale and BMI among the experimental group with significant interaction. Dietary behaviours also improved significantly in the experimental group. CONCLUSION: The DM care model with partnership between general practice and social work demonstrated better diabetic control with improvement of self efficacy and minimisation of risk behaviours. TRIAL REGISTRATION: Current Controlled Trials ISRCTN78882965

Lee, J., Hardesty, L. A., Kunzler, N. M., et al. (2016). "Direct Interactive Public Education by Breast Radiologists About Screening Mammography: Impact on Anxiety and Empowerment." J Am Coll Radiol **13**(11s): R89-r97.

PURPOSE: Anxiety has been called a "harm" of screening mammography. The authors provided direct, interactive education to lay audiences and measured these sessions' impact on anxiety and any increased understanding of breast cancer screening. METHODS: Academic breast radiologist provided seven 1-hour sessions of structured lectures and question-and-answer periods. Lay language and radiologic images were used to discuss disease background, screening guidelines, and areas of debate. One hundred seventeen participants (mean age, 45 +/- 15 years) completed voluntary, anonymous, institutional review board-approved pre and postsession questionnaires relaying their attitudes regarding screening and the impact of the sessions. Results are summarized descriptively. RESULTS: Mean reported anxiety regarding screening (on a scale ranging from 1-5; 1 = no anxiety) was 2.5 +/- 1.3. Anxiety was attributed to unknown results (56.4%), anticipation of pain (21.8%), known risk factors (14.5%), general uncertainty (12.7%), waiting for results (9.1%), possibility of more procedures (3.6%), and personal breast cancer history (3.6%). Ninety-seven percent reported that immediate results would lower anxiety (78% of those women indicated a 75%-100% decrease in anxiety); 93% reported that radiologist consultation with images would lower anxiety (75.6% indicated a 75%-100% decrease in anxiety). After the lecture, women reported (on a scale ranging from 1-5) increased understanding of the topic (4.7 +/- 0.6), encouragement to screen (4.6 +/- 0.7), and reduced anxiety (4.0 +/- 1.1). Ninety-seven percent to 100% provided correct responses to these questions: rationale for screening in the absence of family history, recall does not equate to cancer diagnosis, benefit of prior films, and continued importance of physical examination. CONCLUSION: Attendees of radiologist-provided direct public lectures reported decreased anxiety and improved knowledge regarding screening mammography. The resultant reduced anxiety ("harm") and educational empowerment help enable informed decision making and may promote screening attendance.

Legare, F., Ratte, S., Gravel, K., et al. (2008). "Barriers and facilitators to implementing shared decision-making in clinical practice: update of a systematic review of health professionals' perceptions." Patient Educ Couns **73**(3): 526-535.

> OBJECTIVE: To update a systematic review on the barriers and facilitators to implementing shared decision-making in clinical practice as perceived by health professionals. METHODS: From March to December 2006, PubMed, Embase, CINHAL, PsycINFO, and Dissertation Abstracts were searched. Studies were included if they reported on health professionals' perceived barriers and facilitators to implementing shared decision-making in practice. Quality of the included studies was assessed. Content analysis was performed with a pre-established taxonomy. RESULTS: Out of 1130 titles, 10 new eligible studies were identified for a total of 38 included studies compared to 28 in the previous version. The vast majority of participants (n=3231) were physicians (89%). The three most often reported barriers were: time constraints (22/38) and lack of applicability due to patient characteristics (18/38) and the clinical situation (16/38). The three most often reported facilitators were: provider motivation (23/38) and positive impact on the clinical process (16/38) and patient outcomes (16/38). CONCLUSION: This systematic review update confirms the results of the original review. PRACTICE IMPLICATIONS: Interventions to foster implementation of shared decision-making in clinical practice will need to address a range of factors.

Legare, F., Turcotte, S., Stacey, D., et al. (2012). "Patients' perceptions of sharing in decisions: a systematic review of interventions to enhance shared decision making in routine clinical practice." Patient **5**(1): 1-19.

> BACKGROUND: Shared decision making is the process in which a healthcare choice is made jointly by the health professional and the patient. Little is known about what patients view as effective or ineffective strategies to implement shared decision making in routine clinical practice. OBJECTIVE: This systematic review evaluates the effectiveness of interventions to improve health professionals' adoption of shared decision making in routine clinical practice, as seen by patients. DATA SOURCES: We searched electronic databases (PubMed, the Cochrane Library, EMBASE, CINAHL, and PsycINFO) from their inception to mid-March 2009. We found additional material by reviewing the reference lists of the studies found in the databases; systematic reviews of studies on shared decision making; the proceedings of various editions of the International Shared Decision Making Conference; and the transcripts of the Society for Medical Decision Making's meetings. STUDY SELECTION: In our study selection, we included randomized controlled trials, controlled clinical trials, controlled before-and-after studies, and interrupted time series analyses in which patients evaluated interventions to improve health professionals' adoption of shared decision making. The interventions in question consisted of the distribution of printed educational material; educational meetings; audit and feedback; reminders; and patient-mediated initiatives (e.g. patient decision aids). STUDY APPRAISAL: Two reviewers independently screened the studies and extracted data. Statistical analyses considered categorical and continuous process measures. We computed the standardized effect size for each outcome at the 95% confidence interval. The primary outcome of interest was health professionals' adoption of shared decision making as reported by patients in a self-administered questionnaire. RESULTS: Of the 6764 search results, 21 studies reported 35 relevant comparisons. Overall, the quality of the studies ranged from 0% to 83%. Only three of the 21 studies reported a clinically significant effect for the primary outcome that favored the intervention. The first study compared an educational meeting and a patient-mediated intervention with another patient-mediated intervention (median improvement of 74%). The second compared an educational meeting, a patient-mediated intervention, and audit and feedback with an educational meeting on an alternative topic (improvement of 227%). The third compared an educational meeting and a patient-mediated intervention with usual care (p = 0.003). All three studies were limited to the patient-physician dyad. LIMITATIONS: To reduce bias, future studies should improve methods and reporting, and should analyze costs and benefits, including those associated with training of health professionals. CONCLUSIONS: Multifaceted interventions that include educating health professionals about sharing decisions with patients and patient-mediated interventions, such as patient decision aids, appear promising for improving health professionals' adoption of shared decision making in routine clinical practice as seen by patients.

Lenferink, A., Brusse-Keizer, M., van der Valk, P. D., et al. (2017). "Self-management interventions including action plans for exacerbations versus usual care in patients with chronic obstructive pulmonary disease." Cochrane Database Syst Rev **8**: Cd011682.

BACKGROUND: Chronic Obstructive Pulmonary Disease (COPD) self-management interventions should be structured but personalised and often multi-component, with goals of motivating, engaging and supporting the patients to positively adapt their behaviour(s) and develop skills to better manage disease. Exacerbation action plans are considered to be a key component of COPD self-management interventions. Studies assessing these interventions show contradictory results. In this Cochrane Review, we compared the effectiveness of COPD self-management interventions that include action plans for acute exacerbations of COPD (AECOPD) with usual care. OBJECTIVES: To evaluate the efficacy of COPD-specific self-management interventions that include an action plan for exacerbations of COPD compared with usual care in terms of health-related quality of life, respiratory-related hospital admissions and other health outcomes. SEARCH METHODS: We searched the Cochrane Airways Group Specialised Register of trials, trials registries, and the reference lists of included studies to May 2016. SELECTION CRITERIA: We included randomised controlled trials evaluating a self-management intervention for people with COPD published since 1995. To be eligible for inclusion, the self-management intervention included a written action plan for AECOPD and an iterative process between participant and healthcare provider(s) in which feedback was provided. We excluded disease management programmes classified as pulmonary rehabilitation or exercise classes offered in a hospital, at a rehabilitation centre, or in a community-based setting to avoid overlap with pulmonary rehabilitation as much as possible. DATA COLLECTION AND ANALYSIS: Two review authors independently assessed trial quality and extracted data. We resolved disagreements by reaching consensus or by involving a third review author. Study authors were contacted to obtain additional information and missing outcome data where possible. When appropriate, study results were pooled using a random-effects modelling meta-analysis. The primary outcomes of the review were health-related quality of life (HRQoL) and number of respiratory-related hospital admissions. MAIN RESULTS: We included 22 studies that involved 3,854 participants with COPD. The studies compared the effectiveness of COPD self-management interventions that included an action plan for AECOPD with usual care. The follow-up time ranged from two to 24 months and the content of the interventions was diverse.Over 12 months, there was a statistically significant beneficial effect of self-management interventions with action plans on HRQoL, as measured by the St. George's Respiratory Questionnaire (SGRQ) total score, where a lower score represents better HRQoL. We found a mean difference from usual care of -2.69 points (95% CI -4.49 to -0.90; 1,582 participants; 10 studies; high-quality evidence). Intervention participants were at a statistically significant lower risk for at least one respiratory-related hospital admission compared with participants who received usual care (OR 0.69, 95% CI 0.51 to 0.94; 3,157 participants; 14 studies; moderate-quality evidence). The number needed to treat to prevent one respiratory-related hospital admission over one year was 12 (95% CI 7 to 69) for participants with high baseline risk and 17 (95% CI 11 to 93) for participants with low baseline risk (based on the seven studies with the highest and lowest baseline risk respectively).There was no statistically significant difference in the probability of at least one all-cause hospital admission in the self-management intervention group compared to the usual care group (OR 0.74, 95% CI 0.54 to 1.03; 2467 participants; 14 studies; moderate-quality evidence). Furthermore, we observed no statistically significant difference in the number of all-cause hospitalisation days, emergency department visits, General Practitioner visits, and dyspnoea scores as measured by the (modified) Medical Research Council questionnaire for self-management intervention participants compared to usual care participants. There was no statistically significant effect observed from self-management on the number of COPD exacerbations and no difference in all-cause mortality observed (RD 0.0019, 95% CI -0.0225 to 0.0263; 3296 participants; 16 studies; moderate-quality evidence). Exploratory analysis showed a very small, but significantly higher respiratory-related mortality rate in the self-management intervention group compared to the usual care group (RD 0.028, 95% CI 0.0049 to 0.0511; 1219 participants; 7 studies; very low-quality evidence).Subgroup analyses showed significant improvements in HRQoL in self-management interventions with a smoking cessation programme (MD -4.98, 95% CI -7.17 to -2.78) compared to studies without a smoking cessation programme (MD -1.33, 95% CI -2.94 to 0.27, test for subgroup differences: Chi(2) = 6.89, df = 1, P = 0.009, I(2) = 85.5%). The number of behavioural change techniques clusters integrated in the self-management intervention,

the duration of the intervention and adaptation of maintenance medication as part of the action plan did not affect HRQoL. Subgroup analyses did not detect any potential variables to explain differences in respiratory-related hospital admissions among studies. AUTHORS' CONCLUSIONS: Self-management interventions that include a COPD exacerbation action plan are associated with improvements in HRQoL, as measured with the SGRQ, and lower probability of respiratory-related hospital admissions. No excess all-cause mortality risk was observed, but exploratory analysis showed a small, but significantly higher respiratory-related mortality rate for self-management compared to usual care.For future studies, we would like to urge only using action plans together with self-management interventions that meet the requirements of the most recent COPD self-management intervention definition. To increase transparency, future study authors should provide more detailed information regarding interventions provided. This would help inform further subgroup analyses and increase the ability to provide stronger recommendations regarding effective self-management interventions that include action plans for AECOPD. For safety reasons, COPD self-management action plans should take into account comorbidities when used in the wider population of people with COPD who have comorbidities. Although we were unable to evaluate this strategy in this review, it can be expected to further increase the safety of self-management interventions. We also advise to involve Data and Safety Monitoring Boards for future COPD self-management studies.

Leutgeb, R., Mahler, C., Laux, G., et al. (2009). "[Health insurance discount contracts: problems and risks for the general practitioner in the medical care of patients with chronic illness]." Dtsch. Med Wochenschr **134**(5): 181-186.
http://www.ncbi.nlm.nih.gov/pubmed/19180404

BACKGROUND AND OBJECTIVE: The German federal Health Insurance law to strengthen competition between the pharmaceutical companies commits pharmacies to hand out drugs from discount contract drug suppliers of a patient's health insurance company. Thus patients are confronted with constantly changing drug packets. This study aimed at exploring whether patients have been properly informed about the new discount contracts and if they have experienced changes and problems in their long- term medications. METHODS: Between May and June 2008 male and female patients older than 50 years who had a statutory health insurance and had been diagnosed with coronary heart disease for at least one year answered a standardized questionnaire filled in by doctors' assistants or general practitioners in the doctors' network "Weschnitztal". RESULTS: Of the 188 patients participated in this study 63,8% were informed about health insurance discount contracts. 31,3% of the patients reported that a positive effect due to the discount contracts was that they were discharged from paying the drug prescription fee, 22,2% mentioned that cost saving for the health insurance could also be positive. 120 patients (63,8%) knew that the names of their long-term drugs could change.101 of the questioned patients (53,7%) identified a change in their long-term drugs, 51,5% felt insecure about the permanent changes. 21,7% experienced adverse e effects due to the new drugs. 19% of the patients had serious problems regarding medication intake. CONCLUSION: This study demonstrates that the information which patients have on the new health insurance law is not adequate enough. Many of them felt insecure because of the changes of long-term medications. One fifth of the patients reported errors in their drug intake or their confusion about their drugs. There is a high risk that these circumstances may trigger further diseases or complications. The cost savings as intended by the health insurance companies may therefore not be achieved by discount contracts

Leveille, S. G., Huang, A., Tsai, S. B., et al. (2009). "Health coaching via an internet portal for primary care patients with chronic conditions: a randomized controlled trial." Med Care **47**(1): 41-47.
http://www.ncbi.nlm.nih.gov/pubmed/19106729

BACKGROUND: Efforts to enhance patient-physician communication may improve management of underdiagnosed chronic conditions. Patient internet portals offer an efficient venue for coaching patients to discuss chronic conditions with their primary care physicians (PCP). OBJECTIVES: We sought to test the effectiveness of an internet portal-based coaching intervention to promote patient-PCP discussion about chronic conditions. RESEARCH DESIGN: We conducted a randomized trial of a nurse coach intervention conducted entirely through a patient internet-portal. SUBJECTS: Two hundred forty-one patients who were registered portal users with scheduled PCP appointments were screened through the portal for 3 target conditions, depression, chronic pain, mobility difficulty, and randomized to intervention and control groups. MEASURES: One-week and 3-month patient surveys assessed visit experiences, target conditions, and quality of life; chart abstractions assessed diagnosis and management during PCP visit. RESULTS: Similar high percentages of intervention (85%) and control (80%) participants reported discussing their screened condition during their PCP visit. More intervention than control patients reported their PCP gave them specific advice about their health (94% vs. 84%; P = 0.03) and referred them to a specialist (51% vs. 28%; P = 0.002). Intervention participants reported somewhat higher satisfaction than controls (P = 0.07). Results showed no differences in detection or management of screened conditions, symptom ratings, and quality of life between groups. CONCLUSIONS: Internet portal-based coaching produced some possible benefits in care for chronic conditions but without significantly changing patient outcomes. Limited sample sizes may have contributed to insignificant findings. Further research should explore ways internet portals may improve patient outcomes in primary care. ClinicalTrials.gov registration NCT00130416

Levy, B. T., Joshi, M., Xu, Y., et al. (2008). "Perceptions of Iowa family physicians regarding colorectal cancer screening." Med Care **46**(9 Suppl 1): S103-S108.
http://www.ncbi.nlm.nih.gov/pubmed/18725821

BACKGROUND: Fewer than half of Americans have been screened for colorectal cancer (CRC), a largely preventable disease. METHODS: All physician members (n = 1030) of the Iowa Academy of Family Physicians were mailed a 3-page investigator-developed survey about their attitudes, barriers, and practices regarding CRC screening. RESULTS: The usable response rate was 29%. Forty-three percent practiced in rural settings. Ninety-five percent felt that they were well informed about American Cancer Society guidelines and 90% tried to follow the guidelines. Most doctors (88%) disagreed with the statement that there was "no time to adequately discuss screening," but they would like more time to discuss screening. Only 40% felt their medical records were organized to easily determine screening status, 40% encouraged office staff to participate in screening, and 16% had a written policy regarding CRC screening. Physicians estimated that they recommend screening to 78% of their patients and that 54% of their patients were actually up-to-date. Discussion of CRC screening was strongly dependent on visit type, with physicians estimating that CRC screening is discussed at 11% of acute visits, 42% of chronic visits, and 87% of health maintenance visits. Several office system factors were associated with a recommendation for screening in a multivariable linear regression model (R = 0.33). CONCLUSIONS: Although nearly all physicians felt that they were well informed about American Cancer Society guidelines and tried to follow guidelines for CRC screening, few had office systems to facilitate screening. Physicians would like more time to discuss screening. Office systems likely have the most potential to improve CRC screening among patients attending primary care practices

Liddy, C., Johnston, S., Nash, K., et al. (2014). "Health coaching in primary care: a feasibility model for diabetes care." BMC Fam Pract **15**: 60.

BACKGROUND: Health coaching is a new intervention offering a one-on-one focused self-management support program. This study implemented a health coaching pilot in primary care clinics in Eastern Ontario, Canada to evaluate the feasibility and acceptability of integrating health coaching into primary care for patients who were either at risk for or diagnosed with diabetes. METHODS: We implemented health coaching in three primary care practices. Patients with diabetes were offered six months of support from their health coach, including an initial face-to-face meeting and follow-up by email, telephone, or face-to-face according to patient preference. Feasibility was assessed through provider focus groups and qualitative data analysis methods. RESULTS: All three sites were able to implement the program. A number of themes emerged from the focus groups, including the importance of physician buy-in, wide variation in understanding and implementing of the health coach role, the significant impact of different systems of team communication, and the significant effect of organizational structure and patient readiness on Health coaches' capacity to perform their role. CONCLUSIONS: It is feasible to implement health coaching as an integrated program within small primary care clinics in Canada without adding additional resources into the daily practice. Practices should review their organizational and communication processes to ensure optimal support for health coaches if considering implementing this intervention.

Lillyman, S. et Farquharson, N. (2013). "Self-care management education models in primary care." Br J Community Nurs **18**(11): 556-560.

> Self-care management for people living with long-term conditions aims to assist the individual in taking responsibility for their own health. This literature review explores the value and content of the large range of educational models currently in use. Although no single model was found that addressed all the issues, several themes arose. These included the observation that educational models should be based on self-efficacy principles and patient-centred. Method of delivery favoured small groups, using a variety of approaches supported with written information. Duration of the programmes was mainly 6-8 weeks with a follow-up. Programmes should be offered when the patient is ready and not determined by the condition or at diagnosis. Debate remains over whether group leaders should be laypeople and professionals; however, a mixture of both offered the best outcomes. Programmes should not be problem-focused, offering space for support and experience sharing.

Lin, C., Cohen, E., Livingston, P. M., et al. (2019). "Perceptions of patient participation in symptom management: A qualitative study with cancer patients, doctors, and nurses." J Adv Nurs **75**(2): 412-422.

> AIM: To explore people with cancer, doctors', and nurses' understanding of and attitudes toward, patient participation in symptom management. BACKGROUND: In health service policies worldwide, patients are recognized as the important members of the treatment care team. The concept of patient participation can be understood from a variety of perspectives, reflecting the limited conceptual clarity and poor congruence between patients' and clinicians' understanding. DESIGN: A qualitative study conducted using individual interviews. METHODS: Forty one people with cancer, five doctors, and seven nurses were recruited from two oncological medical units of a cancer specialized hospital in Shanghai, China between November 2013 - March 2014. Individual interviews were semi-structured. Data were analysed through framework analysis. RESULTS: Patient participation was perceived as a mutual interaction requiring contribution from both patients and clinicians. Three main themes were uncovered: (a) information exchange is the key to patient participation; (b) negotiated decision-making can be achieved in various ways; and (c) patients' self-management can be a form of patient participation. Patient participation was recognized by both patients and clinicians as an important component of cancer care, however concerns relating to patients' limited knowledge and their ability to negotiate treatment decisions existed among most of the patients, doctors, and nurses. CONCLUSION: This study identified the wide range of activities where patient participation can occur in the context of cancer care. Positive recognition of patients' roles in treatment and care should be advocated among both patients and clinicians to facilitate patients' participation in their own care and enhance clinicians' skills in involving patients.

Little, P., Everitt, H., Williamson, I., et al. (2001). "Observational study of effect of patient centredness and positive approach on outcomes of general practice consultations." BMJ **323**(7318): 908-911.

> OBJECTIVE: To measure patients' perceptions of patient centredness and the relation of these perceptions to outcomes. DESIGN: Observational study using questionnaires. SETTING: Three general practices. PARTICIPANTS: 865 consecutive patients attending the practices. MAIN OUTCOME MEASURES: Patients' enablement, satisfaction, and burden of symptoms. RESULTS: Factor analysis identified five components. These were communication and partnership (a sympathetic doctor interested in patients' worries and expectations and who discusses and agrees the problem and treatment, Cronbach's alpha=0.96); personal relationship (a doctor who knows the patient and their emotional needs, alpha=0.89); health promotion (alpha=0.87); positive approach (being definite about the problem and when it would settle, alpha=0.84); and interest in effect on patient's life (alpha=0.89). Satisfaction was related to communication and partnership (adjusted beta=19.1; 95% confidence interval 17.7 to 20.7) and a positive approach (4.28; 2.96 to 5.60). Enablement was greater with interest in the effect on life (0.55; 0.25 to 0.86), health promotion (0.57; 0.30 to 0.85), and a positive approach (0.82; 0.52 to 1.11). A positive approach was also associated with reduced symptom burden at one month (beta=-0.25; -0.41 to -0.10). Referrals were fewer if patients felt they had a personal relationship with their doctor (odds ratio 0.70; 0.54 to 0.90). CONCLUSIONS: Components of patients'

perceptions can be measured reliably and predict different outcomes. If doctors don't provide a positive, patient centred approach patients will be less satisfied, less enabled, and may have greater symptom burden and higher rates of referral.

Loeb, D. F., Bayliss, E. A., Candrian, C., et al. (2016). "Primary care providers' experiences caring for complex patients in primary care: a qualitative study." BMC Fam Pract **17**: 34.

BACKGROUND: Complex patients are increasingly common in primary care and often have poor clinical outcomes. Healthcare system barriers to effective care for complex patients have been previously described, but less is known about the potential impact and meaning of caring for complex patients on a daily basis for primary care providers (PCPs). Our objective was to describe PCPs' experiences providing care for complex patients, including their experiences of health system barriers and facilitators and their strategies to enhance provision of effective care. METHODS: Using a general inductive approach, our qualitative research study was guided by an interpretive epistemology, or way of knowing. Our method for understanding included semi-structured in-depth interviews with internal medicine PCPs from two university-based and three community health clinics. We developed an interview guide, which included questions on PCPs' experiences, perceived system barriers and facilitators, and strategies to improve their ability to effectively treat complex patients. To focus interviews on real cases, providers were asked to bring de-identified clinical notes from patients they considered complex to the interview. Interview transcripts were coded and analyzed to develop categories from the raw data, which were then conceptualized into broad themes after team-based discussion. RESULTS: PCPs (N = 15) described complex patients with multidimensional needs, such as socio-economic, medical, and mental health. A vision of optimal care emerged from the data, which included coordinating care, preventing hospitalizations, and developing patient trust. PCPs relied on professional values and individual care strategies to overcome local and system barriers. Team based approaches were endorsed to improve the management of complex patients. CONCLUSIONS: Given the barriers to effective care described by PCPs, individual PCP efforts alone are unlikely to meet the needs of complex patients. To fulfill PCP's expressed concepts of optimal care, implementation of effective systemic approaches should be considered.

Lor, M. et Martinez, G. A. (2020). "Scoping review: Definitions and outcomes of patient-provider language concordance in healthcare." Patient Education and Counseling **103**(10): 1883-1901.
http://www.sciencedirect.com/science/article/pii/S0738399120302913

Objective To conduct a scoping literature review to understand the conceptualization and nature of the research on patient–provider language concordance (LC) in health care. Methods We searched PubMed, EMBASE, CINAHL, PsycINFO, and Scopus to identify peer-reviewed articles between January 1961 and August 2018. We extracted study characteristics, content, definitions, and findings. Results Fifty studies were included. Forty studies were quantitative, seven were qualitative, and three were mixed methods. Overall, the studies revealed inconsistent definitions and measures of patient–provider LC. Outcomes studied in connection to LC included: (1) interpersonal relationships, (2) access to health information, (3) access to care, (4) satisfaction and health-care experience, and (5) patient-related health outcomes. While four studies found that LC care had a negative or no impact on health outcomes, 46 studies reported positive outcomes associated with LC care. Conclusions The study findings highlight the need for more research on LC care and a consistent definition of LC using multiple measures of LC to capture the complex and multidimensional nature of language in social interaction. Practical implications The study findings highlight the importance of how ideologies of language shape the perceptions of language and LC, thereby influence resource allocation and priorities.

Luciano, J. V., Martinez, N., Penarrubia-Maria, M. T., et al. (2011). "Effectiveness of a psychoeducational treatment program implemented in general practice for fibromyalgia patients: a randomized controlled trial." Clin J Pain **27**(5): 383-391.
http://www.ncbi.nlm.nih.gov/pubmed/21317775

> OBJECTIVES: A recent meta-analysis concluded that multicomponent treatments are effective for some fibromyalgia (FM) symptoms. The objective of this study was to examine whether a psychoeducational intervention implemented in primary care is more effective than usual care for improving the functional status of patients with FM. METHODS: This study was based on a randomized controlled trial. The 484 patients with FM included in a database of the Viladecans Hospital (Barcelona, Spain) were eligible for screening. Finally, 108 patients were randomly assigned to the intervention and 108 patients were assigned to usual care. The intervention comprised nine 2-hour sessions (5 sessions of education and 4 sessions of autogenic relaxation). The patients were assessed before and after the intervention with a battery of instruments (measuring sociodemographic data, medical comorbidities, functional status, trait anxiety, and social desirability). RESULTS: The posttreatment drop-out rate was 9.7% (intervention: 6.5%; control: 13%). The intention-to-treat analyses showed significant differences between the groups at posttreatment: the intervention group improved in physical impairment, days not feeling well, pain, general fatigue, morning fatigue, stiffness, anxiety, and depression (medium effect size in most cases). The patients who responded to the intervention reported less trait anxiety at baseline than nonresponders. The absolute risk reduction with the intervention was 36.1% (95% confidence interval: 23.3-48.8) and the number needed to treat was 3 (95% confidence interval: 2.0-4.3). DISCUSSION: A 2-month psychoeducational intervention improves the functional status of FM patients to a greater extent than usual care, at least in the short-term. The social desirability bias did not explain the reported outcomes. Trait anxiety was associated with response to treatment

Lussier, M. T., Richard, C., Glaser, E., et al. (2016). "The impact of a primary care e-communication intervention on the participation of chronic disease patients who had not reached guideline suggested treatment goals." Patient Educ Couns **99**(4): 530-541.

> OBJECTIVE: To evaluate the efficacy of two web-based educational approaches on doctor-patient communication. The study focused on chronic disease (CD) patients in a lengthy relationship with their family physician (FP) who had not reached guideline suggested treatment goals (off-target) for their CDs. METHODS: 322 hypertensive, diabetic, or dyslipidemic patients of 18 FPs were randomised into three groups: Usual Care (UC), e-Learning (e-L) and e-Learning+Workshop (e-L+W). Interventions were based on Cegala's PACE system: Prepare, Ask questions, Check understanding, Express concerns. Communication was evaluated using the Roter Interaction Analysis System (RIAS), MEDICODE and questionnaires. RESULTS: Encounter length was similar across groups. RIAS showed that e-L+W group engaged in more socio-emotional talk and PACE-like utterances. MEDICODE showed that interventions increased frequency, initiative and dialogue for selected CD medication themes. Quality of communication was perceived as satisfactory at baseline and did not change. CONCLUSION: Following interventions, CD patients were more activated even in well-established doctor-patient relationships. PRACTICE IMPLICATIONS: PACE web-based interventions are accessible and effective at increasing CD patients' participation. They increase legitimacy to express the patient experience. FPs should present this type of training to CD patients as an integral part of their routine practice and consider referring patients to complete it.

Lyles, A. A., Overgaard, P. M., Caputo, G. L., et al. (2017). "Stakeholders' Perceptions of Care Coordination: A Participatory Process." J Pediatr Health Care **31**(5): 555-559.

> OBJECTIVE: Children with special health care needs or chronic conditions are more likely to have unmet health needs than other children. The purpose of this study was to use a community engagement research strategy to assess the essential elements of care coordination that can serve as the foundation for a system-wide care coordination model for children with special health care needs. STUDY DESIGN: As part of a summit designed to review the status of pediatric care coordination within the state of Arizona and a call to action, a qualitative descriptive study was conducted to solicit anonymous feedback from 104 stakeholders (family, health care provider, or community entity) on the strengths and areas of improvement in the current system that provides care to Arizona children with special health care needs. Data were analyzed using inductive content analysis. RESULTS: Five essential categories crucial to building an effective and seamless care coordination model were extracted from the data: Communication, Insurance, Health Care Capacity, Provider Knowledge, and

Family Education. CONCLUSIONS: The results from this study can serve as the working foundation to build a system-wide model for pediatric care coordination throughout the state. Providing care coordination services involves many activities across a wide range of organizations and locations. Research that is inclusive of community stakeholders can determine essential components for building a foundation for care coordination.

Maclean, C. (2010). "Patient education: Sharing a passion, sharing resources." Can Fam Physician **56**(7): 721.
http://www.ncbi.nlm.nih.gov/pubmed/20631288

McDonnell, M. E. (2018). "Telemedicine in Complex Diabetes Management." Curr Diab Rep **18**(7): 42.

PURPOSE OF REVIEW: Telehealth has the potential to positively transform the quality and cost-effectiveness of complex diabetes management in adults. This review explores the landscape of telemedicine approaches and evidence for incorporation into general practice. RECENT FINDINGS: Telemedicine for diabetes care is feasible based on over 100 randomized clinical trials. Evidence shows modest benefits in A1c lowering and other clinical outcomes that are better sustained over time vs. usual care. While telemedicine interventions are likely cost-effective in diabetes care, more research is needed using implementation science approaches. Telehealth platforms have been shown to be both feasible and effective for health care delivery in diabetes, although there are many caveats that require tailoring to the institution, clinician, and patient population. Research in diabetes telehealth should focus next on how to increase access to patients who are known to be marginalized from traditional models of health care.

Maguire, P. A., Reay, R. E., Looi, J. C., et al. (2011). "Neither the internist nor the Internet: use of and trust in health information sources by people with schizophrenia." Aust. N Z J Psychiatry **45**(6): 489-497.
http://www.ncbi.nlm.nih.gov/pubmed/21563868

OBJECTIVE: The aim of this study was to explore health information sources accessed by people with schizophrenia and the level of trust invested in them. METHOD: A cross-sectional survey was performed comparing the responses of 71 adults with schizophrenia (recruited from both community and inpatient settings) with 238 general practice attendees on their use of television, radio, the Internet, newspapers, magazines, family and friends, and doctor to obtain information on health matters, and their levels of trust in these sources. RESULTS: People with schizophrenia most commonly reported using a doctor, family and friends, and television to obtain information on health matters. However, compared with general practice attendees, they gained less health information from doctors and the Internet, and had less trust in doctors. Within-group analysis revealed that in people with schizophrenia: living alone increased the likelihood of obtaining health information from television; a higher level of education increased the odds of trusting the Internet as a health information source; a higher estimated household income was associated with an increased likelihood of trusting newspapers; and women with schizophrenia were considerably more likely than men with schizophrenia to trust family and friends as providers of health information. For both groups, there were significant positive correlations between the amount of health information obtained from a given information source and the level of trust invested in it. CONCLUSIONS: There are significant differences in the reported utilization and trust of health information sources between people with schizophrenia and attendees at general practice settings. Those with schizophrenia are less likely to trust and obtain information from a doctor, and less likely to access the Internet. Further research is required to explore this disparity. This is critical given the high rates of comorbid physical illness and reduced longevity in people suffering from schizophrenia

Mahomed, R., St John, W. et Patterson, E. (2012). "Understanding the process of patient satisfaction with nurse-led chronic disease management in general practice." J Adv Nurs **68**(11): 2538-2549.

AIMS: To investigate the process of patient satisfaction with nurse-led chronic disease management in Australian general practice. BACKGROUND: Nurses working in the primary care context of general practice, referred to as practice nurses, are expanding their role in chronic disease management; this is relatively new to Australia. Therefore, determining patient satisfaction with this trend is

pragmatically and ethically important. However, the concept of patient satisfaction is not well understood particularly in relation to care provided by practice nurses. DESIGN: A grounded theory study underpinned by a relativist ontological position and a relativist epistemology. METHODS: Grounded theory was used to develop a theory from data collected through in-depth interviews with 38 participants between November 2007-April 2009. Participants were drawn from a larger project that trialled a practice nurse-led, collaborative model of chronic disease management in three Australian general practices. Theoretical sampling, data collection, and analysis were conducted concurrently consistent with grounded theory methods. RESULTS: Patients undergo a cyclical process of Navigating Care involving three stages, Determining Care Needs, Forming Relationship, and Having Confidence. The latter two processes are inter-related and a feedback loop from them informs subsequent cycles of Determining Care Needs. If any of these steps fails to develop adequately, patients are likely to opt out of nurse-led care. CONCLUSION: Navigating Care explains how and why time, communication, continuity, and trust in general practitioners and nurses are important to patient satisfaction. It can be used in identifying suitable patients for practice nurse-led care and to inform the practice and organization of practice nurse-led care to enhance patient satisfaction.

Maier, C., Aiken, L. et Busse, R. (2017). Nurses in advanced roles in primary care: Policy levers for implementation. OECD Health Working Papers; 98. Paris OCDE**:** 69 ,fig., tabl.
http://www.oecd-ilibrary.org/fr/social-issues-migration-health/nurses-in-advanced-roles-in-primary-care_a8756593-en

Many OECD countries have undergone reforms over the past decade to introduce advanced roles for nurses in primary care to improve access to care, quality of care and/or to reduce costs. This working paper provides an analysis of these nurse role developments and reforms in 37 OECD and EU countries. Four main trends emerge: 1) the development in several countries of specific advanced practice nursing roles at the interface between the traditional nursing and medical professions; 2) the introduction of various new, supplementary nursing roles, often focused on the management of chronic conditions; 3) the rise in educational programmes to train nurses to the required skills and competencies; and 4) the adoption of new laws and regulations in a number of countries since 2010 to allow certain categories of nurses to prescribe pharmaceuticals (including in Estonia, Finland, France, Netherlands, Poland and Spain).

Mallinger, J. B., Griggs, J. J. et Shields, C. G. (2005). "Patient-centered care and breast cancer survivors' satisfaction with information." Patient Educ Couns **57**(3): 342-349.
http://www.ncbi.nlm.nih.gov/pubmed/15893218

Satisfaction with information is an important patient outcome and may be related to the physician's ability to elicit the patients' concerns, to consider the patients' psychosocial needs, and to involve patients in treatment decision making; these communication techniques have been described under the umbrella of "patient-centered." The aim of this study was to examine the relationship between patient-centered care and satisfaction with information among women with a history of breast cancer. We administered a questionnaire to 182 women who had completed treatment for breast cancer. Our findings suggest that, while breast cancer survivors are highly satisfied with information related to treatment, they are less satisfied with information related to the long-term physical, psychological, and social sequelae of the disease and its treatments. In multivariate analysis, patients' perception of patient-centered behaviors was strongly associated with patients' satisfaction with information. These results provide support for the theory that patient satisfaction is improved when physicians incorporate patient-centered behaviors into their care

Markov, Z. et Bosic, Z. D. (2011). "[Role of the chosen general practitioner in educating women on the importance of regular gynecological examinations]." Med Pregl **64**(9-10): 486-489.
http://www.ncbi.nlm.nih.gov/pubmed/22097116

INTRODUCTION: Since regular screening is the best way of preventing the development of cervical cancer, the objective has been set to assess the motivation of women to have regular gynecological examinations and to estimate the role of the chosen general practitioner. MATERIAL AND METHODS:

The survey was performed on the basis of the prospective study done at the Health Centre "Novi Sad" in 2009 during the systematic regular examinations carried out by general practitioners. RESULTS: It was found that 60.8% of the examined women had regular checkups; 21.5% visited their doctor once in the period of two to five years and 4.9% had undergone the examination in a period > 10 years, whereas 1.9 women had never had an examination. Other examinees had occasional check-ups with various time laps between them. DISCUSSION: The reasons for not visiting a gynecologist were fear of the examination, absence of discomforts and lack of time. However, 87.2% of the examinees visited a gynecologist after they had been advised to do so by their general practitioner. Gynecological finding was good in 87.6% of the women, 3.4% were found to have carcinoma and 8.9% had some other abnormal finding. CONCLUSION: According to the obtained results, it has been concluded that the chosen general practitioner has a very important role in motivating women to have regular gynecological examinations and in educating them on the risk factors for developing malignant diseases and on the possible prevention

McCabe, R., Khanom, H., Bailey, P., et al. (2013). "Shared decision-making in ongoing outpatient psychiatric treatment." Patient Educ Couns **91**(3): 326-328.

OBJECTIVE: Research on patient involvement in decision-making in psychiatry has focused on first encounters. This study investigated what decisions are made, level of patient involvement and factors influencing patient involvement in ongoing outpatient visits. METHODS: 72 visits conducted by 20 psychiatrists were video recorded. Patients had a diagnosis of depression or schizophrenia. RESULTS: On average, there was one medication related and one other decision per visit. Some psychiatrists involved patients more in decisions, as did female psychiatrists. Involvement was lower when patients had more negative symptoms. CONCLUSION: Involvement in decision-making appears to be influenced by the individual psychiatrist and specific symptoms but not visit length. PRACTICE IMPLICATIONS: It is noteworthy that patient involvement is not influenced by length of the visit given that this would be a barrier in busy clinical practice. The next step would be to identify the communication patterns of psychiatrists who involve patients more in decision-making.

McCusker, J., Yaffe, M., Sussman, T., et al. "[The Management of Depression in Older Adults and Their Family Caregivers: Findings from a Research Program in Quebec]." Sante Ment Que **42**(1): 273-288.

Objectives A research group based at St. Mary's Research Centre, St. Mary's Hospital, Montreal, has conducted a research program over the past two decades that aims to inform improvements in the management of depression in primary care and general medical settings, among older adults. This paper reviews the findings from this research program, discusses the findings in the context of other research, and highlights the implications for practice and health policy.Methods Narrative review and synthesis of 25 published articles, that included: 4 systematic reviews, 10 observational studies, 9 intervention trials, and 2 consensus conference reports.Results The results pertain to 4 research areas: detection of depression in primary care and general medical settings; collaborative care of depression; depression self-care interventions; and the role of family and friends in supporting depression self-care interventions.Conclusions We propose six recommendations for improving the management of depression in the target population. 1) Depression detection and treatment can be improved through collaborative care models that involve primary care physicians, mental health specialists and non-physician mental health workers who are trained to assist with the detection of depression, with the delivery of brief, low-intensity psychological interventions and with self-care support. More research and evaluation are necessary to determine the factors that enhance the effectiveness, cost-efficiency, and consumer-centeredness of these interventions. 2) Supported depression self-care (and other low-intensity interventions such as short problem-solving therapy) offered by telephone or via internet, either as part of collaborative or usual care are feasible treatment options but more research is necessary to determine their effectiveness in different clinical populations. Some populations (e.g., those aged 75 and over, with visual and/or mild cognitive impairment) are likely to need greater or face-to-face support. 3) As most family physicians are unlikely to have the necessary time or interest to support depression self-care interventions, other sustainable programmatic contexts are needed for delivery of these interventions. Options include: nurses or other mental health workers in multidisciplinary family medicine groups; regional mental health programs; and voluntary organizations dedicated to assisting in the management of chronic illnesses. Research is needed on the feasibility and effectiveness of using peer support workers or volunteers to provide coaching of depression self-care interventions. 4) Involvement of family or friends in depression self-care may improve outcomes (e.g., dyadic interventions) but further research is necessary. 5) Further research should explore the potential of depression self-care interventions to prevent major depression and in depression relapse prevention in this population.

McDonald, J., Jayasuriya, R. et Harris, M. F. (2012). "The influence of power dynamics and trust on multidisciplinary collaboration: a qualitative case study of type 2 diabetes mellitus." BMC Health Serv Res **12**: 63.
http://www.ncbi.nlm.nih.gov/pubmed/22413897

BACKGROUND: Ongoing care for chronic conditions such as diabetes is best provided by a range of health professionals working together. There are challenges in achieving this where collaboration crosses organisational and sector boundaries. The aim of this article is to explore the influence of power dynamics and trust on collaboration between health professionals involved in the management of diabetes and their impact on patient experiences. METHODS: A qualitative case study conducted in a rural city in Australia. Forty five health service providers from nineteen organisations (including fee-for-service practices and block funded public sector services) and eight patients from two services were purposively recruited. Data was collected through semi-structured interviews that were audio-taped and transcribed. A thematic analysis approach was used using a two-level coding scheme and cross-case comparisons. RESULTS: Three themes emerged in relation to power dynamics between health professionals: their use of power to protect their autonomy, power dynamics between private and public sector providers, and reducing their dependency on other health professionals to maintain their power. Despite the intention of government policies to support more shared decision-making, there is little evidence that this is happening. The major trust themes related to role perceptions, demonstrated competence, and the importance of good communication for the development of trust over time. The interaction between trust and role perceptions went beyond understanding each other's roles and professional identity. The level of trust related to the acceptance of each other's roles. The delivery of primary and community-based health services that crosses organisational boundaries adds a layer of complexity to interprofessional relationships. The roles of and role boundaries between and within professional groups and services are changing. The uncertainty and vulnerability associated with these changes has affected the level of trust and mistrust. CONCLUSIONS: Collaboration across organisational boundaries remains challenging. Power dynamics and trust affect the strategic choices made by each health professional about whether to collaborate, with whom, and to what level. These decisions directly influenced patient experiences. Unlike the difficulties in shifting the balance of power in interprofessional relationships, trust and respect can be fostered through a mix of interventions aimed at building personal relationships and establishing agreed rules that govern collaborative care and that are perceived as fair

Meyer, C., Ulbricht, S., Baumeister, S. E., et al. (2008). "Proactive interventions for smoking cessation in general medical practice: a quasi-randomized controlled trial to examine the efficacy of computer-tailored letters and physician-delivered brief advice." Addiction **103**(2): 294-304.
http://www.ncbi.nlm.nih.gov/pubmed/17995993

AIMS: To test the efficacy of (i) computer-generated tailored letters and (ii) practitioner-delivered brief advice for smoking cessation against an assessment-only condition; and to compare both interventions directly. DESIGN: Quasi-randomized controlled trial. SETTING: A total of 34 randomly selected general practices from a German region (participation rate 87%). PARTICIPANTS: A total of 1499 consecutive patients aged 18-70 years with daily cigarette smoking (participation rate 80%). INTERVENTIONS: The tailored letters intervention group received up to three individualized personal letters. Brief advice was delivered during routine consultation by the practitioner after an onsite training session. Both interventions were based on the Transtheoretical Model of behaviour change. MEASUREMENTS: Self-reported point prevalence and prolonged abstinence at 6-, 12-, 18- and 24-month follow-ups. FINDINGS: Among participants completing the last follow-up, 6-month prolonged abstinence was 18.3% in the tailored letters intervention group, 14.8% in the brief advice intervention group and 10.5% in the assessment-only control group. Assuming those lost to follow-up to be smokers, the rates were 10.2%, 9.7% and 6.7%, respectively. Analyses including all follow-ups confirmed statistically significant effects of both interventions compared to assessment only. Using complete case analysis, the tailored letters intervention was significantly more effective than brief advice for 24-hour [odds ratio (OR) = 1.4; P = 0.047] but not for 7-day point prevalence abstinence (OR = 1.4; P = 0.068) for prolonged abstinence, or for alternative assumptions about participants lost to follow-up. CONCLUSIONS: The study demonstrated long-term efficacy of low-cost interventions for smoking cessation in general practice. The interventions are suitable to reach entire populations of general practices and smoking patients. Computer-generated letters are a promising option to overcome barriers to provide smoking cessation counselling routinely

Mitchell, B. L., Carter, J. et Mitchell, A. E. (2019). "A randomised controlled trial of SMS reminders for routine asthma care in an Australian general practice." Aust J Gen Pract **48**(9): 626-630.

BACKGROUND AND OBJECTIVES: Asthma self-management strategies remain core components of evidence-based asthma care. Despite this, only 14% of Australian adults with asthma have written action plans. We aimed to evaluate whether targeted SMS reminders to attend an asthma review could improve asthma action plan and spirometry completions for general practice patients who do not have current asthma action plans. METHOD: A randomised controlled trial comparing targeted SMS reminders with usual care was performed from May to September, 2016, in a metropolitan general practice in South East Queensland. RESULTS: By the three-month follow-up, 35 of 79 patients allocated to intervention had completed action plans in comparison to five of 59 patients allocated to usual care (P < 0.0001). There were more recorded instances of spirometry per patient performed during the follow-up period for intervention (37/79), compared with usual care (8/59; P <0.0001). DISCUSSION: SMS reminders may be a useful tool in the spectrum of care needed for optimal asthma management in general practice.

Mentrup, S., Harris, E., Gomersall, T., et al. (2020). "Patients' Experiences of Cardiovascular Health Education and Risk Communication: A Qualitative Synthesis." Qual Health Res **30**(1): 88-104.

Coronary heart disease (CHD) has no cure, and patients with myocardial infarction are at high risk for further cardiac events. Health education is a key driver for patients' understanding and motivation for lifestyle change, but little is known about patients' experience of such education. In this review, we aimed to explore how patients with CHD experience health education and in particular risk communication. A total of 2,221 articles were identified through a systematic search in five databases. 40 articles were included and synthesized using thematic analysis. Findings show that both "what" was communicated, and "the way" it was communicated, had the potential to influence patients' engagement with lifestyle changes. Communication about the potential of lifestyle change to reduce future risk was largely missing causing uncertainty, anxiety, and, for some, disengagement with lifestyle change. Recommendations for ways to improve health education and risk communication are discussed to inform international practice.

Mitchell, L. J., Macdonald-Wicks, L. et Capra, S. (2011). "Nutrition advice in general practice: the role of general practitioners and practice nurses." Aust. J Prim Health **17**(2): 202-208.
http://www.ncbi.nlm.nih.gov/pubmed/21645478

General practice is an ideal setting to be providing nutrition advice; however, it is important that the role of general practitioners (GPs) and practice nurses in providing nutrition advice is acknowledged and defined. This article aims to discuss the role of GPs and practice nurses in the delivery of nutrition advice. Ten general practitioners and 12 practice nurses from a NSW urban Division of General Practice participated in questionnaires and a Lifescripts implementation study, as well as their consenting patients receiving Lifescripts (n=13). An online survey was conducted with 90 Australian private practice dietitians. Semi-structured telephone interviews were conducted with 52 Australian private practice dietitians. The provision of basic nutrition advice is acknowledged to be part of the role of GPs and practice nurses, as they are the first point of contact for patients, allowing them to raise nutrition awareness. However, it is important that this advice is evidence based and able to be

> delivered in a time-efficient manner. Increased nutrition education and the availability of appropriate resources and nutrition-related best practice guidelines will assist in this process

Moore, A. A., Blow, F. C., Hoffing, M., et al. (2011). "Primary care-based intervention to reduce at-risk drinking in older adults: a randomized controlled trial." Addiction **106**(1): 111-120.
http://www.ncbi.nlm.nih.gov/pubmed/21143686

> AIMS: To examine whether a multi-faceted intervention among older at-risk drinking primary care patients reduced at-risk drinking and alcohol consumption at 3 and 12 months. DESIGN: Randomized controlled trial. SETTING: Three primary care sites in southern California. PARTICIPANTS: Six hundred and thirty-one adults aged >/= 55 years who were at-risk drinkers identified by the Comorbidity Alcohol Risk Evaluation Tool (CARET) were assigned randomly between October 2004 and April 2007 during an office visit to receive a booklet on healthy behaviors or an intervention including a personalized report, booklet on alcohol and aging, drinking diary, advice from the primary care provider and telephone counseling from a health educator at 2, 4 and 8 weeks. MEASUREMENTS: The primary outcome was the proportion of participants meeting at-risk criteria, and secondary outcomes were number of drinks in past 7 days, heavy drinking (four or more drinks in a day) in the past 7 days and risk score. FINDINGS: At 3 months, relative to controls, fewer intervention group participants were at-risk drinkers [odds ratio (OR) 0.41; 95% confidence interval (CI) 0.22-0.75]; they reported drinking fewer drinks in the past 7 days [rate ratio (RR) 0.79; 95% CI 0.70-0.90], less heavy drinking (OR 0.46; 95% CI 0.22-0.99) and had lower risk scores (RR 0.77 95% CI 0.63-0.94). At 12 months, only the difference in number of drinks remained statistically significant (RR 0.87; 95% CI 0.76-0.99). CONCLUSIONS: A multi-faceted intervention among older at-risk drinkers in primary care does not reduce the proportions of at-risk or heavy drinkers, but does reduce amount of drinking at 12 months

Morera-Balaguer, J., Botella-Rico, J. M., Martinez-Gonzalez, M. C., et al. (2018). "Physical therapists' perceptions and experiences about barriers and facilitators of therapeutic patient-centred relationships during outpatient rehabilitation: a qualitative study." Braz J Phys Ther.

> BACKGROUND: Over recent years there has been a paradigm shift towards a patient-centred biopsychosocial care model in physical therapy. This new paradigm features a growing interest in understanding the contextual factors that influence the patient's experience of disease, pain and recovery. This includes generalized consensus regarding the importance of establishing a therapeutic relationship that is centred on the patient. OBJECTIVE: To explore physical therapists' perceptions and experiences regarding barriers and facilitators of therapeutic patient-centred relationships in outpatient rehabilitation settings. METHODS: This is a qualitative study with four focus groups including twenty-one physical therapists. Two researchers conducted the focus groups, using a topic guide with predetermined questions. The focus group discussions were audiotaped and videotaped, transcribed verbatim and analysed thematically using a modified grounded theory approach. RESULTS: Physical therapists perceived that the therapeutic patient-centred relationship not only depends on the personal qualities of the professional, but also on the patient's attitudes and the characteristics of the context, including the organization and team coordination. CONCLUSIONS: Although being more linked towards the patients' contextual factors and needs than towards the practice of the profession, a therapeutic relationship is worth considering by physical therapists. Furthermore this study highlights the need for physical therapists and administrators to rethink the situation and propose strategies for improvement.

Morgan, H. M., Entwistle, V. A., Cribb, A., et al. (2017). "We need to talk about purpose: a critical interpretive synthesis of health and social care professionals' approaches to self-management support for people with long-term conditions." Health Expect **20**(2): 243-259.

> BACKGROUND: Health policies internationally advocate 'support for self-management', but it is not clear how the promise of the concept can be fulfilled. OBJECTIVE: To synthesize research into professional practitioners' perspectives, practices and experiences to help inform a reconceptualization of support for self-management. DESIGN: Critical interpretive synthesis using systematic searches of literature published 2000-2014. FINDINGS: We summarized key insights from

164 relevant papers in an annotated bibliography. The literature illustrates striking variations in approaches to support for self-management and interpretations of associated concepts. We focused particularly on the somewhat neglected question of the purpose of support. We suggest that this can illuminate and explain important differences between narrower and broader approaches. Narrower approaches support people to manage their condition(s) well in terms of disease control. This purpose can underpin more hierarchical practitioner-patient communication and more limited views of patient empowerment. It is often associated with experiences of failure and frustration. Broader approaches support people to manage well with their condition(s). They can keep work on disease control in perspective as attention focuses on what matters to people and how they can be supported to shape their own lives. Broader approaches are currently less evident in practice. DISCUSSION AND CONCLUSION: Broader approaches seem necessary to fulfil the promise of support for self-management, especially for patient empowerment. A commitment to enable people to live well with long-term conditions could provide a coherent basis for the forms and outcomes of support that policies aspire to. The implications of such a commitment need further attention.

Morin, L., FOURY, C. et Briot, P. (2010). "Modalités d'application du "disease management" concernant l'organisation et la rémunération des professionnels aux USA, en Allemagne et en Angleterre : perspectives pour la France." Sante Publique // **22**(5).

[BDSP. Notice produite par EHESP BR0xsoIF. Diffusion soumise à autorisation]. Ledisease management développé aux États-Unis dans les années 90, est une démarche globale qui cherche à intégrer toutes les étapes de la prise en charge de la maladie chronique, de la prévention à l'éducation pour la santé. Sa mise en oeuvre se traduit aux États-Unis par le concept de Medical Home en Allemagne par des contrats incitant les médecins généralistes et les caisses de sécurité sociale à prendre en charge les patients atteints de pathologies chroniques, et au Royaume-Uni par des dispositifs favorisant la délégation de tâches et la coopération entre professionnels des soins primaires. En France, ce concept fait progressivement partie intégrante de la stratégie d'accroissement de la qualité des soins développée par l'Assurance Maladie en promouvant son développement encore expérimental sur les soins de premier recours. (R.A.)

Mudge, S., Kayes, N. et McPherson, K. (2015). "Who is in control? Clinicians' view on their role in self-management approaches: a qualitative metasynthesis." BMJ Open **5**(5): e007413.

OBJECTIVE: To explore clinician perceptions of involvement in delivery of self-management approaches. SETTING: All healthcare settings. DESIGN: EBSCO, Scopus and AMED databases were searched, in July 2013, for peer-reviewed studies in English reporting original qualitative data concerning perceptions of clinicians regarding their involvement in or integration of a self-management approach. Of 1930 studies identified, 1889 did not meet the inclusion criteria. Full text of 41 studies were reviewed by two independent reviewers; 14 papers were included for metasynthesis. Findings and discussion sections were imported into Nvivo-10 and coded line-by-line. Codes were organised into descriptive themes and cross-checked against original sources to check interpretation, and refined iteratively until findings represented an agreed understanding. Studies were appraised for quality. RESULTS: Delivering self-management in practice appeared to be a complex process for many clinicians. The issue of 'control' arose in all studies, both in the qualitative data and authors' interpretations. The first theme: Who is in control?--represented ways clinicians talked of exercising control over patients and the control they expected patients to have over their condition. The second theme: Changing clinician views--reflected what appeared to be an essential transformation of practice experienced by some clinicians in the process of integrating self-management approaches into the practice. A range of challenges associated with shifting towards a self-management approach were reflected in the third theme, Overcoming challenges to change. Tensions appeared to exist around forming partnerships with patients. Strategies found helpful in the process of change included: dedicating time to practice reciprocity in communication style, peer support and self-reflection. CONCLUSIONS: A consistent finding across studies is that 'control' is a key feature of how self-management is viewed by clinicians. They described challenges associated with the paradigm shift required to share or let go of control. Future research should identify whether strategies described by clinicians are key to successful self-management.

Murray, E., Charles, C. et Gafni, A. (2006). "Shared decision-making in primary care: tailoring the Charles et al. model to fit the context of general practice." Patient Educ Couns **62**(2): 205-211.
http://www.ncbi.nlm.nih.gov/pubmed/16139467

> OBJECTIVE: To explore the application of the original Charles et al. model of shared treatment decision-making [Charles C, Gafni A, Whelan T. Shared decision-making in the medical encounter: what does it mean? (or it takes at least two to tango). Soc Sci Med 1997;44:681-92; Charles C, Gafni A, Whelan T. Decision-making in the physician-patient encounter: revisiting the shared treatment decision-making model. Soc Sci Med 1999;49:651-61] in the context of general practice, and to determine whether the model needs tailoring for use in this clinical context. METHODS: Conceptual paper, presenting the defining characteristics of general practice compared to the original clinical context for which the model was developed (i.e. life threatening disease with different treatment options), and exploring how the model can be tailored for use in the context of general practice. RESULTS: We identify two areas where the original model requires tailoring: sharing the decision-making around agreeing on an agenda for each consultation; and adapting the information transfer component of the model to acknowledge that doctors may not be the only, or even the main, source of technical information for patients. Finally, we explore the importance of shared decision-making in the context of chronic disease. CONCLUSION: The Charles et al. model can be tailored for use in general practice. PRACTICE IMPLICATIONS: Tailoring the model for use in general practice has implications for research, in terms of identifying the additional physician competencies needed for implementation. Policy makers who wish to promote shared decision-making need to ensure that incentives which prioritize access and health outcomes do not militate against shared decision-making in general practice.

Nafradi, L., Nakamoto, K. et Schulz, P. J. (2017). "Is patient empowerment the key to promote adherence? A systematic review of the relationship between self-efficacy, health locus of control and medication adherence." Plos One **12**(10): e0186458.

> BACKGROUND: Current health policies emphasize the need for an equitable doctor-patient relationship, and this requires a certain level of patient empowerment. However, a systematic review of the empirical evidence on how empowerment affects medication adherence-the extent to which patients follow the physician's prescription of medication intake-is still missing. The goal of this systematic review is to sum up current state-of-the-art knowledge concerning the relationship between patient empowerment and medication adherence across medical conditions. As our conceptualization defines health locus of control and self-efficacy as being crucial components of empowerment, we explored the relationship between these two constructs and medication adherence. METHODS: Relevant studies were retrieved through a comprehensive search of Medline and PsychINFO databases (1967 to 2017). In total, 4903 publications were identified. After applying inclusion and exclusion criteria and quality assessment, 154 articles were deemed relevant. Peer-reviewed articles, written in English, addressing the relationship between empowerment (predictor) and medication adherence (outcome) were included. FINDINGS: High levels of self-efficacy and Internal Health Locus of Control are consistently found to promote medication adherence. External control dimensions were found to have mainly negative (Chance and God attributed control beliefs) or ambiguous (Powerful others attributed control beliefs) links to adherence, except for Doctor Health Locus of Control which had a positive association with medication adherence. To fully capture how health locus of control dimensions influence medication adherence, the interaction between the sub-dimensions and the attitudinal symmetry between the doctor and patient, regarding the patient's control over the disease management, can provide promising new alternatives. DISCUSSION: The beneficial effect of patients' high internal and concurrent physician-attributed control beliefs suggests that a so-called "joint empowerment" approach can be suitable in order to foster medication adherence, enabling us to address the question of control as a versatile component in the doctor-patient relationship.

Nanchahal, K., Townsend, J., Letley, L., et al. (2009). "Weight-management interventions in primary care: a pilot randomised controlled trial." Br J Gen Pract **59**(562): e157-e166.

http://www.ncbi.nlm.nih.gov/pubmed/19401009

BACKGROUND: There is a paucity of randomised controlled trials of weight management in primary care. AIM: To ascertain the feasibility of a full trial of a nurse-led weight-management programme in general practice. DESIGN OF STUDY: Factorial randomised control trial. SETTING: Primary care, UK. METHOD: A total of 123 adults (80.3% women, mean age 47.2 years) with body mass index > or =27 kg/m(2), recruited from eight practices, were randomised to receive structured lifestyle support (n = 30), structured lifestyle support plus pedometer (n = 31), usual care (n = 31), or usual care plus pedometer (n = 31) for a 12-week period. RESULTS: A total of 103 participants were successfully followed up. The adjusted mean difference in weight in structured support compared to usual care groups was -2.63 kg (95% confidence interval [CI] = -4.06 to -1.20 kg), and for pedometer compared to no pedometer groups it was -0.11 kg (95% CI = -1.52 to 1.30 kg). One in three participants in the structured-support groups (17/50, 34.0%) lost 5% or more of their initial weight, compared to less than one in five (10/53, 18.9%) in usual-care groups; provision of a pedometer made little difference (14/48, 29.2% pedometer; 13/55, 23.6% no pedometer). Difference in waist circumference change between structured-support and usual-care groups was -1.80 cm (95% CI = -3.39 to -0.20 cm), and between the pedometer and no pedometer groups it was -0.84 cm (95% CI = -2.42 to 0.73 cm). When asked about their experience of study participation, most participants found structured support helpful. CONCLUSION: The structured lifestyle support package could make substantial contributions to improving weight-management services. A trial of the intervention in general practice is feasible and practicable

Navaratnam, V., Forrester, D. L., Eg, K. P., et al. (2019). "Paediatric and adult bronchiectasis: Monitoring, cross-infection, role of multidisciplinary teams and self-management plans." Respirology **24**(2): 115-126.

Bronchiectasis is a chronic lung disease associated with structurally abnormal bronchi, clinically manifested by a persistent wet/productive cough, airway infections and recurrent exacerbations. Early identification and treatment of acute exacerbations is an integral part of monitoring and annual review, in both adults and children, to minimize further damage due to infection and inflammation. Common modalities used to monitor disease progression include clinical signs and symptoms, frequency of exacerbations and/or number of hospital admissions, lung function (forced expiratory volume in 1 s (FEV(1))% predicted), imaging (radiological severity of disease) and sputum microbiology (chronic infection with Pseudomonas aeruginosa). There is good evidence that these monitoring tools can be used to accurately assess severity of disease and predict prognosis in terms of mortality and future hospitalization. Other tools that are currently used in research settings such as health-related quality of life (QoL) questionnaires, magnetic resonance imaging and lung clearance index can be burdensome and require additional expertise or resource, which limits their use in clinical practice. Studies have demonstrated that cross-infection, especially with P. aeruginosa between patients with bronchiectasis is possible but infrequent. This should not limit participation of patients in group activities such as pulmonary rehabilitation, and simple infection control measures should be carried out to limit the risk of cross-transmission. A multidisciplinary approach to care which includes respiratory physicians, chest physiotherapists, nurse specialists and other allied health professionals are vital in providing holistic care. Patient education and personalized self-management plans are also important despite limited evidence it improves QoL or frequency of exacerbations.

Naldemirci, Ö., Lydahl, D., Britten, N., et al. (2018). "Tenacious assumptions of person-centred care? Exploring tensions and variations in practice." Health (London) **22**(1): 54-71.

In recent decades, the 'tenacious assumptions' of biomedicine regarding the neutrality and universality of its knowledge claims have been significantly challenged by the growth of new collaborative and patient-focused models of Healthcare delivery. In this article, we discuss and critically reflect upon one such alternative Healthcare model developed at the University of Gothenburg Centre for Person-Centred Care in Sweden. This centre uses three clinical routines of narrative, partnership and documentation to provide Healthcare to people recognized as unique individuals rather than patients. Person-centred care in Gothenburg and more broadly is based on the assumption that a person is independently capable of reasoning and verbal expression and willing to provide clear and genuine narratives and cooperate with Healthcare professionals. However, we argue that by emphasizing individual capabilities of reasoning and verbal expression, an unnecessarily limited conception of personhood risks being imposed on these routines. Drawing upon semi-structured interviews with researchers in three very different Gothenburg Centre for Person-Centred Care research projects - about healthy ageing in migrant communities, neurogenic communication disorders, and psychosis - we highlight that how persons are recognized as unique and capable varies significantly in practice across different Healthcare settings. Thus, we assert that person-centred care's own potentially tenacious assumptions about the attributes of personhood risk distracting attention away from the variety of creative ways that professionals and persons promisingly find for translating the ideal of person-centred care into practice.

Newcomb, P. A., McGrath, K. W., Covington, J. K., et al. (2010). "Barriers to patient-clinician collaboration in asthma management: the patient experience." J Asthma **47**(2): 192-197.
http://www.ncbi.nlm.nih.gov/pubmed/20170328

OBJECTIVE: To describe what adult patients with asthma report about their experiences with their own self-management behavior and working with their clinicians to control asthma. METHODS: The study sample consisted of 104 patients with persistent asthma participating in a clinical trial on asthma monitoring. All subjects were seen by primary care clinicians of a large, academic medical center. This qualitative post hoc analysis examined the views of adults with asthma about their asthma-related health care. Patients attended monthly visits as part of their study participation, during which data were derived from semistructured interviews. All patients included in this analysis participated in the study for 1 year. At the end of study participation, patients were asked to complete an evaluation of their clinician's communication behavior. All study clinicians were also asked to complete a self-evaluation of their own communication behavior. RESULTS: Five major themes of barriers to successful self-management were identified, including personal constraints, social constraints, communication failures, medication issues, and health care system barriers to collaboration with their clinicians. Patients most frequently reported lack of communication surrounding issues relating to day-to-day management of asthma (31%) and home management of asthma (24%). Clinicians generally rated themselves well for consistency in showing nonverbal attentiveness (89%) and maintaining interactive conversations (93%). However, only 30% of clinicians reported consistency in helping patients make decisions about asthma management and only 33% of clinicians reported consistency in tailoring medication schedules to the patient's routines. CONCLUSION: These findings emphasize the difficulties of establishing and maintaining a therapeutic partnership between patients and clinicians. The results underscore the need for system-wide interventions that promote the success of a therapeutic patient-clinician relationship in order to achieve long-term success in chronic disease management

Nicholls, S., Hankins, M., Hooley, C., et al. (2009). "A survey of the quality and accuracy of information leaflets about skin cancer and sun-protective behaviour available from UK general practices and community pharmacies." J Eur Acad. Dermatol. Venereol **23**(5): 566-569.
http://www.ncbi.nlm.nih.gov/pubmed/19175488

BACKGROUND: Better information promotes sun protection behaviour and is associated with earlier presentation and survival for malignant melanoma. Aim To assess the quality of patient information leaflets about skin cancer and sun-protective behaviour available from general practices and community pharmacies. DESIGN OF STUDY: A structured review of patient information leaflets. Setting All community pharmacies and general practices in one Primary Care Trust were invited to supply leaflets. METHODS: Readability was assessed using the SMOG scoring system. Presentation and content were reviewed using the Ensuring Quality Information for Patients (EQIP) guidelines. Three consultant dermatologists assessed each leaflet for accuracy. RESULTS: Thirty-one different patient information leaflets were returned. Thirteen (42%) were published in the previous 2 years, but 10 (32%) were over 5 years old. Nine (29%) leaflets were produced by the NHS or Health Education Authority, and 8 (27%) were linked to a commercial organization. One leaflet had readability in the primary education range (SMOG score = 6), and none with the recommended range for health education material (SMOG score < or = 5). Two leaflets (6%) were in the highest quartile of EQIP score for presentation and content. Five leaflets (17%) had a major inaccuracy such as over-reliance on sun screen products instead of shade and clothing. CONCLUSIONS: Leaflets were of variable quality in presentation and content. All required a reading age higher than recommended. All leaflets with major inaccuracies had links with commercial organizations. This study raises important issues about the potential conflict between marketing and health messages in the way sun creams are promoted

Nicoloro-SantaBarbara, J., Rosenthal, L., Auerbach, M. V., et al. (2017). "Patient-provider communication, maternal anxiety, and self-care in pregnancy." Soc Sci Med **190**: 133-140.

RATIONALE: Favorable relationships with health care providers predict greater patient satisfaction and adherence to provider recommendations. However, the specific components of patient-provider relationships that account for these benefits have not been identified. The potential benefits of strong patient-provider relationships in pregnancy may be especially important, as care providers have frequent, intimate interactions with pregnant women that can affect their emotions and behaviors. In turn, prenatal emotions and health behaviors have potent effects on birth outcomes. OBJECTIVE: This study investigated whether pregnant women's relationships with their midwives predicted better self-care. Specific components of the patient-provider relationship (communication, integration, collaboration, and empowerment) were examined. We also investigated a mechanism through which these relationship components may be associated with salutary health behaviors: by alleviating women's anxiety. METHODS: In total, 139 low-risk patients of a university-affiliated midwifery practice in the northeastern United States completed well-validated measures assessing their relationship with midwives, state anxiety, and prenatal health behaviors in late pregnancy; state anxiety was also assessed in mid-pregnancy. RESULTS: Women's perceptions of better communication, collaboration, and empowerment from their midwives were associated with more frequent salutary health behavior practices in late pregnancy. Controlling for mid-pregnancy anxiety, lower anxiety in late pregnancy mediated associations of communication and collaboration with health behavior practices, indicating that these associations were attributable to reductions in anxiety from mid- to late pregnancy. CONCLUSION: Results substantiate that benefits of patient-provider relationships in pregnancy may extend beyond providing medical expertise. Some aspects of patient-provider relationships may offer direct benefits to pregnant women in promoting better health practices; other aspects of these relationships may indirectly contribute to better health practices by alleviating negative emotions. The benefits of strong midwife relationships may derive from the reassurance, comfort, and warmth these relationships offer, as well as the information and education that midwives provide to their patients.

Noordman, J., Driesenaar, J. A., Henselmans, I., et al. (2017). "Patient participation during oncological encounters: Barriers and need for supportive interventions experienced by elderly cancer patients." Patient Educ Couns **100**(12): 2262-2268.

OBJECTIVE: To enhance patient participation during (oncological) encounters, this study aims to gain insight into communication barriers and supportive interventions experienced by elderly patients with cancer. METHOD: A mixed method design, including both quantitative (secondary survey data analysis) and qualitative (interviews) methods Survey data were used to identify communication barriers and need for supportive interventions of elderly cancer patients, compared to younger patients. Next, interviews provided in-depth insight into elderly patients' experiences and underlying mechanisms. RESULTS: A majority of the 70 participating elderly cancer patients (53%) felt confident in communicating and participating during medical encounters. However, 47% of patients experienced barriers to effectively communicate with their healthcare provider and felt the need for supportive interventions. The 14 interviewed patients mentioned barriers and facilitators related to attributes of themselves (e.g. feeling sick, self-efficacy), the provider (e.g. taking patient seriously) and the healthcare system (e.g. time constraints). CONCLUSIONS: Although many elderly cancer patients feel confident, offering support to patients who feel less confident in communicating with their provider is recommended. PRACTICE IMPLICATIONS: The outcomes of this study can be used as a first step for developing interventions for elderly cancer patients to overcome communication barriers, and help providers to facilitate this process.

Noseworthy, D. A., Phibbs, S. R. et Benn, C. A. (2013). "Towards a relational model of decision-making in midwifery care." Midwifery **29**(7): e42-48.

> OBJECTIVE: current individualistic ideas of autonomy and decision making do not fit within the context of decision-making in the midwife-woman relationship. This article critically explores current issues around decision-making and proposes a relational decision-making model for midwifery care. DESIGN: qualitative prenatal and postnatal interviews around decision-making within childbirth in general, and the third stage of labour in particular. PARTICIPANTS: eight midwife-woman pairs in urban settings in New Zealand. FINDINGS: a range of relational, social and political factors that are not present within existing decision-making models were highlighted. The themes included ontological and philosophical influences on decision-making; uncertainty, vulnerability and relational trust; and socio-political and cultural influences. Inconsistencies in knowledge arising from social, cultural and familial considerations as well as identities, beliefs, values, conversations, and practices were found to produce uncertainties around potential courses of action, expected consequences and outcomes. 'Unplanned' birth experiences decreased client autonomy and increased vulnerability thereby intensifying relational trust within decision-making. The political context may also open up or close down possibilities for decision-making at both national and local levels. CONCLUSION: decision-making for women and midwives is influenced by complex human, contextual and political factors. This study supports a relational model of decision-making that is embedded in understandings of choice as 'entangled'. A relational model enables consideration of how factors such as identity projects, individual practices, the organisation of maternity care, local hospital cultures, medicalised childbirth, workforce shortages, funding cuts and poverty shape the way in which care decisions are made.

Nover, C. et Jackson, S. S. (2013). "Primary care-based educational interventions to decrease risk factors for metabolic syndrome for adults with major psychotic and/or affective disorders: a systematic review." Syst Rev **2**: 116.

> BACKGROUND: Individuals with major psychotic and/or affective disorders are at increased risk for developing metabolic syndrome due to lifestyle- and treatment-related factors. Numerous pharmacological and non-pharmacological interventions have been tested in inpatient and outpatient mental health settings to decrease these risk factors. This review focuses on primary care-based non-pharmacological (educational or behavioral) interventions to decrease metabolic syndrome risk factors in adults with major psychotic and/or affective disorders. METHODS: The authors conducted database searches of PsychINFO, MEDLINE and the Cochrane Database of Systematic Reviews, as well as manual searches and gray literature searches to identify included studies. RESULTS: The authors were unable to identify any studies meeting a priori inclusion criteria because there were no primary care-based studies. CONCLUSIONS: This review was unable to demonstrate effectiveness of educational interventions in primary care. Interventions to decrease metabolic syndrome risk have been demonstrated to be effective in mental health and other outpatient settings. The prevalence of mental illness in primary care settings warrants similar interventions to improve health outcomes for this population.

Nunstedt, H., Rudolfsson, G., Alsen, P., et al. (2017). "Strategies for healthcare professionals to facilitate patient illness understanding." J Clin Nurs **26**(23-24): 4696-4706.

> AIMS AND OBJECTIVES: To describe how healthcare professionals facilitate patient illness understanding. BACKGROUND: Healthcare professionals and patients differ in their illness understanding. If the information provided by healthcare professionals is not adapted to the patient's daily life, it may be unusable for the patient. Previous research has found that healthcare professionals should individualise the information to enable the patient to apply the knowledge to the personal situation and to develop illness understanding. However, little is known of how healthcare professionals can facilitate patient illness understanding. METHOD: A qualitative descriptive study based on individual, semi-structured, open-ended and face-to-face interviews was conducted with healthcare professionals (n = 11) concerning how they facilitate patients illness understanding. Three health centres were involved during the period of March to November 2014. The interviews were analysed with qualitative content analysis. RESULTS: The result identified a continuous and

collaborative process with three strategies used by healthcare professionals to facilitate the patient's illness understanding: (i) assess the patient's illness understanding, (ii) interact with the patient to develop illness understanding and (iii) support the patient's personal development for illness understanding. The steps in the process depend on each other. CONCLUSIONS: The results of our analysis indicate that healthcare professionals can use the continuous and collaborative process to enhance the patient's self-care ability and turn his or her knowledge into action for improving illness understanding. RELEVANCE TO CLINICAL PRACTICE: The three continuous and collaborative process strategies involving pedagogical approaches can create conditions for healthcare professionals to obtain a holistic view of the patient's life and to be a key resource for person-centred care.

Ofstad, E. H., Frich, J. C., Schei, E., et al. (2016). "What is a medical decision? A taxonomy based on physician statements in hospital encounters: a qualitative study." BMJ Open **6**(2): e010098.

OBJECTIVE: The medical literature lacks a comprehensive taxonomy of decisions made by physicians in medical encounters. Such a taxonomy might be useful in understanding the physician-centred, patient-centred and shared decision-making in clinical settings. We aimed to identify and classify all decisions emerging in conversations between patients and physicians. DESIGN: Qualitative study of video recorded patient-physician encounters. PARTICIPANTS AND SETTING: 380 patients in consultations with 59 physicians from 17 clinical specialties and three different settings (emergency room, ward round, outpatient clinic) in a Norwegian teaching hospital. A randomised sample of 30 encounters from internal medicine was used to identify and classify decisions, a maximum variation sample of 20 encounters was used for reliability assessments, and the remaining encounters were analysed to test for applicability across specialties. RESULTS: On the basis of physician statements in our material, we developed a taxonomy of clinical decisions--the Decision Identification and Classification Taxonomy for Use in Medicine (DICTUM). We categorised decisions into 10 mutually exclusive categories: gathering additional information, evaluating test results, defining problem, drug-related, therapeutic procedure-related, legal and insurance-related, contact-related, advice and precaution, treatment goal, and deferment. Four-coder inter-rater reliability using Krippendorff's alpha was 0.79. CONCLUSIONS: DICTUM represents a precise, detailed and comprehensive taxonomy of medical decisions communicated within patient-physician encounters. Compared to previous normative frameworks, the taxonomy is descriptive, substantially broader and offers new categories to the variety of clinical decisions. The taxonomy could prove helpful in studies on the quality of medical work, use of time and resources, and understanding of why, when and how patients are or are not involved in decisions.

Olaiya, M. T., Kim, J., Nelson, M. R., et al. (2017). "Effectiveness of a shared team approach between nurses and doctors for improved risk factor management in survivors of stroke: a cluster randomized controlled trial." Eur J Neurol **24**(7): 920-928.

BACKGROUND AND PURPOSE: Limited evidence exists on the benefits of organized care for improving risk factor control in patients with stroke or transient ischaemic attack. The effectiveness of an individualized management programme in reducing absolute cardiovascular disease risk in this high-risk population was determined. METHODS: This was a prospective, multicentre, cluster-randomized controlled trial with blinded assessment of outcomes and intention-to-treat analysis. Patients hospitalized for stroke/transient ischaemic attack and aged >/=18 years were recruited from four hospitals. General practices treating recruited patients were randomized to provide either usual care or an individualized management programme comprising nurse-led education and review of care plans by stroke specialists in addition to usual care. The primary outcome was a change in cardiovascular Framingham Risk Score between baseline and 12 months. RESULTS: From January 2010 to November 2013, 156 general practices (280 patients) were randomly assigned to usual care (control) and 159 (283 patients) to the intervention. The median age was 70.1 years; 65% were male. Overall, >80% of participants were prescribed recommended secondary prevention therapies at baseline. The primary efficacy analysis comprised 533 participants, with 30 either dying or lost to follow-up. In adjusted analyses, no significant between-group difference was found in the cardiovascular risk score at 12 months (0.04, 95% confidence interval -1.7, 1.8). CONCLUSIONS: The effectiveness of an organized secondary prevention programme for stroke may be limited in patients from high-performing hospitals with regular post-discharge follow-up and communication with general practices.

Ostbye, T., Yarnall, K. S., Krause, K. M., et al. (2005). "Is there time for management of patients with chronic diseases in primary care?" Ann Fam Med **3**(3): 209-214.

PURPOSE: Despite the availability of national practice guidelines, many patients fail to receive recommended chronic disease care. Physician time constraints in primary care are likely one cause. METHODS: We applied guideline recommendations for 10 common chronic diseases to a panel of 2,500 primary care patients with an age-sex distribution and chronic disease prevalences similar to those of the general population, and estimated the minimum physician time required to deliver high-quality care for these conditions. The result was compared with time available for patient care for the average primary care physician. RESULTS: Eight hundred twenty-eight hours per year, or 3.5 hours a day, were required to provide care for the top 10 chronic diseases, provided the disease is stable and in good control. We recalculated this estimate based on increased time requirements for uncontrolled disease. Estimated time required increased by a factor of 3. Applying this factor to all 10 diseases, time demands increased to 2,484 hours, or 10.6 hours a day. CONCLUSIONS: Current practice guidelines for only 10 chronic illnesses require more time than primary care physicians have available for patient care overall. Streamlined guidelines and alternative methods of service delivery are needed to meet recommended standards for quality health care.

Otero-Sabogal, R., Arretz, D., Siebold, S., et al. (2010). "Physician-community health worker partnering to support diabetes self-management in primary care." Qual. Prim Care **18**(6): 363-372.
http://www.ncbi.nlm.nih.gov/pubmed/21294977

BACKGROUND: The role of community health workers (CHWs) has expanded from outreach and education to working within a clinical team in a primary care setting. AIM: To improve self-management among patients with type 2 diabetes incorporating CHWs as members of a clinical team. METHODS: A cohort of 114 patients with type 2 diabetes enrolled in 2007 participated in a teambased self-management intervention with followup in 2008. The study assessed whether significant changes occurred in clinical, patient satisfaction and activation measures after the intervention compared with baseline. The programme was located at St Luke's Health Care Center in San Francisco, California, in an ethnically diverse neighbourhood serving predominantly low-income Latino patients. Clinical outcomes measured included glycosylated haemoglobin (HbA1c), low-density lipoprotein (LDL), blood pressure and total cholesterol. A Patient Activation Measure (PAM) assessed self-management. Both provider and patient experiences with the programme were also assessed using a patient telephone satisfaction survey and provider focus group. RESULTS: The majority of patients were Latino Spanish speaking women on public insurance. Thirty-one patients participated in a telephone satisfaction survey. Six providers participated in a focus group to assess satisfaction with care. HealthFirst had a positive impact, improving HbA1c among high-risk patients with type 2 diabetes (HbA1c>/= 9.0) and maintaining glycaemic control among patients with controlled glycaemic level at baseline (HbA1c<7.0). In addition, LDL, total cholesterol and self-management outcomes significantly improved. Ninety-seven percent of patients were satisfied with the CHWs' support. Overall, providers' comfort level in referring patients to CHWs was very high. CONCLUSIONS: Physician-CHW partnership had a positive impact on patients' self-management skills and clinical outcomes. Patients and physicians also had higher satisfaction with overall care. With appropriate training, CHWs can collaborate as team members with primary care providers and with non-medical providers to improve the quality of care

Owens, J., Entwistle, V. A., Cribb, A., et al. (2017). ""Was that a success or not a success?": a qualitative study of health professionals' perspectives on support for people with long-term conditions." BMC Fam Pract **18**(1): 39.

BACKGROUND: Support for self-management (SSM) is a prominent strand of health policy internationally, particularly for primary care. It is often discussed and evaluated in terms of patients' knowledge, skills and confidence, health-related behaviours, disease control or risk reduction, and service use and costs. However, these goals are limited, both as guides to professional practice and as indicators of its quality. In order to better understand what it means to support self-management well, we examined health professionals' views of success in their work with people with long-term conditions. This study formed part of a broader project to develop a conceptual account of SSM that can reflect and promote good practice. METHODS: Semi-structured individual interviews (n = 26) and subsequent group discussions (n = 5 groups, 30 participants) with diverse health professionals working with people with diabetes and/or Parkinson's disease in NHS services in London, northern England or Scotland. The interviews explored examples of more and less successful work, ways of defining success, and ideas about what facilitates success in practice. Subsequent group discussions considered the practical implications of different accounts of SSM. Interviews and group discussions were audio-recorded, transcribed and analysed thematically. RESULTS: Participants identified a wide range of interlinked aspects or elements of success relating to: health, wellbeing and quality of life; how well people (can) manage; and professional-patient relationships. They also mentioned a number of considerations that have important implications for assessing the quality of their own performance. These considerations in part reflect variations in what matters and what is realistically achievable for particular people, in particular situations and at particular times, as well as the complexity of questions of attribution. CONCLUSIONS: A nuanced assessment of the quality of support for self-management requires attention to the responsiveness of professional practice to a wide, complex range of personal and situational states, as well as actions and interactions over time. A narrow focus on particular indicators can lead to insensitive or even perverse judgements and perhaps counterproductive effects. More open, critical discussions about both success and the assessment of quality are needed to facilitate good professional practice and service improvement initiatives.

Partridge, M. R., Caress, A. L., Brown, C., et al. (2008). "Can lay people deliver asthma self-management education as effectively as primary care based practice nurses?" Thorax **63**(9): 778-783.
http://www.ncbi.nlm.nih.gov/pubmed/18281394

OBJECTIVES: To determine whether well trained lay people could deliver asthma self-management education with comparable outcomes to that achieved by primary care based practice nurses. DESIGN: Randomised equivalence trial. SETTING: 39 general practices in West London and North West England. PARTICIPANTS: 567 patients with asthma who were on regular maintenance therapy. 15 lay educators were recruited and trained to deliver asthma self-management education. INTERVENTION: An initial consultation of up to 45 min offered either by a lay educator or a practice based primary care nurse, followed by a second shorter face to face consultation and telephone follow-up for 1 year. MAIN OUTCOME MEASURES: Unscheduled need for healthcare. Secondary outcome measures: Patient satisfaction and need for courses of oral steroids. RESULTS: 567 patients were randomised to care by a nurse (n = 287) or a lay educator (n = 280) and 146 and 171, respectively, attended the first face to face educational session. During the first two consultations, management changes were made in 35/146 patients seen by a practice nurse (24.0%) and in 56/171 patients (32.7%) seen by a lay educator. For 418/567 patients (73.7%), we have 1 year data on use of unscheduled healthcare. Under an intention to treat approach, 61/205 patients (29.8%) in the nurse led group required unscheduled care compared with 65/213 (30.5%) in the lay led group (90% CI for difference -8.1% to 6.6%; 95% CI for difference -9.5% to 8.0%). The 90% CI contained the predetermined equivalence region (-5% to +5%) giving an inconclusive result regarding the equivalence of the two approaches. Despite the fact that all patients had been prescribed regular maintenance therapy, 122/418 patients (29.2%) required courses of steroid tablets during the course of 1 year. Patient satisfaction following the initial face to face consultation was similar in both groups. CONCLUSIONS: It is possible to recruit and train lay educators to deliver a discrete area of respiratory care, with comparable outcomes to those seen by nurses

Paterniti, D. A., Fancher, T. L., Cipri, C. S., et al. (2010). "Getting to "no": strategies primary care physicians use to deny patient requests." Arch Intern Med **170**(4): 381-388.

BACKGROUND: Physicians need strategies for addressing patient requests for medically inappropriate tests and treatments. We examined communication processes that physicians use to deal with patient requests of questionable appropriateness. METHODS: Data come from audio-recorded visits and postvisit questionnaires of standardized patient visits to primary care offices in Sacramento and San Francisco, California, and Rochester, New York, from May 2003 to May 2004. Investigators performed an iterative review of visit transcripts in which patients requested, but did not receive, an antidepressant prescription. Measurements include qualitative analysis of strategies for communicating request denial. The relationship between strategies and satisfaction reports in postvisit questionnaires was examined using the Fisher exact test. RESULTS: Standardized patients requested antidepressants in 199 visits; the antidepressants were not prescribed in 88 visits (44%), 84 of which were available for analysis. In 53 of 84 visits (63%), physicians used 1 or more of the following 3 strategies that explicitly incorporated the patient perspective: (1) exploring the context of the request, (2) referring to a mental health professional, and (3) offering an alternative diagnosis. Twenty-six visits (31%) involved emphasis on biomedical approaches: prescribing a sleep aid or ordering a diagnostic workup. In 5 visits (6%), physicians rejected the request outright. Standardized patients reported significantly higher visit satisfaction when approaches relying on the patient perspective were used to deny the request (P = .001). CONCLUSIONS: Strategies for saying no may be used to communicate appropriate care plans, to reduce provision of medically inappropriate services, and to preserve the physician-patient relationship. These findings should be considered in the context of physician education and training in light of increasing health care costs.

Patton, A. P., Liu, Y., Hartwig, D. M., et al. (2017). "Community pharmacy transition of care services and rural hospital readmissions: A case study." J Am Pharm Assoc (2003) **57**(3s): S252-S258.e253.

OBJECTIVES: To explore community pharmacist involvement in the transition of care (TOC) process for patients discharged with acute myocardial infarction (AMI), heart failure (HF), pneumonia, chronic obstructive pulmonary disease (COPD), or elective total hip or knee arthroplasty (THA/TKA). SETTING: Patients discharged from a 60-bed acute care hospital located in rural Missouri were seen by a community pharmacist in 2 independent community pharmacy locations. PRACTICE INNOVATION: Patients admitted with 1 of the 5 qualifying conditions and identifying the participating pharmacy as their primary pharmacy spoke with a community pharmacist within 72 hours of discharge to complete a comprehensive medication review. A follow-up telephone call occurred 7 days after the encounter to evaluate for drug-related problems, adherence, and key information recalled from the previous visit. A final telephone call occurred on the 30th day after discharge to assess for hospital readmissions and emergency department (ED) visits. EVALUATION: Number of patients readmitted or visiting the ED within 30 days after discharge. RESULTS: Of the 9 patients completing the study, none were readmitted or visited the ED within 30 days after discharge. All of the participants were satisfied with the care and education provided by pharmacists. The majority of patients recalled points related to specific medication education topics. Based on the adherence tool, 8 of the 9 study participants had at least 1 barrier to medication access or adherence that could lead to post-discharge medication-related problems. CONCLUSION: Community pharmacist involvement in the TOC process may help to prevent readmissions for patients with AMI, HF, pneumonia, COPD, and elective THA/TKA. Patients are overall satisfied with community pharmacist involvement as they move from inpatient care to home. In addition, there are multiple barriers affecting access and adherence to medication therapy while at home, providing opportunities for pharmacist intervention and assistance.

Perry, J., Watkins, M., Gilbert, A., et al. (2013). "A systematic review of the evidence on service user involvement in interpersonal skills training of mental health students." J Psychiatr Ment Health Nurs **20**(6): 525-540.

Service user involvement has become a common feature of education programmes for mental health students. However, little is known about the effects of this type of education on the interpersonal skills of students taking part. This paper reports findings from a systematic review that formed part of a wider investigation into service user involvement in teaching interpersonal skills. The review aimed to locate and assess the quality of the published evidence relating to the effects of service user involvement on mental health students interpersonal skills and to synthesize results, using a definition of interpersonal skill that includes attitudes, empathy and skills as its key components. Results from this study indicate that the quality of evidence in this area is poor. However, sufficient synthesis of the evidence base was possible to allow conclusions and recommendations for both research and practice. Conclusions were that the involvement of service users in this area is both acceptable and valuable for students and had specific impacts on attitudes, empathy and skills. Some difficulties and reservations about the style of involvement are discussed. Recommendations for the conduct of future research are also made.

Pipe, A., Sorensen, M. et Reid, R. (2009). "Physician smoking status, attitudes toward smoking, and cessation advice to patients: an international survey." Patient Educ Couns **74**(1): 118-123.
http://www.ncbi.nlm.nih.gov/pubmed/18774670

OBJECTIVE: The smoking status of physicians can impact interactions with patients about smoking. The 'Smoking: The Opinions of Physicians' (STOP) survey examined whether an association existed between physician smoking status and beliefs about smoking and cessation and a physician's clinical interactions with patients relevant to smoking cessation, and perceptions of barriers to assisting with quitting. METHODS: General and family practitioners across 16 countries were surveyed via telephone or face-to-face interviews using a convenience-sample methodology. Physician smoking status was self-reported. RESULTS: Of 4473 physicians invited, 2836 (63%) participated in the survey, 1200 (42%) of whom were smokers. Significantly fewer smoking than non-smoking physicians volunteered that smoking was a harmful activity (64% vs 77%; P<0.001). More non-smokers agreed that smoking cessation was the single biggest step to improving health (88% vs 82%; P<0.001) and discussed smoking at every visit (45% vs 34%; P<0.001). Although more non-smoking physicians identified willpower (37% vs 32%; P<0.001) and lack of interest (28% vs 22%; P<0.001) as barriers to quitting, more smoking physicians saw stress as a barrier (16% vs 10%; P<0.001). CONCLUSION: Smoking physicians are less likely to initiate cessation interventions. PRACTICE IMPLICATIONS: There is a need for specific strategies to encourage smoking physicians to quit, and to motivate all practitioners to adopt systematic approaches to assisting with smoking cessation

Prandi, C., Garrino, L., Clerico, M., et al. (2014). "Therapeutic education to cancer patients: experiences of Italian nurses." Prof Inferm **67**(4): 243-251.

INTRODUCTION: Therapeutic patient' education is a complex process requiring a proper level of communication between the patient and the healthcare professional. Nurses play a key role in providing the patients and their families with educational activities. OBJECTIVE: This paper is the report of a study which investigates the experiences of some Italian nurses with regards to their role in therapeutic education to cancer patients. METHODS: Qualitative research. Semi-structured interviews were carried out with 52 nurses working in different Local Health Service Units of two northern Italy regions: Piedmont and Valle d'Aosta. To identify categories and items arising from the data, the researchers used a qualitative content analysis. RESULTS: The interview format was classified into six main categories: a) Patient education as daily care activity; b) Relevance of communication and dialogue for educational purposes; c) Relative usefulness of written information; d) Therapeutic education recording; e) Patients' feedbacks as a tool for assessing therapeutic education; and f) Difficult communication. CONCLUSIONS: The experience of nurses in terms of their professional role in therapeutic education for cancer patients shows the steady presence of educational activities carried out in a non-planned way. This research confirms the need to launch educational interventions for nurses. IMPLICATIONS FOR PRACTICE: It is essential to implement an action plan to promote opportunities of professional training in the field since among the most frequent reasons for project failure in therapeutic education is the lack of expert human resources.

Ratanawongsa, N., Bhandari, V. K., Handley, M., et al. (2012). "Primary care provider perceptions of the effectiveness of two self-management support programs for vulnerable patients with diabetes." J Diabetes Sci Technol **6**(1): 116-124.
http://www.ncbi.nlm.nih.gov/pubmed/22401329

BACKGROUND: Primary care providers (PCPs) in safety net settings face barriers to optimizing care for patients with diabetes. We conducted this study to assess PCPs' perspectives on the effectiveness of two language-concordant diabetes self-management support programs. METHODS: One year postintervention, we surveyed PCPs whose patients with diabetes participated in a three-arm multiclinic randomized controlled trial comparing usual care (UC), weekly automated telephone self-management (ATSM) support with nurse care management, and monthly group medical visits (GMVs).

We compared PCP perspectives on patient activation to create and achieve goals, quality of care, and barriers to care using regression models accounting for within-PCP clustering. RESULTS: Of 113 eligible PCPs caring for 330 enrolled patients, 87 PCPs (77%) responded to surveys about 245 (74%) enrolled patients. Intervention patients were more likely to be perceived by PCPs as activated to create and achieve goals for chronic care when compared with UC patients (standardized effect size, ATSM vs UC, +0.41, p = 0.01; GMV vs UC, +0.31, p = 0.05). Primary care providers rated quality of care as higher for patients exposed to ATSM compared to UC (odds ratio 3.6, p < 0.01). Compared with GMV patients, ATSM patients were more likely to be perceived by PCPs as overcoming barriers related to limited English proficiency (82% ATSM vs 44% GMV, p = 0.01) and managing medications (80% ATSM vs 53% GMV, p = 0.01). CONCLUSIONS: Primary care providers perceived that patients receiving ATSM support had overcome barriers, participated more actively, and received higher quality diabetes care. These views of clinician stakeholders lend additional evidence for the potential to upscale ATSM more broadly to support PCPs in their care of diverse, multilinguistic populations

Ramond-Roquin, A., Chouinard, M. C., Diallo, B. B., et al. (2019). "Chronic disease prevention and management programs in primary care: Realist synthesis of 6 programs in Quebec." Can Fam Physician **65**(8): 559-566.

OBJECTIVE: To identify the mechanisms associated with success and failure of chronic disease prevention and management (CDPM) programs, as well as their key contexts. DESIGN: Realist synthesis. SETTING: Six primary care CDPM programs funded between 2011 and 2013 in Quebec. PARTICIPANTS: Patients, health providers, program leaders, and other stakeholders involved in CDPM programs. METHODS: A collaborative research process was implemented, involving representatives from the executive and advisory committees: researchers, health care providers, decision makers, and patients and families. Leaders were asked to provide all documents related to their programs to the research team. The documents were selected depending on their relevance and rigour. The thematic analysis of each program consisted of identifying the outcomes and mechanisms, as well as the specific contexts associated with these outcomes. Results for each program were validated by its leader before synthesizing the results of all programs together. MAIN FINDINGS: A total of 108 documents (eg, grant applications, scientific reports) were collected from the programs. Positive and negative outcomes were observed at the patient, health care provider, and health care system levels. Four main mechanism categories were associated with outcomes: patient-centred interdisciplinary care; self-management support and a motivational approach; professional support; and care coordination and relationships with partners. The main contextual factors that influenced the successes of these mechanisms were related to patients (multimorbidity, involvement of family caregivers), to health care providers (professional training, culture of interprofessional collaboration, mobilization of family physician), and to health care organizations (coordination between services, history of collaboration between partners, funding). CONCLUSION: This study confirms the essential role of patient-centred interdisciplinary care; self-management support and a motivational approach; professional support; and care coordination and relationships with partners when caring for patients with chronic diseases. It constitutes a relevant contribution for stakeholders involved in primary care transformation and should be used to inform the sustainability and scaling up of CDPM programs.

Reichsman, A., Werner, J., Cella, P., et al. (2009). "Opportunities for improved diabetes care among patients of safety net practices: a safety net providers' strategic alliance study." J Natl Med Assoc **101**(1): 4-11.
http://www.ncbi.nlm.nih.gov/pubmed/19245066

OBJECTIVE: To identify barriers and opportunities for quality diabetes care in safety net practices. METHODS: In 3 federally qualified health centers and 1 free clinic, 19 primary care clinicians profiled patient and visit characteristics and quality of care measures for 181 consecutive visits by adult type 2 diabetic patients. Open-ended questions assessed patient and clinician perception of barriers to diabetes care and patient report of enabling factors. A multidisciplinary team identified themes from open-ended responses. Logistic regression analyses assessed the association of the identified barriers/enablers with 2 measures of quality care: glycosylated hemoglobin and prophylactic aspirin use. RESULTS: Ranked barriers noted by patients included adherence (40%), financial/insurance (23%), and psychosocial (13%) factors. Clinicians ranked systemic factors, including financial/ insurance (32%) and cultural/psychosocial (29%) factors, as important to adherence (29%) in determining quality diabetes care. Patients reported dietary and medical adherence (37%) and family/health care worker support (17%) as helpful factors. Among 175 patients with available data, glycosylated hemoglobin levels were associated with patient report of financial/insurance factors both as a barrier when visits and medications were unaffordable and as an opportunity when free or low-cost medications and services were provided. Patients' adherence with aspirin prophylaxis was strongly associated with African American race, prior prescription of aspirin and distribution of aspirin at the practice site (p<.001). CONCLUSIONS: Patients were less likely than clinicians to identify systemic and contextual factors contributing to poor diabetes care. From the front line's perspective, enabling patient self-management and systemic support is a target for improving diabetes care in safety net practices

Richardson, G. C., Derouin, A. L., Vorderstrasse, A. A., et al. (2014). "Nurse practitioner management of type 2 diabetes." Perm J **18**(2): e134-140.

CONTEXT: Multifactorial barriers prevent primary care clinicians from helping their adult patients with type 2 diabetes achieve good control of hemoglobin A1c (HbA1c) levels. Patients' depression and low self-efficacy can complicate diabetes management by impairing tasks needed for effective disease self-management. OBJECTIVES: To evaluate whether nurse practitioners in collaborative practices with primary care clinicians are effective in helping improve control of HbA1c, blood pressure (BP), and low-density lipoprotein cholesterol (LDL-C) in adults with uncontrolled hyperglycemia, and to assess whether nurse practitioner-guided care affects depression and self-efficacy in these patients. DESIGN: De-identified preintervention and postintervention data were collected from prospective review of medical charts of patients in a managed care organization's primary care clinics. MAIN OUTCOME MEASURES: Preintervention and postintervention HbA1c values were evaluated as the primary outcome measure. Preintervention and postintervention values for BP, LDL-C, body weight, and depression and self-efficacy scores were secondary outcome measures. RESULTS: After intervention, 50% of 26 patients achieved HbA1c benchmarks, 95.6% achieved systolic and diastolic BP benchmarks, and 57.8% achieved LDL-C benchmarks. Wilcoxon paired samples tests showed significantly increased self-efficacy (z = -3.42, p < 0.001) from preintervention to postintervention. Depression scores decreased slightly from preintervention (mean = 0.44, standard deviation = 1.34, median < 0.001) to postintervention values (mean = 0.18, standard deviation = 0.73, median < 0.001), but this decrease was not significant. CONCLUSION: Integrating nurse practitioners into primary care teams to provide innovative methods of support to adults with uncontrolled hyperglycemia improves clinical outcomes and self-efficacy for patients with type 2 diabetes.

Riedl, D. et Schussler, G. (2017). "The Influence of Doctor-Patient Communication on Health Outcomes: A Systematic Review." Z Psychosom Med Psychother **63**(2): 131-150.

Rise, M. B., Solbjor, M., Lara, M. C., et al. (2013). "Same description, different values. How service users and providers define patient and public involvement in health care." Health Expect **16**(3): 266-276.

BACKGROUND: Patient and public involvement in health care is important, but the existing definitions of the concept do not integrate the stakeholders' own perceptions. OBJECTIVE: To investigate and compare service users' and service providers' own definitions of patient and public involvement and their implications. DESIGN, SETTING AND PARTICIPANTS: Qualitative study with mainly individual in-depth semi-structured interviews conducted between June 2007 and June 2009. Data were analysed using a grounded theory approach. RESULTS: A total of 20 patients, 13 public representatives and 44 health service providers/managers in both somatic and mental health care were interviewed. A common definition of patient and public involvement emerged: It is founded on mutual respect, carried out through dialogue aiming at achieving shared decision making. Nevertheless, users and providers assigned different values to the core aspects: Respect was imperative for service users and implied for providers, dialogue was a way to gain respect for service users and to achieve good outcome for providers, and both worried that the other party wanted to make sole decisions. CONCLUSIONS: Users and providers need to consider that although they have a common definition of involvement in health care, they assign different values to its aspects. Increasing and improving patient and public involvement therefore requires knowledge on and dialogue between the parties about these differences.

Roberts, N. J., Boyd, K. A., Briggs, A. H., et al. (2012). "Nurse led versus lay educators support for those with asthma in primary care: a costing study." BMC Pulm Med **12**: 52.

> BACKGROUND: Regular review and support for asthma self-management is promoted in guidelines. A randomised controlled trial suggested that unscheduled health care usage was similar when patients were offered self management support by a lay-trainer or practice nurses. METHODS: Following the RCT, a costing study was undertaken using the trial data to account for the cost of delivery of the service under both strategies and the resulting impact on unscheduled healthcare (measure of effectiveness) in this trial. RESULTS: One year data (n = 418) showed that 29% (61/205) of the nurse group required unscheduled healthcare (177 events) compared with 30.5% (65/213) for lay-trainers (178 events).The training costs for the lay-trainers were greater than nurses (pound36 versus pound18 respectively per patient, p<0.001), however, the consultation cost for lay-trainers were lower than nurses (pound6 per patient versus pound24, p<0.001). If the cost of unscheduled healthcare are accounted for then the costs of nurses is pound161, and pound135 for lay-trainers (mean difference pound25, [95% CI = - pound97, pound149, p = 0.681]). The total costs (delivery and unscheduled healthcare) were pound202 per patient for nurses versus pound178 for lay-trainers, (mean difference pound24, [95%CI = - pound100, pound147, p = 0.707]). CONCLUSIONS: There were no significant differences in the cost of training and healthcare delivery between nurse and lay trainers, and no significant difference in the cost of unscheduled health care use.

Roberts, N. J., Evans, G., Blenkhorn, P., et al. (2010). "Development of an electronic pictorial asthma action plan and its use in primary care." Patient Educ Couns **80**(1): 141-146.
http://www.ncbi.nlm.nih.gov/pubmed/19879092

> OBJECTIVE: Self-management education and the issuing of a written action plan improve outcomes for asthma. Many do not receive a plan and some cannot use the written word. We have developed an electronic pictorial asthma action plan (E-PAAP). METHODS: A pictorial action plan was incorporated into a software package. 21 general practices were offered this tool and the software was loaded onto 63 desktop computers (46 GPs and 17 nurses). Usage was assessed and health care professionals questioned as to its use. RESULTS: 190 plans had been printed in a 4-month period (17 for test purposes). The individual usage rate ranged from 0 to 28 plans. Doctors printed 73% (139/190) a mean of 3 per doctor and nurses printed 27% a mean of 2 per nurse (37/190). Excluding the test copies, 116/173(67%) were printed as picture and text together. CONCLUSION: Nearly half of all healthcare professionals used the E-PAAP software. Usage was skewed with some individuals using the software significantly more than others. The software package should help overcome problems of access to paper templates, by calculating peak flow action thresholds and by prompting correct completion. Barriers to the use of asthma action plans, such as perceived time constraints, persist. PRACTICE IMPLICATIONS: The development of an electronic asthma action plan facilitates health professional access to a basic template and prompts the user as to correct usage. It is to be hoped that such facilitation enhances the number of action plans issued and in this study GPs were greater users than the nurses

Robertson, S., Witty, K., Braybrook, D., et al. (2013). "'It's coming at things from a very different standpoint': evaluating the 'Supporting Self-Care in General Practice Programme' in NHS East of England." Prim Health Care Res Dev **14**(2): 113-125.

> AIM: To undertake a service evaluation of the NHS East of England Supporting Self-Care in General Practice programme. BACKGROUND: The number of people purported to live with long-term conditions continues to rise generating increasing policy emphasis on the importance of self-care. Previous work has highlighted barriers to implementing self-care interventions in general practice, including a lack of organisational approaches to providing self-care and limited engagement and training of healthcare professionals. In response to these barriers and policy drivers, NHS East of England Strategic Health Authority developed and commenced the Supporting Self-care in General Practice (SSCiGP) programme, which seeks to transform the relationships between people with long-term conditions and primary care practitioners. METHODS: This was a mixed methods study, carried

out over two phases, which included interviews, survey work and practice-based case studies. RESULTS: This paper focuses on findings related to clinician and practice level change. Clinicians reported changes in their perceptions and in consultation practices following attendance on the SSCiGP programme. These changes were linked to empathy and patient-centredness that mirrored what patients valued in interactions with clinicians. There were qualitative and descriptive differences, but no statistically significant differences between clinicians who had and had not attended the SSCiGP programme. Time was recognised as a significant barrier to implementing, and sustaining skills learnt from the SSCiGP programme. Greater impact at practice level could be achieved when there was whole practice commitment to values that underpinned the SSCiGP programme. There was evidence that such approaches are being incorporated to change practice systems and structures to better facilitate self-care, particularly in practices who were early programme adopters. CONCLUSION: This evaluation demonstrates that training around clinician change can be effective in shifting service delivery when sat within a cultural framework that genuinely situates patients at the centre of consultations and practice activity.

Rogers, A., Vassilev, I., Brooks, H., et al. (2016). "Brief encounters: what do primary care professionals contribute to peoples' self-care support network for long-term conditions? A mixed methods study." BMC Fam Pract **17**: 21.

BACKGROUND: Primary care professionals are presumed to play a central role in delivering long-term condition management. However the value of their contribution relative to other sources of support in the life worlds of patients has been less acknowledged. Here we explore the value of primary care professionals in people's personal communities of support for long-term condition management. METHODS: A mixed methods survey with nested qualitative study designed to identify relationships and social network member's (SNM) contributions to the support work of managing a long-term condition conducted in 2010 in the North West of England. Through engagement with a concentric circles diagram three hundred participants identified 2544 network members who contributed to illness management. RESULTS: The results demonstrated how primary care professionals are involved relative to others in ongoing self-care management. Primary care professionals constituted 15.5 % of overall network members involved in chronic illness work. Their contribution was identified as being related to illness specific work providing less in terms of emotional work than close family members or pets and little to everyday work. The qualitative accounts suggested that primary care professionals are valued mainly for access to medication and nurses for informational and monitoring activities. Overall primary care is perceived as providing less input in terms of extended self-management support than the current literature on policy and practice suggests. Thus primary care professionals can be described as providing 'minimally provided support'. This sense of a 'minimally' provided input reinforces limited expectations and value about what primary care professionals can provide in terms of support for long-term condition management. CONCLUSIONS: Primary care was perceived as having an essential but limited role in making a contribution to support work for long-term conditions. This coalesces with evidence of a restricted capacity of primary care to take on the work load of self-management support work. There is a need to prioritise exploring the means by which extended self-care support could be enhanced out-with primary care. Central to this is building a system capable of engaging network capacity to mobilise resources for self-management support from open settings and the broader community.

Rogers, A., Vassilev, I., Pumar, M. J., et al. (2015). "Meso level influences on long term condition self-management: stakeholder accounts of commonalities and differences across six European countries." BMC Public Health **15**: 622.

BACKGROUND: European countries are increasingly adopting systems of self -care support (SMS) for long term conditions which focus on enhancing individual, competencies, skills, behaviour and lifestyle changes. To date the focus of policy for engendering greater self- management in the population has been focused in the main on the actions and motivations of individuals. Less attention has been paid to how the broader influences relevant to SMS policy and practice such as those related to food production, distribution and consumption and the structural aspects and economics relating to physical exercise and governance of health care delivery systems might be implicated in the

> populations ability to self- manage. This study aimed to identify key informants operating with knowledge of both policy and practice related to SMS in order to explore how these influences are seen to impact on the self-management support environment for diabetes type 2. METHODS: Ninety semi-structured interviews were conducted with key stakeholder informants in Bulgaria, Spain, Greece, Norway, Netherlands and UK. Interviews were transcribed and analysed using thematic and textual analysis. RESULTS: Stakeholders in the six countries identified a range of influences which shaped diabetes self-management (SM). The infrastructure and culture for supporting self-management practice is viewed as driven by political decision-makers, the socio-economic and policy environment, and the ethos and delivery of chronic illness management in formal health care systems. Three key themes emerged during the analysis of data. These were 1) social environmental influences on diabetes self-management 2) reluctance or inability of policy makers to regulate processes and environments related to chronic illness management 3) the focus of healthcare system governance and gaps in provision of self-management support (SMS). Nuances in the salience and content of these themes between partner countries related to the presence and articulation of dedicated prevention and self- management policies, behavioural interventions in primary care, drug company involvement and the impact of measures resulting from economic crises, and differences between countries with higher versus lower social welfare support and public spending on shaping illness management. CONCLUSIONS: The results suggest reasons for giving increasing prominence to meso level influences as a means of rebalancing and improving the effectiveness of implementing an agenda for SMS. There is a need to acknowledge the greater economic and policy challenging environment operating in some countries which act as a source of inequality between countries in addressing SMS for chronic illness management and impacts on people's capacity to undertake self-care activities.

Rose, V., Harris, M., Ho, M. T., et al. (2009). "A better model of diabetes self-management? Interactions between GP communication and patient self-efficacy in self-monitoring of blood glucose." Patient Educ Couns **77**(2): 260-265.

> OBJECTIVE: The aim of this exploratory study was to investigate the interaction between patient self-efficacy and GP communication in explaining diabetes self-management in a disadvantaged region of Sydney, Australia. METHODS: This study was undertaken in South West Sydney with the Fairfield Division of General Practice. We used a cross-sectional survey design to assess patients' self-reported beliefs and behaviours about diabetes self-management. We used hierarchical multiple linear regression to test for interaction effects in diabetes self-management, following tests for clustering using multilevel modeling. RESULTS: Of those eligible for survey, 105 patients completed the telephone survey (72%). There was a significant interaction between diabetes self-efficacy and GP communication in blood glucose testing; high-ratings of GP communication enhanced self-monitoring of blood glucose when patient self-efficacy was high but impeded self-monitoring of blood glucose when self-efficacy was low. There were no significant interaction effects for the general diet or exercise scales. CONCLUSION: This exploratory study suggests a complex relationship between patient self-efficacy and GP communication in self-monitoring of blood glucose. It is likely optimal diabetes self-management behaviours are produced by a fit between high patient self-efficacy and high quality GP communication. PRACTICE IMPLICATIONS: There is a risk that GPs who are sensitive to their patients' low self-efficacy in self-monitoring of blood glucose may step in and take over the monitoring role and inadvertently reduce self-management.

Rose, O., Jaehde, U. et Köberlein-Neu, J. (2018). "Discrepancies between home medication and patient documentation in primary care." Res Social Adm Pharm **14**(4): 340-346.

> BACKGROUND: Medication Reconciliation leads to quick detection of drug-related problems, studies in ambulatory care are scarce. The recently introduced Medication Plan in Germany serves as an ideal basis for Medication Reconciliation. OBJECTIVE: The study aim was to provide accurate data on the magnitude of discrepancy between the prescription and the actually taken medicine. Clinical relevance of discrepancies was assessed to estimate the impact on medication safety. METHODS: Patients were assessed at home, data was reconciled with the physician's documentation. Discrepancies were analyzed and stratified. Risk for hospitalization, risk for falls and the potential for drug-drug interactions was estimated based on literature. Drugs were tested for its origin and grouped to

indication clusters. Detected DRPs at a Medication Review were linked to the results at Medication Reconciliation. RESULTS: Medication of 142 elderly patients from 12 practices was reconciled. 1498 drugs were found at the home assessment, 1099 (73.4%) of which were detected in the physician's documentation. 94.4% of the patients were affected by discrepancies. A total of 2.8 ± 2.4 drugs was undocumented per patient. 26.6% of missing drugs were prescribed by medical specialists, 42.5% of drugs of unknown origin were prescription drugs. 53.9% of the patients used a undocumented drug, which carried a high risk for hospitalization. 23.1% of the drugs not covered were used for treatment of cardiovascular diseases. 65.8% of the differing drugs caused at least one DRP. CONCLUSION: A high discrepancy between the drugs used by the patient and the medication documented by the primary care physician could be found. Relating drugs had a profound systemic effect and were particular relevant to medication safety. Many drugs were prescription drugs. The majority of differing drugs caused DRPs. A collaborative Medication Reconciliation as part of a Medication Management could compile the entire medication and increase patient safety.

Rosland, A. M., Piette, J. D., Choi, H., et al. (2011). "Family and friend participation in primary care visits of patients with diabetes or heart failure: patient and physician determinants and experiences." Med Care **49**(1): 37-45.
http://www.ncbi.nlm.nih.gov/pubmed/21102357

BACKGROUND: Professional and patient groups have called for increased participation of patients' informal support networks in chronic disease care, as a means to improve clinical care and self-management. Little is known about the current level of participation of family and friends in the physician visits of adults with chronic illnesses or how that participation affects the experience of patients and physicians. METHODS: Written survey of 439 functionally independent adults with diabetes or heart failure and 88 of their primary care physicians (PCPs). Patients were ineligible if they had a memory disorder, needed help with activities of daily living, or were undergoing cancer treatment. RESULTS: Nonprofessional friends or family ("companions") regularly participated in PCP visits for nearly half (48%) of patients. In multivariable models, patients with low health literacy (adjusted odds ratio [AOR]: 2.9, confidence interval [CI]: 1.4-5.7), more depressive symptoms (AOR: 1.3, CI: 1.1-1.6), and 4 or more comorbid illnesses (AOR: 3.7, CI: 1.3-10.5) were more likely to report companion participation. Patients reported that they were more likely to understand PCP advice (77%) and discuss difficult topics with the physician (44%) when companions participated in clinic visits. In multivariable models, companion participation was associated with greater patient satisfaction with their PCP (AOR: 1.7, CI: 1.1-2.7). Most PCPs perceived visit companions positively, however 66% perceived 1 or more barriers to increasing companion participation, including increased physician burden (39%), inadequate physician training (27%), and patient privacy concerns (24%). CONCLUSION: Patients' companions represent an important source of potential support for the clinical care of functionally independent patients with diabetes or heart failure, particularly for patients vulnerable to worse outcomes. Companion participation in care was associated with positive patient and physician experiences. Physician concerns about companion participation are potentially addressable through existing training resources

Roter, D. L., Wexler, R., Naragon, P., et al. (2012). "The impact of patient and physician computer mediated communication skill training on reported communication and patient satisfaction." Patient Educ Couns **88**(3): 406-413.

OBJECTIVE: The objective was to evaluate parallel patient and physician computer-mediated communication skill training on participants' report of skill use and patient satisfaction. METHODS: Separate patient and clinician web-tools comprised of over 500, 10-s video clips demonstrating patient-centered skills in various ways. Four clinician members of the American Academy of Family Physicians National Research Network participated by enrolling 194 patients into a randomized patient trial and 29 physicians into a non-randomized clinician trial of respective interventions. All participants completed baseline and follow-up self-report measures of visit communication and satisfaction. RESULTS: Intervention patients reported using more skills than controls in five of six skill areas, including identification of problems/concerns, information exchange, treatment adherence, shared decision-making and interpersonal rapport (all $p<.05$); post intervention, physicians reported using more skills in the same 5 areas (all p<.01). Intervention group patients reported higher levels of satisfaction than controls in five of six domains (all p<.05). CONCLUSION: Communication skill training delivered in a computer mediated format had a positive and parallel impact on both patient and clinician reported use of patient-centered communication and in patient satisfaction. PRACTICE IMPLICATIONS: Computer-mediated interventions are cost and time effective thereby increasing patient and clinician willingness to undertake training.

Ryan, D., Murphy, A., Stallberg, B., et al. (2013). "'SIMPLES': a structured primary care approach to adults with difficult asthma." Prim Care Respir J **22**(3): 365-373.

The substantial majority of patients with asthma can expect minimal breakthrough symptoms on standard doses of inhaled corticosteroids with or without additional add-on therapies. SIMPLES is a structured primary care approach to the review of a person with uncontrolled asthma which encompasses patient education monitoring, lifestyle and pharmacological management and addressing support needs which will achieve control in most patients. The small group of patients presenting with persistent asthma symptoms despite being prescribed high levels of treatment are often referred to as having 'difficult asthma'. Some will have difficult, 'therapy resistant' asthma, some will have psychosocial problems which make it difficult for them to achieve asthma control and some may prove to have an alternative diagnosis driving their symptoms. A few patients will benefit from referral to a 'difficult asthma' clinic. The SIMPLES approach, aligned with close co-operation between primary and specialist care, can identify this patient group, avoid inappropriate escalation of treatment, and streamline clinical assessment and management.

Saha, S., Korthuis, P. T., Cohn, J. A., et al. (2013). "Primary care provider cultural competence and racial disparities in HIV care and outcomes." J Gen Intern Med **28**(5): 622-629.
http://www.ncbi.nlm.nih.gov/pubmed/23307396

BACKGROUND: Health professional organizations have advocated for increasing the "cultural competence" (CC) of healthcare providers, to reduce racial and ethnic disparities in patient care. It is unclear whether provider CC is associated with more equitable care. OBJECTIVE: To evaluate whether provider CC is associated with quality of care and outcomes for patients with HIV/AIDS. DESIGN AND PARTICIPANTS: Survey of 45 providers and 437 patients at four urban HIV clinics in the U.S. MAIN MEASURES: Providers' self-rated CC was measured using a novel, 20-item instrument. Outcome measures included patients' receipt of antiretroviral (ARV) therapy, self-efficacy in managing medication regimens, complete 3-day ARV adherence, and viral suppression. KEY RESULTS: Providers' mean age was 44 years; 56 % were women, and 64 % were white. Patients' mean age was 45; 67 % were men, and 77 % were nonwhite. Minority patients whose providers scored in the middle or highest third on self-rated CC were more likely than those with providers in the lowest third to be on ARVs, have high self-efficacy, and report complete ARV adherence. Racial disparities were observed in receipt of ARVs (adjusted OR, 95 % CI for white vs. nonwhite: 6.21, 1.50-25.7), self-efficacy (3.77, 1.24-11.4), and viral suppression (13.0, 3.43-49.0) among patients of low CC providers, but not among patients of moderate and high CC providers (receipt of ARVs: 0.71, 0.32-1.61; self-efficacy: 1.14, 0.59-2.22; viral suppression: 1.20, 0.60-2.42). CONCLUSIONS: Provider CC was associated with the quality and equity of HIV care. These findings suggest that enhancing provider CC may reduce racial disparities in healthcare quality and outcomes

Saheb Kashaf, M., McGill, E. T. et Berger, Z. D. (2017). "Shared decision-making and outcomes in type 2 diabetes: A systematic review and meta-analysis." Patient Educ Couns **100**(12): 2159-2171.

OBJECTIVE: Type 2 diabetes is a chronic disease which necessitates the development of a therapeutic alliance between patient and provider. This review systematically examines the association between treatment shared decision-making (SDM) and outcomes in diabetes. METHODS: A range of bibliographic databases and gray literature sources was searched. Included studies were subjected to dual data extraction and quality assessment. Outcomes were synthesized using meta-analyses where reporting was sufficiently homogenous or alternatively synthesized in narrative fashion. RESULTS: The search retrieved 4592 records, which were screened by title, abstract, and full text to identify 16 studies with a range of study designs and populations. We found evidence of an association between SDM and improved decision quality, patient knowledge and patient risk perception. We found little evidence of an association between SDM and glycemic control, patient satisfaction, quality of life, medication adherence or trust in physician. CONCLUSIONS: This work elucidates the potential clinical utility of SDM interventions in the management of Type 2 Diabetes and helps inform future research on the topic. PRACTICE IMPLICATIONS: A more complete understanding of the associations between SDM and outcomes will guide and motivate efforts aimed at improving uptake of the SDM paradigm.

Salter, C. (2010). "Compliance and concordance during domiciliary medication review involving pharmacists and older people." Sociol Health Illn **32**(1): 21-36.

Medication review is an advanced service registered pharmacists can now offer patients in the UK. This in-depth study of pharmacist-older patient communication during domiciliary medication review encounters examines how the interactions are constructed by participants and the influence of the compliance paradigm on the interaction. Twenty-nine observed, taped and transcribed consultations were analysed using discourse analysis. Ethnographic-style interviews in the field with pharmacists, follow-up interviews with patients and feedback workshops with pharmacists allowed interpretations to be tested and strengthened. The findings presented here use discourse analysis to look at the task-driven nature of the medication review encounters. The analysis explores the interactional format of three over-lapping phases of the consultations: (i) introductions and agenda setting; (ii) screening and testing patients' ability to comply; and, (iii) investigating over-the-counter medicines. Analysis suggests that a dominant compliance paradigm encourages pharmacist-led encounters with patients failing to engage in the medication review process. Little evidence of two-way reciprocated discussion or concordance was evident. The strategic nature of the discourse of compliance heard in these medication review encounters and its effect on older patients are discussed. The paper concludes with a consideration of the implications for pharmacy practice and policy development.

Sammut, M. R. (2006). "Family doctors and health promotion : do we practise what we preach?" MMJ **18**(1): 6p.
https://www.um.edu.mt/library/oar//handle/123456789/727

A survey on `Attitudes and Knowledge of General Practitioners (GPs) in Prevention and Health Promotion' was carried out in 2000 by EUROPREV (European Network for Prevention and Health Promotion in General Practice / Family Medicine). Method: All local general practitioners (GPs) known to the Malta College of Family Doctors were mailed a questionnaire to elicit beliefs and attitudes in practice, possible barriers in implementing preventive activities, and their personal health behaviour. Results: The response rate was 50% (156 replies out of 313). A difference was found between GPs' beliefs that certain preventive and health promotion activities should be done and their actually doing them in clinical practice. Forty-nine percent found some or great difficulty in carrying out such activities, mainly due to heavy workload and lack of time, problems in patients' accessibility to these activities, and patients' doubts about their effectiveness. Discrepancies were revealed between GPs' health promotion beliefs and their own personal behaviour. Discussion: As this study is based on GPs' self-reporting of activities, more objective evidence is needed through audit of properly-kept medical records. A practical protocol of health promotion activities needs to be devised for, and distributed to, family doctors. Health promotion activities may be facilitated by reduction of doctors' workload through patient registration and an appointment system. As doctors seem to prefer ordering investigations to giving verbal advice, other healthcare professionals could provide the latter. GPs should set an example to their patients by adopting a healthy lifestyle to reinforce their advice regarding health promotion.

Sand, J., Felzien, M., Haeme, R., et al. (2017). "The North American Primary Care Research Group's Patient and Clinician Engagement Program (PaCE): Demystifying patient engagement through a dyad model." Fam Pract **34**(3): 285-289.

Background: Community engagement in research is essential for translating the best evidence into community and clinical practice to improve the health and well-being of the population. Objective:

North American Primary Care Research Group's Patient and Clinician Engagement Program (PaCE) program aims to develop a robust community of patients and primary care providers with knowledge and understanding of the unique features of patient-centred outcomes research related to primary care in order to advocate for and engage in research. Methods: PaCE employs a 'dyad' model in which a patient and a primary care provider collaborate to learn about and engage in primary care, primary care research, grant review, proposal development and advocacy. A series of educational trainings held in conjunction with national primary care conferences, international webinars and local symposia make up the foundation of the PaCE curriculum. Results and Conclusions: To date, 186 participants have completed the full-day, interactive PaCE training, and more than 250 people have participated in PaCE webinars and/or symposia. A 6-month follow-up sent to PaCE participants evaluates engagement activities following training.

Sandman, L. et Munthe, C. (2009). "Shared decision-making and patient autonomy." Theor Med Bioeth **30**(4): 289-310.

In patient-centred care, shared decision-making is advocated as the preferred form of medical decision-making. Shared decision-making is supported with reference to patient autonomy without abandoning the patient or giving up the possibility of influencing how the patient is benefited. It is, however, not transparent how shared decision-making is related to autonomy and, in effect, what support autonomy can give shared decision-making. In the article, different forms of shared decision-making are analysed in relation to five different aspects of autonomy: (1) self-realisation; (2) preference satisfaction; (3) self-direction; (4) binary autonomy of the person; (5) gradual autonomy of the person. It is argued that both individually and jointly these aspects will support the models called shared rational deliberative patient choice and joint decision as the preferred versions from an autonomy perspective. Acknowledging that both of these models may fail, the professionally driven best interest compromise model is held out as a satisfactory second-best choice.

Santema, T. B., Stoffer, E. A., Kunneman, M., et al. (2017). "What are the decision-making preferences of patients in vascular surgery? A mixed-methods study." BMJ Open **7**(2): e013272.

OBJECTIVES: Shared decision-making (SDM) has been advocated as the preferred method of choosing a suitable treatment option. However, patient involvement in treatment decision-making is not yet common practice in the field of vascular surgery. The aim of this mixed-methods study was to explore patients' decision-making preferences and to investigate which facilitators and barriers patients perceive as important for the application of SDM in vascular surgery. DESIGN AND SETTING: Patients were invited to participate after visiting the vascular surgical outpatient clinic of an Academic Medical Center in the Netherlands. A treatment decision was made during the consultation for an abdominal aortic aneurysm or peripheral arterial occlusive disease. Patients filled in a number of questionnaires (quantitative part) and a random subgroup of patients participated in an in-depth interview (qualitative part). RESULTS: A total of 67 patients participated in this study. 58 per cent of them (n=39) indicated that they preferred a shared role in decision-making. In more than half of the patients (55%; n=37) their preferred role was in disagreement with what they had experienced. 31 per cent of the patients (n=21) preferred a more active role in the decision-making process than they had experienced. Patients indicated a good patient-doctor relationship as an important facilitator for the application of SDM. CONCLUSIONS: The vast majority of vascular surgical patients preferred, but did not experience a shared role in the decision-making process, although the concept of SDM was insufficiently clear to some patients. This emphasises the importance of explaining the concept of SDM and implementing it in the clinical encounter.

Schatz, M., Gibbons, C., Nelle, C., et al. (2006). "Impact of a care manager on the outcomes of higher risk asthmatic patients: a randomized controlled trial." J Asthma **43**(3): 225-229.
http://www.ncbi.nlm.nih.gov/pubmed/16754526

Asthma care management programs may improve outcomes, but it is not clear which aspects of such management are responsible for the improvement. We performed a randomized controlled trial of a limited intervention (one visit with asthma self-management education and provision of inhaled budesonide) compared to this visit plus regular asthma care manager follow-up. Quality of life, symptom-free days, emergency hospital care, and beta-agonist dispensings did not differ between groups at 12 months. Patients who entered the study did receive significantly less beta-agonists in the follow-up year than patients who did not enter the study. These data suggest that the limited intervention in our setting improved outcomes but that regular care manager follow-up thereafter did not add significantly to this intervention

Schenker, Y., Fernandez, A., Sudore, R., et al. (2011). "Interventions to improve patient comprehension in informed consent for medical and surgical procedures: a systematic review." Med Decis Making **31**(1): 151-173.

BACKGROUND: Patient understanding in clinical informed consent is often poor. Little is known about the effectiveness of interventions to improve comprehension or the extent to which such interventions address different elements of understanding in informed consent. PURPOSE: . To systematically review communication interventions to improve patient comprehension in informed consent for medical and surgical procedures. Data Sources. A systematic literature search of English-language articles in MEDLINE (1949-2008) and EMBASE (1974-2008) was performed. In addition, a published bibliography of empirical research on informed consent and the reference lists of all eligible studies were reviewed. Study Selection. Randomized controlled trials and controlled trials with nonrandom allocation were included if they compared comprehension in informed consent for a medical or surgical procedure. Only studies that used a quantitative, objective measure of understanding were included. All studies addressed informed consent for a needed or recommended procedure in actual patients. Data Extraction. Reviewers independently extracted data using a standardized form. All results were compared, and disagreements were resolved by consensus. Data Synthesis. Forty-four studies were eligible. Intervention categories included written information, audiovisual/multimedia, extended discussions, and test/feedback techniques. The majority of studies assessed patient understanding of procedural risks; other elements included benefits, alternatives, and general knowledge about the procedure. Only 6 of 44 studies assessed all 4 elements of understanding. Interventions were generally effective in improving patient comprehension, especially regarding risks and general knowledge. Limitations. Many studies failed to include adequate description of the study population, and outcome measures varied widely. CONCLUSIONS: . A wide range of communication interventions improve comprehension in clinical informed consent. Decisions to enhance informed consent should consider the importance of different elements of understanding, beyond procedural risks, as well as feasibility and acceptability of the intervention to clinicians and patients. Conceptual clarity regarding the key elements of informed consent knowledge will help to focus improvements and standardize evaluations.

Schieber, A. C., Kelly-Irving, M., Delpierre, C., et al. (2013). "Is perceived social distance between the patient and the general practitioner related to their disagreement on patient's health status ?" Patient Education and Counseling **91**(1): 97-104.

Schildmann, J., Grunke, M., Kalden, J. R., et al. (2008). "Information and participation in decision-making about treatment: a qualitative study of the perceptions and preferences of patients with rheumatoid arthritis." J Med Ethics **34**(11): 775-779.

OBJECTIVES: To elicit the perceptions and preferences of patients with rheumatoid arthritis regarding information and participation in treatment decision-making. To analyse the patients' narratives on the background of the ethical discourse on various approaches to treatment decision-making. DESIGN: In-depth interviews with themes identified using principles of grounded theory. PARTICIPANTS: 22 patients with long-standing rheumatoid arthritis. MAIN OUTCOME MEASURES: Qualitative data on patients' perceptions and preferences regarding information and participation in decision-making about treatment. RESULTS: Decision-making about treatment has been described by the patients as a process consisting of different stages with shifting loci of control and responsibility. Patients initially received one treatment recommendation and were not aware of alternative treatment options. Those participants in this study who wanted information about negative effects of a treatment cited "interest in one's own health" and the potential "use of information" as reasons for their preference. The physicians' expert knowledge and clinical experience regarding the effects of medication were cited as arguments by patients for a treatment recommendation. CONCLUSIONS: The patients' accounts of decision-making about treatment differ from models of physician-patient relationship that have been put forward in ethical discourse. These differences may be relevant with respect to the starting point of an ethical analysis of treatment decision-making. Patients' accounts with respect to a lack of information on treatment alternatives point to ethically relevant challenges regarding treatment decision-making in clinical practice.

Schouten, B. C., Meeuwesen, L. et Harmsen, H. A. (2009). "GPs' interactional styles in consultations with Dutch and ethnic minority patients." J Immigr. Minor. Health **11**(6): 468-475.
http://www.ncbi.nlm.nih.gov/pubmed/18360790

The aim of this study was to examine interactional styles of general practitioners (GPs) in consultations with Dutch patients as compared to ethnic minority patients, from the perspective of level of mutual understanding between patient and GP. Data of 103 transcripts of video-registered medical interviews were analyzed to assess GPs' communication styles in terms of involvement, detachment, shared decision-making and patient-centeredness. Surveys were used to collect data on patients' characteristics and mutual understanding. Results show that overall, GPs communicate less adequately with ethnic minority patients than with Dutch patients; they involve them less in decision-making and check their understanding of what has been discussed less often. Intercultural consultations are thus markedly distinguishable from intracultural consultations by a lack of adequate communicative behavior by GPs. As every patient has a moral and legal right to make informed decisions, it is concluded that GPs should check more often whether their ethnic minority patients have understood what has been said during the medical consultation

Serrano-Gil, M. et Jacob, S. (2010). "Engaging and empowering patients to manage their type 2 diabetes, Part I: a knowledge, attitude, and practice gap?" Adv Ther **27**(6): 321-333.

For over 20 years, the World Health Assembly has recognized diabetes (type 1 and type 2) as a serious threat to national health and economic development and called for action regarding its prevention and control. However, the prevalence of type 2 diabetes continues to rise despite a significant percentage of cases being preventable. Furthermore, data suggest that in many patients diagnosed with type 2 diabetes, glycated hemoglobin (HbA(1c)) levels remain above the agreed international and national target levels, despite the availability of numerous antihyperglycemic agents, the best intentions of both patient and physician, and the support of the wider healthcare team. Part I of this two-part review considers evidence that seems to suggest there is a knowledge, attitude, and practice (KAP) gap in type 2 diabetes, and that although theoretical knowledge of how type 2 diabetes should be managed exists, the attitude of patients and healthcare professionals may influence the practicalities of implementing life-enhancing changes for patients living day-to-day with the condition. Here, we consider why there may be a KAP gap, how type 2 diabetes is currently being assessed and managed, and whether these current management approaches remain valid in the light of recent studies evaluating the impact of lowering current target HbA(1c) levels. This article also explores how encouraging patients to self-manage their disease, as well as engaging all stakeholders in the necessary behavioral changes, can positively influence the long-term treatment outcomes of patients with type 2 diabetes.

Sharma, S., Wallace, L. M., Kosmala-Anderson, J., et al. (2013). "A process evaluation using a Self Determination Theory measure of the co-delivery of self management training by clinicians and by lay tutors." Patient Educ Couns **90**(1): 38-45.

OBJECTIVE: To evaluate the co-delivery style of lay and clinician co-tutors of courses for patients, and courses for clinicians to support their patients' self-management skills. METHODS: Motivational style of course delivery was assessed in 37 patient course sessions and 14 clinician workshops by independent observers using four Self Determination Theory rating scales and ethnographic notes. Forty-five tutors and 35 attendees were interviewed about their experience of co-delivered courses. RESULTS: Lay and clinician tutors had similar motivational styles, with significant differences between the four motivational style scales; patient courses (F(3, 216)=3.437, p=.018); and clinician courses (F(3, 78)=3.37, p=.025). The courses were experienced as co productive in style as suggested during interviews, but adherence to manuals limited the tutors' contributions. Lay and clinician tutors scored higher on providing structure and engaging participants than they scored on supporting autonomous decision making and involvement. CONCLUSION: Co-delivery was a successful model, affording opportunities to demonstrate co-production skills. PRACTICE IMPLICATIONS: There is more scope to enable lay and clinician tutors to use their respective expertise in supporting self-management, and for tutor training to encourage a less didactic delivery style.

Shay, L. A., Dumenci, L., Siminoff, L. A., et al. (2012). "Factors associated with patient reports of positive physician relational communication." Patient Educ Couns **89**(1): 96-101.
http://www.ncbi.nlm.nih.gov/pubmed/22554386

OBJECTIVE: To evaluate the patient, physician, and visit-related factors associated with patient ratings of positive physician relational communication. METHODS: Pre- and post-visit surveys were conducted with 485 patients attending a routine periodic health exam with one of 64 participating physicians. The audio-recorded visits were coded for elements of patient-physician communication including assertive responses, partnership building, question asking, supportive talk, and expressions of concern. RESULTS: Patient reports of positive physician relational communication were associated with patient perceptions of how well the physician understood the patient's health care preferences and values, a patient-physician interaction outside of the exam room, and physician-prompted patient expressions of concern. CONCLUSION: In addition to a patient's perception of their relationship with their physician going into the visit, relatively simple acts like extending the interaction beyond the exam room and ensuring that patients feel invited to express concerns they may have during the visit may influence patient perceptions of physician relational communication. PRACTICE IMPLICATIONS: This study offers preliminary support for the idea that relational communication and its associated benefits may be fostered through simple physician-driven acts such as interacting with patients outside of the exam room and encouraging patients to express concerns within the visit

Shepardson, R. L., Tapio, J. et Funderburk, J. S. (2017). "Self-Management Strategies for Stress and Anxiety Used by Nontreatment Seeking Veteran Primary Care Patients." Mil Med **182**(7): e1747-e1754.

INTRODUCTION: One of the most common reasons individuals do not seek mental health treatment is a preference to manage emotional concerns on their own. Self-management refers to the strategies that individuals use on their own (i.e., without professional guidance) to manage symptoms. Little research has examined self-management for anxiety despite its potential utility as the first step in a stepped care approach to primary care. The objectives of this study were to describe patients' anxiety self-management strategies, identify which types were perceived to be effective, and explore potential correlates. MATERIALS AND METHODS: This was an exploratory descriptive study (N = 182) of nontreatment seeking Veterans Health Administration primary care patients (M = 58.3 years of age, SD = 14.9) who reported current anxiety symptoms (>/=8 on Generalized Anxiety Disorder-7). The Institutional Review Board approved the study, and all participants provided informed consent. We assessed self-management strategies, anxiety and depression symptoms, and past-year treatment via telephone. Two independent raters coded strategies into 1 of 7 categories (kappa = 0.85) and 23 subcategories (kappa M = 0.82, SD = 0.16). RESULTS: Participants reported nearly universal (98%) use of self-management, with an average of 2.96 (SD = 1.2) strategies used in the past 3 months, and 91% of all strategies perceived as effective. Self-care (37.0%), cognitive (15.8%), and avoidance (15.1%) strategies were reported most commonly; the most prevalent subcategories were exercise (11.0% of all strategies), redirecting thoughts (9.1%), and family/friends (8.1%). Age and depression screen status were associated with self-management strategy use. CONCLUSION: Our results demonstrate the ubiquity and high perceived effectiveness of self-management for anxiety among Veteran primary care patients. Although avoidance strategies were fairly common, self-care strategies, particularly exercising, and cognitive strategies, such as redirecting thoughts, were most prevalent in this sample. Strengths of the study include its novelty, our sample of non-treatment seeking Veteran primary care patients with current symptoms, and the open-ended format of the strategies questions. Limitations include reliance on self-report data, dichotomous response options for the perceived effectiveness item, limited number of potential correlates, and sampling from a single medical center. Overall, this research highlights the opportunity that health care providers have to engage primary care patients around self-management to determine what strategies they are using and how effective those strategies may be. Future directions include identification of the most effective and feasible self-management strategies for anxiety to facilitate promotion of evidence-based self-management among primary care patients.

Sheridan, N. F., Kenealy, T. W., Kidd, J. D., et al. (2015). "Patients' engagement in primary care: powerlessness and compounding jeopardy. A qualitative study." Health Expect **18**(1): 32-43.

BACKGROUND: Primary health care does not adequately respond to populations known to have high needs such as those with compounding jeopardy from chronic conditions, poverty, minority status and age; as such populations report powerlessness. OBJECTIVE: To explore what poor older adults with chronic conditions who mostly belong to ethnic minority groups say they want from clinicians. SETTING AND PARTICIPANTS: Participants were older adults whose chronic conditions were severe enough to require hospital admission more than twice in the previous 12 months. All participants lived in poor localities in Auckland, New Zealand's largest city. METHODS: Forty-two in-depth interviews were conducted and analysed using qualitative description. RESULTS: An outward acceptance of health care belied an underlying dissatisfaction with low engagement. Participants did not feel heard and wanted information conveyed in a way that indicated clinicians understood them in the context of their lives. Powerlessness, anger, frustration and non-concordance were frequent responses. DISCUSSION AND CONCLUSIONS: Despite socio-cultural and disease-related complexity, patients pursue the (unrealised) ideal of an engaged therapeutic relationship with an understanding clinician. Powerlessness means that the onus is upon the health system and the clinician to engage. Engagement means building a relationship on the basis of social, cultural and clinical knowledge and demonstrating a shift in the way clinicians choose to think and interact in patient care. Respectful listening and questioning can deepen clinicians' awareness of patients' most important concerns. Enabling patients to direct the consultation is a way to integrate clinician expertise with what patients need and value.

Shippee, N. D., Shah, N. D., May, C. R., et al. (2012). "Cumulative complexity: a functional, patient-centered model of patient complexity can improve research and practice." J Clin Epidemiol **65**(10): 1041-1051.
http://www.ncbi.nlm.nih.gov/pubmed/22910536

OBJECTIVE: To design a functional, patient-centered model of patient complexity with practical applicability to analytic design and clinical practice. Existing literature on patient complexity has mainly identified its components descriptively and in isolation, lacking clarity as to their combined functions in disrupting care or to how complexity changes over time. STUDY DESIGN AND SETTING: The authors developed a cumulative complexity model, which integrates existing literature and emphasizes how clinical and social factors accumulate and interact to complicate patient care. A narrative literature review is used to explicate the model. RESULTS: The model emphasizes a core, patient-level mechanism whereby complicating factors impact care and outcomes: the balance between patient workload of demands and patient capacity to address demands. Workload encompasses the demands on the patient's time and energy, including demands of treatment, self-care, and life in general. Capacity concerns ability to handle work (e.g., functional morbidity, financial/social resources, literacy). Workload-capacity imbalances comprise the mechanism driving patient complexity. Treatment and illness burdens serve as feedback loops, linking negative outcomes to further imbalances, such that complexity may accumulate over time. CONCLUSION: With its components largely supported by existing literature, the model has implications for analytic design, clinical epidemiology, and clinical practice

Shirazian, S., Crnosija, N., Weinger, K., et al. (2016). "The self-management experience of patients with type 2 diabetes and chronic kidney disease: A qualitative study." Chronic Illn **12**(1): 18-28.

BACKGROUND: The purpose of this study was to explore views related to the self-management of type 2 diabetes and chronic kidney disease. METHODS: We conducted three semi-structured focus groups in participants with type 2 diabetes and chronic kidney disease. Interviews were transcribed, coded,

> and analyzed using thematic analysis. Credibility was supported through triangulation of data sources and the use of multiple investigators from different disciplines. RESULTS: Twenty-three adults participated. Three major themes were identified: emotional reactions to health state, the impact of family dynamics on self-management, and the burden of self-management regimens. Family dynamics were found to be a barrier and support to self-management, while complicated self-management regimens were found to be a barrier. Additionally, participants expressed several emotional reactions related to their CKD status, including regret related to having developed CKD and distress related both to their treatment regimens and the future possibility of dialysis. CONCLUSIONS: This exploratory study of patients with type 2 diabetes and chronic kidney disease describes barriers and supports to self-management and emotional reactions to chronic kidney disease status. Future research should confirm these findings in a larger population and should include family members and/or health care providers to help further define problems with self-management in patients with type 2 diabetes and chronic kidney disease.

Silver, I. (2018). "Bridging the gap: person centred, place-based self-management support." Future Healthc J **5**(3): 188-191.

> Placing the person at the centre of their health and care has been a key part of health and care policy for nearly 2 decades. Fundamental to this approach is the role self-management support plays in increasing the confidence, skills and knowledge of a person in manging their health and wellbeing. This practical review article sets out to explore the historical context of self-management in England, its current status and the challenges faced in delivering self-management programmes. The demand on the health and care system continues to grow and so the need to move to a more holistic system of care with the person at its centre is greater than it has ever been before. With an increasingly fiscally restricted environment with which to operate, how can commissioners, health specialists and service providers work together to develop integrated pathways of care that provide the right care, at the right time and in the right place.

Sinnige, J., Korevaar, J. C., van Lieshout, J., et al. (2016). "Medication management strategy for older people with polypharmacy in general practice: a qualitative study on prescribing behaviour in primary care." Br J Gen Pract **66**(649): e540-551.

> BACKGROUND: For older patients with polypharmacy, medication management is a process of careful deliberation that needs periodic adjustment based on treatment effects and changing conditions. Because of the heterogeneity of the patient group, and limited applicability of current guidelines, it is difficult for GPs to build up a routine. AIM: To gain insight into GPs' medication management strategies for patients with polypharmacy, and to explore the GPs' perspectives and needs on decision-making support to facilitate this medication management. DESIGN AND SETTING: Two focus group meetings with Dutch GPs, discussing four clinical vignettes of patients with multimorbidity and polypharmacy. METHOD: Questions about medication management of the vignettes were answered individually; the strategy chosen in each case was discussed in plenary. Analysis followed a Framework approach. RESULTS: In total, 12 GPs described a similar strategy regarding the patients' medication management: defining treatment goals; determining primary goals; and adjusting medications based on the treatment effect, GPs' and patients' preferences, and patient characteristics. There was variation in the execution of this strategy between the GPs. The GPs would like to discuss their choices with other professionals and they valued structured medication reviews with the patient, as well as quick and practical support tools that work on demand. CONCLUSION: To facilitate decision making, a more extensive and structured collaboration between healthcare professionals is desired, as well as support to execute structured medication reviews with eligible patients, and some on-demand tools for individual consultations.

Siyam, T., Shahid, A., Perram, M., et al. (2019). "A scoping review of interventions to promote the adoption of shared decision-making (SDM) among health care professionals in clinical practice." Patient Educ Couns **102**(6): 1057-1066.

OBJECTIVES: To identify and summarize evidence on interventions to promote the adoption of shared decision-making (SDM) among health care professionals (HCPs) in clinical practice. METHODS: Electronic databases including: MEDLINE, EMBASE, CINAHL, PsycINFO and Cochrane library were searched to determine eligible peer-reviewed articles. Grey literature was searched for additional interventions. Eligibility screening and data extraction were independently completed. Results are presented as written evidence summaries and tables. RESULTS: Our search yielded 238 articles that met our inclusion criteria. Interventions mostly targeted physicians (46%), had multiple educational modalities (46%), and were administered in group settings (44%) before the clinical encounter (71%). Very few were developed based on the learning needs of targeted HCPs (24%). Many of the SDM outcome tools used for evaluation were developed for the respective study and lacked evidence of validity and reliability (30%). CONCLUSION: We identified a sizable number of interventions to promote the adoption of SDM, however, these interventions were heterogeneous in their assessments for effectiveness and implementation. Therefore, it is a challenge to infer which strategies and practices are best to promote SDM adoption. PRACTICE IMPLICATIONS: The need for evidence-based standards for developing SDM interventions targeting HCPs and assessing acceptability, effectiveness and implementation is suggested.

Sleath, B., Callahan, L., DeVellis, R. F., et al. (2005). "Patients' perceptions of primary care physicians' participatory decision-making style and communication about complementary and alternative medicine for arthritis." J Altern. Complement. Med **11**(3): 449-453.
http://www.ncbi.nlm.nih.gov/pubmed/15992228

OBJECTIVE: The purpose of this study was to examine: (1) which patient demographics were related to whether patients rated their family physicians as using a participatory decision-making style, and (2) whether arthritis patients who reported using complementary and alternative medicine (CAM) were more likely to report discussing CAM use with their providers if they saw family physicians rated with participatory decision-making styles. METHODS: A survey that asked about health status, demographics, physician use of a participatory decision-making style, and medical skepticism was sent to 2178 patients with arthritis who attended 16 different family practice sites that were part of a research network in rural and urban North Carolina. Generalized estimating equations were used to analyze the data. RESULTS: Younger and more educated patients were more likely to rate their family physicians as using participatory styles. In all, 71% of patients who reported having used one or more CAM strategy reported having discussed it with their physicians. Patients who rated their health as worse, reported using more categories of CAM, and rated their physicians as being using participatory styles were more likely to tell their physicians about their CAM use. CONCLUSION: Our findings suggest that if providers use more participatory styles with patients and involve them when making treatment decisions; patients will tell providers more about what they are doing for their health

Smailhodzic, E., Hooijsma, W., Boonstra, A., et al. (2016). "Social media use in healthcare: A systematic review of effects on patients and on their relationship with healthcare professionals." BMC Health Serv Res **16**: 442.

BACKGROUND: Since the emergence of social media in 2004, a growing percentage of patients use this technology for health related reasons. To reflect on the alleged beneficial and potentially harmful effects of social media use by patients, the aim of this paper is to provide an overview of the extant literature on the effects of social media use for health related reasons on patients and their relationship with healthcare professionals. METHODS: We conducted a systematic literature review on empirical research regarding the effects of social media use by patients for health related reasons. The papers we included met the following selection criteria: (1) published in a peer-reviewed journal, (2) written in English, (3) full text available to the researcher, (4) contain primary empirical data, (5) the users of social media are patients, (6) the effects of patients using social media are clearly stated, (7) satisfy established quality criteria. RESULTS: Initially, a total of 1,743 articles were identified from which 22 were included in the study. From these articles six categories of patients' use of social media were identified, namely: emotional, information, esteem, network support, social comparison and emotional expression. The types of use were found to lead to seven identified types of effects on patients, namely improved self-management and control, enhanced psychological well-being, and enhanced subjective well-being, diminished subjective well-being, addiction to social media, loss of privacy, and being targeted for promotion. Social media use by patients was found to affect the healthcare professional and patient relationship, by leading to more equal communication between the patient and healthcare professional, increased switching of doctors, harmonious relationships, and suboptimal interaction between the patient and healthcare professional. CONCLUSIONS: Our review provides insights into the emerging utilization of social media in healthcare. In particular, it identifies types of use by patients as well as the effects of such use, which may differ between patients and doctors. Accordingly, our results framework and propositions can serve to guide future research, and they also have practical implications for healthcare providers and policy makers.

Smith, C. A. (2010). "A systematic review of healthcare professional-led education for patients with osteoporosis or those at high risk for the disease." Orthop Nurs **29**(2): 119-132.

BACKGROUND: The effect of healthcare professional-led education for patients with osteoporosis or those at high risk for the disease on adherence with treatment recommendations was investigated. METHODS: Eight databases were searched using multiple key words, and combinations of key words, to find the highest level of evidence available. Four randomized controlled trials, 2 quasi-experimental trials, and 3 descriptive longitudinal comparative studies were identified and assessed. FINDINGS: Eight of the 9 studies showed improved adherence with treatment recommendations for patients with osteoporosis or those at high risk for the disease after the healthcare professional-led educational intervention. A professional nurse may be in the best position to lead this type of education, with 6 of the 9 studies using nurses as educators.

Smolders, M., Laurant, M., Roberge, P., et al. (2008). "How well do GPs fulfill their educator role in consultations for depression and anxiety?" Patient Educ Couns **73**(2): 389-395.
http://www.ncbi.nlm.nih.gov/pubmed/18783910

OBJECTIVE: To assess general practitioners' (GPs) provision of patient education with respect to patients with depression or anxiety. METHODS: The study relied on the prospective self-recording of patient consultations by GPs. The participating GPs (n = 78) completed 385 registration forms. For each performance indicator, an indicator score was calculated by dividing the number of clinical situations in which the GPs actually offered patient education by the total number of situations demanding for the provision of such education. RESULTS: High indicator scores (> 85%) were found for the provision of patient education about the effect and side effects of antidepressant medication in depression care. Moderate indicator scores (60-85%) were found for the provision of patient education about the prevalence and the course of both depression and anxiety. Giving advice to depressed patients to place restrictions upon the amount of demands the patient places on himself showed a substantial gap between recommended and actual care. Furthermore, a low indicator score was also found for patient education about the side effects of antidepressant medication in anxiety care (indicator scores < 60%). The variance across GPs was considerable. The clinical characteristic that had the most robust relationship with a variety of performance indicators was first or follow-up consultation for depression or anxiety. CONCLUSION: GPs' provision of patient education in depression and anxiety care ranged from poor to excellent, depending on the type of educational item. PRACTICE IMPLICATIONS: Insight into both the actual clinical performance of GPs and determinants of variation in their performance contributes to select the most appropriate means for quality improvement in depression and anxiety care

Solbjor, M., Rise, M. B., Westerlund, H., et al. (2013). "Patient participation in mental healthcare: when is it difficult? A qualitative study of users and providers in a mental health hospital in Norway." Int J Soc Psychiatry **59**(2): 107-113.

BACKGROUND: In western countries, patient participation is requested in policies on mental health services. Participation is built on ideas of democracy and individual responsibility. Mental illness has, however, been characterized by its irrational features. AIM: To investigate mental health service users' and providers' views on patient participation during episodes of mental illness. METHODS: Qualitative interview study with 20 users and 25 staff from a mental health hospital in central Norway. RESULTS: Both users and professionals saw poor illness phases as an obstacle to patient participation. Lack of insight, lack of verbal ability and difficulty cooperating made participation difficult. During such phases, patient participation was redefined. There was a shift in responsibility where professionals took charge through strategies of providing information, motivating patients and reducing choices. Respect and dignity were maintained and not redefined. CONCLUSIONS: In poor phases of mental illness, patient participation was redefined and weighed against what was perceived to be the patient's best interest.

Solomon, P. (2011). "Student perspectives on patient educators as facilitators of interprofessional education." Med Teach **33**(10): 851-853.

BACKGROUND: There has been increasing interest in the active involvement of patients in the education of health professionals. Few have examined the potential role of patient educators in the facilitation of interprofessional education (IPE). AIM: This qualitative program evaluation examined students' perceptions of their learning in a patient-facilitated IPE event. METHODS: One hundred and forty two students from physiotherapy, occupational therapy, medicine, and nursing participated in a 2.5-h session in which they interviewed patient educators living with a variety of chronic illnesses about their experiences. Patient educators participated in a 3-h training session prior to the event. RESULTS: Content analyses of six focus group transcripts (n = 27) and critical incident questionnaires (n = 138) revealed that students felt this was a positive experience, recognized the importance of advocating for their professional role, and valued the interprofessional learning. Students also valued participation from a variety of health professions and felt that IPE should be mandatory for all. CONCLUSION: Results suggest that trained patient educators can effectively facilitate interprofessional interactions.

SOMMER, J., RIEDER NAKHLE, A. et GACHE, P. (2007). "L'intervention br�ve motivationnelle au cabinet du m�decin de premier recours." Rev Med Suisse **3**(126): 2162-2166.

Le m�decin de premier recours voit une grande proportion de la population : il est donc bien plac� pour promouvoir la sant� par la pr�vention et aider les patients � changer de comportement de sant�. Deux m�thodes reconnues efficaces pour aider les patients � changer sont l'intervention br�ve "5 A's" et l'entretien motivationnel. Nous pr�sentons la combinaison de ces deux pratiques. L'entretien est structur� d'apr�s les recommandations de l'intervention br�ve, adapt�es en six �tapes : 1) l'agenda ; 2) l'exploration de l'ambivalence ; 3) aviser, conseiller ; 4) l'accord ; 5) aider et 6) arranger, organiser. Il s'inspire de l'entretien motivationnel pour ce qui est du climat de non-jugement, du respect de l'autonomie du patient et du climat de partenariat pour aider le patient � explorer puis sortir de son ambivalence afin d'engager le changement. [R.A.]

Soto Mas, F. G., Balcazar, H. G., Valderrama, A. J., et al. (2008). "Correlates of tobacco cessation counseling among Hispanic physicians in the US: a cross-sectional survey study." BMC Public Health **8**: 5.
http://www.ncbi.nlm.nih.gov/pubmed/18179722

BACKGROUND: Physician advice is an important motivator for attempting to stop smoking. However, physicians' lack of intervention with smokers has only modestly improved in the last decade. Although the literature includes extensive research in the area of the smoking intervention practices of clinicians, few studies have focused on Hispanic physicians. The purpose of this study was to explore the correlates of tobacco cessation counseling practices among Hispanic physicians in the US. METHODS: Data were collected through a validated survey instrument among a cross-sectional sample of self-reported Hispanic physicians practicing in New Mexico, and who were members of the New Mexico Hispanic Medical Society in the year 2001. Domains of interest included counseling practices, self-efficacy, attitudes/responsibility, and knowledge/skills. Returned surveys were analyzed to obtain frequencies and descriptive statistics for each survey item. Other analyses included: bivariate Pearson's correlation, factorial ANOVAs, and multiple linear regressions. RESULTS: Respondents (n = 45) reported a low level of compliance with tobacco control guidelines and recommendations. Results indicate that physicians' familiarity with standard cessation protocols has a significant effect on their tobacco-related practices (r = .35, variance shared = 12%). Self-efficacy and gender were both significantly correlated to tobacco related practices (r = .42, variance shared = 17%). A significant correlation was also found between self-efficacy and knowledge/skills (r = .60, variance shared = 36%). Attitudes/responsibility was not significantly correlated with any of the other measures. CONCLUSION: More resources should be dedicated to training Hispanic physicians in tobacco intervention. Training may facilitate practice by increasing knowledge, developing skills and, ultimately, enhancing feelings of self-efficacy

Spillman, M., Cheffins, T., Buhrer-Skinner, M., et al. (2012). "Genital Chlamydia trachomatis infection - a study on testing in general practice." Aust. Fam Physician **41**(10): 811-813.
http://www.ncbi.nlm.nih.gov/pubmed/23210107

BACKGROUND: Genital Chlamydia trachomatis infection is prevalent in Australia. Although testing rates are increasing, studies suggest that levels of testing of asymptomatic, sexually active people aged 16-29 years remain relatively low. Various barriers to testing in general practice have been identified. This article reports on one component of a study conducted to gain an understanding of chlamydia management in general practice in northern Queensland. METHODS: Nine general practices participated in a prospective audit over a 3 month period, which recorded the reason for chlamydia testing and if a follow up visit for test results was recommended. RESULTS: A total of 521 patients had chlamydia testing recorded, with females comprising over three-quarters of patients (77%). Asymptomatic presentations accounted for 50% of referrals for testing; of these, less than half had a recommendation for follow up of test results recorded (41%). Patients with a known positive case contact were most often recommended for follow up (59%). DISCUSSION: Half of those undergoing chlamydia testing were asymptomatic, with a third screened at the time of Pap testing. This suggests that general practitioners are appropriately initiating chlamydia screening with Pap tests.There is potential to increase rates of opportunistic testing for asymptomatic women

Stacciarini, T. S., Haas, V. J. et Pace, A. E. (2008). "[Factors associated with insulin self-administration by diabetes mellitus patients in the Family Health Strategy]." Cad Saude Publica **24**(6): 1314-1322.
http://www.ncbi.nlm.nih.gov/pubmed/18545757

This cross-sectional study aimed to compare two groups of patients with diabetes mellitus treated under the Family Health Strategy, with insulin self-administration versus non-self-administration, in relation to socio-demographic variables, perceived difficulties, and the person responsible for the self-application. A total of 269 patients participated, included through simple random sampling, from 37 Family Health Strategy units in the urban area of a municipality in the State of Minas Gerais, Brazil. The self-administration group consisted of 169 individuals (62.8%), as compared to 100 (37.2%) in the non-self-administration group. Comparing the two groups, schooling was statistically significant; 45% of those who did not self-administer reported absence of physical or cognitive difficulties that might prevent them from conducting the procedure, demonstrating the potential for adherence; 90% reported needing assistance in the insulin administration process at home, and of these, 75% reported receiving assistance from family members. The Family Health Strategy favors the development of interventions centered on users' needs, encouraging them to adopt and develop self-care skills, and the results of the present study can contribute to the planning of such interventions

Stein, B. D., Kogan, J. N., Mihalyo, M. J., et al. (2013). "Use of a computerized medication shared decision making tool in community mental health settings: impact on psychotropic medication adherence." Community Ment. Health J **49**(2): 185-192.
http://www.ncbi.nlm.nih.gov/pubmed/22837104

Healthcare reform emphasizes patient-centered care and shared decision-making. This study examined the impact on psychotropic adherence of a decision support center and computerized tool designed to empower and activate consumers prior to an outpatient medication management visit. Administrative data were used to identify 1,122 Medicaid-enrolled adults receiving psychotropic medication from community mental health centers over a two-year period from community mental health centers. Multivariate linear regression models were used to examine if tool users had higher rates of 180-day medication adherence than non-users. Older clients, Caucasian clients, those without recent hospitalizations, and those who were Medicaid-eligible due to disability had higher rates of

180-day medication adherence. After controlling for sociodemographics, clinical characteristics, baseline adherence, and secular changes over time, using the computerized tool did not affect adherence to psychotropic medications. The computerized decision tool did not affect medication adherence among clients in outpatient mental health clinics. Additional research should clarify the impact of decision-making tools on other important outcomes such as engagement, patient-prescriber communication, quality of care, self-management, and long-term clinical and functional outcomes

Stenner, K. L., Courtenay, M. et Carey, N. (2011). "Consultations between nurse prescribers and patients with diabetes in primary care: A qualitative study of patient views." Int J Nurs Stud **48**(1): 37-46.

BACKGROUND: There is a drive to improve the quality of service provision for patients with diabetes and to enable better self-management of this condition. The adoption of prescribing by nurses is increasing worldwide and can potentially enhance service provision. Evidence suggests that patients prefer services where their lifestyle factors and opinions are considered by healthcare professionals within a partnership approach. Few studies have explored patients' views about their consultations with a nurse prescriber. OBJECTIVE: To explore the views patients with diabetes have about their consultations with nurse prescribers and any impact this may have on their medications management. DESIGN: A qualitative study involving semi-structured interviews and thematic analysis. SETTING: Six primary care sites in which nurses prescribed medications for patients with diabetes in England. Data was collected in 2009. PARTICIPANTS: Interviews took place with 41 patients with diabetes from the case loads of 7 nurse prescribers. RESULTS: Findings are reported under three themes; the nurse consultation style, benefits of the nurse prescriber consultation and views on involvement and decision-making. Key aspects of the nurse consultation style were a non-hurried approach, care and rapport, approachability, continuity, and providing clear information based on specialist knowledge. Many benefits were described, including improved access to appropriate advice and medication, greater understanding and ability to self-manage, ability to address problems and improved confidence, trust and wellbeing. While patients were happy with the amount of information received and involvement they had decisions about their treatment, there was some controversy over the consistency of information provided on side-effects of treatment. CONCLUSIONS: The study provides new knowledge about what patients with diabetes value and benefit from in respect to care provided by nurse prescribers. Continuity of relationship, flexibility over consultation length, nurses' interpersonal skills and specialist diabetes knowledge were identified as crucial to good quality care. Patients require that nurse prescribers are skilled in providing a person-centred approach and have access to specialist training. The level of information and involvement offered to patients should reflect patients' requirements.

Stenov, V., Wind, G., Vallis, M., et al. (2019). "Group-based, person-centered diabetes self-management education: healthcare professionals' implementation of new approaches." BMC Health Serv Res **19**(1): 368.

BACKGROUND: Healthcare professionals' person-centered communication skills are pivotal for delivering successful diabetes education. Many healthcare professionals favor person-centeredness as a concept, but implementation in practice remains challenging. Today, programs have often a fixed curriculum dominated by biomedical issues. Most person-centered methods are developed targeting individual consultations, although group-based programs are a widespread and efficient method of support. Person-centeredness in group-based programs requires a change in practice towards addressing biopsychosocial issues and facilitating group processes. The objective of this study was to explore how healthcare professionals implement new approaches to facilitate group-based, person-centered diabetes education targeting people with type 2 diabetes. METHODS: The study was guided by action research and divided into three studies: investigation, development, and pilot using a variety of qualitative methods. In the first study; observations across five settings were conducted. Forty-nine group participants and 13 professionals took part; the focus was to investigate approaches that supported or hindered person-centeredness in groups. Observations were supplemented by interviews (n = 12) and two focus groups (n = 16) with group participants, as well as interviews (n = 5) with professionals. In the second study; 14 professionals collaborated in two workshops to develop new approaches. In the third study, new approaches were pilot-tested using observations in three settings. Twenty-five group participants and five professionals took part. The analysis of the pilot test led to the final workshop where six professionals took part. RESULTS: Implementation was characterized by three categories. Some professionals chose not to implement the methods because they conflicted with their practice relying on the biomedical model. Other incorporated some approaches but was unable to structure the process, leaving participants uncertain about the aim. Finally, one setting succeeded with implementation, tailoring content and processes to group participants' needs. CONCLUSION: The use of action research created context-sensitive approaches and increased professionals' readiness to implement. More attention should be paid to systematic training of professionals. Training should be structured stepwise incorporating techniques directed towards existing skills including ample time to train and reiterate skills.

Stenov, V., Wind, G., Skinner, T., et al. (2017). "The potential of a self-assessment tool to identify healthcare professionals' strengths and areas in need of professional development to aid effective facilitation of group-based, person-centered diabetes education." BMC Med Educ **17**(1): 166.

BACKGROUND: Healthcare professionals' person-centered communication skills are pivotal for successful group-based diabetes education. However, healthcare professionals are often insufficiently equipped to facilitate person-centeredness and many have never received post-graduate training. Currently, assessing professionals' skills in conducting group-based, person-centered diabetes education primarily focus on experts measuring and coding skills on various scales. However, learner-centered approaches such as adequate self-reflective tools have been shown to emphasize professional autonomy and promote engagement. The aim of this study was to explore the potential of a self-assessment tool to identify healthcare professionals' strengths and areas in need of professional development to aid effective facilitation of group-based, person-centered diabetes education. METHODS: The study entails of two components: 1) Field observations of five different educational settings including 49 persons with diabetes and 13 healthcare professionals, followed by interviews with 5 healthcare professionals and 28 persons with type 2 diabetes. 2) One professional development workshop involving 14 healthcare professionals. Healthcare professionals were asked to assess their person-centered communication skills using a self-assessment tool based on challenges and skills related to four educator roles: Embracer, Facilitator, Translator, and Initiator. Data were analyzed by hermeneutic analysis. Theories derived from theoretical model 'The Health Education Juggler' and techniques from 'Motivational Interviewing in Groups' were used as a framework to analyze data. Subsequently, the analysis from the field notes and interview transcript were compared with healthcare professionals' self-assessments of strengths and areas in need to effectively facilitate group-based, person-centered diabetes education. RESULTS: Healthcare professionals self-assessed the Translator and the Embracer to be the two most skilled roles whereas the Facilitator and the Initiator were identified to be the most challenged roles. Self-assessments corresponded to observations of professional skills in educational programs and were confirmed in the interviews. CONCLUSION: Healthcare professionals self-assessed the same professional skills as observed in practice. Thus, a tool to self-assess professional skills in facilitating group-based diabetes education seems to be useful as a starting point to promote self-reflections and identification of healthcare professionals' strengths and areas of need of professional development.

Stern, R. J., Fernandez, A., Jacobs, E. A., et al. (2012). "Advances in measuring culturally competent care: a confirmatory factor analysis of CAHPS-CC in a safety-net population." Med Care **50**(9 Suppl 2): S49-S55.
http://www.ncbi.nlm.nih.gov/pubmed/22895231

BACKGROUND: Providing culturally competent care shows promise as a mechanism to reduce health care inequalities. Until the recent development of the Consumer Assessment of Healthcare Providers and Systems Cultural Competency Item Set (CAHPS-CC), no measures capturing patient-level experiences with culturally competent care have been suitable for broad-scale administration. METHODS: We performed confirmatory factor analysis and internal consistency reliability analysis of CAHPS-CC among patients with type 2 diabetes (n=600) receiving primary care in safety-net clinics. CAHPS-CC domains were also correlated with global physician ratings. RESULTS: A 7-factor model demonstrated satisfactory fit (chi(2)(2)(3)(1)=484.34, P<0.0001) with significant factor loadings at P<0.05. Three domains showed excellent reliability-Doctor Communication-Positive Behaviors (alpha=0.82), Trust (alpha=0.77), and Doctor Communication-Health Promotion (alpha=0.72). Four domains showed inadequate reliability either among Spanish speakers or overall (overall reliabilities listed): Doctor Communication-Negative Behaviors (alpha=0.54), Equitable Treatment (alpha=0.69), Doctor Communication-Alternative Medicine (alpha=0.52), and Shared Decision-Making (alpha=0.51). CAHPS-CC domains were positively and significantly correlated with global physician rating. CONCLUSIONS: Select CAHPS-CC domains are suitable for broad-scale administration among safety-net patients. Those domains may be used to target quality-improvement efforts focused on providing culturally competent care in safety-net settings

Stevenson, F., Hall, L., Sequin, M., et al. (2019). "General Practitioner's use of online resources during medical visits: managing the boundary between inside and outside the clinic." Sociol Health Illn **41 Suppl 1**: 65-81.

In an increasingly connected world, information about health can be exchanged at any time, in any location or direction, and is no longer dominated by traditional authoritative sources. We consider the ways information and advice given in consultations by doctors transcends the boundary between the clinic and the home. We explore how information that is widely accessible outside the consultation is transformed by General Practitioners (GPs) into a medical offering. Data comprise 18 consultations identified from 144 consultations between unselected patients and five GPs. We use conversation analytic methods to explore four ways in which GPs used online resources; (i) to check information; (ii) as an explanatory tool; (iii) to provide information for patients for outside the consultation; (iv) to signpost further explanation and self-help. We demonstrate the interactional delicacy with which resources from the Internet are introduced and discussed, developing and extending Nettleton's (2004) idea of 'e-scaped medicine' to argue that Internet resources may be 'recaptured' by GPs, with information transformed and translated into a medical offering so as to maintain the asymmetry between patients and practitioners necessary for the successful functioning of medical practice.

Stringer, K., Terry, A. L., Ryan, B. L., et al. (2018). "Patient-centred primary care of adults with severe and profound intellectual and developmental disabilities: Patient-caregiver-physician relationship." Can Fam Physician **64**(Suppl 2): S63-s69.

OBJECTIVE: To explore the process of the development of the patient-physician relationship in adult patients with severe or profound intellectual and developmental disabilities (IDD), from the perspective of the patients' caregivers. DESIGN: Constructivist grounded theory. SETTING: St John's, NL. PARTICIPANTS: Thirteen primary caregivers (5 males, 8 females) of 1 or more adults with severe or profound IDD. METHODS: Data were collected via in-depth, semistructured interviews conducted in person or by telephone. Interviews were audiorecorded and transcribed verbatim. Field notes were documented immediately by the interviewer and discussed with the research team. Memos in the form of reflective notes served as additional sources of data. MAIN FINDINGS: From the perspective of the caregivers, the core process in the development of the patient-physician relationship was protection. This process began as a result of the caregiver's recognition of the patient's vulnerability and moved through a number of stages before resulting in the development of a dynamic triangular interaction between the patient, caregiver, and family physician. First, the caregiver provides extreme nurturing to the patient, which results in the development of a strong bond between them. The patient and caregiver approached the family physician together as one unit, and then decided together on whether or not to open the patient-caregiver bond to the physician. The resultant dynamic triangular interaction formed the starting point from which 1 of 4 different relationship-development trajectories began. Which trajectory was taken and, therefore, the character of the relationships that developed was determined by how the caregiver and patient experienced their interaction with the family physician. CONCLUSION: Findings highlight the process of protection and the centrality of the patient-caregiver bond within the development of a triadic relationship involving the patient with IDD, the caregiver, and the family physician. How a physician approaches this bond can influence the trajectory of the resulting relationship.

Strupeit, S., Buss, A. et Dassen, T. (2016). "Effectiveness of nurse-delivered patient education interventions on quality of life in elders in the hospital: A systematic review." Appl Nurs Res **32**: 217-221.

BACKGROUND: Nurse-delivered education is a crucial part of nursing practice; however, evidence regarding its impact on quality of life is lacking. To our knowledge, no systematic review has addressed the effects of nurse-delivered education interventions on the quality of life in a general elderly inpatient population. OBJECTIVES: To evaluate the effectiveness of nurse-delivered education interventions compared to usual care with regard to the quality of life in elders in the hospital. METHODS: A systematic review was performed to identify randomized controlled trials examining the effects of nurse-delivered educational interventions on the quality of life in elders in the hospital. The search was performed in December 2012 in the MEDLINE (via PubMed), EMBASE (via Ovid), and CINAHL (via EBSCO) databases and was limited with regard to publication time and language. The studies were appraised according to methodological quality, and p-values were extracted to determine the effectiveness of the interventions. RESULTS: Four studies were included in the review. One study testing multicomponent interventions showed positive effects on quality of life. Two studies showed no effect, and one study showed a negative effect of the intervention on quality of life. Methodological appraisal revealed single biases in most of the studies. CONCLUSIONS AND IMPLICATIONS OF KEY FINDINGS: Because of the scarcity of positive findings, methodological issues, and heterogeneity between studies, this review could not provide evidence of the effectiveness of nurse-delivered education interventions in elders in the hospital for improving quality of life. Nurse-delivered education may be more effective as a part of multifactorial interventions. Further studies should examine interventions that focus on quality of life using validated measures.

Sustersic, M., Meneau, A., Dremont, R., et al. (2008). "[Developing patient information sheets in general practice. Proposal for a methodology]." Rev Prat **58**(19 Suppl): 17-24.
http://www.ncbi.nlm.nih.gov/pubmed/19253787

BACKGROUND: Health information is patients' wish and right. For general practitioners, it is a duty, a legal obligation and a pre-requisite in any preventive approach. Written information must complete oral information since it improves health care quality. However, in general practice, there are no patient documents which are scientifically valid, understandable and efficient in terms of communication. OBJECTIVE: To develop a method for creating patient information sheets and to experiment its feasibility through the development of 125 sheets focused on the most common clinical conditions in general practice. METHOD: Research and literature review pour the development of specifications, and creation of 125 sheets following these specifications. RESULTS: The specifications developed consist of the 10 following steps: selection of the topic and the objectives, literature review, selection of the sections, drafting, validation of the scientific contents, assessment among patients, validation of the layout, selection of the media, delivery to patients and update. Following these specifications, we developed 125 information sheets. Each of these was reviewed by several physicians and assessed with R. Flesh readability test (the established acceptable threshold value was 40). The 30 sheets associated with the lowest scores were selected and reviewed to improve their overall readability. CONCLUSION: Even though some difficulties cannot be avoided when developing patient information sheets, each physician or physician association can create its own documents following the proposed specifications and thus deliver a customized message

Szecsenyi, J. (2010). "Programme de disease management et organisation des soins primaires en Allemagne. In : Politiques et organisation des soins primaires en Europe et aux États-Unis : quels enseignements pour la France ?" Revue Francaise des Affaires Sociales(3).

Joachim Szecsenyi, directeur du département de recherche médicale et de médecine générale à l’université de Heidelberg, propose un aperçu de l?organisation des soins ambulatoires en Allemagne, et notamment des programmes de disease management introduits en 2002. En Allemagne, comme en France, l’organisation des soins est très fragmentée, avec une distinction institutionnelle claire en matière de délivrance des soins primaires et secondaires (soins ambulatoires et hospitaliers). La place des soins primaires y est peu structurée, au sein d’une médecine ambulatoire prise en charge par des médecins libéraux. Ce n’est que récemment que certaines réformes, notamment l’introduction d?incitations financières et d?une plus grande flexibilité dans la contractualisation entre les assureurs et les professionnels, ont tenté de favoriser une meilleure coordination des soins et un renforcement de la place des soins primaires. Différents dispositifs viennent ainsi s’ajouter à l’instauration du disease

> management : l'introduction d'un mécanisme incitatif au choix d'un médecin référent, la mise en place de contrats de soins intégrés, le développement des centres de soins médicaux regroupant des médecins et d'autres professions de santé, et la promotion du rôle des infirmières praticiennes ayant acquis une formation spécifique orientée vers l'intervention auprès de groupes de patients.

Taal, M. W. (2013). "Chronic kidney disease in general populations and primary care: diagnostic and therapeutic considerations." Curr Opin Nephrol Hypertens **22**(6): 593-598.

> PURPOSE OF REVIEW: The majority of people with chronic kidney disease (CKD) are managed by primary care physicians and nurses, but much of the initial research on CKD care was based in secondary care. The purpose of this article is to review the important recent studies of CKD in primary care that are starting to provide an evidence base for the strategies to improve the management and outcomes of the unreferred majority of people with CKD. RECENT FINDINGS: People with CKD in primary care populations differ substantially from those familiar to nephrologists in secondary care by being older, having less reduction in glomerular filtration rate (GFR) and lower prevalence of proteinuria. These differences have important implications for management priorities. Detailed studies have identified widespread deficiencies in the care of patients with CKD in primary care (though these are also reported in secondary care). Interventions that may improve performance include automated reporting of estimated GFR, incentivizing primary care practitioners to achieve therapeutic goals and quality improvement strategies such as audit-based education. SUMMARY: Studies have identified a need for improved management of CKD in primary care as well as methods to achieve this. Future studies should focus on the promotion of self-management through telemedicine and the Internet.

Tarn, D. M., Paterniti, D. A., Williams, B. R., et al. (2009). "Which providers should communicate which critical information about a new medication? Patient, pharmacist, and physician perspectives." J Am Geriatr Soc **57**(3): 462-469.

> OBJECTIVES: To investigate older patient, pharmacist, and physician perspectives about what information is essential to impart to patients receiving new medication prescriptions and who should provide the information. DESIGN: Qualitative focus group discussions. SETTINGS: Senior centers, retail pharmacies, and primary care physician offices. PARTICIPANTS: Forty-two patients aged 65 and older, 13 pharmacists, and 17 physicians participated in eight focus groups. MEASUREMENT: Qualitative analysis of transcribed focus group interviews and consensus through iterative review by multidisciplinary auditors. RESULTS: Patient, pharmacist, and physician groups all affirmed the importance of discussing medication directions and side effects and said that physicians should educate about side effects and that pharmacists could adequately counsel about certain important issues. However, there was substantial disagreement between groups about which provider could communicate which critical elements of medication-related information. Some pharmacists felt that they were best equipped to discuss medication-related issues but acknowledged that many patients want physicians to do this. Physicians tended to believe that they should provide most new-medication education for patients. Patients had mixed preferences. Patients aged 80 and older listed fewer critical topics of discussion than younger patients. CONCLUSION: Patients, pharmacists, and physicians have incongruent beliefs about who should provide essential medication-related information. Differing expectations could lead to overlapping, inefficient efforts that result in communication deficiencies when patients receive a new medication. Collaborative efforts to ensure that patients receive complete information about new medications could be explored.

Taylor, K. (2009). "Paternalism, participation and partnership - the evolution of patient centeredness in the consultation." Patient Educ Couns **74**(2): 150-155.
http://www.ncbi.nlm.nih.gov/pubmed/18930624

> OBJECTIVE: There is much discussion at present on the need for a more patient-centered health service. However, it is not always clear what exactly this means for patients or healthcare providers. Furthermore many current trends in healthcare and society may in fact move the consultation further from the patient-centered model. In this article I shall critically review the current state of the

> consultation. METHODS: This article is based on a critical review of the literature. I shall firstly outline what is meant by the terms 'patient centeredness' and 'participation'. I shall then examine what wider factors may facilitate or impede effective communication within the consultation. RESULTS: Patient centeredness and participation is challenged by several factors including the 'co-modification' of healthcare, the information revolution, the tension between choice and continuity, the process of medicalisation, population health strategies and the availability of resources. CONCLUSION: I will argue that precisely because of these wider trends in society the consultation is now more important than ever as a point of access, communication, understanding and delivery of healthcare. PRACTICE IMPLICATIONS: The structure and aims of the consultation must be re-visited in the light of the rapid pace of change in service delivery. As such, healthcare professionals may need to advocate for the continuing role of the patient-centered consultation

Thom, D. H., Hessler, D., Willard-Grace, R., et al. (2014). "Does health coaching change patients' trust in their primary care provider?" Patient Educ Couns **96**(1): 135-138.

> OBJECTIVE: To assess the impact of health coaching on patients' in their primary care provider. METHODS: Randomized controlled trial comparing health coaching with usual care. PARTICIPANTS: Low-income English or Spanish speaking patients age 18-75 with poorly controlled type 2 diabetes, hypertension and/or hyperlipidemia. MAIN OUTCOME MEASURE: Patient trust in their primary care provider measured by the 11-item Trust in Physician Scale, converted to a 0-100 scale. ANALYSIS: Linear mixed modeling. RESULTS: A total of 441 patients were randomized to receive 12 months of health coaching (n=224) vs. usual care (n=217). At baseline, the two groups were similar to those in the usual care group with respect to demographic characteristics and levels of trust in their provider. After 12 months, the mean trust level had increased more in patients receiving health coaching (3.9 vs. 1.5, p=0.47), this difference remained significant after adjustment for number of visits to primary care providers (adjusted p=.03). CONCLUSIONS: Health coaching appears to increase patients trust in their primary care providers. PRACTICE IMPLICATIONS: Primary care providers should consider adding health coaches to their team as a way to enhance their relationship with their patients.

Thomas, H., Best, M. et Mitchell, G. (2020). "Whole-person care in general practice: Factors affecting the provision of whole-person care." Aust J Gen Pract **49**(4): 215-220.

> BACKGROUND AND OBJECTIVES: Whole-person care (WPC) is a key characteristic of general practice, but it may not be consistently practised. Previous articles in this series suggest a model of WPC that views patients as multidimensional persons; has length, breadth and depth of scope; is founded on a strong doctor-patient relationship and involves a healthcare team. This article reports factors that general practitioners (GPs) believe affect their provision of WPC. METHOD: Semi-structured interviews were conducted with 20 Australian GPs or general practice registrars and analysed using grounded theory methodology. RESULTS: Participants identified overarching factors (time, perceived value of WPC) and factors related to immediate (interpersonal dynamic), local (practice structure, relationship between care providers) and broader (health system structure) contexts that affect WPC. They volunteered practical suggestions to support WPC. DISCUSSION: GPs believe that multiple factors acting at micro and macro levels affect WPC provision. These findings provide a basis for strategies to support WPC.

Thomas, H., Best, M. et Mitchell, G. (2020). "Whole-person care in general practice: The doctor-patient relationship." Aust J Gen Pract **49**(3): 139-144.

> BACKGROUND AND OBJECTIVES: Whole-person care (WPC) is a defining feature of general practice, but it may not be consistently implemented. These authors conducted a qualitative study to define WPC and determine factors that influence its provision. Part one of this series suggested a model of WPC. Its foundation is the doctor-patient relationship; this article reports the findings concerning this theme. METHOD: Semi-structured interviews were conducted with 20 Australian GPs or general practice registrars and analysed using grounded theory methodology. RESULTS: GPs viewed the doctor-patient relationship as foundational to WPC, facilitating knowledge of the patient, trust and management. Participants' descriptions of the doctor-patient relationship were multidimensional,

encompassing interacting professional, personal and business-transactional dimensions. DISCUSSION: The results suggest that a multidimensional doctor-patient relationship underpins WPC. It is not adequately described by a consumerist/contractual model; future work could further elucidate its nature. This relationship must be valued to provide quality WPC.

Thomas, H., Best, M. et Mitchell, G. (2020). "Whole-person care in general practice: The nature of whole-person care." Aust J Gen Pract **49**(1-2): 54-60.

BACKGROUND AND OBJECTIVES: Whole-person care (WPC) is a core value of general practice and is particularly relevant with increasing population multimorbidity. However, WPC has lacked consensus definition, and some argue that it is not consistently practised. The aim of this study was to determine Australian general practitioners' (GPs') understanding of WPC and factors affecting its provision. This article (the first in a three-part series) describes GPs' understanding of WPC. METHOD: Semi-structured interviews were conducted with 20 Australian GPs or general practice registrars and analysed using grounded theory methodology. RESULTS: Four themes encapsulated GPs' understanding of WPC: 1) treats patients as multidimensional persons; 2) length, breadth and depth of scope; 3) based on the foundation of a doctor-patient relationship; and 4) may involve team-based care. DISCUSSION: WPC encompasses several defining characteristics of generalism. Previous evidence supports the efficacy of several of its dimensions. The current findings provide a basis for education, self-reflection and assessment of implementation and outcomes of WPCs.

Tiedje, K., Shippee, N. D., Johnson, A. M., et al. (2013). "'They leave at least believing they had a part in the discussion': understanding decision aid use and patient-clinician decision-making through qualitative research." Patient Educ Couns **93**(1): 86-94.

OBJECTIVE: This study explores how patient decision aids (DAs) for antihyperglycemic agents and statins, designed for use during clinical consultations, are embedded into practice, examining how patients and clinicians understand and experience DAs in primary care visits. METHODS: We conducted semistructured in-depth interviews with patients (n=22) and primary care clinicians (n=19), and videorecorded consultations (n=44). Two researchers coded all transcripts. Inductive analyses guided by grounded theory led to the identification of themes. Video and interview data were compared and organized by themes. RESULTS: DAs used during consultations became flexible artifacts, incorporated into existing decision making roles for clinicians (experts, authority figures, persuaders, advisors) and patients (drivers of healthcare, learners, partners). DAs were applied to different decision making steps (deliberation, bargaining, convincing, case assessment), and introduced into an existing knowledge context (participants' literacy regarding shared decision-making (SDM) and DAs). CONCLUSION: DAs' flexible use during consultations effectively provided space for discussion, even when SDM was not achieved. DAs can be used within any decision-making model. PRACTICE IMPLICATIONS: Clinician training in DA use and SDM practice may be needed to facilitate DA implementation and promote more ideal-type forms of sharing in decision making.

Trigoni, M., Griffiths, F., Tsiftsis, D., et al. (2008). "Mammography screening: views from women and primary care physicians in Crete." BMC Womens Health **8**: 20.
http://www.ncbi.nlm.nih.gov/pubmed/18990253

BACKGROUND: Breast cancer is the most commonly diagnosed cancer among women and a leading cause of death from cancer in women in Europe. Although breast cancer incidence is on the rise worldwide, breast cancer mortality over the past 25 years has been stable or decreasing in some countries and a fall in breast cancer mortality rates in most European countries in the 1990s was reported by several studies, in contrast, in Greece have not reported these favourable trends. In Greece, the age-standardised incidence and mortality rate for breast cancer per 100.000 in 2006 was 81,8 and 21,7 and although it is lower than most other countries in Europe, the fall in breast cancer mortality that observed has not been as great as in other European countries. There is no national strategy for screening in this country. This study reports on the use of mammography among middle-aged women in rural Crete and investigates barriers to mammography screening encountered by women and their primary care physicians. METHODS: Design: Semi-structured individual interviews.

Setting and participants: Thirty women between 45-65 years of age, with a mean age of 54,6 years, and standard deviation 6,8 from rural areas of Crete and 28 qualified primary care physicians, with a mean age of 44,7 years and standard deviation 7,0 serving this rural population. Main outcome measure: Qualitative thematic analysis. RESULTS: Most women identified several reasons for not using mammography. These included poor knowledge of the benefits and indications for mammography screening, fear of pain during the procedure, fear of a serious diagnosis, embarrassment, stress while anticipating the results, cost and lack of physician recommendation. Physicians identified difficulties in scheduling an appointment as one reason women did not use mammography and both women and physicians identified distance from the screening site, transportation problems and the absence of symptoms as reasons for non-use. CONCLUSION: Women are inhibited from participating in mammography screening in rural Crete. The provision of more accessible screening services may improve this. However physician recommendation is important in overcoming women's inhibitions. Primary care physicians serving rural areas need to be aware of barriers preventing women from attending mammography screening and provide women with information and advice in a sensitive way so women can make informed decisions regarding breast cancer screening

Twigg, G., Motsko, J., Thomas, J., et al. (2017). "Pharmacist-Managed Diabetes Center Interventions Ensure Quality and Safety in Elderly Patients." Consult Pharm **32**(5): 299-310.

OBJECTIVES: This quality-improvement study aimed to replicate historical Patient Safety Clinical Pharmacy Services Collaborative results in high-risk Medicare beneficiaries with diabetes to achieve reductions in A1C, adverse drug events (ADEs), and potential ADEs (pADEs). DESIGN: The model included an interdisciplinary team led by a pharmacist located inside a community pharmacy to provide disease state management and medication therapy management (MTM) to the study population. SETTING: Apple Discount Drugs is an independent community pharmacy located in Salisbury, Maryland. The interdisciplinary team included pharmacists, respiratory therapists, durable medical equipment (DME) specialists, and a referring prescriber. PARTICIPANTS: High-risk Medicare beneficiaries, defined as patients with A1C > 9.0% and/or a documented history of three or more hypoglycemic events in the previous six months (defined by blood glucose < 70 mg/dL, patient-described signs and symptoms of hypoglycemia, or a combination of each). All patients were 65 years of age and older and diagnosed with type 2 diabetes mellitus. INTERVENTIONS: Patients received longitudinal diabetes self-management education (DSME) and MTM from pharmacist certified diabetes educators. MTM included a comprehensive medication review performed by a pharmacist. MAIN OUTCOME MEASURE: The study looked at the effects of the program's interventions on A1C and ADEs. RESULTS: The study cohort saw a 90% reduction of patients with an A1C > 9.0% compared with baseline. ADEs were reduced by 49% and pADEs were reduced by 67%. CONCLUSIONS: An integrated, pharmacist-directed DSME and MTM program for high-risk Medicare beneficiaries resulted in improvements in A1C quality measure and mitigated medication associated harm.

Uhl, M. C., Muth, C., Gerlach, F. M., et al. (2018). "Patient-perceived barriers and facilitators to the implementation of a medication review in primary care: a qualitative thematic analysis." BMC Fam Pract **19**(1): 3.

BACKGROUND: Although polypharmacy can cause adverse health outcomes, patients often know little about their medication. A regularly conducted medication review (MR) can help provide an overview of a patient's medication, and benefit patients by enhancing their knowledge of their drugs. As little is known about patient attitudes towards MRs in primary care, the objective of this study was to gain insight into patient-perceived barriers and facilitators to the implementation of an MR. METHODS: We conducted a qualitative study with a convenience sample of 31 patients (age ≥ 60 years, ≥3 chronic diseases, taking ≥5 drugs/d); in Hesse, Germany, in February 2016. We conducted two focus groups and, in order to ensure the participation of elderly patients with reduced mobility, 16 telephone interviews. Both relied on a semi-structured interview guide dealing with the following subjects: patients' experience of polypharmacy, general design of MRs, potential barriers and facilitators to implementation etc. Interviews were audio-recorded, transcribed verbatim, and analysed by two researchers using thematic analysis. RESULTS: Patients' average age was 74 years (range 62-88 years). We identified barriers and facilitators for four main topics regarding the implementation of MRs in primary care: patient participation, GP-led MRs, pharmacist-led MRs, and the involvement of healthcare assistants in MRs. Barriers to patient participation concerned patient autonomy, while facilitators involved patient awareness of medication-related problems. Barriers to GP-led MRs concerned GP's lack of resources while facilitators related to the trusting relationship between patient and GP. Pharmacist-led MRs might be hindered by a lack of patients' confidence in pharmacists' expertise, but facilitated by pharmacies' digital records of the patients' medications. Regarding the involvement of healthcare assistants in MRs, a potential barrier was patients' uncertainty regarding the extent of their training. Patients could, however, imagine GPs delegating some aspects of MRs to them. CONCLUSIONS: Our study suggests that patients regard MRs as beneficial and expect indications for their medicines to be checked, and possible interactions to be identified. To foster the implementation of MRs in primary care, it is important to consider barriers and facilitators to the four identified topics.

Ulbrich, E. M., Mantovani, M. F., Mattei Â, T., et al. (2018). "Scale for supported care in primary care: a methodological study." Rev Gaucha Enferm **38**(4): e63922.

OBJECTIVE: To develop a predictive scale for determining complications in adults with hypertension and actions for care supported in primary care. METHOD: Methodological research developed in the municipality of Curitiba-PR in 2013 and 2014, carried out in two stages, the first through the collection of data from 387 adults with hypertension through a structured interview and anxiety scales, depression, quality of life, medication adherence and social support. The second step was the construction of the scale from the statistically significant variables in the multivariate analysis. RESULTS: The scale consisted of age, sex, smoking, time of diagnosis, and risk classification in the health unit, medications in use and depression. Later, through literature review, actions were suggested for supported self-care. CONCLUSION: The scale enables identification of factors that may predict the development of complications of hypertension and provides actions to supported careVaillant-Roussel, H., Laporte, C., Pereira, B., et al. (2016). "Impact of patient education on chronic heart failure in primary care (ETIC): a cluster randomised trial." BMC Fam Pract **17**: 80.

BACKGROUND: The Education Therapeutique des patients Insuffisants Cardiaques (ETIC; Therapeutic Education for Patients with Cardiac Failure) trial aimed to determine whether a pragmatic education intervention in general practice could improve the quality of life of patients with chronic heart failure (CHF) compared with routine care. RESULTS: This cluster randomised controlled clinical trial included 241 patients with CHF attending 54 general practitioners (GPs) in France and involved 19 months of follow-up. The GPs in the Intervention Group were trained during a 2-day interactive workshop to provide a patient education programme. The mean age of the patients was 74 years (+/-10.5), 62 % were men and their mean left-ventricular ejection fraction was 49.3 % (+/- 14.3). At the end of the follow-up period, the mean Minnesota Living with Heart Failure Questionnaire scores in the Intervention and Control Groups were 33.4 (+/- 22.1) versus 27.2 (+/- 23.3; P = 0.74, intra-cluster coefficient [ICC] = 0.11). At the end of the follow-up period, the 36-Item Short Form Health Survey (mental health and physical health) scores in the Intervention and Control Groups were 58 (+/- 22.1) versus 58.7 (+/- 23.9; P = 0.58, ICC = 0.01) and 52.8 (+/- 23.8) versus 51.6 (+/- 25.5; P = 0.57, ICC = 0.01), respectively. CONCLUSIONS: Patient education delivered by GPs to elderly patients with stable heart failure in the ETIC programme did not achieve an improvement in their quality of life compared with routine care. Further research on improving the quality of life and clinical outcomes of elderly patients with CHF in primary care is necessary. TRIAL REGISTRATION: The Education Therapeutique des patients Insuffisants Cardiaques (ETIC; Therapeutic Education for Patients with Cardiac Failure) trial is a cluster randomised controlled trial registered with ClinicalTrials.gov (REGISTRATION NUMBER: NCT01065142) and the French Drug Agency (Agence Nationale de Securite du Medicament et des Produits de Sante; REGISTRATION NUMBER: 2009-A01142-55).

Van Camp, Y. P., Van Rompaey, B. et Elseviers, M. M. (2013). "Nurse-led interventions to enhance adherence to chronic medication: systematic review and meta-analysis of randomised controlled trials." Eur J Clin Pharmacol **69**(4): 761-770.

> PURPOSE: Non-adherence to chronic medication remains an important problem with vast consequences and without solutions to date. Nurses are well positioned to provide adherence care, yet currently represent an underutilised force in improving adherence and outcomes. This review aims to synthesise the effect of nurse-led interventions on adherence to chronic medication. METHODS: Using Review Manager software, a meta-analysis was conducted. The search term medication adherence was combined with random* and nurse in PubMed and ISI Web of Knowledge. Retrieved articles' reference lists were hand searched. Included were randomised controlled trials on nurse-led interventions, aiming to improve chronic medication adherence. Articles were to be in English and published from 2006 to 2011. Quality was assessed using an adapted version of the CONSORT tool. RESULTS: Ten studies met the selection criteria, seven of which were on HIV-positive patients. Their quality was acceptable to high. Counselling was the intervention most frequently assessed, mostly given face-to-face, but also in groups and via electronic messages. All interventions enhanced adherence. Of the five studies reporting adherence as mean percentage of adherence, pooled mean differences were +5.39 (1.70-9.07) (short term) and +9.49 (4.68-14.30) (long term), favouring the intervention groups. Of the studies reporting adherence dichotomously, odd's ratios were 1.55 (1.04-2.29) (short term) and 1.87 (1.35-2.61) (long term). The longer counselling was effectuated, the better the results. CONCLUSIONS: Counselling appears to be an effective approach that nurses can use to supplement other methods, building a multifaceted strategy to enhance adherence. Tackling non-adherence seems to demand continuous efforts and follow-up.

van den Nieuwenhof, L., Schermer, T., Heins, M., et al. (2008). "Tracing uncontrolled asthma in family practice using a mailed asthma control questionnaire." Ann Fam Med **6 Suppl 1**: S16-S22.
http://www.ncbi.nlm.nih.gov/pubmed/18195302

> PURPOSE: A substantial proportion of adult patients with asthma have inadequately controlled symptoms despite the availability of effective treatment. The Asthma Control Questionnaire (ACQ) can be used to discriminate between asthma patients with well- and suboptimally controlled asthma symptoms. The objective of this study was to investigate whether a postal mailing of the ACQ can be used to identify asthma patients with suboptimal symptom control in family practice. METHODS: In this observational study, we sent 434 asthma patients from 6 Dutch family practices an ACQ by mail to measure control of their asthma symptoms. Both respondents and nonrespondents were characterized by information gathered from their medical records. Patients with an ACQ sum score (total score) of greater than 3 were considered to have suboptimally controlled asthma symptoms. RESULTS: The response rate was 77%. Respondents were more likely than non-respondents to be female and to use asthma medication. The mean ACQ sum score of the respondents was 5.2. Of this group, 53.4% (95% confidence interval, 48.0%-58.8%) had suboptimally controlled asthma symptoms. Of the 168 respondents who had not visited their family physician in the 2 years before the study, 42.9% (95% confidence interval, 35.4%-50.4%) had inadequate asthma symptom control. CONCLUSIONS: Our results show that a postal mailing of the ACQ is an effective approach for tracing asthma patients who need medical attention. It also traces patients who would otherwise not have consulted their family physician. The ACQ seems to be a useful starting point for health care professionals in family practice to improve the level of asthma symptom control in their patient population

van der Weijden, T., van, S. B., Stoffers, H. E., et al. (2007). "Primary prevention of cardiovascular diseases in general practice: mismatch between cardiovascular risk and patients' risk perceptions." Med Decis. Making **27**(6): 754-761.
http://www.ncbi.nlm.nih.gov/pubmed/17873263

> OBJECTIVE: Guidelines on primary prevention of cardiovascular disease (CVD) emphasize identifying high-risk patients for more intensive management, but patients' misconceptions of risk hamper implementation. Insight is needed into the type of patients that general practitioners (GPs) encounter in their cardiovascular prevention activities. How appropriate are the risk perceptions and worries of patients with whom GPs discuss CVD risks? What determines inappropriate risk perception? METHOD: Cross-sectional study in 34 general practices. The study included patients aged 40 to 70 years with whom CVD risk was discussed during consultation. After the consultation, the GPs completed a

registration form, and patients completed a questionnaire. Correlations between patients' actual CVD risk and risk perceptions were analyzed. RESULTS: In total, 490 patients were included. In 17% of the consultations, patients were actually at high risk. Risk was perceived inappropriately by nearly 4 in 5 high-risk patients (incorrect optimism) and by 1 in 5 low-risk patients (incorrect pessimism). Smoking, hypertension, and obesity were determinants of perceiving CVD risk as high, whereas surprisingly, diabetic patients did not report any anxiety about their CVD risk. Men were more likely to perceive their CVD risk inappropriately than women. CONCLUSION: In communicating CVD risk, GPs must be aware that they mostly encounter low-risk patients and that the perceived risk and worry do not necessarily correspond with the actual risk. Incorrect perceptions of CVD risk among men and patients with diabetes were striking

van Gaalen, J. L., van Bodegom-Vos, L., Bakker, M. J., et al. (2016). "Internet-based self-management support for adults with asthma: a qualitative study among patients, general practitioners and practice nurses on barriers to implementation." BMJ Open **6**(8): e010809.

OBJECTIVES: The aim of this study was to explore barriers among patients, general practitioners (GPs) and practice nurses to implement internet-based self-management support as provided by PatientCoach for asthma in primary care. SETTING: Primary care within South Holland, the Netherlands. PARTICIPANTS: Twenty-two patients (12 women, mean age 38 years), 21 GPs (6 women, mean age 52 years) and 13 practice nurses (all women, mean age 41 years). DESIGN: A qualitative study using focus groups and interviews. OUTCOMES: Barriers as perceived by patients, GPs and practice nurses to implementation of PatientCoach. METHODS: 10 focus groups and 12 interviews were held to collect data: 4 patient focus groups, 4 GP focus groups, 2 practice nurse focus group, 2 patient interviews, 5 GP interviews and 5 practice nurse interviews. A prototype of PatientCoach that included modules for coaching, personalised information, asthma self-monitoring, medication treatment plan, feedback, e-consultations and a forum was demonstrated. A semistructured topic guide was used. Directed content analysis was used to analyse data. Reported barriers were classified according to a framework by Grol and Wensing. RESULTS: A variety of barriers emerged among all participant groups. Barriers identified among patients include a lack of a patient-professional partnership in using PatientCoach and a lack of perceived benefit in improving asthma symptoms. Barriers identified among GPs include a low sense of urgency towards asthma care and current work routines. Practice nurses identified a low level of structured asthma care and a lack of support by colleagues as barriers. Among all participant groups, insufficient ease of use of PatientCoach, lack of financial arrangements and patient characteristics such as a lack of asthma symptoms were reported as barriers. CONCLUSIONS: We identified a variety of barriers to implementation of PatientCoach. An effective implementation strategy for internet-based self-management support in asthma care should focus on these barriers.

Van Roy, K., Vanheule, S. et Deveugele, M. (2013). "What makes up good consultations? A qualitative study of GPs' discourses." BMC Fam Pract **14**: 62.

BACKGROUND: In medical literature, several principles that define 'good consultations' have been outlined. These principles tend to be prescriptive in nature, overlooking the complexity of general practitioners (GPs)' perspectives of everyday practice. Focusing on perspectives might be particularly relevant, since they may affect decisions and actions. Therefore, the present study adopts a bottom-up approach, analyzing GPs' narratives about 'good' and 'bad' consultations. We aimed at describing the range of discourses GPs use in relating on their practice. METHODS: Semi-structured interviews were conducted with 19 Belgian GPs. By means of a qualitative analysis, the authors mapped patterns in the interview narratives and described the range of different discourses. RESULTS: Four discourses were identified: a biomedically-centered discourse, a communication-focused discourse, a problem-solving discourse and a satisfaction-oriented discourse. Each discourse was further specified in terms of predominant themes, problems the GPs prefer to deal with and inherent difficulties. Although most participants used elements from all four discourses, the majority of the GPs relied on an individual set of predominant discourses and focused on a limited number of themes. CONCLUSION: This study clearly indicates that there is no uniform way in which GPs perceive clinical practice. Each of the participants used a subtle mix of different criteria to define good and bad medical consultations. Some discourse elements appear to be rooted in medical literature, whereas others are of a more personal nature. By focusing on the limitations of each discourse, this study can shed new light on some of the difficulties GPs encounter in their daily practice: being confronted with specific problems might be an effect of adhering to a specific discourse. The typification of different discourses on consultations may function as a framework to help GPs reflect on how they perceive their practice, and help them manage some of the challenges met in daily practice.

van, S. B., van der Weijden, T. M., Stoffers, J. H., et al. (2008). "Patients' responsiveness to a decision support tool for primary prevention of cardiovascular diseases in primary care." Patient Educ Couns **72**(1): 63-70.
http://www.ncbi.nlm.nih.gov/pubmed/18395393

OBJECTIVE: Assessment of patients' responsiveness to a decision support tool for primary prevention of cardiovascular diseases (CVDs). The booklet focuses on barriers at patient level. METHODS: Process evaluation of an intervention in primary care. Patients at high or potentially high-cardiovascular risk were asked by their GP to prepare themselves for a second consultation in order to participate in decisions on risk management. OUTCOMES: Patients' actually having read the booklet and returning for the second consultation; comprehension and perceived relevance of the information; perceived reassurance. RESULTS: 17 GPs, in the intervention arm of a cluster RCT, issued 276 decision support tools during the first consultation and were instructed to ask them to return for a second consultation to discuss their CVD risk. Patients had a mean age of 54 years, 47% were male and 19% actually had a high cardiovascular risk. Data on 239 patients, a mixture of returnees and non-returnees, showed that they all read the booklet; comprehension was fair to good; 85% perceived the information as relevant; 68% of the patients felt reassured by the information. Satisfaction with the first consultation was higher in the non-returnees. CONCLUSIONS: Cardiovascular prevention spread over two consultations with use of a decision support tool for patients is not easily applicable for GPs. However, based on the findings of good patients' responsiveness, we recommend further development and implementation of decision support tools in primary care. PRACTICE IMPLICATIONS: Decision support for primary CV-prevention is welcomed by patients but needs further adjustment of both the GP and the organization of CV-prevention in primary care. Sharing information between professional and patient on a personal CV-risk management plan is difficult, more training is needed

van Weel, WC. (2008). "[The practice guideline 'Smoking cessation' from the Dutch College of General Practitioners; a response from the perspective of general practice]." Ned Tijdschr Geneeskd **152**(26): 1455-1456.
http://www.ncbi.nlm.nih.gov/pubmed/18666661

This article reviews the practice guideline from the Dutch College of General Practitioners on smoking cessation. General practitioners (GP) should strive after smoking cessation when patients consult and ask for support to stop smoking. Moreover, the practitioner should also show such initiative when patients present signs and symptoms related to smoking; in parents of children with asthma; and in pregnant women. The strength of general practice is its accessibility to the population: more than 60% of the population consults their GP at least once a year. However, it is important to realize that it is not always possible to raise the issue of smoking cessation, and in some consultations this might be inappropriate. The effectiveness of individual advice in smoking cessation is enhanced by public health campaigns, and it is expected that the smoking ban in Dutch bars and restaurants, that is to come into effect in July 2008, will support the role of GPs. A problem in the implementation of the practice guideline remains, however: medication and methods to support withdrawal symptoms are still not covered by health care insurers

Vanwesemael, T., Boussery, K., Manias, E., et al. (2018). "Self-management of medication during hospitalisation: Healthcare providers' and patients' perspectives." J Clin Nurs **27**(3-4): 753-768.

AIMS AND OBJECTIVES: To explore healthcare providers' and patients' perspectives on self-management of medication during the patients' hospital stay. BACKGROUND: Self-administration of medications relates to the process in which hospitalised patients-instead of healthcare professionals-prepare and consume medications by themselves. Literature suggests possible advantages of medication self-management such as increased patient satisfaction, adherence to pharmacotherapy and self-care competence. DESIGN: A qualitative descriptive study design was adopted, using semistructured interviews and qualitative content analysis to examine data. METHODS: Six physicians, 11 nurses, six hospital pharmacists and seven patients were recruited from one regional hospital and two university hospitals, situated in Belgium. Interviews were conducted between October 2014-January 2015. RESULTS: Strengths of medication self-management were described by participants, relating to benefits of self-management for patients, time-saving benefits for nurses and benefits for better collaboration between patients and healthcare providers. Weaknesses were also apparent for patients as well as for nurses and physicians. Opportunities for self-management of medication were described, relating to the organisation, the patient and the process for implementing self-management. Threats for self-management of medication included obstacles related to implementation of self-managed medications and the actual process of providing medication self-management. A structured overview of conditions that should be fulfilled before allowing self-management of medication concerned patient-related conditions, the self-managed medication and the organisation of self-management of medication. CONCLUSIONS: This study provides new insights on the strengths, weaknesses, opportunities and threats from the perspectives of key stakeholders. Interpretation of these findings resulted in an overview of adaptations in the medication management process to facilitate implementation of self-management of medication. RELEVANCE TO CLINICAL PRACTICE: A medication management process for self-management of medication was proposed. Further interventional studies are needed to test and refine this process before implementing it in daily practice.

Victoor, A., Delnoij, D. M., Friele, R. D., et al. (2012). "Determinants of patient choice of healthcare providers: a scoping review." BMC Health Serv Res **12**: 272.

BACKGROUND: In several northwest European countries, a demand-driven healthcare system has been implemented that stresses the importance of patient healthcare provider choice. In this study, we are conducting a scoping review aiming to map out what is known about the determinants of patient choice of a wide range of healthcare providers. As far as we know, not many studies are currently available that attempt to draw a general picture of how patients choose a healthcare provider and of the status of research on this subject. This study is therefore a valuable contribution to the growing amount of literature about patient choice. METHODS: We carried out a specific type of literature review known as a scoping review. Scoping reviews try to examine the breadth of knowledge that is available about a particular topic and therefore do not make selections or apply quality constraints. Firstly, we defined our research questions and searched the literature in Embase, Medline and PubMed. Secondly, we selected the literature, and finally we analysed and summarized the information. RESULTS: Our review shows that patients' choices are determined by a complex interplay between patient and provider characteristics. A variety of patient characteristics determines whether patients make choices, are willing and able to choose, and how they choose. Patients take account of a variety of structural, process and outcome characteristics of providers, differing in the relative importance they attach to these characteristics. CONCLUSIONS: There is no such thing as the typical patient: different patients make different choices in different situations. Comparative information seems to have a relatively limited influence on the choices made by many patients and patients base their decisions on a variety of provider characteristics instead of solely on outcome characteristics. The assumptions made in health policy about patient choice may therefore be an oversimplification of reality. Several knowledge gaps were identified that need follow-up research.

Viera, A. J., Cohen, L. W., Mitchell, C. M., et al. (2008). "High blood pressure knowledge among primary care patients with known hypertension: a North Carolina Family Medicine Research Network (NC-FM-RN) study." J Am Board Fam Med **21**(4): 300-308.
http://www.ncbi.nlm.nih.gov/pubmed/18612056

BACKGROUND: We sought to assess primary care patients' current knowledge about various aspects of high blood pressure (BP). METHODS: We mailed a questionnaire to 700 hypertensive patients enrolled in a practice-based research network cohort from 24 practices in North Carolina. We determined percentages of respondents (total and by subgroups) incorrectly answering each of 6 questions pertaining to various aspects of high BP. We then examined bivariate and multivariate associations with answering 2 or more items incorrectly ("lower hypertension knowledge"). RESULTS: We received 530 completed surveys (76% response rate). Twenty-six percent (95% CI, 22-30) of respondents did not know that most of the time people with high BP do not feel it. Twenty-two percent (95% CI, 18-26) either were not sure whether anything could be done to prevent high BP or believe that there is nothing that can be done. Nineteen percent (95% CI, 16-22) either believe taking medications will cure high BP or are not sure whether it will. Twenty-two percent (95% CI, 19-26) of respondents had overall lower hypertension knowledge. Independent associations with lower hypertension knowledge were African-American race (odds ratio, 1.77; 95% CI, 1.10-2.86), having less than high school education (odds ratio, 2.43; 95% CI, 1.34-4.41), and history of stroke/mini-stroke (odds ratio, 1.94; 95% CI, 1.00-3.75). CONCLUSIONS: Patients may need to be taught the difference between curing hypertension and treating it with medications. Efforts to educate the public that lifestyle modifications can prevent hypertension and that it usually causes no symptoms need to continue. It seems especially important to develop messages that reach African-Americans and people with less education

Vijn, T. W., Fluit, C., Kremer, J. A. M., et al. (2017). "Involving Medical Students in Providing Patient Education for Real Patients: A Scoping Review." J Gen Intern Med **32**(9): 1031-1043.

BACKGROUND: Studies suggest that involving students in patient education can contribute to the quality of care and medical education. Interventions and outcomes in this field, however, have not yet been systematically reviewed. The authors examined the scientific literature for studies on interventions and outcomes of student-provided patient education. METHODS: Four databases (MEDLINE, EMBASE, ERIC, PsycINFO) were searched for studies reporting patient education, undergraduate medical students, and outcomes of patient education, published between January 1990 and October 2015. Facilitators of and barriers to educational interventions were assessed using the Learning Transfer System Inventory. The learning yield, impact on quality of care, and practical feasibility of the interventions were rated by patients, care professionals, researchers, and education professionals. RESULTS: The search resulted in 4991 hits. Eighteen studies were included in the final synthesis. Studies suggested that student-provided patient education improved patients' health knowledge, attitude, and behavior (nine studies), disease management (three studies), medication adherence (one study), and shared decision-making (one study). In addition, involving students in patient education was reported to enhance students' patient education self-efficacy (four studies), skills (two studies), and behavior (one study), their relationships with patients (two studies), and communication skills (two studies). DISCUSSION: Our findings suggest that student-provided patient education-specifically, student-run patient education clinics, student-provided outreach programs, student health coaching, and clerkships on patient education-has the potential to improve quality of care and medical education. To enhance the learning effectiveness and quality of student-provided patient education, factors including professional roles for students, training preparation, constructive supervision, peer support on organizational and individual levels, and learning aids should be taken into account. Future research should focus on further investigating the effects found in this study with high-level evidence.

Villa-Roel, C., Nikel, T., Ospina, M., et al. (2016). "Effectiveness of Educational Interventions to Increase Primary Care Follow-up for Adults Seen in the Emergency Department for Acute Asthma: A Systematic Review and Meta-analysis." Acad Emerg Med **23**(1): 5-13.

OBJECTIVES: Patients with asthma commonly present to emergency departments (ED) with exacerbations. Asthma guidelines recommend close follow-up with a primary care provider (PCP) after ED discharge; however, this linkage is often delayed or absent. The objective of this study was to assess whether ED-directed educational interventions improve office follow-up with PCPs after ED discharge for acute asthma. METHODS: Comprehensive literature searches were conducted in seven electronic databases (1946 to 2014). Randomized controlled clinical trials examining the effectiveness of educational interventions to increase office follow-up with a PCP were included. Study quality was determined using the Cochrane risk of bias tool; fidelity of the interventions was assessed using the Treatment Fidelity Assessment Grid. Using study data, risk ratios (RRs),and the number needed to treat for benefit (NNTB) with 95% confidence intervals (CI) were calculated using random-effects models. RESULTS: From 427 potentially relevant studies, five (n = 825) were included. The overall risk of bias was unclear, and the description of intervention fidelity varied across the studies. Educational interventions targeting either patients or PCPs led to a greater likelihood of having primary care follow-up after ED discharge (RR = 1.6; 95% CI = 1.31 to 1.87; I(2) = 0%). The number needed to treat for benefit was six (95% CI = 4 to 11). No significant benefit was observed in reductions of relapses (RR = 1.3; 95% CI = 0.82 to 1.98; I(2) = 23%) and admissions (RR = 0.51; 95% CI = 0.24 to 1.06; I(2) = 0%). Due to the small number of studies for each comparison, publication bias was not formally assessed. CONCLUSIONS: ED-directed educational interventions targeting either patients or providers increase the chance of having office follow-up visits with PCPs after asthma exacerbations. Their impact on health-related outcomes (e.g., relapse and admissions) remains unclear.

Vine, M., Hargreaves, M. B., Briefel, R. R., et al. (2013). "Expanding the role of primary care in the prevention and treatment of childhood obesity: a review of clinic- and community-based recommendations and interventions." J Obes **2013**: 172035.

Although pediatric providers have traditionally assessed and treated childhood obesity and associated health-related conditions in the clinic setting, there is a recognized need to expand the provider role. We reviewed the literature published from 2005 to 2012 to (1) provide examples of the spectrum of roles that primary care providers can play in the successful treatment and prevention of childhood obesity in both clinic and community settings and (2) synthesize the evidence of important characteristics, factors, or strategies in successful community-based models. The review identified 96 articles that provide evidence of how primary care providers can successfully prevent and treat childhood obesity by coordinating efforts within the primary care setting and through linkages to obesity prevention and treatment resources within the community. By aligning the most promising interventions with recommendations published over the past decade by the Institute of Medicine, the American Academy of Pediatrics, and other health organizations, we present nine areas in which providers can promote the prevention and treatment of childhood obesity through efforts in clinical and community settings: weight status assessment and monitoring, healthy lifestyle promotion, treatment, clinician skill development, clinic infrastructure development, community program referrals, community health education, multisector community initiatives, and policy advocacy.

von dem Knesebeck O, Hoehne, A., Link, C., et al. (2012). "Talking about smoking in primary care medical practice--results of experimental studies from the US, UK and Germany." Patient Educ Couns **89**(1): 51-56.
http://www.ncbi.nlm.nih.gov/pubmed/22595655

OBJECTIVE: To analyse effects of patient and physician characteristics on questions and advice about smoking in primary care practice and to examine country differences. METHODS: We conducted a factorial experiment, employing filmed scenarios in which actors played the role of patients with symptoms of coronary heart disease (CHD) or type 2 diabetes. Versions were filmed with patient-actors of different gender, age, race, and socioeconomic status. The videotapes were presented to primary care physicians in the US, UK and Germany. Physicians were asked whether they would ask questions about smoking or give cessation advice. RESULTS: Female and older CHD patients are less likely to be asked or get advice about smoking in all three countries. Effects of physician attributes are weak and inconsistent. Compared to physicians in the US and the UK, German doctors are least likely to ask questions or give advice. CONCLUSIONS: Although all physicians viewed the same cases their questioning and advice giving differed according to patient attributes and country. Due to the experimental design external validity of the study may be limited. PRACTICE IMPLICATIONS: Findings have implications for medical education and professional training of physicians as well as for the organization and financing of health care

Von Voshaar, T., Behr, J., Bruggenjurgen, B., et al. (2012). "[On general practitioners' care of patients with asthma]." MMW Fortschr Med **154 Suppl 1**: 1-7.

UNLABELLED: This review offers readers new aspects for the guideline-compliant care of asthma patients. Here, attention is focused on illustrating the bottlenecks in the administration of good and practicable therapeutic care and listing these as "major challenges for GPs". The interdisciplinary team of authors - consisting of three hospital-based pulmonologists, one pulmonologist in private practice, one internist in general practice, one pharmacist and one health economist discussed aspects of asthma therapy relevant in clinical practice. RESULTS AND CONCLUSIONS: Practicable results for the reader included an asthma pentagram, a graphic depicting the links and interactions between diagnosis, symptom management, communication, application and costs. From this emerged a consensus on four recommendations that can help GPs improve their care of their patients: (1) Whenever possible, have a specialist verifythe diagnosis. (2) Practice inhalation techniques with the patient and check up on their technique at regular intervals. (3) Monitor and fine-tune the therapeutic goals set down together with the patient. (4) Clearly define the (patient's) responsibilities and who is organizing care (communication between GP-specialist-patient-pharmacist-family members).

Waldron, C. A., van der Weijden, T., Ludt, S., et al. (2011). "What are effective strategies to communicate cardiovascular risk information to patients? A systematic review." Patient Educ Couns **82**(2): 169-181.

OBJECTIVE: To compare different interventions used to communicate cardiovascular risk and assess their impact on patient related outcomes. METHODS: A systematic search of six electronic data sources from January 1980 to November 2008. Data was extracted from the included studies and a narrative synthesis of the results was conducted. RESULTS: Fifteen studies were included. Only four studies assessed individuals' actual cardiovascular risk; the rest were analogue studies using hypothetical risk profiles. Heterogeneity in study design and outcomes was found. The results from individual studies suggest that presenting patients with their cardiovascular risk in percentages or frequencies, using graphical representation and short timeframes, is best for achieving risk reduction through behaviour change. However, this summary is tentative and needs further exploration. CONCLUSION: Better quality trials are needed that compare different risk presentation formats, before conclusions can be drawn as to the most effective ways to communicate cardiovascular risk to patients. PRACTICE IMPLICATIONS: Instead of directing attention to the accuracy of cardiovascular risk prediction, more should be paid to the effective presentation of risk, to help patients reduce risk by lifestyle change or active treatment.

Walseth, L. T., Abildsnes, E. et Schei, E. (2011). "Lifestyle, health and the ethics of good living. Health behaviour counselling in general practice." Patient Educ Couns **83**(2): 180-184.

OBJECTIVE: To present theory that illustrates the relevance of ethics for lifestyle counselling in patient-centred general practice, and to illustrate the theory by a qualitative study exploring how doctors may obstruct or enhance the possibilities for ethical dialogue. METHODS: The theoretical part is based on theory of common morality and Habermas' communication theory. The empirical study consists of 12 consultations concerning lifestyle changes, followed by interviews of doctors and patients. ANALYSIS: Identification of two contrasting consultations holding much and little ethical dialogue, "translation" into speech acts, and interpretation of speech acts and interviews guided by theory. RESULTS: General advice obstructed possibilities for ethical clarification and patient-centredness. Ethical clarification was asked for, and was enhanced by the doctor using communication techniques such as interpretation, summarization, and exploration of the objective, subjective and social dimensions of the patients' lifeworlds. However, to produce concrete good decisions an additional reflection over possibilities and obstacles in the patient's lifeworld is necessary. CONCLUSION: Consultations concerning lifestyle changes hold opportunities for ethical clarification and reflection which may create decisions rooted in the patient's everyday life. PRACTICE IMPLICATIONS: The study suggests that GPs should encourage active reflection and deliberation on values and norms in consultations concerning lifestyle changes.

Walseth, L. T., Abildsnes, E. et Schei, E. (2011). "Patients' experiences with lifestyle counselling in general practice: a qualitative study." Scand J Prim Health Care **29**(2): 99-103.
http://www.ncbi.nlm.nih.gov/pubmed/21294605

OBJECTIVE. (1) To elucidate the relevance of Habermas's theory as a practical deliberation procedure in lifestyle counselling in general practice, using a patient perspective. (2) To search for topics which patients consider of significance in such consultations. DESIGN. Qualitative observation and interview study. SETTING. General practice. Subjects. A total of 12 patients were interviewed after lifestyle consultations with their GPs. MAIN OUTCOME MEASURES. How the patients perceived the counselling, how it affected them, and what they wanted from their GP in follow-up consultations. RESULTS. The GP should be a source of medical knowledge and a caretaker, but also actively discuss contextual reasons for lifestyle choices, and be a reflective partner exploring values and norms. The patients wanted their GP to acknowledge emotions and to direct the dialogue towards common ground where advice was adjusted to the concrete life situation. A good, personal doctor-patient relationship created motivation and obligation to change, and allowed counselling to be interpreted as care. CONCLUSION. The findings underscore the necessity of a patient-centred approach in lifestyle counselling and support the relevance of Habermas's theory as practical guidance for deliberation. IMPLICATIONS. The findings suggest that GPs should trust the long-term effects of investing in a good relationship and personalized care in lifestyle consultations. The study should incite the GP to act as an encouraging informer, an explorer of everyday life and reasons for behaviour, a reflective partner, and a caretaker, adjusting medical advice to patients' identity, context, and values

Walters, J. A., Cameron-Tucker, H., Courtney-Pratt, H., et al. (2012). "Supporting health behaviour change in chronic obstructive pulmonary disease with telephone health-mentoring: insights from a qualitative study." BMC Fam Pract **13**: 55.
http://www.ncbi.nlm.nih.gov/pubmed/22694996

BACKGROUND: Adoption and maintenance of healthy behaviours is pivotal to chronic disease self-management as this influences disease progression and impact. This qualitative study investigated health behaviour changes adopted by participants with moderate or severe chronic obstructive pulmonary disease (COPD) recruited to a randomised controlled study of telephone-delivered health-mentoring. METHODS: Community nurses trained as health-mentors used a patient-centred approach with COPD patients recruited in general practice to facilitate behaviour change, using a framework of health behaviours; 'SNAPPS' Smoking, Nutrition, Alcohol, Physical activity, Psychosocial well-being, and Symptom management, through regular phone calls over 12 months. Semi-structured interviews in a purposive sample sought feedback on mentoring and behaviour changes adopted. Interviews were analysed using iterative thematic and interpretative content approaches by two investigators. RESULTS: Of 90 participants allocated to health-mentoring, 65 (72%) were invited for interview at 12-month follow up. The 44 interviewees, 75% with moderate COPD, had a median of 13 mentor contacts over 12 months, range 5-20. Interviewed participants (n=44, 55% male, 43% current smokers, 75% moderate COPD) were representative of the total group with a mean age 65 years while 82% had at least one additional co-morbid chronic condition. Telephone delivery was highly acceptable and enabled good rapport. Participants rated 'being listened to by a caring health professional' as very valuable. Three participant groups were identified by attitude to health behaviour change: 14 (32%) actively making changes; 18 (41%) open to and making some changes and 12 (27%) more resistant to change. COPD severity or current smoking status was not related to group category. Mentoring increased awareness of COPD effects, helping develop and personalise behaviour change strategies, even by those not actively making changes. Physical activity was targeted by 43 (98%) participants and smoking by 14 (74%) current smokers with 21% reporting quitting. Motivation to maintain changes was increased by mentor support. CONCLUSIONS: Telephone delivery of health-mentoring is feasible and acceptable to people with COPD in primary care. Health behaviours targeted by this population, mostly with moderate disease, were mainly physical activity and smoking reduction or cessation. Health-mentoring increased motivation and assisted people to develop strategies for making and sustaining beneficial change. TRIAL REGISTRATION: ACTR12608000112368

Wang, L., Mårtensson, J., Zhao, Y., et al. (2018). "Experiences of a health coaching self-management program in patients with COPD: a qualitative content analysis." Int J Chron Obstruct Pulmon Dis **13**: 1527-1536.

PURPOSE: To describe the experiences of patients with COPD participating in a health coaching self-management program. PATIENTS AND METHODS: Twenty patients who had participated in a 6-month health coaching self-management program intervention were purposefully selected for a qualitative evaluation of the program using semi-structured interviews. The interviews were analyzed using inductive qualitative content analysis. RESULTS: Four categories and 13 subcategories emerged describing the participants' experiences of the program. Their experiences were expressed as gaining insight into the importance of knowledge and personal responsibilities in the management of COPD, taking action to maintain a healthy lifestyle, feeling supported by the program, and being hindered by individual and program limitations. CONCLUSION: Iterative interactions between patients and health care professionals together with the content of the program are described as important to develop skills to manage COPD. However, in future self-management programs more awareness of individual prerequisites should be considered.

Ward, R. (2009). "Talking with your patients about dietary cholesterol, diet and nutrition: best practices for family physicians." Int J Clin Pract Suppl(163): 22-27.
http://www.ncbi.nlm.nih.gov/pubmed/19751446

BACKGROUND: Family physicians, as gatekeepers for the healthcare system, are at the forefront of detecting, diagnosing, and managing diseases. When it comes to coronary heart disease (CHD), patients expect them to be knowledgeable about ways to reduce CHD risk, such as through diet. Unfortunately, most family physicians have not received formal training about nutritional counselling for patients. There is also little time or incentive to educate patients about diet. RESULTS: This has led to the preference for referring patients for dietary counselling. However, when properly informed, family physicians can be effective conduits for dietary counselling. A Danish study showed that patients at risk for CHD who were given nutritional counselling by family physicians experienced significant weight loss, reduction of waist circumference and body mass index, a significant increase in high-density lipoprotein cholesterol, and a significant reduction in the risk of developing cardiovascular disease. CONCLUSIONS: By providing nutritional counselling, physicians can serve as a source for current information and help to correct long-held misperceptions that patients may have regarding diet

Weiner, S. S., Weiser, S. R., Carragee, E. J., et al. (2011). "Managing nonspecific low back pain: do nonclinical patient characteristics matter?" Spine (Phila Pa 1976.) **36**(23): 1987-1994.
http://www.ncbi.nlm.nih.gov/pubmed/21289556

STUDY DESIGN: A fully blocked experimental design using clinical vignettes to query primary care physicians on prescription for management of acute nonspecific low back pain. OBJECTIVE: To identify how nonclinical patient factors, specifically sex, patient presentation, and socioeconomic status, influence physician treatment recommendations for assessing and treating acute nonspecific low back pain. SUMMARY OF BACKGROUND DATA: Adherence to evidence-based practice guidelines for nonspecific low back pain remains inconsistent. Therefore, it is important to understand what factors guide physician management of these cases. METHODS: One vignette and questionnaire was distributed to primary care and emergency department clinical physicians during meetings at five teaching hospitals. The questionnaire asked for diagnostic and treatment recommendations including specific tests, medications, therapeutic procedures, activity, referral to other services, and patient education for the case represented in the vignette. RESULTS: Subjects included 284 physicians and approximately 75% had less than 5 years of clinical practice experience. Multivariate logistic regression showed seven significant associations of patient factors with treatment recommendations for acute nonspecific low back pain (one sex, two socioeconomic status, and four patient presentation; $P < 0.05$). CONCLUSION: All three assessed nonclinical factors influenced physician decisions regarding diagnostic and treatment recommendations for acute nonspecific low back pain. Patient presentation, suggestive of a patient's emotional state, was shown to be the most influential

Westland, H., Schröder, C. D., de Wit, J., et al. (2018). "Self-management support in routine primary care by nurses." Br J Health Psychol **23**(1): 88-107.

OBJECTIVES: To examine how and to what extent self-management support, including behaviour change support, is provided by primary care nurses in routine consultations with chronically ill patients. DESIGN: Observational study design. METHODS: Routine consultations of primary care nurses in the Netherlands with chronically ill patients were audio-taped and analysed. The analysis identified health topics addressed according to health care standards, self-management topics addressed using a validated set of topics, and behaviour change techniques (BCTs) using the Behaviour Change Techniques Taxonomy v1. RESULTS: Seventy-eight routine consultations of 17 primary care nurses with chronically ill patients were included in the analysis. Nurses addressed both health topics and self-management topics in brief, fragmented, and often inconsistent manners. Dietary intake and physical activity were the most frequently addressed topics. Nurses applied 21 BCTs to target behaviour change, but the use of these techniques was mainly inconsistent and implicit. The most consistently used BCTs were review behaviour goal(s) (56.4%) and feedback on behaviour (51.3%). CONCLUSIONS: Nurses addressed both health topics and self-management topics in their routine consultations. The duration, frequency, and number of addressed topics differed throughout the consultations. Nurses tended to prioritize the monitoring and optimization of patients' medical treatment and provided limited self-management support. Nurses seldom deepened their focus on behaviour change and infrequently used effective techniques to support this change. Adoption of self-management in primary care, including behaviour change, might be enhanced if nurses consistently and explicitly use effective BCTs in their consultations. Statement of contribution What is already known on this subject? Primary care nurses play a pivotal role in self-management support for patients with a chronic condition. Adequate self-management support requires nurses to activate patients and enhance behaviour change. Little is known regarding to what extent nurses provide self-management support in routine primary care. What does this study add? Self-management support is brief, fragmented, and inconsistently provided by nurses. Nurses tend to prioritize medical treatment optimization and seldom focus on behavioural change. Nurses' use of effective behaviour change techniques is low and should be enhanced.

Wheat, H., Horrell, J., Valderas, J. M., et al. (2018). "Can practitioners use patient reported measures to enhance person centred coordinated care in practice? A qualitative study." Health Qual Life Outcomes **16**(1): 223.

BACKGROUND: To ascertain whether person centred coordinated care (P3C) is being delivered in healthcare services, components relating to the construct need to be measured. Patient reported measures (PRMs) can be used to provide a measurement of patients' experiences of P3C. Traditionally, they have been used to assess whether interventions are delivering P3C. Recently there has been an increased interest in using them to directly enhance P3C in clinical practice by, for example, improving practitioner-patient communication. However, there is limited research available on how P3C can be implemented in practice. This study aimed to extend this literature base by exploring how professionals use PRMs to enhance P3C. METHODS: Cross sectional thematic analysis of 26 semi-structured interviews with a variety of professionals who have experience of how PRMs can be used to make improvements to P3C. Inductive themes were mapped onto components of P3C care that fell under five established domains of P3C (Information and Communication; My Goals/Outcomes; Decision making; Care Planning and Transitions) to explore whether and how individual components of P3C were being improved through PRMs. Barriers and facilitators that affected the delivery and the results of the PRMs were also identified. RESULTS: Three P3C domains (Information and Communication, My Goals/Outcomes and Care Planning) were mapped frequently onto themes generated by the participants' interviews about PRM use. However, the domain 'Decision Making' was only mapped onto one theme and 'Transitions' was not mapped at all. Participant reports suggested that PRM use by practitioners enhanced patients' ability to self-manage, communicate, engage and reflect during consultations. Barriers to PRM use were related to a lack of a whole service approach to implementation. CONCLUSIONS: Practitioners use both PROMs and PREMs in various ways to improve different aspects of patient care. By sharing experiences professionals can benefit from each other's learning and work together to extend the potential value that PRMs can offer to P3C delivery.

White, A., South, J., Bagnall, A. M., et al. (2012). "The self-care for people initiative: the outcome evaluation." Prim Health Care Res Dev **13**(4): 382-394.
http://www.ncbi.nlm.nih.gov/pubmed/22717369

AIM: To determine the effects of a community-based training programme in self-care on the lay population. BACKGROUND: Self Care is recognised as being a cornerstone of the populations health, but to date there have been few large-scale studies of its effectiveness on the general public. This paper reports on an evaluation of a self-care skills training course delivered in small group sessions within workplace and parent and toddler group settings to a lay population. METHODS: A quasi-experimental longitudinal study of 12-month duration was conducted in three intervention primary care trusts (PCTs) and two similar comparison PCTs in England. The sample comprised 1568 self-selecting participants: 868 received the intervention and 700 did not. FINDINGS: No changes were seen in usage of General Practitioner services, the primary outcome, however, statistical analysis suggested that being in the intervention group may be associated with increased use of out-of-hours and secondary care services. At six months' follow-up small but statistically significant positive effects of being in the intervention group were seen on self-esteem, well-being and anxiety scores. At 12 months' follow-up small but statistically significant positive effects of being in the intervention group were also seen on recovery locus of control, health literacy and self-esteem scores, and on knowledge of adult cough. The clinical significance of these very small changes is unclear. The training programme had a small but positive effect, which was still evident at 12 months, on individuals' knowledge and confidence levels with regard to managing their own health, but did not lead to reductions in health service use

Wieringa, T. H., Rodriguez-Gutierrez, R., Spencer-Bonilla, G., et al. (2019). "Decision aids that facilitate elements of shared decision making in chronic illnesses: a systematic review." Syst Rev **8**(1): 121.

BACKGROUND: Shared decision making (SDM) is a patient-centered approach in which clinicians and patients work together to find and choose the best course of action for each patient's particular situation. Six SDM key elements can be identified: situation diagnosis, choice awareness, option clarification, discussion of harms and benefits, deliberation of patient preferences, and making the decision. The International Patient Decision Aid Standards (IPDAS) require that a decision aid (DA) support these key elements. Yet, the extent to which DAs support these six key SDM elements and how this relates to their impact remain unknown. METHODS: We searched bibliographic databases (from inception until November 2017), reference lists of included studies, trial registries, and experts for randomized controlled trials of DAs in patients with cardiovascular, or chronic respiratory conditions or diabetes. Reviewers worked in duplicate and independently selected studies for inclusion, extracted trial, and DA characteristics, and evaluated the quality of each trial. RESULTS: DAs most commonly clarified options (20 of 20; 100%) and discussed their harms and benefits (18 of 20; 90%; unclear in two DAs); all six elements were clearly supported in 4 DAs (20%). We found no association between the presence of these elements and SDM outcomes. CONCLUSIONS: DAs for selected chronic conditions are mostly designed to transfer information about options and their harms and benefits. The extent to which their support of SDM key elements relates to their impact on SDM outcomes could not be ascertained. SYSTEMATIC REVIEW REGISTRATION: PROSPERO registration number: CRD42016050320 .

Williams, A. M., Dennis, S. et Harris, M. F. (2011). "How effective are the linkages between self-management programmes and primary care providers, especially for disadvantaged patients?" Chronic Illn **7**(1): 20-30.

OBJECTIVES: To describe the extent and effectiveness of strategies that have been used to improve linkages between primary healthcare (PHC) and chronic disease self-management programmes, especially for disadvantaged patients. METHODS: A systematic review of the published peer-reviewed literature. Studies conducted in an Organisation for Economic Co-operation and Development country evaluating a group self-management programme of at least 4-week duration with some linkage between PHC and the programme were included. Linkage strategies were qualitatively derived. Studies were descriptively analysed in terms of the type of self-management programme, strategy for linking with PHC, culturally and linguistically diverse and socio-economic status and impact on health service usage. RESULTS: Sixteen studies were identified that used linkage strategies for a variety of functions-supporting communication, ongoing clinical care, programme development, recruitment or implementation. Of the four studies that evaluated impact on health service use, only one reported a positive change. DISCUSSION: Few programmes of self-management support included specific strategies to increase linkages with PHC as part of their intervention. There is insufficient evidence to determine which strategies or linkages are more effective and in what context.

Winders, T. A., Wilson, A. M., Fletcher, M. J., et al. (2019). "A Patient-Centered Description of Severe Asthma: Patient Understanding Leading to Assessment for a Severe Asthma Referral (PULSAR)." Patient **12**(5): 539-549.

> BACKGROUND: Although severe asthma can be life-threatening, many patients are unaware they have this condition. OBJECTIVES: Patient Understanding Leading to Assessment for a Severe Asthma Referral (PULSAR) is a novel, multidisciplinary working group aiming to develop and disseminate a global, patient-centered description of severe asthma to improve patient understanding of severe asthma and effect a change in patient behavior whereby patients are encouraged to visit their healthcare professional, when appropriate. METHODS: Current definitions from patient organization websites, asthma guidelines, and medication information for key asthma drugs were assessed and informed a multidisciplinary working group, convened to identify common concepts and terminology used to define severe asthma. A patient-centered description of severe asthma and patient checklist were drafted based on working-group discussions and reviewed by an external behavioral scientist for patient understanding and relevance. These were tested using an online US/Canadian survey. RESULTS: The patient-centered description of severe asthma and patient checklist were reviewed and re-drafted by the authors. The text was simplified following the behavioral-scientist review. The survey (n = 153) included 105 patients with severe asthma. Of those with severe asthma, 92.2% of patients reported that the description was consistent with their experiences of severe asthma and 92.6% of patients reported that the PULSAR initiative would encourage them to visit their healthcare provider. CONCLUSION: A patient-centered description of severe asthma has been developed and tested using patients with severe asthma; this description will allow patients to assess whether they might have severe asthma and prompt them to visit their healthcare provider, if appropriate.
> Severe asthma is a serious form of asthma. It can be harmful to your health and affect the way you live your life. Some patients do not know that they have severe asthma or visit their doctor and ask for help. A new group, called Patient Understanding Leading to Assessment for a Severe Asthma Referral (PULSAR), would like to help patients understand their asthma symptoms. They have developed a description of severe asthma and a checklist. These may help patients decide if their symptoms require a visit to the doctor.The PULSAR description and checklist were developed in four parts. Part 1 looked at if patients and doctors/nurses defined severe asthma in the same way. Results showed that patients defined severe asthma using symptoms and doctors defined severe asthma using treatments. In Part 2, patients, patient advocacy group members, nurses, doctors, specialists, and a scientist talked about the ways severe asthma were described in Part 1. The group agreed on a set of words to describe severe asthma. These words were then used in the PULSAR description and checklist. In Part 3, a behavioral scientist reviewed the PULSAR description and checklist. They said that simple language would make it easy to understand. In Part 4, patients with severe asthma were asked what they thought about the description and checklist using an online survey. The survey showed that almost all patients understood the description and checklist. Many patients said that the description and checklist encouraged them to see a doctor.A new description of severe asthma and checklist have been developed by PULSAR. Testing shows that they should encourage patients to visit their doctor when needed. This may help patients understand their symptoms and help doctors make the correct diagnosis. This should help patients get the support and treatment they need.

Winkley, K., Stahl, D., Chamley, M., et al. (2016). "Low attendance at structured education for people with newly diagnosed type 2 diabetes: General practice characteristics and individual patient factors predict uptake." Patient Educ Couns **99**(1): 101-107.

> OBJECTIVE: The aims were to determine the association between individual and neighbourhood factors and attendance at structured education amongst people with newly diagnosed type 2 diabetes (T2DM). METHODS: Multi-level analysis of questionnaire data from a prospective cohort of adults newly diagnosed T2DM. Setting was primary care, London, UK. Main outcome was attendance at structured education within 2 years. RESULTS: Of 1790 people recruited, attendance data were available for 1626 (91%). Only 22.4% (n=365/1626) attended education. Attendance was independently associated with female gender (OR 1.28, 95% CI 1.05-1.46), lower HbA1c (OR 0.98 mmol/mol 95% CI 0.97-0.99) and non-smoker status (OR 1.36, 95% CI 1.07-1.55). General practice covariates, achievement of primary care targets for glycaemic control (OR 1.05, 95% C.I. 1.01-1.08) and recording of retinal screening (OR 0.96, 95% C.I. 0.93-0.99) were independently associated with

attendance but unexplained general practice clustering accounted for 17% of the variance. CONCLUSION: Education uptake is low amongst people with new onset T2DM. Attenders are more likely to be female, non-smokers with better HbA1c. General practices achieving glycaemic targets are more likely to have patients who attend education. PRACTICE IMPLICATIONS: Strategies are needed to improve attendance at structured diabetes education particularly amongst hard to reach groups.

Wolf, A., Moore, L., Lydahl, D., et al. (2017). "The realities of partnership in person-centred care: a qualitative interview study with patients and professionals." BMJ Open **7**(7): e016491.

OBJECTIVE: Although conceptual definitions of person-centred care (PCC) vary, most models value the involvement of patients through patient-professional partnerships. While this may increase patients' sense of responsibility and control, research is needed to further understand how this partnership is created and perceived. This study aims to explore the realities of partnership as perceived by patients and health professionals in everyday PCC practice. DESIGN: Qualitative study employing a thematic analysis of semistructured interviews with professionals and patients. SETTING: Four internal medicine wards and two primary care centres in western Sweden. PARTICIPANTS: 16 health professionals based at hospital wards or primary care centres delivering person-centred care, and 20 patients admitted to one of the hospital wards. RESULTS: Our findings identified both informal and formal aspects of partnership. Informal aspects, emerging during the interaction between healthcare professionals and patients, without any prior guidelines or regulations, incorporated proximity and receptiveness of professionals and building a close connection and confidence. This epitomised a caring, respectful relationship congruent across accounts. Formal aspects, including structured ways of sustaining partnership were experienced differently. Professionals described collaborating with patients to encourage participation, capture personal goals, plan and document care. However, although patients felt listened to and informed, they were content to ask questions and felt less involved in care planning, documentation or exploring lifeworld goals. They commonly perceived participation as informed discussion and agreement, deferring to professional knowledge and expertise in the presence of an empathetic and trusting relationship. CONCLUSIONS: In our study, patients appear to value a process of human connectedness above and beyond formalised aspects of documenting agreed goals and care planning. PCC increases patients' confidence in professionals who are competent and able to make them feel safe and secure. Informal elements of partnership provide the conditions for communication and cooperation on which formal relations of partnership can be constructed.

Wolstenholme, D., Ross, H., Cobb, M., et al. (2017). "Participatory design facilitates Person Centred Nursing in service improvement with older people: a secondary directed content analysis." J Clin Nurs **26**(9-10): 1217-1225.

AIMS AND OBJECTIVES: To explore, using the example of a project working with older people in an outpatient setting in a large UK NHS Teaching hospital, how the constructs of Person Centred Nursing are reflected in interviews from participants in a Co-design led service improvement project. BACKGROUND: Person Centred Care and Person Centred Nursing are recognised terms in healthcare. Co-design (sometimes called participatory design) is an approach that seeks to involve all stakeholders in a creative process to deliver the best result, be this a product, technology or in this case a service. Co-design practice shares some of the underpinning philosophy of Person Centred Nursing and potentially has methods to aid in Person Centred Nursing implementation. RESEARCH DESIGN: The research design was a qualitative secondary Directed analysis. METHODS: Seven interview transcripts from nurses and older people who had participated in a Co-design led improvement project in a large teaching hospital were transcribed and analysed. Two researchers analysed the transcripts for codes derived from McCormack & McCance's Person Centred Nursing Framework. RESULTS: The four most expressed codes were as follows: from the pre-requisites: knowing self; from care processes, engagement, working with patient's beliefs and values and shared Decision-making; and from Expected outcomes, involvement in care. This study describes the Co-design theory and practice that the participants responded to in the interviews and look at how the co-design activity facilitated elements of the Person Centred Nursing framework. CONCLUSIONS: This study adds to the rich literature about using emancipatory and transformational approaches to Person Centred Nursing development, and is the first study exploring explicitly the potential contribution of Co-design to this area. IMPLICATIONS FOR PRACTICE: Methods from Co-design allow older people to contribute as equals in a practice development project, co-design methods can facilitate nursing staff to engage meaningfully with older participants and develop a shared understanding and goals. The co-produced outputs of Co-design projects embody and value the expressed beliefs and values of staff and older people.

Wong, S. T., Peterson, S. et Black, C. (2011). "Patient activation in primary healthcare: a comparison between healthier individuals and those with a chronic illness." Med Care **49**(5): 469-479.
http://www.ncbi.nlm.nih.gov/pubmed/21422955

BACKGROUND AND OBJECTIVE: Current policy directions place increasing expectations on patients to actively engage in their care, especially in chronic disease management. We examined relationships between patient activation and multiple dimensions of primary healthcare (PHC), including access, utilization, responsiveness, interpersonal communication, and satisfaction for patients with and without chronic illness. RESEARCH DESIGN: Cross-sectional, random digit dial survey conducted in British Columbia (BC), Canada. SUBJECTS: Stratified sample of adults (n=504), aged 19 to 90 years, who had visited their regular provider within the past 24 months. All data were weighted to represent residents living in BC. MEASURES: Patient activation and PHC experiences include accessibility, continuity, whole-person care, interpersonal communication, responsiveness, chronic disease management, and satisfaction. RESULTS: The multivariate models provide evidence that both quantity of time and quality of interactions with one's regular provider are associated with higher patient activation. Those with no chronic illness had higher activation scores when they spent more time talking with their regular provider, experienced less hurried communication, or if their test results were explained. The more time people with chronic illness are able to spend with their physician, the more activated they were. Chronic illness respondents also had higher activation scores if they reported higher whole-person care or if they were more satisfied. CONCLUSIONS: Positive interactions between the patient and the provider can influence the patient's abilities to engage in and be confident in maintaining/improving his/her health. Supporting patients in becoming actively engaged, in ways that work for them, is essential to providing high quality care, especially among those with a chronic condition

Wood, M. R. et Bolyard, D. (2011). "Making education count: the nurse's role in asthma education using a medical home model of care." J Pediatr. Nurs **26**(6): 552-558.
http://www.ncbi.nlm.nih.gov/pubmed/22055375

Asthma care for patients who have limited health literacy is very costly. The resources to help patients who have lower health literacy levels are very few are not well identified. Significant gains in asthma control, self-efficacy in managing asthma, and improvement in overall costs of care for this patient population can be achieved when health literacy challenges are addressed. This research suggests that one-on-one education with an asthma educator that specifically addresses health literacy levels and care designed around the National Asthma Guidelines can produce significant reductions in the cost for asthma care through decreased emergency department visits and hospitalizations, and improved self-management of asthma exacerbations

Woodward-Kron, R., Connor, M., Schulz, P. J., et al. (2014). "Educating the patient for health care communication in the age of the world wide web: a qualitative study." Acad Med **89**(2): 318-325.

PURPOSE: Communication skills teaching in medical education has yet to acknowledge the impact of the Internet on physician-patient communication. The authors present a conceptual model showing the variables influencing how and to what extent physicians and patients discuss Internet-sourced health information as part of the consultation with the purpose of educating the patient. METHOD: A study exploring the role physicians play in patient education mediated through health information available on the Internet provided the foundation for the conceptual model. Twenty-one physicians participated in semistructured interviews between 2011 and 2013. Participants were from Australia and Switzerland, whose citizens demonstrate different degrees of Internet usage and who differ culturally and ethnically. The authors analyzed the interviews thematically and iteratively. The themes as well as their interrelationships informed the components of the conceptual model. RESULTS: The intrinsic elements of the conceptual model are the physician, the patient, and Internet based health information. The extrinsic variables of setting, time, and communication activities as well as the quality, availability, and usability of the Internet-based health information influenced the degree to which physicians engaged with, and were engaged by, their patients about Internet-based health information. CONCLUSIONS: The empirically informed model provides a means of understanding the environment, enablers, and constraints of discussing Internet-based health information, as well as the benefits for patients' understanding of their health. It also provides medical educators with a conceptual tool to engage and support physicians in their activities of communicating health information to patients.

Wouda, J. C., Zandbelt, L. C., Smets, E. M., et al. (2011). "Assessment of physician competency in patient education: reliability and validity of a model-based instrument." Patient Educ Couns **85**(1): 92-98.

OBJECTIVE: Establish the inter-rater reliability and the concept, convergent and construct validity of an instrument for assessing the competency of physicians in patient education. METHODS: Three raters assessed the quality of patient education in 30 outpatient consultations with the CELI instrument. This instrument is based on a goal-directed model of patient education and assesses distinctive skills for patient education categorized in four subcompetencies. The inter-rater reliability was calculated. The concept validity was explored by factor analysis. The convergent validity was established by a comparison with two measures of patient-centred behaviour. The construct validity was explored by relating the subcompetencies with physician gender and patient satisfaction. RESULTS: The inter-rater reliability for the subcompetencies varied between 0.65 and 0.91. The factor analysis distinguished the four subcompetencies. All subcompetencies correlated with the measures of patient-centred behaviour. Female physicians performed better than male physicians on three subcompetencies. Positive correlations were found for three subcompetencies and patient satisfaction. CONCLUSION: The CELI instrument appears to be a reliable and valid instrument. However, further research is needed to establish the generalizability and construct validity. PRACTICE IMPLICATION: The CELI instrument is a useful tool for assessment and feedback in medical education since it assesses the performance of distinctive skills.

Yawn, B. P. (2011). "The role of the primary care physician in helping adolescent and adult patients improve asthma control." Mayo Clin Proc **86**(9): 894-902.

Many adolescents and adults with asthma continue to have poorly controlled disease, often attributable to poor adherence to asthma therapy. Failure to adhere to recommended treatment may result from a desire to avoid regular reliance on medications, inappropriate high tolerance of asthma symptoms, failure to perceive the chronic nature of asthma, and poor inhaler technique. Primary care physicians need to find opportunities and methods to address these and other issues related to poor asthma control. Few adolescents or adults with asthma currently have asthma "checkup" visits, usually seeking medical care only with an exacerbation. Therefore, nonrespiratory-related office visits represent an important opportunity to assess baseline asthma control and the factors that most commonly lead to poor control. Tools such as the Asthma Control Test, the Asthma Therapy Assessment Questionnaire, the Asthma Control Questionnaire, and the Asthma APGAR provide standardized, patient-friendly ways to capture necessary asthma information. For uncontrolled asthma, physicians can refer to the stepwise approach in the 2007 National Asthma Education and Prevention Program guidelines to adjust medication use, but they must consider step-up decisions in the context of quality of the patient's inhaler technique, adherence, and ability to recognize and avoid or eliminate triggers. For this review, a literature search of PubMed from 2000 through August 31, 2010, was performed using the following terms (or a combination of these terms): asthma, asthma control, primary care, NAEPP guidelines, assessment, uncontrolled asthma, burden, impact, assessment tools, triggers, pharmacotherapy, safety. Studies were limited to human studies published in English. Articles were also identified by a manual search of bibliographies from retrieved articles and from article archives of the author.

Yawn, B. P. (2011). "Optimizing chronic obstructive pulmonary disease management in primary care." South Med J **104**(2): 121-127.

> Diagnosis of chronic obstructive pulmonary disease (COPD) in primary care is complex, as many clinical symptoms are similar to asthma and heart disease, which may lead to misdiagnosis and suboptimal disease management. Spirometry is the best method for diagnosing COPD and distinguishing between COPD, asthma, and cardiovascular diseases. Airway obstruction is fully reversible in asthma, but not in COPD, and can be confirmed when the postbronchodilator ratio of forced expiratory volume in one second (FEV1) to forced vital capacity (FVC) is <0.7. Knowledge of COPD treatment guidelines and a proactive attitude toward disease management by primary care physicians are key to improving symptom control and patients' quality of life. Identification of the appropriate drug/inhaler combination, patient education, training on inhaler use followed by regular monitoring, and pulmonary rehabilitation are also vital to successful COPD management. This review outlines steps to aid physicians in devising and implementing an optimal management plan for COPD patients.

Yeh, M. Y., Wu, S. C. et Tung, T. H. (2018). "The relation between patient education, patient empowerment and patient satisfaction: A cross-sectional-comparison study." Applied Nursing Research **39**: 11-17.
http://www.sciencedirect.com/science/article/pii/S0897189717303427

> Purpose Patient empowerment is a paradigm of clinical practice. The goal of patient empowerment is to lead patients' health and wellbeing. The aim of this study is to evaluate the relation between patient education, patient empowerment and patient satisfaction based on multi-hospital cross-sectional study design in Taiwan. Methods In this cross-sectional survey, 609 inpatients in four teaching hospitals in northern Taiwan from August 2009 to July 2010 were recruited. Data were collected using Chinese version of the Patient Perceptions of Empowerment Scale (PPES), Sufficiency of Patient Education Questionnaire (SPEQ) and Patient Satisfaction Questionnaire (PSQ). The multiple linear regression model was used to assess the independent effects of relevant factors on patient empowerment after controlling for the covariates. Results The overall mean empowerment scores was 44.80±5.94. There was a significant difference between the total scores and four dimensions of patient empowerment at different hospitals ($t=5.44$, $p\leq0.01$). Sufficient patient education ($\beta=0.568$, 95%CI: 0.486–0.649) and patient satisfaction ($\beta=0.317$, 95%CI: 0.259–0.375) could significantly predict patient empowerment based on the multiple linear regression analysis, with a total variance was 54.4%. Conclusions In conclusion, both sufficient patient education and patient satisfaction were positively related to patient empowerment. Hospitals in Taiwan should try to improve their patients' active involvement toward empowerment.

Yoffe, S. J., Moore, R. W., Gibson, J. O., et al. (2011). "A reduction in emergency department use by children from a parent educational intervention." Fam Med **43**(2): 106-111.
http://www.ncbi.nlm.nih.gov/pubmed/21305425

> BACKGROUND AND OBJECTIVES: A substantial proportion of emergency department (ED) visits by children are for non-urgent care. The objective of this research is to determine whether a parent-focused educational intervention can reduce non-urgent ED visits. METHODS: A regional hospital system (which includes a central hospital, four satellite hospitals, and two primary care clinics) provided monthly data retrospectively from January 2006 to October 2007 on ED visits by children. The same information was provided prospectively from November 2007 to April 2009. Starting in November 2007, a family medicine residency program affiliated with the same hospital network distributed a 6.7 grade reading level booklet on non-urgent care of children to the parents who brought their children to the outpatient clinic. The number of ED visits as a proportion of outpatient clinic visits at the residency program was calculated for each month and compared to historical and geographic trends. RESULTS: Long-term changes were observed only among the intervention group. There was a substantial and statistically significant reduction in ED use for non-urgent care of children. There was also a proportional reduction in ED charges for this group. CONCLUSION: An educational intervention among parents can substantially reduce non-urgent ED visits for their children

Young, H. M., Hudson, N., Clarke, A. L., et al. (2015). "Patient and Staff Perceptions of Intradialytic Exercise before and after Implementation: A Qualitative Study." Plos One **10**(6): e0128995.

> INTRODUCTION: Despite guidance and evidence for the beneficial effects of intradialytic exercise (IDE), such programmes are rarely adopted within practice and little is known about how they may best be sustained. The Theoretical Domains Framework (TDF) was used to guide the understanding of the barriers and facilitators to initial and ongoing IDE participation and to understand how these are influential at each stage. MATERIALS AND METHODS: Focus groups explored patient (n=24) and staff (n=9) perceptions of IDE prior to the introduction of a programme and, six months later, face to face semi-structured interviews captured exercising patients (n=11) and staffs' (n=8) actual experiences. Data were collected at private and NHS haemodialysis units within the UK. All data were audio-recorded, translated where necessary, transcribed verbatim and subject to framework analysis. RESULTS: IDE initiation can be facilitated by addressing the pre-existing beliefs about IDE through the influence of peers (for patients) and training (for staff). Participation was sustained through the observation of positive outcomes and through social influences such as teamwork and collaboration. Despite this, environment and resource limitations remained the greatest barrier perceived by both groups. CONCLUSIONS: Novel methods of staff training and patient education should enhance engagement. Programmes that clearly highlight the benefits of IDE should be more successful in the longer term. The barrier of staff workload needs to be addressed through specific guidance that includes recommendations on staffing levels, roles, training and skill mix.

Young, H. N., Dilworth, T. J. et Mott, D. A. (2011). "Disparities in pharmacists' patient education for Hispanics using antidepressants." J Am Pharm Assoc (2003) **51**(3): 388-396.
http://www.ncbi.nlm.nih.gov/pubmed/21555291

> OBJECTIVES: To assess pharmacists' provision of antidepressant information and to examine the effect of patient ethnicity and language skills on pharmacists' provision of information and patient education. DESIGN: Cross-sectional, randomized, between-subjects study. SETTING: Wisconsin, from September to November 2008. PARTICIPANTS: 540 community pharmacists. INTERVENTION: Participants were exposed to one of three vignettes describing a patient coming into the pharmacy for an initial dispensation of an antidepressant. Vignettes varied according to patient ethnicity (white or Hispanic) and language spoken (English or Spanish). MAIN OUTCOME MEASURES: Respondents' information and education messages given to patients about antidepressants and whether Hispanic patient ethnicity and English language ability reduced pharmacists' communication about antidepressants. RESULTS: A majority of participants would provide information regarding the medication's name (93.3%) and dosage schedule (92.8%). Many pharmacists also reported that they would tell the patient to take the medication on a daily basis (92.6%) and that it takes 2 to 4 weeks for the medication to have a noticeable effect (87.8%). Multivariate models showed that pharmacists would provide significantly less information (beta = -0.24 [95% CI -0.31 to -0.17]) and education messages (-0.17 [-0.24 to -0.09]) to Spanish-speaking patients. CONCLUSION: These findings suggest that Spanish-speaking patients may face disparities in the level of care received from community pharmacists. Interventions should be available to enhance pharmacists' communication with Spanish-speaking patients in an effort to facilitate safe and effective medication use

Young, R. A., Bayles, B., Benold, T. B., et al. (2013). "Family physicians' perceptions on how they deliver cost-effective care: a qualitative study from the Residency Research Network of Texas (RRNeT)." Fam Med **45**(5): 311-318.

> BACKGROUND AND OBJECTIVES: The aim of our study was to deepen our understanding of the factors that may explain the observational literature that more primary care physicians in an area contribute to better population health outcomes and lower health care costs. METHODS: This study used in-depth, qualitative interviewing of family physicians in both urban and rural, academic, and private practices. Interviews were initiated with a series of grand tour questions asking subjects to give examples and personal narratives demonstrating cost-effectiveness and cost inefficiencies in their own practices. An iterative open-coding approach was used to analyze transcripts to search for unifying themes and sub-themes until consensus among investigators was achieved. RESULTS: Thirty-

eight respondents gave examples of how their decision-making approaches resulted in improved patient outcomes and lower costs. Family physicians' cost-effective care was founded on two themes-characteristic attitudes and skills of the physicians themselves and a thorough knowledge of the whole patient. Family physicians also felt their approaches to gathering information and then making diagnostic and treatment decisions resulted in fewer tests and fewer treatments ordered overall. Family physicians also delivered care in less expensive facilities and generated lower overall charges for physician fees. CONCLUSIONS: Family physicians perceived that their approaches to patient care result in medical decision making priorities and care delivery processes that contribute to more cost-effective health care. These outcomes were achieved less by providing preventive services and strictly adhering to guidelines but rather by how they individualized the management of new symptoms and chronic conditions.

Yu, G. C. et Beresford, R. (2010). "Implementation of a chronic illness model for diabetes care in a family medicine residency program." J Gen Intern Med **25 Suppl 4**: S615-S619.
http://www.ncbi.nlm.nih.gov/pubmed/20737237

INTRODUCTION: While the Chronic Care Model (CCM) has been shown to improve the care of patients with chronic illnesses, primary care physicians have been unprepared in its use, and residencies have encountered challenges in introducing it into the academic environment. AIM: Our residency program has implemented a diabetes management program modeled on the CCM to evaluate its impact on health outcomes of diabetic patients and educational outcomes of residents. SETTING: University-affiliated, community-based family medicine residency program. PROGRAM DESCRIPTION: Six residents, two faculty clinicians, and clinic staff formed a diabetes management team. We redesigned the outpatient experience for diabetic patients by incorporating elements of the CCM: multidisciplinary team care through planned and group visits; creation of a diabetes registry; use of guidelines-based flow sheets; and incorporation of self-management goal-setting. Residents received extensive instruction in diabetes management, quality improvement, and patient self-management. PROGRAM EVALUATION: We achieved overall improvement in all metabolic and process measures for patients, with the percentage achieving HbA1c, LDL, and BP goals simultaneously increasing from 5.7% to 17.1%. Educational outcomes for residents, as measured by compliance with review of provider performance reports and self-management goal-setting with patients, also significantly improved. DISCUSSION: Through a learning collaborative experience, residency programs can successfully incorporate chronic care training for residents while addressing gaps in care for patients with diabetes

Zajdel, J. et Gorski, P. (2010). "[The analysis the doctor-patient communication on the basis of selected clinical and demographic factors]." Med Pr **61**(2): 165-181.
http://www.ncbi.nlm.nih.gov/pubmed/20509554

BACKGROUND: The aim of the study was to analyze the doctor-patient communication on the basis of selected clinical and demographic factors. MATERIAL AND METHODS: The author assessed the level of patients' knowledge about their rights, availability, scope and reliability of the information conveyed by doctors, completeness and influence of information given by doctors on the validity of consent given by patients. The mentioned variables were analyzed on the basis of selected clinical and demographic factors including age, gender, education, place of residence, employment, form of employment, marital status, income, number of hospitalizations (NoH) and ICD10. The data were collected by questionnaires completed by 500 patients. RESULTS: Performing the doctor's duty of giving information to the patient and the patients' knowledge about their rights depends on their education, monthly income, place of residence, cause of hospitalization and NoH. The scope, way and perception of the conveyed information depends on patients' education, place of residence, income, cause and NoH. The influence of the information given by the doctor on the validity of consent given by the patient depends on his/her education, place of residence, income and cause and NoH. Patients have limited knowledge about their right to have a contact person established. CONCLUSIONS: The importance of obtaining adequate information before the patient gives informed consent, insufficient patients' knowledge concerning their rights and lack of similar analyses carried out in the past indicate the need to continue the relevant research in the future

Zhang, J., Chen, Y., Ashfaq, S., et al. (2016). "Strategizing EHR use to achieve patient-centered care in exam rooms: a qualitative study on primary care providers." J Am Med Inform Assoc **23**(1): 137-143.

> OBJECTIVE: Electronic health records (EHRs) have great potential to improve quality of care. However, their use may diminish "patient-centeredness" in exam rooms by distracting the healthcare provider from focusing on direct patient interaction. The authors conducted a qualitative interview study to understand the magnitude of this issue, and the strategies that primary care providers devised to mitigate the unintended adverse effect associated with EHR use. METHODS AND MATERIALS: Semi-structured interviews were conducted with 21 healthcare providers at 4 Veterans Affairs (VAs) outpatient primary care clinics in San Diego County. Data analysis was performed using the grounded theory approach. RESULTS: The results show that providers face demands from both patients and the EHR system. To cope with these demands, and to provide patient-centered care, providers attempt to perform EHR work outside of patient encounters and create templates to streamline documentation work. Providers also attempt to use the EHR to engage patients, establish patient buy-in for EHR use, and multitask between communicating with patients and using the EHR. DISCUSSION AND CONCLUSION: This study has uncovered the challenges that primary care providers face in integrating the EHR into their work practice, and the strategies they use to overcome these challenges in order to maintain patient-centered care. These findings illuminate the importance of developing "best" practices to improve patient-centered care in today's highly "wired" health environment. These findings also show that more user-centered EHR design is needed to improve system usability.

Zhou, L., Liu, X. L., Tan, J. Y., et al. (2015). "Nurse-led educational interventions on cancer pain outcomes for oncology outpatients: a systematic review." Int Nurs Rev **62**(2): 218-230.

> BACKGROUND: Cancer pain management is still unsatisfactory, although some effective guidelines exist. Educational interventions are reported to be useful in pain relief for oncology outpatients. AIM: The aims of this systematic review were to evaluate the effects of nurse-led educational interventions on improving cancer pain outcomes for oncology patients, and to establish an effective cancer pain protocol for clinical nursing practice in China. METHODS: A three-step search strategy was utilized. Eight databases were searched using the standards provided by the Joanna Briggs Institute that guided article selection, critical appraisal, data collection and data synthesis. RESULTS: A total of 1093 studies were identified through a literature search. Only six studies complied with the inclusion criteria and were found to be methodologically sound. In general, the included studies indicated positive results pertaining to patient's knowledge and attitudes towards analgesics and cancer pain management and decreased pain intensity. Studies reported minimal effects of intervention on anxiety, depression, satisfaction regarding cancer pain management and patient's quality of life. CONCLUSIONS: Educational interventions were reported as effective methods to improve cancer pain outcomes. Analysis of the six included studies demonstrated the overall positive effects of nurse-led educational interventions for improving cancer pain management. IMPLICATIONS FOR NURSING AND HEALTH POLICY: The results suggest that an effective cancer pain protocol for improving cancer pain management can be established in China.

Formation médicale et recommandations de bonne pratique

ÉTUDES FRANÇAISES

Albano, M. G., Gagnayre, R., de Andrade, V., et al. (2020). "L'éducation précédant la sortie de l'hôpital : nouvelle forme d'éducation thérapeutique. Critères de qualité et perspectives d'application à notre contexte." Rech Soins Infirm **141**(2): 70-77.
https://www.cairn.info/revue-recherche-en-soins-infirmiers-2020-2-page-70.htm

> L'ETP sh (Éducation thérapeutique précédant la sortie de l'hôpital) est une pratique développée sous le nom de « discharge education » dans les pays anglo-saxons. Cette nouvelle forme d'éducation thérapeutique s'adresse à des patients aigus ou chroniques et intéresse toutes les spécialités hospitalières ; elle vise à faciliter la transition hôpital-domicile et éviter les réadmissions précoces. Cet examen de 43 études scientifiques porte spécifiquement sur la description, l'analyse et l'évaluation de l'ETP sh, ainsi que sur des recommandations. Près de la moitié des études sont publiées dans des revues de sciences infirmières. L'ETP sh est une intervention éducative intense et brève (de 30 minutes à une heure) délivrée majoritairement dans des situations aiguës. La pédiatrie représente, avec les soins postopératoires, le plus grand nombre de publications. Dans la plupart des études, l'ETP sh se révèle efficace pour améliorer des paramètres cliniques et psychosociaux, réduire les réadmissions précoces, augmenter les compétences et l'observance des patients. Pour atteindre ses buts, l'ETP sh doit être structurée et comporter un suivi systématique. Centrée sur les besoins, les capacités d'apprentissage du patient, elle fait appel à une pédagogie spécifique, interactive, à laquelle les soignants doivent être formés. L'analyse de la recherche internationale ne laisse aucun doute sur les apports positifs de l'ETP sh. Il serait important que soignants et décideurs s'en saisissent comme une opportunité d'améliorer la qualité des soins et de les humaniser.

Foucaud, J., Balcou-Debussche, M., Gautier, A., et al. (2013). "Training in therapeutic patient education of French primary care physicians : practices and perceived needs." Educ Ther Patient/Ther Patient Educ **5**(1): 123-130.
https://doi.org/10.1051/tpe/2012021

HAS (2007). L'éducation thérapeutique dans la prise en charge des maladies chroniques : Analyse économique et organisationnelle. Evaluation économique. Haute Autorité, d. S. Saint-Denis : HAS.
http://www.has-sante.fr/portail/upload/docs/application/pdf/rapport_dorientation_analyse_economique_et_organisationnelle.pdf

> [BDSP. Notice produite par HAS FR0x8p8D. Diffusion soumise à autorisation]. L'éducation thérapeutique est aujourd'hui reconnue comme un élément essentiel de la prise en charge des patients atteints d'une pathologie chronique. Cependant, l'analyse du contexte et les différentes enquêtes de terrain existantes montrent que l'ETP pose de nombreux problèmes de mise en ouvre concrète : hétérogénéité des pratiques, implication variable des professionnels et des patients, modalités de financement et d'organisation incertaines, etc. Or, les études médico-économiques mettent en évidence que, dans ces conditions, le résultat clinique et économique que l'on peut attendre d'une action d'éducation thérapeutique est pour le moins incertain. En conséquence, si l'on veut développer l'ETP, cela doit impérativement se faire dans le cadre d'une stratégie globale visant à rendre cohérents les différents vecteurs possibles de l'offre d'ETP et à garantir la qualité de l'ETP dispensée. Le développement de l'éducation thérapeutique doit reposer sur le respect de deux principes opérationnels fondamentaux : la coordination de l'offre sur le territoire et la promotion d'une démarche qualité. Concrètement, une coordination en trois niveaux peut être mise en place. - Au niveau national, la définition des orientations générales du développement de l'ETP en France (organisation, recommandations professionnelles, etc.) peut reposer sur des structures existantes, dont une serait chargée en outre d'assurer une veille sur l'activité. - Au niveau régional, il s'agit de coordonner l'offre et le financement de l'éducation thérapeutique tout en disposant d'un centre d'information pour les patients et les professionnels de santé. - Au niveau local, des structures et acteurs prestataires garantiraient une offre de proximité. Les méthodes permettant de mettre en

place rapidement une démarche qualité existent (certification, évaluation des pratiques professionnelles) mais les outils permettant leur adaptation à l'ETP doivent encore être élaborés : recommandations de pratiques professionnelles déclinées par pathologie, cahiers des charges listant les critères de qualité d'une structure prestataire, référentiel d'évaluation des pratiques professionnelles. Deux autres éléments sont indispensables en amont du développement d'une éducation thérapeutique de qualité et adaptée aux besoins de la population : l'inscription de l'ETP dans la formation initiale et continue des professionnels de santé concernés ; le financement harmonisé des actions d'ETP mises en ouvre par des structures ou des professionnels inscrits dans une démarche qualité

HAS (2007). Structuration d'un programme d'éducation thérapeutique du patient dans le champ des maladies chroniques. Haute Autorité, d. S. Saint-Denis : HAS.
http://www.has-sante.fr/portail/upload/docs/application/pdf/etp_-_guide_version_finale_pdf.pdf

Ce guide méthodologique a pour but de définir l?éducation thérapeutique du patient (ETP), ses finalités, son organisation; de décrire la démarche d?ETP, le contenu de ses étapes; de proposer une structuration de programme d?ETP; de proposer une évaluation du processus d?ETP et une réflexion pour évaluer l?efficacité de l?ETP

HAS (2012). Auto-évaluation annuelle d'un programme d'éducation thérapeutique du patient. Guide pour les coordonnateurs et les équipes. Saint-Denis La Plaine HAS**:** 36 , tabl., fig., ann.
http://www.has-sante.fr/portail/upload/docs/application/pdf/2012-04/etp_auto-evaluation-programme_2012-04-02_16-39-56_681.pdf

[BDSP. Notice produite par CERFEP m8CR0xJl. Diffusion soumise à autorisation]. Ce guide rédigé par la Haute Autorité de Santé est destiné à faciliter la réalisation de l'auto-évaluation annuelle de chaque programme d'éducation thérapeutique du patient (ETP), afin de préparer à leur évaluation quadriennale. Il est destiné aux coordonnateurs et aux équipes qui mettent en oeuvre un programme. Il détaille la démarche en 4 étapes : les choix des objets d'évaluation, le recueil des données, l'identification des forces, faiblesses et difficultés de mise en oeuvre du programme, et enfin la mise en oeuvre d'actions d'amélioration. Il présente également des outils et des exemples concrets d'analyse qualitative et quantitative.

HAS (2014). Cahier des charges pour la mise en oeuvre de l’éducation thérapeutique du patient (ETP) dans le cadre de l’expérimentation PAERPA. Note méthodologique et de synthèse documentaire. Haute Autorité, d. S. Saint-Denis : HAS.
http://www.has-sante.fr/portail/upload/docs/application/pdf/2014-05/note_methodo_cdc_etp_paerpa_web.pdf

L’expérimentation PAERPA (personne âgée en risque de perte d’autonomie) obéit à un cahier des charges adopté par le comité de pilotage national et prévoit, outre des outils de coordination élaborés par la HAS, l’utilisation de programmes d’éducation thérapeutique (ETP) de la personne âgée. Ces programmes concernent les quatre facteurs d’hospitalisation identifiés : les chutes, la dépression, les problèmes liés à la polymédication et la dénutrition

HAS (2014). Comment organiser les fonctions d’appui aux professionnels de soins primaires. Saint-Denis : HAS**:** 2 vol. (12;45), fig., annexes.
http://www.has-sante.fr/portail/jcms/c_1764278/fr/comment-organiser-les-fonctions-dappui-aux-professionnels-de-soins-primaires

La mise en place de fonctions d’appui consiste à proposer aux professionnels de premier recours des aides pour organiser les parcours des patients en situation complexe. Il peut s’agir de prestations ponctuelles (par ex l’évaluation multidimensionnelle des personnes âgées) ou plus durables (par ex une assistance personnalisée au parcours des personnes en grande difficulté sanitaires ou sociales). Leur déploiement est une mission des ARS : il fait suite à une évaluation des besoins et est cohérent avec le projet régional de santé. Ce déploiement doit tenir compte des cinq conditions d’efficacité repérées dans la littérature :l'inscription dans une dynamique d'intégration territoriale, apportant des outils communs pour évaluer et orienter les personnes ;la localisation du dispositif d'appui en proximité des médecins et des équipes de santé primaire ;un ciblage approprié des patients pouvant en bénéficier ;l'aide à l'organisation des transitions hôpital-domicile, intervention qui a un fort niveau de preuve sur le recours aux soins ;la transmission d'outils, de savoirs et de savoir-faire aux professionnels de santé.Cette fiche traite du contenu des fonctions d'appui et des facteurs conditionnant leur efficacité, y compris en termes d'organisation. Elle n'aborde pas les aspects réglementaires de cette organisation.s (résumé de l'éditeur).

HAS (2015). Démarche centrée sur le patient : information, conseil, éducation thérapeutique, suivi. Saint-Denis : HAS**:** 8p.

L'objectif est de proposer des points de repère visant à développer et renforcer les compétences du patient à partager des décisions avec les soignants, et à s'engager dans ses soins, dans la gestion de sa vie avec la maladie.

HCSP (2010). L'éducation thérapeutique intégrée aux soins de premier recours. Paris : La Documentation Française

Ivernois, J.-F. et Gagnayre, R. (2008). Apprendre à éduquer le patient: approche pédagogique. Paris, Maloine

Cette éducation concerne les personnes atteintes de maladies de longue durée qui doivent apprendre à assurer par elles-mêmes leur surveillance et leur traitement. Ce livre analyse les principes théoriques sur lesquels se fonde l'éducation du patient

La Tribonnière, X. d. (2016). Pratiquer l'éducation thérapeutique: L'équipe et les patients. IssylesMoulineaux, Elsevier Masson

Lacroix, A. et Assal, J.-P. (2011). L'éducation thérapeutique des patients: accompagner les patients avec une maladie chronique : nouvelles approches. Paris, Maloine

Lasserre Moutet, A., Dupuis, J., Chambouleyron, M., et al. (2008). "Transformer son identité professionnelle : impact d'un programme de formation continue de soignants en éducation thérapeutique du patient." PEDAGOGIE MEDICALE **9**(2): 83-93.

Le Diplôme de formation continue en éducation thérapeutique du patient (DiFEP) décerné par la Faculté de Médecine de l'Université de Genève a été créé en 1998 pour encourager la développement des compétences des soignants dans l'accompagnement des personnes vivant avec une maladie chronique. Selon nous, l'Education Thérapeutique du Patient (ETP) remet profondément en question le rapport soignant-soigné et incite le soignant à faire évoluer son identité professionnelle. But : Cette étude a pour objectif d'évaluer l'impact du DiFEP sur la transformation de l'identité professionnelle des soignants. Méthode : Un questionnaire a été adressé aux 49 soignants diplômés ; 28 questionnaires nous ont été retournés (57 %). Résultats : Les résultats montrent que 65 % des soignants ont tout à fait évolué dans leur perception du rôle du patient dans son traitement : de profane, celui-ci devient partenaire de soin ; 53 % des soignants témoignent d'une importante évolution de leur perception de leur rôle : la relation thérapeutique est maintenant considérée comme un soin à part entière. Enfin, 44 % des soignants occupent de nouvelles responsabilités en lien direct avec l'éducation thérapeutique du patient au sein de leurs institutions. Conclusion : La formation continue est donc l'occasion de transformations qui ont une portée identitaire. Les formateurs doivent se préoccuper non seulement des connaissances qu'ils transmettent mais aussi d'accompagner ces transformations identitaires.

Lechopier, N. et granier, B. (2020). Patiente expérience. Savoirs expérientiels et épistémologie de la formation médicale. Éducation à la santé. Entre Savoir et Pouvoir. Jacqueline, D., Rémi, G., Nicolas, L. etFranck, P. Paris, L'Harmattan.
https://halshs.archives-ouvertes.fr/halshs-01521725

Alors que l'implication des usagers dans la gestion du système de santé est inscrite dans la loi française de démocratie sanitaire, que l'expertise des patients atteints de maladies chroniques est reconnue dans le cadre de l'éducation thérapeutique, les facultés de médecine restent pour la plupart réticentes à l'intervention des patients dans la formation des médecins. En effet, les patient-e-s formateurs questionnent le fossé entre connaissances médicales générales fondées sur des études populationnelles (qui seraient l'apanage de l'université), et pratique médicale clinique adaptée aux cas singuliers. Quelles valeurs épistémiques et pédagogiques peuvent avoir ces contributions issues des patient-e-s ? Trois réponses peuvent être esquissées. Le témoignage d'expérience vécue, s'il a une portée heuristique, enferme le patient dans le rôle d'illustration d'un savoir dispensé par d'autres. La transmission d'une expertise issue de l'expérience, qu'elle soit médico-scientifique ou de sciences humaines, s'ajoute à un cursus déjà critiqué pour son caractère pléthorique. La troisième figure du patient-formateur serait celle d'un aiguillon épistémologique, engageant les étudiant-e-s dans une enquête réflexive sur leurs modes d'apprentissage académiques, et dans l'exploration d'un collectif qui ne se limite pas aux professionnels de santé.

Pellecchia, A., Certain, A., Mohammed, R., et al. (2019). "Formation et conditions facilitant l'intégration de patients dans la coanimation de séances collectives d'éducation thérapeutique." Santé Publique **31**(5): 683-692.
https://www.cairn.info/revue-sante-publique-2019-5-page-683.htm

But de l'étude : L'objectif de cette étude était de favoriser l'implication et l'intervention des patients-intervenants (PI) dans des séances collectives d'éducation thérapeutique du patient (ETP), notamment par une formation et un accompagnement à la mise en place de ces séances, en coanimation avec un professionnel de santé (PDS). Il s'agissait donc de coconstruire un modèle de formation, d'expérimenter un début d'application et de définir des conditions favorables à cette collaboration. Méthodes : Il s'agit d'une recherche collaborative orientée par la conception (RoC), menée par un comité de pilotage représentatif des différentes catégories d'acteurs concernés, qui s'est déployée sur deux ans, en Région parisienne et à Montpellier. La recherche a comporté quatre phases : 1/ exploration (revue bibliographique et enquête) ; 2/ recrutement des PI concernés par différentes pathologies ; 3/ mise en œuvre et évaluation de la formation des PI en interpathologie ; 4/ mise en œuvre et évaluation des séances collectives coanimées.Résultats : Parmi les 35 patients sollicités, 24 (69 %) ont accepté de participer à l'étude et 22 (92 %) ont suivi la formation dans son intégralité ; 17 séances (vs 15 initialement prévues) ont été réalisées en coanimation avec les PDS pour 151 patients bénéficiaires (vs 150 prévus). Les taux de satisfaction des PI, PDS et patients bénéficiaires ont été très élevés. Conclusions : Cette recherche a permis de valider un modèle de formation pour les PI en éducation thérapeutique et de préciser quelques conditions pouvant faciliter leur intégration dans les programmes d'ETP.

Revillot, J.-M. (2016). Manuel d'éducation thérapeutique du patient: modèles, méthodes, pratiques. Malakoff HautsdeSeine, Dunod

S'appuyant sur des cas cliniques, cet ouvrage propose un état des lieux de l'éducation thérapeutique du patient (ETP). Il détermine les différentes étapes du cheminement du malade atteint d'une pathologie chronique dans la reconquête de son autonomie et d'une vie normale. Avec des quiz d'autoformation et des tableaux de synthèse.--[Memento]

Tison, B. et Hervé-Désirat, E. (2007). Soins et cultures: formation des soignants à l'approche interculturelle. IssyLesMoulineaux, Elsevier Masson
http://www.masson.fr/masson/portal/bookmark?Global=2&Page2=0&MenuIdSelected=223&MenuItemSelected=0&MenuSupportSelected=0&Product=408285&ProductCode=408285

Cet ouvrage propose une initiation pratique aux soins infirmiers interculturels, c'est-à-dire à la prise en charge du patient d'origine étrangère. Il fournit d'abord des fondements théoriques en définissant les concepts à l'oeuvre dans cette relation interculturelle soignant-soigné (communication, culture, acculturation, identité culturelle, identité du soignant, etc.), puis dans un second temps donne des clés de compréhension pour la prise en charge du patient migrant, en déroulant les situations de soins selon les différents moments de la vie et les classes d'âge, selon les différentes cultures : - la maternité et la naissance ; - l'enfant et l'adolescent, l'éducation et le passage à la vie adulte mais aussi les conduites à risque ; - l'adulte malade et le rapport au corps, à l'hygiène ; - la personne âgée et la mort. L'ouvrage se termine enfin par un aperçu de la pratique des soins infirmiers dans d'autres cultures, à l'occasion par exemple de missions humanitaires

Vanmeerbeek, M., Mathonet, J., Miermans, M. C., et al. (2015). "[Preventive health care and health promotion: Which models for supporting the evolution of clinical practice in primary health care?]." Presse Med **44**(6 Pt 1): e211-220.
http://www.sciencedirect.com/science/article/pii/S0755498215001220

OBJECTIVES: Published operating models about preventive health care and health promotion in primary care were sought with the aim of (1) compiling a functional inventory; and (2) to formulate working hypotheses for the improvement of clinical practice towards more efficiency and more equity. METHODS: Narrative literature review, using keywords related to the various prevention classes, health promotion, primary care, practice models and health care delivery. The diversity of models led to a multi-criteria analysis. RESULTS: Twelve models were selected. Their characteristics were unevenly distributed. The models, whose authors announce that they apply to prevention, mainly describe approaches that focus on individuals within physician-patient relationship, and take into account practice organization. Some socio-ecological and systems models illustrate health promotion: educational practice, group- or population-based targets, community environment and social determinants of health. There is little room for patients in elaborating the models, as they have little role in health care systems. The definitions of prevention, health promotion and patient education greatly differ from one model to another. DISCUSSION: Little is known about practical implementation of the models; assessment data are scarce. Some elements valued by health promotion could be integrated to health care: empowerment of citizens, addressing community environment; increased involvement in local health professionals' networks; integration of individual and collective approaches within the same health care facilities to address simultaneously individual customization, efficiency and equity objectives. These developments may call for adaptation in vocational training and continuous professional development: communication skills, awareness to public health concepts, and early and longitudinal exposure to community-based learning experiences for students.

Weber, J.-C. (2019). Se former au contact des patients : que faire de leur expérience ? Recherche en santé, formation des soignants : agir dans les révolutions en cours. Paris, France.
https://hal.archives-ouvertes.fr/hal-03022776

Alors que l'expérience individuelle du clinicien fait l'objet de nombreuses critiques, celle du patient est l'objet de toutes les attentions : patients experts de l'éducation thérapeutique, patients standardisés des ECOS, mais aussi patients victimes du Levothyrox. Néanmoins, son premier accueil fait le quotidien de la clinique. Est-ce que le médecin s'en distrait ou s'en instruit? Comment une expérience vécue peut-elle devenir source d'une connaissance ? Si l'expérience vécue est la toile de fond de l'expertise du patient, n'est-elle pas pourtant fragile au point de nécessiter l'intervention du médecin "exégète" des symptômes dont le sens n'est pas clair pour le malade (Canguilhem)? Le médecin malade n'a-t-il pas besoin d'un autre médecin pour être bien soigné ? En son temps, Wittgenstein prévenait qu'avec " le concept d'expérience vécue (...) nous nous figurons qu'ici nous prenons pied sur la terre ferme de l'origine, plus profond que toutes les méthodes (...) ". En réalité, ce terme a " une signification floue au plus haut point. Il se rapporte en fait à une quantité énorme de cas spéciaux, mais cela ne les rend pas plus fermes, cela les rend seulement plus fuyants ". D'un autre côté, s'il est "impossible d'annuler dans l'objectivité du savoir médical la subjectivité de l'expérience vécue du malade (Canguilhem), nous nous trouvons devant une difficulté : que faire de l'expérience des patients? Nous proposerons une piste pour la lever, qui fait entrer médecin et malade dans une pratique d'expérimentation.

ÉTUDES INTERNATIOALES

AARC (2010). "AARC Clinical Practice Guidelines. Providing patient and caregiver training 2010." Respir Care **55**(6): 765-769.

An electronic literature search for articles published between January 1990 and October 2009 was conducted by using the MEDLINE, CINAHL, and Cochrane Library databases. The update of this clinical practice guideline is the result of reviewing a total of 7 clinical trials and systematic reviews, and 33 articles investigating patient, family, and caregiver training. The following recommendations are made following the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) criteria: (1) It is suggested that RTs take an active role in educating patient, family, and caregivers in the management of their cardiopulmonary disease state.

Arnold, C. L., Coran, J. J. et Hagen, M. G. (2012). "Revisiting patient communication training: an updated needs assessment and the AGENDA model." Patient Educ Couns **88**(3): 399-405.

OBJECTIVE: To assess physician needs for patient-centered communication training for medical consultations and to develop an updated patient training curriculum. METHODS: An online needs assessment was distributed through physician email listserves at the University of Florida College of Medicine. Frequency tabulation and content analyses were conducted to assess patient communication themes. RESULTS: Responses were received from 336 physicians. Physicians reported that patients are reluctant to ask questions when they do not understand information related to their medical condition, treatment plan, or medical advice. Furthermore, physicians reported that a lack of patient negotiation inhibits patient-centered communication and may negatively influence patient adherence and compliance. Based on these results the AGENDA model was created for patient training and consists of (1) agenda setting; (2) goals for health; (3) expressing concerns, questions, and negotiations; (4) navigating health literacy issues; (5) disclosing detailed information; and (6) active types of listening. CONCLUSION: This study supports revisiting patient communication training and tailoring future training interventions to specific communities. PRACTICE IMPLICATIONS: The AGENDA model can be used to train patients to enhance patient-centered communication with physicians. Additionally, patient communication training could help to address the barriers to care identified by the physicians in our study.

Battersby, M., Von Korff, M., Schaefer, J., et al. (2010). "Twelve evidence-based principles for implementing self-management support in primary care." Jt Comm J Qual Patient Saf **36**(12): 561-570.

BACKGROUND: Recommendations to improve self-management support and health outcomes for people with chronic conditions in primary care settings are provided on the basis of expert opinion supported by evidence for practices and processes. Practices and processes that could improve self-management support in primary care were identified through a nominal group process. In a targeted search strategy, reviews and meta-analyses were then identifed using terms from a wide range of chronic conditions and behavioral risk factors in combination with Self-Care, Self-Management, and Primary Care. On the basis of these reviews, evidence-based principles for self-management support were developed. FINDINGS: The evidence is organized within the framework of the Chronic Care Model. Evidence-based principles in 12 areas were associated with improved patient self-management and/or health outcomes: (1) brief targeted assessment, (2) evidence-based information to guide shared decision-making, (3) use of a nonjudgmental approach, (4) collaborative priority and goal setting, (5) collaborative problem solving, (6) self-management support by diverse providers, (7) self-management interventions delivered by diverse formats, (8) patient self-efficacy, (9) active followup, (10) guideline-based case management for selected patients, (11) linkages to evidence-based community programs, and (12) multifaceted interventions. A framework is provided for implementing these principles in three phases of the primary care visit: enhanced previsit assessment, a focused clinical encounter, and expanded postvisit options. CONCLUSIONS: There is a growing evidence base for how self-management support for chronic conditions can be integrated into routine health care.

Beune, E. J., Haafkens, J. A. et Bindels, P. J. (2011). "Barriers and enablers in the implementation of a provider-based intervention to stimulate culturally appropriate hypertension education." Patient Educ Couns **82**(1): 74-80.

OBJECTIVE: to identify barriers and enablers influencing the implementation of an intervention to stimulate culturally appropriate hypertension education (CAHE) among health care providers in primary care. METHODS: the intervention was piloted in three Dutch health centers. It consists of a toolkit for CAHE, training, and feedback meetings for hypertension educators. Data were collected from 16 hypertension educators (nurse practitioners and general practice assistants) during feedback meetings and analyzed using qualitative content analysis. RESULTS: perceived barriers to the implementation of the intervention fell into three main categories: political context (health care system financing); organizational factors (ongoing organizational changes, work environment, time constraints and staffing) and care provider-related factors (routines, attitudes, computer and educational skills, and cultural background). Few barriers were specifically related to the delivery of CAHE (e.g. resistance to registering ethnicity). Enabling strategies addressing these barriers consisted of reorganizing practice procedures, team coordination, and providing reminders and additional instructions to hypertension educators. CONCLUSION AND PRACTICE IMPLICATIONS: the adoption of a tool for CAHE by care providers can be accomplished if barriers are identified and addressed. The majority of these barriers are commonly associated with the implementation of health care innovations in general and do not indicate resistance to providing culturally appropriate care.

Bird, G. C., Marian, K. et Bagley, B. (2013). "Effect of a performance improvement CME activity on management of patients with diabetes." J Contin Educ Health Prof **33**(3): 155-163.

INTRODUCTION: Primary care in the United States faces unprecedented challenges from an aging population and the accompanying prevalence of chronic disease. In response, continuing medical education (CME) initiatives have begun to adopt the principles of performance improvement (PI) into their design, although currently there is a dearth of evidence from national initiatives supporting the effectiveness of this methodology. The specific aim of this study was to demonstrate the value of a national PI-CME activity to improve the performance of physicians treating patients with diabetes. METHODS: We analyzed data from the American Academy of Family Physicians' METRIC(R) PI-CME activity in a cohort of family physician learners. The study utilized the 3-stage design standard approved for PI-CME. Baseline and follow-up performance data across a range of clinical and systems-based measures were compared in aggregate. RESULTS: Data were assessed for 509 learners who completed the activity. Statistically significant changes occurred both for self-assessment of a range of practice aspects and for diabetes care measures. Learners recognized that the organization of their practices had improved, and mechanisms were in place for better staff feedback, as well as aspects of patient self-management. Based on the clinical data obtained from 11 538 patient charts, 6 out of 8 diabetes measures were significantly improved. DISCUSSION: The activity appears to have had a positive, measurable impact on the medical practice of learners and suggests that, when appropriately designed and executed, PI-CME on a national scale can be a useful vehicle to influence performance change in physicians and to inform future CME activities.

Bosnic-Anticevich, S. Z., Stuart, M., Mackson, J., et al. (2014). "Development and evaluation of an innovative model of inter-professional education focused on asthma medication use." BMC Med Educ **14**: 72.

BACKGROUND: Inter-professional learning has been promoted as the solution to many clinical management issues. One such issue is the correct use of asthma inhaler devices. Up to 80% of people with asthma use their inhaler device incorrectly. The implications of this are poor asthma control and quality of life. Correct inhaler technique can be taught, however these educational instructions need to be repeated if correct technique is to be maintained. It is important to maximise the opportunities to deliver this education in primary care. In light of this, it is important to explore how health care providers, in particular pharmacists and general medical practitioners, can work together in delivering inhaler technique education to patients, over time. Therefore, there is a need to develop and evaluate effective inter-professional education, which will address the need to educate patients in the correct use of their inhalers as well as equip health care professionals with skills to engage in collaborative relationships with each other. METHODS: This mixed methods study involves the development and evaluation of three modules of continuing education, Model 1, Model 2 and Model 3. A fourth group, Model 4, acting as a control.Model 1 consists of face-to-face continuing professional education on asthma inhaler technique, aimed at pharmacists, general medical practitioners and their practice nurses.Model 2 is an electronic online continuing education module based on Model 1 principles.Model 3 is also based on asthma inhaler technique education but employs a learning intervention targeting health care professional relationships and is based on sociocultural theory.This study took the form of a parallel group, repeated measure design. Following the completion of continuing professional education, health care professionals recruited people with asthma and followed them up for 6 months. During this period, inhaler device technique training was delivered and data on patient inhaler technique, clinical and humanistic outcomes were collected. Outcomes related to professional collaborative relationships were also measured. DISCUSSION: Challenges presented included the requirement of significant financial resources for development of study materials and limited availability of validated tools to measure health care professional collaboration over time.

Bracht, M., Basevitz, D., Cranis, M., et al. (2012). "Practical resources for nurses and other health care providers involved in the care of children at risk for respiratory syncytial virus infection." Neonatal Netw **31**(6): 387-400.

Health care staff and families with young children are often unware of the ease of respiratory syncytial virus (RSV) spread and potential clinical consequences of serious respiratory illness. Successful Canadian RSV prophylaxis (RSVP) programs (a) provide practical educational resources on RSV and respiratory disease that consider language and cultural barriers; (b) develop policies to identify all children eligible for RSVP with palivizumab; (c) emphasize compliance with RSVP, particularly during patient transfer between hospitals, community clinics, and remote outpost centers; and (d) establish collaborative networks to help ensure optimum RSVP compliance for all high-risk children. Herein, we share practical resources and key educational references for counseling of caregivers with infants or young children at risk for RSV infection, and health care providers participating in RSVP program development.

Braido, F., Baiardini, I., Menoni, S., et al. (2011). "Asthma management failure: a flaw in physicians' behavior or in patients' knowledge?" J Asthma **48**(3): 266-274.

OBJECTIVES: Patient-physician communication and patients' knowledge about asthma are relevant factors that influence health outcomes. The aim of this study was to explore general practitioners' (GPs) behaviors, asthma patients' knowledge requirements, and the relationship between physicians' communicative issues, and failures in patients' knowledge. METHODS: GPs participating in a continuing medical education program on asthma completed an ad hoc survey on communicative style and recruited at least three adult asthma patients to indicate, among 10 options, three aspects of asthma about which they felt less informed. RESULTS: The survey was completed by 2332 GPs (mean age 54.39 +/- 5.93 years) and 7884 patients (mean age 49.59 +/- 18.03 years). Several ineffective strategies emerged in the physicians' behaviors: 28.5% of GPs did not encourage patients to express doubts, expectations, or concerns; 39.4% tried to frighten patients concerning disease-related risks; only 25.7% used a written action plan. In addition, 18.6% of GPs were not averse to informing the patient about potential side effects; 16.3% did not try to simplify asthma treatment; approximately 30% considered ease of use when selecting drugs; 18% were not disposed to carry out a partnership with the patient; 36.9% were unlikely to involve the patient in asthma management; and 73% tried to retain control over their patients. Finally, 90.3% of GPs declared they want to be consulted before any treatment change. The three topics on which patients felt less informed were the meaning of asthma control (14% of patients); integration of asthma into daily life (13.3%); and periodic checkups (12.7%). There were significant associations between patients' choices and physicians' answers. CONCLUSION: These results demonstrate that in general medicine the recommendations of international guidelines on education, communication, and development of a doctor-patient partnership are still ignored and that patients' educational priorities may differ from those identified by medical specialists and by patients belonging to patients' associations.

Buring, S. M., Kirby, J. et Conrad, W. F. (2007). "A structured approach for teaching students to counsel self-care patients." Am J Pharm Educ **71**(1): 8.

OBJECTIVES: To determine whether the use of a structured interviewing framework improved students' ability to treat self-care patients. DESIGN: First-professional year pharmacy students (P1) in their first quarter of Pharmacy Practice Skills Development were taught self-care through a series of 4 modules. In each module students' content knowledge and application were assessed using quizzes and role-play scenarios, respectively. During the second module, a structured interview model (QuEST process) was presented by the instructor and students were tested on the same content and role-play used in module 1. ASSESSMENT: Sixty-four students completed the 4 self-care modules. Quiz scores improved from the first to the second module (75.8% vs. 88.4%, p < 0.001). Mean role-play scores also significantly improved after learning the QuEST process. CONCLUSION: The QuEST process is an effective tool to teach students how to counsel patients with self-care issues.

Campione, J. R., Sleath, B., Biddle, A. K., et al. (2005). "The influence of physicians' guideline compliance on patients' statin adherence: a retrospective cohort study." Am J Geriatr. Pharmacother **3**(4): 229-239.
http://www.ncbi.nlm.nih.gov/pubmed/16503318

BACKGROUND: National cholesterol management guidelines recommend regular follow-up of patients and annual lipid evaluations to promote adherence to statin therapy. OBJECTIVE: This study examined the relationship between primary care physicians' (PCPs') compliance with primary care guidelines and patients' adherence to statin therapy. METHODS: A retrospective cohort study was conducted among statin users aged > or = 50 years who had an assigned PCP at a Veterans Affairs Medical Center. The dependent variable was statin adherence by patients over 24 months. Computerized pharmacy, laboratory, and medical records were used to measure PCPs' compliance with 4 recommendations in national cholesterol management guidelines: (1) lipid-lowering drug (LLD) initiation; (2) 8-week follow-up visit after an initial LLD prescription; (3) 6- or 12-month follow-up visit for established LLD users; and (4) annual lipid evaluation. Multilevel, multivariable regression models were used to estimate the effects of PCPs' guideline compliance on patients' adherence while controlling for patients' demographic characteristics, comorbid conditions, and pharmacotherapy factors. RESULTS: The sample included 82 PCPs caring for 4707 patients. The mean statin adherence rate was 83.9%. An increase in the annual lipid evaluation rate resulted in an increase in patients' adherence (P = 0.037). Black race and higher statin dose negatively influenced patients' adherence (both, P < 0.001). The effects of PCPs' compliance rates were not homogeneous across race. Specifically, the 8-week follow-up visit rate after initial LLD prescription was significantly associated with improved statin adherence among the black subpopulation only. CONCLUSIONS: Patients' adherence to statin therapy was influenced by their PCPs' compliance with cholesterol management guidelines. Efforts should be made to align PCPs' practice with published guidelines for optimal statin therapy, especially for vulnerable subpopulations of patients

Chen, Q., Zhang, X., Gu, J., et al. (2013). "General practitioners' hypertension knowledge and training needs: a survey in Xuhui district, Shanghai." BMC Fam Pract **14**: 16.

BACKGROUND: Hypertension prevalence is high in China, while patients' levels of hypertension awareness, treatment and control are low. General practitioners' knowledge and training relating to hypertension prevention may be an important related factor. We aimed to investigate general practitioners' knowledge of hypertension prevention and potential training needs. METHODS: A questionnaire survey was conducted among all general practitioners at five community health service centers selected by convenience sampling. A total of 160 questionnaires were distributed and 147 were returned (response rate 91.9%) The questionnaire included general information; 12 subjective questions on health promotion, education and training needs; and 19 objective questions in 5 domains (epidemiology, diagnosis, treatment, referral and community management) measuring knowledge of hypertension prevention and treatment. RESULTS: The major difficulties in health education practice for general practitioners were poor patient compliance (77.6%) and lack of medical consultation time (49.0%). The average accuracy rate of hypertension prevention knowledge was 49.2%, ranging from 10.5% to 94.7%. The factors associated with accuracy rate were physician's education level (medical university vs. professional school, beta = 13.3, P = 0.003), and type of center (training base vs. community healthcare center, beta = 12.3, P < 0.0001). Most physicians (87.8%) reported being willing to attend training courses regularly and the preferred frequency was once every 2 ~ 3 months (53.5%).

The preferred course was medical treatment of hypertension (82.3%) and the most favored training approach was expert lectures (80.3%). CONCLUSIONS: The knowledge level of hypertension prevention is low among general practitioners in urban settings. Physicians working in community clinics where they participate in a series of teaching, assessing and evaluating systems for hypertension prevention perform better than those in general healthcare centers who lack specific training. Continuing hypertension education is urgently needed to ensure that physicians in general practice are aware of and adhere to the national hypertension prevention guidelines.

Chiswell, M., Smissen, A., Ugalde, A., et al. (2018). "Using Webinars for the Education of Health Professionals and People Affected by Cancer: Processes and Evaluation." J Cancer Educ **33**(3): 583-591.

Technology provides an opportunity to engage with a variety of audiences to provide cancer education, information and support. Webinars are one such format that allow live presentations by experts that can be accessed online, from people's homes or other convenient locations. In 2015, Cancer Council Victoria (CCV) undertook a program of work to design and evaluate the effectiveness of a suite of webinars: four designed for people affected by cancer and two for health professionals. Webinars included a series of expert presentations, a panel discussion and an interactive component where participants posed questions to the panel. Evaluation included analysis of online metrics and a post-event survey covering experience and satisfaction with the webinar, self-reported changes in knowledge of key webinar concepts and confidence to discuss concepts with health professionals or patients. A total of 438 people participated in the webinars (41.5% of 1056 registrations), and 207 post-event surveys were completed by participants (47.3%). Overall, 90.1% indicated that webinar content was relevant to their interests and needs. Self-ratings of knowledge, awareness of resources and confidence to discuss webinar topics increased after the webinar. The majority (63.9%) had not participated in a webinar before, and 92.6% were interested in participating in future webinars. Over half of respondents (52.8%) had not accessed CCV resources before. This work provided a new opportunity to consolidate consistency of delivery and evaluation of webinars, demonstrating they are an effective, acceptable, accessible and sustainable vehicle for delivering information and support to health professionals and people affected by cancer.

Ciccone, M. M., Aquilino, A., Cortese, F., et al. (2010). "Feasibility and effectiveness of a disease and care management model in the primary health care system for patients with heart failure and diabetes (Project Leonardo)." Vasc Health Risk Manag **6**: 297-305.

PURPOSE: Project Leonardo represented a feasibility study to evaluate the impact of a disease and care management (D&CM) model and of the introduction of "care manager" nurses, trained in this specialized role, into the primary health care system. PATIENTS AND METHODS: Thirty care managers were placed into the offices of 83 general practitioners and family physicians in the Apulia Region of Italy with the purpose of creating a strong cooperative and collaborative "team" consisting of physicians, care managers, specialists, and patients. The central aim of the health team collaboration was to empower 1,160 patients living with cardiovascular disease (CVD), diabetes, heart failure, and/or at risk of cardiovascular disease (CVD risk) to take a more active role in their health. With the support of dedicated software for data collection and care management decision making, Project Leonardo implemented guidelines and recommendations for each condition aimed to improve patient health outcomes and promote appropriate resource utilization. RESULTS: Results show that Leonardo was feasible and highly effective in increasing patient health knowledge, self-management skills, and readiness to make changes in health behaviors. Patient skill-building and ongoing monitoring by the health care team of diagnostic tests and services as well as treatment paths helped promote confidence and enhance safety of chronic patient management at home. CONCLUSION: Physicians, care managers, and patients showed unanimous agreement regarding the positive impact on patient health and self-management, and attributed the outcomes to the strong "partnership" between the care manager and the patient and the collaboration between the physician and the care manager. Future studies should consider the possibility of incorporating a patient empowerment model which considers the patient as the most important member of the health team and care managers as key health care collaborators able to enhance and support services to patients provided by physicians in the primary health care system.

Cohen, A. G., Kitai, E., David, S. B., et al. (2014). "Standardized patient-based simulation training as a tool to improve the management of chronic disease." Simul Healthc **9**(1): 40-47.

> INTRODUCTION: Patient education is a critical factor in the treatment of chronic disease because it reduces gaps in health care and disease management. We implemented different methods of physician training for patient education of asthma and compared the effects on patients' health. METHOD: Four interventions were administered to groups of primary care physicians in one health care maintenance organization. All physicians received a list of their patients who were classified with uncontrolled asthma. Additional educational methods were implemented as follows: no additional intervention (group 1); lectures on patient education (group 2); standardized patient-based simulation training (group 3); and lectures and standardized patient-based simulations (group 4). We compared among the intervention groups and to a control group changes in rates of patients with uncontrolled asthma at 1 and 2 years after the intervention. RESULTS: During 1 year of follow-up, rates of uncontrolled asthma decreased from 7.2% to 6.2% (by 15%), from 7.5% to 6.5% (by 13%), from 6.4% to 5.1% (by 19%), and from 6.3% to 4.6% (by 27%) in intervention groups 1 to 4, respectively (P<0.01). Rates decreased by approximately 7% more in all intervention groups at 2 years of follow-up. No decrease in rates was observed in the control group. CONCLUSIONS: An intervention for primary care physicians on educating patients with asthma to manage their disease resulted in improved patient health. The most effective intervention was the combination of lectures and standardized patient-based simulation.

Cotter, V. T., Hasan, M. M., Ahn, J., et al. (2019). "A Practice Improvement Project to Increase Advance Care Planning in a Dementia Specialty Practice." Am J Hosp Palliat Care **36**(9): 831-835.

> This study was conducted to enhance the rate of advance care planning (ACP) conversations and documentation in a dementia specialty practice by increasing physician knowledge, attitudes, and skills. We used a pre- and postintervention paired design for physicians and 2 independent groups for patients. The ACP dementia educational program encompassed 3 objectives: (1) to understand the relevance of ACP to the dementia specialty practice, (2) to provide a framework to discuss ACP with patients and caregivers, and (3) to discuss ways to improve ACP documentation and billing in the electronic medical record. A 10-item survey was utilized pre- and posteducational intervention to assess knowledge, attitudes, and skill. The prevalence of ACP documentation was assessed through chart review 3 months pre- and postintervention. The educational intervention was associated with increased confidence in ability to discuss ACP (P = .033), belief that ACP improves outcomes in dementia (P = .035), knowledge about ACP Medicare billing codes and requirements (P = .002), and belief that they have support from other personnel to implement ACP (P = .017). In 2 independent groups of patients with dementia, documentation rates of an advance directive increased from 13.6% to 19.7% (P = .045) and the Medical Order for Life-Sustaining Treatment (MOLST) increased from 11.0% to 19.0% (P = .006). The MOLST documentation in 2 independent groups of patients with nondementia increased from 7.3% to 10.7% (P = .046). Continuing efforts to initiate educational interventions are warranted to increase the effectiveness ACP documentation and future care of persons with dementia.

de Belvis, A. G., Pelone, F., Biasco, A., et al. (2009). "Can primary care professionals' adherence to Evidence Based Medicine tools improve quality of care in type 2 diabetes mellitus? A systematic review." Diabetes Res Clin Pract **85**(2): 119-131.

> BACKGROUND: Our aim is to review the effectiveness of EBM tools available to primary care professionals to improve the quality of Type 2 diabetes disease management. METHODS: A systematic review of RCT was performed according to the Cochrane methods. RESULTS: Starting from an overall number of 1737 references found, a total of 13 studies met all the inclusion criteria. CONCLUSIONS: The adherence to EBM instruments is likely to improve process of care, rather than patient outcomes. In addition, our review outlines that feedback reports and use of ICT devices are likely to be effective in diabetes disease management.

Early, F., Wellwood, I., Kuhn, I., et al. (2018). "Interventions to increase referral and uptake to pulmonary rehabilitation in people with COPD: a systematic review." Int J Chron Obstruct Pulmon Dis **13**: 3571-3586.

> Pulmonary rehabilitation (PR) reduces the number and duration of hospital admissions and readmissions, and improves health-related quality of life in patients with COPD. Despite clinical guideline recommendations, under-referral and limited uptake to PR contribute to poor treatment access. We reviewed published literature on the effectiveness of interventions to improve referral to and uptake of PR in patients with COPD when compared to standard care, alternative interventions, or no intervention. The review followed recognized methods. Search terms included "pulmonary rehabilitation" AND "referral" OR "uptake" applied to MEDLINE, EMBASE, CINAHL, PsycINFO, ASSIA, BNI, Web of Science, and Cochrane Library up to January 2018. Titles, abstracts, and full papers were reviewed independently and quality appraised. The protocol was registered (PROSPERO # 2016:CRD42016043762). We screened 5,328 references. Fourteen papers met the inclusion criteria. Ten assessed referral and five assessed uptake (46,146 patients, 409 clinicians, 82 hospital departments, 122 general practices). One was a systematic review which assessed uptake. Designs, interventions, and scope of studies were diverse, often part of multifaceted evidence-based management of COPD. Examples included computer-based prompts at practice nurse review, patient information, clinician education, and financial incentives. Four studies reported statistically significant improvements in referral (range 3.5%-36%). Two studies reported statistically significant increases in uptake (range 18%-21.5%). Most studies had methodological and reporting limitations. Meta-analysis was not conducted due to heterogeneity of study designs. This review demonstrates the range of approaches aimed at increasing referral and uptake to PR but identifies limited evidence of effectiveness due to the heterogeneity and limitations of study designs. Research using robust methods with clear descriptions of intervention, setting, and target population is required to optimize access to PR across a range of settings.

Fong, S., Tan, A., Czupryn, J., et al. (2019). "Patient-centred education: How do learners' perceptions change as they experience clinical training?" Adv Health Sci Educ Theory Pract **24**(1): 15-32.

> The use of patient educators is one of many teaching strategies meant to foster principles of patient-centred care. We previously found that early patient educator exposure helped to shape the understanding of patient-centredness in pre-clerkship learners. We now expand on this work to evaluate whether there is persistence of initial perceptions and to explore general reflections on longer-term impacts of early patient educator exposures once learners are immersed in the clinical phase of their training. In this follow-up study, we conducted group interviews with a sample of learners who wrote reflections as part of their pre-clerkship patient educator experience. We explored how perspectives on patient educators changed over time, and determined which themes identified during pre-clerkship remained relevant to clinical trainees. Audio recordings were transcribed and analyzed thematically using a hybrid inductive and deductive analysis to construct a thematic framework derived through a method of constant comparison. We identified three new themes: "value of early clinical experience", "change in learners' perspectives", and "valuing and applying CanMEDS roles other than Medical Expert". Themes from pre-clerkship that remained relevant included: "patients' perspective humanizes disease", "patients' experiences with navigating the healthcare system", "learners' perceptions of the learning strategy", and "inaccuracies and inconsistencies in the learning experience." Many themes identified in pre-clerkship learners remain relevant in early clinical trainees. Further, insights from pre-clerkship experiences with patient educators evolve as learners experience clerkship with definite shifts in emphasis and new perspectives. This work illuminates the utility of patient educators for those considering this strategy for supporting the development of patient-centredness in undergraduate medical education.

Gordon, M., Gupta, S., Thornton, D., et al. (2020). "Patient/service user involvement in medical education: A best evidence medical education (BEME) systematic review: BEME Guide No. 58." Med Teach **42**(1): 4-16.

> Background: The extent to which patients and service users are involved in medical education varies widely. There is a need for an up to date systematic review of the literature that examines what involvement (description), the potential outcome of such involvement (justification) and 'why' such

involvement impacts students (clarification).Methods: Systematic searches of four databases were undertaken. Citations were screened and consensus reached for inclusion/exclusion of studies. Quality of study design and interventional presentation were assessed.Results: Of the 39 studies included in the review, 4 studies were encounter based, 17 sharing experiences, 16 with patients involved in teaching, 2 studies describing consumers as tutors, and none with involvement at the institutional level. Outcomes in terms of benefits to learners included increased empathy and understanding of illness as experienced by patients, improved communication with patients and a greater understanding of patient-center care. Educational quality assessment showed specific weaknesses in theoretical underpinning, curriculum outcomes, content or pedagogy.Conclusions: Patients can enrich medical education by allowing learners to explore patient-centered perspectives in holistic care. For educators this review highlights the lack of an underpinning conceptual basis for which to translate theory into practice.

Helmer, S. M., Rogge, A. A., Fischer, F., et al. (2019). "Evaluation of a blended-learning training concept to train oncology physicians to advise their patients about complementary and integrative medicine (KOKON-KTO): study protocol for a prospective, multi-center, cluster-randomized trial." Trials **20**(1): 90.

BACKGROUND: Many cancer patients are interested in complementary and integrative medicine during and after regular cancer treatment. Given the high number of users it is important that physicians and patients engage in a dialog about useful complementary and integrative medicine therapies during cancer treatment. In a prospective, multi-center, cluster-randomized evaluation study we will develop, implement and evaluate a training program for oncology physicians advising their patients on complementary and integrative medicine. The main objective of the study is to evaluate whether training physicians in a blended-learning approach (e-learning + skills-training workshop) in providing advice to their cancer patients on complementary and integrative medicine, in addition to handing out an information leaflet about reputable websites, has different effects on the outcomes of patients, physicians, and their interaction level, compared to only giving out the information leaflet. METHODS/DESIGN: Forty-eight oncology physicians will be included into a cluster-randomized trial to either participate or not in the blended-learning training. Physicians will then advise 10 cancer patients each, resulting in 480 patients participating in the trial. The blended learning consists of nine units of up to 45 min of e-learning and 18 units of up to 45 min of on-site skills-training workshop focusing. Outcomes will be measured on the physician, patient, and physician-patient-interaction level. DISCUSSION: A blended-learning program for oncology physicians to advise their cancer patients in a systematic way and a reasonable time frame on complementary and integrative medicine will be evaluated in depth in a large cluster-randomized trial. TRIAL REGISTRATION: German Clinical Trials Register, ID: DRKS00012704 . Registered on 28 August 2017.

Franck, J. R., Snell, L., Sherbino, J., et al. (2015). Référentiel de compétences CanMEDS 2015 pour les médecins. Ottawa Collège royal des médecins et chirurgiens du Canada**:** 30 , tab., graph., fig.

Les Associés du Collège royal des médecins et chirurgiens du Canada (Collège royal) se sont engagés à améliorer la santé des Canadiens et les soins qui leur sont prodigués. Le Collège royal s'acquitte de cette mission en partie par l'établissement de normes élevées pour la formation médicale et la pratique. Ces normes s'appuient sur le Référentiel de compétences CanMEDS pour les médecins qui contribue directement à la prestation de soins de santé de qualité. CanMEDS 2015 représente la troisième édition du référentiel et constitue sa plus importante révision à bien des égards. Le Collège royal a entrepris le processus de renouvellement de CanMEDS dans le contexte d'une autre initiative pluriannuelle connue sous le nom de La compétence par conception (CPC). La CPC est une initiative visant à mettre en oeuvre un modèle amélioré de formation médicale axé sur l'approche par compétences, de la résidence à l'exercice de la médecine spécialisée au Canada. La combinaison du projet CanMEDS 2015 et de la CPC a donné lieu à l'émergence d'un nouveau contenu dans le référentiel, de même que de nouveaux jalons pour marquer la trajectoire de développement de la compétence dans chacun des rôles CanMEDS à toutes les étapes du continuum de la formation médicale.

Gagliardino, J. J., Lapertosa, S., Pfirter, G., et al. (2013). "Clinical, metabolic and psychological outcomes and treatment costs of a prospective randomized trial based on different educational strategies to improve diabetes care (PRODIACOR)." Diabet Med **30**(9): 1102-1111.

> AIM: To evaluate the effect of system interventions (formalized data collection and 100% coverage of medications and supplies) combined with physician and/or patient education on therapeutic indicators and costs in Type 2 diabetes. METHODS: This was a randomized 2 x 2 design in public health, social security or private prepaid primary care clinics in Corrientes, Argentina. Thirty-six general practitioners and 468 adults with Type 2 diabetes participated. Patients of nine participating physicians were selected randomly and assigned to one of four structured group education programmes (117 patients each): control (group 1), physician education (group 2), patient education (group 3), and both physician education and patient education (group 4), with identical system interventions in all four groups. Outcome measures included HbA(1c), BMI, blood pressure, fasting glucose, lipid profile, drug consumption, resource use and patient well-being at baseline and every 6 months up to 42 months. RESULTS: HbA(1c) decreased significantly from 4 mmol/mol to 10 mmol/mol by 42 months (P < 0.05); the largest and more consistent decrease was in the groups where patients and physicians were educated. Blood pressure and triglycerides decreased significantly in all groups; the largest changes were recorded in the combined education group. The World Health Organization-5 Lowe score showed significant improvements, without differences among groups. The lowest treatment cost was seen in the combined education group. CONCLUSIONS: In a primary care setting, educational interventions combined with comprehensive care coverage resulted in long-term improvement in clinical, metabolic and psychological outcomes at the best cost-effectiveness ratio.

Gallardo-Rincon, H., Saucedo-Martinez, R., Mujica-Rosales, R., et al. (2017). "Online continuing medical education as a key link for successful noncommunicable disease self-management: the CASALUD Model." Diabetes Metab Syndr Obes **10**: 443-455.

> PURPOSE: The purpose of this study is to evaluate how the benefits of online continuing medical education (CME) provided to health care professionals traveled along a patient "educational chain". In this study, the educational chain begins with the influence that CME can have on the quality of health care, with subsequent influence on patient knowledge, disease self-management, and disease biomarkers. METHODS: A total of 422 patients with at least one noncommunicable disease (NCD) treated in eight different Mexican public health clinics were followed over 3 years. All clinics were participants in the CASALUD Model, an NCD care model for primary care, where all clinic staff were offered CME. Data were collected through a questionnaire on health care, patient disease knowledge, and self-management behaviors; blood samples and anthropometric measurements were collected to measure patient disease biomarkers. RESULTS: Between 2013 and 2015, the indexes measuring quality of health care, patient health knowledge, and diabetes self-management activities rose moderately but significantly (from 0.54 to 0.64, 0.80 to 0.84, and 0.62 to 0.67, respectively). Performing self-care activities - including owning and using a glucometer and belonging to a disease support group - saw the highest increase (from 0.65 to 0.75). A1C levels increased between 2013 and 2015 from 7.95 to 8.41% (63-68 mmol/mol) (P<0.001), and blood pressure decreased between 2014 and 2015 from 143.7/76.8 to 137.5/74.4 (systolic/diastolic reported in mmHg) (P<0.001). The mean levels of other disease biomarkers remained statistically unchanged, despite the improvements seen in the previous "links" of the educational chain. CONCLUSION: Online CME can effect certain changes in the educational chain linking quality of health care, patient knowledge, and self-management behaviors. However, in order to assure adequate NCD control, the entire health care system must be improved in tandem. Online CME programs, such as CASALUD's, are feasible strategies for impacting changes in disease self-management at a clinic level throughout a country.

Gefter, L., Merrell, S. B., Rosas, L. G., et al. (2015). "Service-Based Learning for Residents: A Success for Communities and Medical Education." Fam Med **47**(10): 803-806.

> BACKGROUND AND OBJECTIVES: Community-based service-learning opportunities could support residents' acquisition of Accreditation Council for Graduate Medical Education (ACGME) competencies, but this concept has not been tested, and such programs are difficult to find. The

objective of this work was to assess the value and the ACGME competency relevance of a service-learning program for residents that could be easily replicated nationally. METHODS: Forty-one family medicine residents from three training programs participated in the Stanford Youth Diabetes Coaches Program at six high schools in California and Georgia serving minority students of low socioeconomic status. Residents completed online surveys to provide qualitative feedback and assess the program's impact on their acquisition of residency program competencies and self-management support proficiencies, including prior use and planned use of action plans-a key self-management support strategy. RESULTS: Ninety-five percent of residents indicated that the program was a valuable experience that contributed to acquisition of residency program competencies, including interpersonal and communication skills and communication with teens. Compared with baseline, significantly more residents reported intention to use action plans with patients following participation. Themes from qualitative feedback included: valuing the overall experience, increasing opportunities to practice teaching, enhancing their ability to communicate with adolescents, contributing to the health of the community, recognizing the potential of action plans, and increasing intent to use action plans. CONCLUSIONS: This pilot demonstrated that a brief service-learning program can enhance standard residency curriculum by encouraging acquisition of ACGME competencies and promoting utilization of self-management support in clinical practice.

Gordon, M., Gupta, S., Thornton, D., et al. (2020). "Patient/service user involvement in medical education: A best evidence medical education (BEME) systematic review: BEME Guide No. 58." Med Teach **42**(1): 4-16.

Background: The extent to which patients and service users are involved in medical education varies widely. There is a need for an up to date systematic review of the literature that examines what involvement (description), the potential outcome of such involvement (justification) and 'why' such involvement impacts students (clarification).Methods: Systematic searches of four databases were undertaken. Citations were screened and consensus reached for inclusion/exclusion of studies. Quality of study design and interventional presentation were assessed.Results: Of the 39 studies included in the review, 4 studies were encounter based, 17 sharing experiences, 16 with patients involved in teaching, 2 studies describing consumers as tutors, and none with involvement at the institutional level. Outcomes in terms of benefits to learners included increased empathy and understanding of illness as experienced by patients, improved communication with patients and a greater understanding of patient-center care. Educational quality assessment showed specific weaknesses in theoretical underpinning, curriculum outcomes, content or pedagogy.Conclusions: Patients can enrich medical education by allowing learners to explore patient-centered perspectives in holistic care. For educators this review highlights the lack of an underpinning conceptual basis for which to translate theory into practice.

Helmer, S. M., Rogge, A. A., Fischer, F., et al. (2019). "Evaluation of a blended-learning training concept to train oncology physicians to advise their patients about complementary and integrative medicine (KOKON-KTO): study protocol for a prospective, multi-center, cluster-randomized trial." Trials **20**(1): 90.

BACKGROUND: Many cancer patients are interested in complementary and integrative medicine during and after regular cancer treatment. Given the high number of users it is important that physicians and patients engage in a dialog about useful complementary and integrative medicine therapies during cancer treatment. In a prospective, multi-center, cluster-randomized evaluation study we will develop, implement and evaluate a training program for oncology physicians advising their patients on complementary and integrative medicine. The main objective of the study is to evaluate whether training physicians in a blended-learning approach (e-learning + skills-training workshop) in providing advice to their cancer patients on complementary and integrative medicine, in addition to handing out an information leaflet about reputable websites, has different effects on the outcomes of patients, physicians, and their interaction level, compared to only giving out the information leaflet. METHODS/DESIGN: Forty-eight oncology physicians will be included into a cluster-randomized trial to either participate or not in the blended-learning training. Physicians will then advise 10 cancer patients each, resulting in 480 patients participating in the trial. The blended learning consists of nine units of up to 45 min of e-learning and 18 units of up to 45 min of on-site skills-training workshop focusing. Outcomes will be measured on the physician, patient, and physician-patient-interaction level. DISCUSSION: A blended-learning program for oncology physicians to advise their cancer patients in a systematic way and a reasonable time frame on complementary and integrative medicine will be evaluated in depth in a large cluster-randomized trial. TRIAL REGISTRATION: German Clinical Trials Register, ID: DRKS00012704 . Registered on 28 August 2017.

Hunt, J. S., Siemienczuk, J., Gillanders, W., et al. (2009). "The impact of a physician-directed health information technology system on diabetes outcomes in primary care: a pre- and post-implementation study." Inform Prim Care **17**(3): 165-174.

PURPOSE: To determine the impact of a physician-directed, multifaceted health information technology (HIT) system on diabetes outcomes. METHODS: A pre/post-interventional study. SETTING AND PARTICIPANTS: The setting was Providence Primary Care Research Network in Oregon, with approximately 71 physicians caring for 117 369 patients in 13 clinic locations. The study covered Network patients with diabetes age 18 years and older. INTERVENTION: The study intervention included implementation of the CareManager HIT system which augments an electronic medical record (EMR) by automating physician driven quality improvement interventions, including point-of-care decision support and care reminders, diabetes registry with care prompts, performance feedback with benchmarking and access to published evidence and patient educational materials. MEASURES: The primary clinical measures included the change in mean value for low density lipoprotein (LDL) target <100 mg/dL or 2.6 mmol/l, blood pressure (BP) target <130/80 mmHg and glycated haemoglobin (HbA1c) target <7%, and the proportion of patients meeting guideline-recommended targets for those measures. All measures were analysed using closed and open cohort approaches. RESULTS: A total of 6072 patients were identified at baseline, 70% of whom were continuously enrolled during the 24-month study. Significant improvements were observed in all diabetes related outcomes except mean HbA1c. LDL goal attainment improved from 32% to 56% (P=0.002), while mean LDL decreased by 13 mg/dL (0.33 mmol/l, P=0.002). BP goal attainment increased significantly from 30% to 52%, with significant decreases in both mean systolic and diastolic BP. The proportion of patients with an HbA1c below 7% was higher at the end of the study (P=0.008). Mean patient satisfaction remained high, with no significant difference between baseline and follow-up. Total Relative Value Units per patient per year significantly increased as a result of an increase in the number of visits in year one and the coding complexity throughout. CONCLUSION: Implementation of a physician-directed, multifaceted HIT system in primary care was associated with significantly improved diabetes process and outcome measures.

Jacobsen, J., Whitlock, S. N., Lee, H., et al. (2015). "Teaching colleagues how to discuss prognosis as part of a hospital-wide quality improvement project: the positive impact of a 90-minute workshop." J Pain Symptom Manage **49**(5): 960-963.

BACKGROUND: Many physicians have difficulty with discussions about prognosis. The aims of this study were to evaluate why physicians struggle to discuss prognosis and to measure the effect of a 90-minute communication workshop on self-reported skill. MEASURES: An evaluation study was used with three measurement points: before the 90-minute communication workshop (e-mail survey); immediately after the workshop (paper survey); and one month after the workshop (e-mail survey). INTERVENTION: Physicians from diverse specialties at a single academic institution were paid to participate in a 90-minute communication workshop on discussing prognosis. OUTCOMES: Physicians identified several reasons why discussions of prognosis are hard: "I am not sure of the actual prognosis" (58.9%; 95% CI, 50.9, 66.5), "I worry I will take away hope (42.9%; 95% CI, 35.2, 50.9), and "I worry the patient is not ready to hear the information" (42.9%; 95% CI, 35.2, 50.9). Physicians who attended this short workshop reported that they could apply what was learned to their work immediately (4.6, range 1-5). One month after the workshop, 91% of respondents reported trying a skill learned in the workshop. The most frequently used skill was Ask/Tell/Ask (61.5%; 95% CI, 51.6, 70.6). CONCLUSIONS/LESSONS LEARNED: A short workshop on discussing prognosis was highly valued by physicians from diverse specialties and a majority reported using at least one of the communication skills learned.

Jerant, A., Lichte, M., Kravitz, R. L., et al. (2016). "Physician training in self-efficacy enhancing interviewing techniques (SEE IT): Effects on patient psychological health behavior change mediators." Patient Educ Couns **99**(11): 1865-1872.

> OBJECTIVE: To explore how physician training in self-efficacy enhancing interviewing techniques (SEE IT) affects patient psychological health behavior change mediators (HBCMs). METHODS: We analyzed data from 131 patients visiting primary care physicians >/=4 months after the physicians participated in a randomized controlled trial. Experimental arm physicians (N=27) received SEE IT training during three </=20min standardized patient instructor (SPI) visits. Control physicians (N=23) viewed a diabetes medications video during one SPI visit. Physicians were blinded to patient participation. Outcomes were self-care self-efficacy, readiness, and health locus of control (Internal, Chance, Powerful Others), examined as a summary HBCM score (average of standardized means) and individually. Analyses adjusted for pre-visit values of the dependent variables. RESULTS: Patients visiting SEE IT-trained physicians had higher summary HBCM scores (+0.42, 95% CI 0.07-0.77; p=0.021). They also had greater self-care readiness (AOR 3.04, 95% CI 1.02-9.03, p=0.046) and less Chance health locus of control (-0.27 points, 95% CI -0.50-0.04, p=0.023), with no significant differences in other HBCMs versus controls. CONCLUSION: Improvement in psychological HBCMs occurred among patients visiting SEE IT-trained physicians, PRACTICE IMPLICATIONS: If further research shows the observed HBCM effects improve health behaviors and outcomes, SEE IT training might be offered widely to physicians.

Iezzoni, L. I. et Long-Bellil, L. M. (2012). "Training physicians about caring for persons with disabilities: "Nothing about us without us!"." Disabil. Health J **5**(3): 136-139.
http://www.ncbi.nlm.nih.gov/pubmed/22726853

> According to the World Report on Disability, physicians worldwide generally lack training about caring for persons with disabilities, thus frequently compromising their health care experiences and health outcomes. Many U.S. physicians are similarly untrained about critical aspects of providing care to persons with disabilities, perhaps contributing to disparities in their care. Recognizing these inadequacies, U.S. medical educators are beginning to develop core competencies for trainees relating to the care of patients with disabilities, including understanding patients' perceptions of their quality of life and skills in providing patient-centered care. Having today's physicians, even when genuinely well-intentioned, retain control over designing disability-related training programs for future doctors may miss critical issues in caring empathically and effectively for persons with disabilities. Involving persons with disabilities in identifying training needs and implementing curricula for future physicians may offer important opportunities for ensuring their competency to provide patient-centered care to persons with disabilities

Jordan, K. P., Edwards, J. J., Porcheret, M., et al. (2017). "Effect of a model consultation informed by guidelines on recorded quality of care of osteoarthritis (MOSAICS): a cluster randomised controlled trial in primary care." Osteoarthritis Cartilage **25**(10): 1588-1597.

> OBJECTIVE: To determine the effect of a model osteoarthritis (OA) consultation (MOAC) informed by National Institute for Health and Care Excellence (NICE) recommendations compared with usual care on recorded quality of care of clinical OA in general practice. DESIGN: Two-arm cluster randomised controlled trial. SETTING: Eight general practices in Cheshire, Shropshire, or Staffordshire UK. PARTICIPANTS: General practitioners and nurses with patients consulting with clinical OA. INTERVENTION: Following six-month baseline period practices were randomised to intervention (n = 4) or usual care (n = 4). Intervention practices delivered MOAC (enhanced initial GP consultation, nurse-led clinic, OA guidebook) to patients aged >/=45 years consulting with clinical OA. An electronic (e-)template for consultations was used in all practices to record OA quality care indicators. OUTCOMES: Quality of OA care over six months recorded in the medical record. RESULTS: 1851 patients consulted in baseline period (1015 intervention; 836 control); 1960 consulted following randomisation (1118 intervention; 842 control). At baseline wide variations in quality of care were noted. Post-randomisation increases were found for written advice on OA (4-28%), exercise (4-22%) and weight loss (1-15%) in intervention practices but not controls (1-3%). Intervention practices were more likely

> to refer to physiotherapy (10% vs 2%, odds ratio 5.30; 95% CI 2.11, 13.34), and prescribe paracetamol (22% vs 14%, 1.74; 95% CI 1.27, 2.38). CONCLUSIONS: The intervention did not improve all aspects of care but increased core NICE recommendations of written advice on OA, exercise and weight management. There remains a need to reduce variation and uniformly enhance improvement in recorded OA care. TRIAL REGISTRATION NUMBER: ISRCTN06984617.

Klok, T., Kaptein, A. A. et Brand, P. L. P. (2015). "Non-adherence in children with asthma reviewed: The need for improvement of asthma care and medical education." Pediatr Allergy Immunol **26**(3): 197-205.

> Adherence to daily inhaled corticosteroid therapy is a key determinant of asthma control. Therefore, improving adherence to inhaled corticosteroids is the most effective method through which healthcare providers can help children with uncontrolled asthma. However, identifying non-adherent patients is difficult, and electronic monitoring is the only reliable method to assess adherence. (Non-)adherence is a complex behavioural process influenced by many interacting factors. Intentional barriers to adherence are common; driven by illness perceptions and medication beliefs, patients and parents deliberately choose not to follow the doctor's recommendations. Common non-intentional barriers are related to family routines, child-raising issues, and to social issues such as poverty. Effective interventions improving adherence are complex, because they take intentional and non-intentional barriers to adherence into account. There is evidence that comprehensive, guideline-based asthma self-management programmes can be successful, with excellent adherence and good asthma control. Patient-centred care focused on healthcare provider-patient/parent collaboration is the key factor determining the success of guided self-management programmes. Such care should focus on shared decision-making as this has been shown to improve adherence and healthcare outcomes. Current asthma care falls short because many physicians fail to adhere to asthma guidelines in their diagnostic approach and therapeutic prescriptions, and because of the lack of application of patient-centred health care. Increased awareness of the importance of patient-centred communication and increased training in patient-centred communication skills of undergraduates and experienced attending physicians are needed to improve adherence to daily controller therapy and asthma control in children with asthma.

Koster, E. S., van Meeteren, M. M., van Dijk, M., et al. (2015). "Patient-provider interaction during medication encounters: A study in outpatient pharmacies in the Netherlands." Patient Educ Couns **98**(7): 843-848.

> OBJECTIVE: To describe communication between pharmacy staff and patients at the counter in outpatient pharmacies. Both content and communication style were investigated. METHODS: Pharmaceutical encounters in three outpatient pharmacies in the Netherlands were video-recorded. Videos were analyzed based on an observation protocol for the following information: content of encounter, initiator of a theme and pharmacy staff's communication style. RESULTS: In total, 119 encounters were recorded which concerned 42 first prescriptions, 16 first refill prescriptions and 61 follow-up refill prescriptions. During all encounters, discussion was mostly initiated by pharmacy staff (85%). In first prescription encounters topics most frequently discussed included instructions for use (83%) and dosage instructions (95%). In first refill encounters, patient experiences such as adverse effects (44%) and beneficial effects (38%) were regularly discussed in contrast to follow-up refills (7% and 5%). Patients' opinion on medication was hardly discussed. CONCLUSION: Pharmacy staff in outpatient pharmacies generally provide practical information, less frequently they discuss patients' experiences and seldom discuss patients' perceptions and preferences about prescribed medication. PRACTICE IMPLICATIONS: This study shows there is room for improvement, as communication is still not according to professional guidelines. To implement professional guidelines successfully, it is necessary to identify underlying reasons for not following the guidelines.

Kuehn, B. M. (2012). "Materials educate patients to make wise choices on tests and procedures." Jama **307**(21): 2245-2246.

Lee, J. A., Ha, I. H., Choi, T. Y., et al. (2017). "Evaluating the clinical application of a leaflet for clinical practice guideline in patients with lumbar herniated intervertebral discs: Randomized controlled trial." Medicine (Baltimore) **96**(51): e9406.

> BACKGROUND: This study aims to demonstrate the effectiveness of using clinical practice guideline (CPG) leaflets as a communication tool between doctors and patients. We evaluated the leaflets as a communication tool in the treatment of lumbar herniated intervertebral discs (HIVDs) in terms of patient and physician satisfaction and ease of treatment. METHODS: This study is a 2-parallel-arm, assessor-blinded, randomized controlled trial at Jaseng Hospital, Seoul, South Korea. We evaluated efficacy through a comparison of satisfaction and clinical outcomes in randomly allocated groups of HIVD lumbar patients visiting Jaseng Hospital of Korean Medicine. We used leaflets on the basis of Korean medicine CPG recommendations as an intervention. The intervention group received treatment and diagnosis using the leaflet, and the control group received the typical intervention, which was provided without the leaflet. RESULTS: The levels of patient satisfaction with and understanding of the doctors' explanation was 92% in the leaflet group and 64% in the nonleaflet group, which showed that, compared with patient satisfaction in the nonleaflet group, patient satisfaction was considerably higher by 28% in the leaflet group. In addition, the level of the reliability with treatment was 92% in the leaflet group and 64% in the control group. However, there were no significant differences in statistical analyses. The level of doctors' satisfaction with communicating with patients using the leaflet was 100% in the leaflet group. Given this satisfaction, the ease of persuasion of treatment was highest (84%) and followed the improvement in the patient's understanding of the treatment (16%) in the leaflet group. In addition, in the nonleaflet user group, almost all doctors thought that having a leaflet would be a more effective treatment. CONCLUSION: Although this study failed to show significant differences between the intervention and control groups, the leaflet, which included CPG information in the treatment of HIVD patients, was an effective communication tool between patients and doctors. However, further studies with larger samples should be conducted to investigate the effectiveness of the communication tool based on the CPG. TRIAL REGISTRATION NUMBER: Clinical Research Information Service: KCT0001762.

Leiva-Fernandez, J., Vazquez-Alarcon, R. L., Aguiar-Leiva, V., et al. (2016). "Efficacy of an educational intervention in primary health care in inhalation techniques: study protocol for a pragmatic cluster randomised controlled trial." Trials **17**(1): 144.

> BACKGROUND: Chronic obstructive pulmonary disease (COPD) accounts for 10-12 % of primary care consultations, 7 % of hospital admissions and 35 % of chronic incapacity related to productivity. The misuse of inhalers is a significant problem in COPD because it is associated with reduced therapeutic drug effects leading to lack of control of both symptoms and disease. Despite all advice, health care professionals' practice management of inhalation treatments is usually deficient. Interventions to improve inhaler technique by health care professionals are limited, especially among primary care professionals, who provide the most care to patients with COPD. The aim of this study is to evaluate the efficacy of an educational intervention to train general practitioners (GPs) in the right inhalation technique for the most commonly used inhalers. METHODS/DESIGN: We are conducting a pragmatic cluster randomised controlled trial. The sample population is composed of 267 patients diagnosed with COPD using inhalation therapy selected from among those in 20 general practices, divided into two groups (control and intervention) by block randomisation at 8 primary care centres. The sample has two levels. The first level is patients with COPD who agree to participate in the trial and receive the educational intervention from their GPs. The second level is GPs who are primary health care professionals and receive the educational intervention. The intervention is one session of the educational intervention with a monitor given to GPs for training in the right inhalation technique. The primary outcome is correct inhalation technique in patients. Secondary outcomes are functional status (spirometry) and quality of life. The follow-up period will be 1 year. GPs will have two visits (baseline and at the 1-year follow-up visit. Patients will have four visits (at baseline and 3, 6 and 12 months). Analysis will be done on an intention-to-treat basis. DISCUSSION: We carried out three previous clinical trials in patients with COPD, which showed the efficacy of an educational intervention based on monitor training to improve the inhalation technique in patients. This intervention is suitable and feasible in the context of clinical practice. Now we are seeking to know if we can improve it when the monitor is the GP (the real care provider in daily practise). TRIAL REGISTRATION: ISRCTN Registry identifier ISRCTN93725230 . Registered on 18 August 2014.

Leon-Carlyle, M., Srivastava, R. et Levinson, W. (2015). "Choosing wisely Canada: integrating stewardship in medical education." Acad Med **90**(11): 1430.

Leung, J., Bhutani, M., Leigh, R., et al. (2015). "Empowering family physicians to impart proper inhaler teaching to patients with chronic obstructive pulmonary disease and asthma." Can Respir J **22**(5): 266-270.

> BACKGROUND: Patients with chronic obstructive pulmonary disease (COPD) and asthma depend on inhalers for management, but critical errors committed during inhaler use can limit drug effectiveness. Outpatient education in inhaler technique remains inconsistent due to limited resources and inadequate provider knowledge. OBJECTIVE: To determine whether a simple, two-session inhaler education program can improve physician attitudes toward inhaler teaching in primary care practice. METHODS: An inhaler education program with small-group hands-on device training was instituted for family physicians (FP) in British Columbia and Alberta. Sessions were spaced one to three months apart. All critical errors were corrected in the first session. Questionnaires surveying current inhaler teaching practices and attitudes toward inhaler teaching were distributed to physicians before and after the program. RESULTS: Forty-one (60%) of a total 68 participating FPs completed both before and after program questionnaires. Before the program, only 20 (49%) reported providing some form of inhaler teaching in their practices, and only four (10%) felt fully competent to teach patients inhaler technique. After the program, 40 (98%) rated their inhaler teaching as good to excellent. Thirty-four (83%) reported providing inhaler teaching in their practices, either by themselves or by an allied health care professional they had personally trained. All stated they could teach inhaler technique within 5 min. Observation of FPs during the second session by certified respiratory educators found that none made critical errors and all had excellent technique. CONCLUSION: A physician inhaler education program can improve attitudes toward inhaler teaching and facilitate implementation in clinical practices.

Liegl, G., Plessen, C. Y., Leitner, A., et al. (2015). "Guided self-help interventions for irritable bowel syndrome: a systematic review and meta-analysis." Eur J Gastroenterol Hepatol **27**(10): 1209-1221.

> OBJECTIVE: Although irritable bowel syndrome (IBS) is highly prevalent and is accompanied by high costs for respective healthcare systems, the data on treatment effectiveness are limited. Current treatment methods have limitations in terms of side effects and availability. Guided self-help (GSH) might be an easily accessible and cost-effective treatment alternative. This study is the first systematic review and meta-analysis of GSH interventions for IBS. METHODS: Using electronic databases (MEDLINE, SCOPUS, PsycINFO, and Web of Science), we performed a systematic search for randomized-controlled trials. Using a random-effect model, we calculated the pooled standardized mean differences (SMDs) of GSH on IBS symptom severity (primary outcome) and quality of life (secondary outcome). We additionally examined the moderating effects of online-based interventions and face-to-face therapist contact by applying mixed models. RESULTS: A systematic literature search identified 10 eligible randomized-controlled trials, including 886 participants. Compared with the control conditions, the effect size was medium for the decrease in IBS symptom severity (SMD=0.72; 95% confidence interval: 0.34-1.08) and large for the increase in patients' quality of life (SMD=0.84; 95% confidence interval: 0.46-1.22). Neither treatment format nor face-to-face contact was a predictor of therapy outcomes in between-group analyses. In contrast, within-group analyses led to the conclusion that online-based interventions are more effective than other self-help formats. CONCLUSION: GSH is an effective alternative for the treatment of IBS. As GSH methods are easy to implement, it seems sensible to integrate GSH into clinical practice. LIMITATIONS: With respect to the high study heterogeneity, the number of studies included was relatively small.

Linder, D., Dall'olio, E., Gisondi, P., et al. (2009). "Perception of disease and doctor-patient relationship experienced by patients with psoriasis: a questionnaire-based study." Am J Clin Dermatol **10**(5): 325-330.

> Many studies have addressed the impact of psoriasis on quality of life, but few studies have investigated patient perception of the disease or the patient-physician relationship. As with most chronic diseases, improvement in the patient-physician relationship may be important in the proper management of patients with psoriasis. To assess how psoriasis and its treatments are subjectively

experienced by patients as well as patient expectations with regard to the patient-physician relationship. A discussion agenda for 'focus group meetings' was organized by a group of sociologists, psychologists, educators, researchers, and clinicians active in the field of psychodermatology. Four meetings were held in Northern and Central Italy and participants included one moderator and either eight dermatologists or eight patients. Discussions were based on a predefined agenda and included: (i) the psychological representation of psoriasis; (ii) the hetero- and self-perception of the patient; (iii) the patient-physician relationship; and (iv) the development of an educational intervention for dermatologists in order to improve the patient-physician relationship. A questionnaire, based on the information gathered at the focus groups, was administered to 323 patients with moderate to severe chronic plaque psoriasis from 17 dermatology clinics throughout Italy. Three hundred patients completed the questionnaire. Psoriasis elicited anger, annoyance at the inconvenience of the disease, and irritation in approximately 50% of the patients, whilst 38% of patients were unable to describe their emotional state. Aspects of life that were limited by psoriasis included clothing (57%), social interactions (43%), and personal hygiene (31%). The disease was often seen by patients as incomprehensible, incurable, and uncontrollable. More than half of the patients stressed their need to be listened to by the treating physician, and their wish that the physician should use simple language and should improve their psychological skills and interpersonal communication techniques. Dermatologists need to convey to patients with psoriasis the feeling of 'understanding the disease,' of hope about its curability, and the 'perception of control.' These elements should be taken into account when treating patients and whenever educational interventions are planned.

Llor, C., Bjerrum, L., Munck, A., et al. (2014). "Access to point-of-care tests reduces the prescription of antibiotics among antibiotic-requesting subjects with respiratory tract infections." Respir Care **59**(12): 1918-1923.

BACKGROUND: General practitioners (GPs) often feel uncomfortable when patients request an antibiotic when there is likely little benefit. This study evaluates the effect of access to point-of-care tests on decreasing the prescription of antibiotics in respiratory tract infections in subjects who explicitly requested an antibiotic prescription. METHODS: Spanish GPs registered all cases of respiratory tract infections over a 3-week period before and after an intervention undertaken in 2008 and 2009. Patients with acute sinusitis, pneumonia, and exacerbations of COPD were excluded. Two types of interventions were performed: the full intervention group received prescriber feedback with discussion of the results of the first registry, courses for GPs, guidelines, patient information leaflets, workshops, and access to point-of-care tests (rapid streptococcal antigen detection test and C-reactive protein test); and the partial intervention group underwent all of the above interventions except for the workshop and access to point-of-care tests. RESULTS: A total of 210 GPs were assigned to the full intervention group and 71 to the partial intervention group. A total of 25,479 subjects with respiratory tract infections were included, of whom 344 (1.4%) requested antibiotic prescribing. Antibiotics were more frequently prescribed to subjects requesting them compared with those who did not (49.1% vs 18.5%, P < .001). In the group of GPs assigned to the partial intervention group, 53.1% of subjects requesting antibiotics received a prescription before and 60% after the intervention, without statistical differences being observed. In the group of GPs assigned to the full intervention group, the percentages were 55.1% and 36.2%, respectively, with a difference of 18.9% (95% CI: 6.4%-30.6%, P < .05). CONCLUSIONS: Access to point-of-care tests reduces antibiotic use in subjects who explicitly request an antibiotic prescription.

Luckett, T., Spencer, L., Morton, R. L., et al. (2017). "Advance care planning in chronic kidney disease: A survey of current practice in Australia." Nephrology (Carlton) **22**(2): 139-149.

AIM: Advance care planning (ACP) in nephrology is widely advocated but not always implemented. The aims of this study were to describe current ACP practice and identify barriers/facilitators and perceived need for health professional education and chronic kidney disease (CKD)-specific approaches. METHODS: An anonymous cross-sectional survey was administered online. Nephrology health professionals in Australia and New Zealand were recruited via professional societies, email lists and nephrology conferences. Multiple regression explored the influence of respondents' attributes on extent of involvement in ACP and willingness to engage in future. RESULTS: A total of 375 respondents

included nephrologists (23%), nurses (65%), social workers (4%) and others (8%) with 54% indicated that ACP at their workplace was performed ad hoc and 61% poorly. Perceived barriers included patient/family discomfort (84%), difficulty engaging families (83%), lack of clinician expertise (83%) and time (82%), health professional discomfort (72%), cultural/language barriers (65%), lack of private space (61%) and lack of formal policy/procedures (60%). Respondents overwhelmingly endorsed the need for more dialysis-specific ACP programs (96%) and education (95%). Whilst 85% thought ACP would be optimally performed by specially trained staff, comments emphasized that all clinicians should have a working proficiency. Respondents who were more willing to engage in future ACP tended to be non-physicians (odds ratio (OR) 4.96, 95% confidence intervals (CI) 1.74-14.07) and reported a greater need for CKD-specific ACP materials (OR 10.88, 95% CI 2.38-49.79). CONCLUSION: Advance care planning in nephrology needs support through education and CKD-specific resources. Endorsement by nephrologists is important. A multidisciplinary approach with a gradient of ACP expertise is also recommended.

McMullen, S., Szabo, S., Halbert, R. J., et al. (2017). "Tools for Communication: Novel infrastructure to address patient-perceived gaps in oncology care." Clin J Oncol Nurs **21**(2): E38-e48.

BACKGROUND: Healthcare providers (HCPs) and patient communication are integral to high-quality oncology care. The patient and HCP perspectives are needed to identify gaps in care and develop communication tools.. OBJECTIVES: This study aimed to understand patient- and HCP-perceived elements of and gaps in high-quality care to develop novel communication tools to improve care. . METHODS: Qualitative interviews were conducted among 16 patients with cancer and 10 HCPs in the United States. Trained interviewers elicited patients' and HCPs' concerns, views, and perceived needs for communication tools. A thematic analysis was used to identify four quality of care domains, depicted in a conceptual model, and two draft communication tools were developed to address identified gaps.. FINDINGS: No patients reported previously using a communication tool, and gaps in communication regarding treatment aims and education were evident. Two tools were developed to assess patients' life and treatment goals and the importance of ongoing education.

Mills, A. L. et Pierce, J. P. (2008). "Using teachable moments to improve nutrition and physical activity in patients." Am Fam Physician **77**(11): 1510-1511.
http://www.ncbi.nlm.nih.gov/pubmed/18581830

Moore, P. M., Rivera, S., Bravo-Soto, G. A., et al. (2018). "Communication skills training for healthcare professionals working with people who have cancer." Cochrane Database of Systematic Reviews(7).
http://dx.doi.org/10.1002/14651858.CD003751.pub4

Moseng, T., Dagfinrud, H. et Østerås, N. (2019). "Implementing international osteoarthritis guidelines in primary care: uptake and fidelity among health professionals and patients." Osteoarthritis Cartilage **27**(8): 1138-1147.

OBJECTIVE: This paper evaluates the implementation fidelity of a strategy and intervention used to implement osteoarthritis (OA) treatment recommendations in primary care. We also evaluate uptake of core treatment (patient information, exercise and referral to weight management) among OA patients. DESIGN: A stepped-wedge cluster-randomised controlled study (RCT) in primary care. The study involved general practitioners (GPs), physiotherapists (PTs) and patients with hip and/or knee OA in six Norwegian municipalities (clusters). Workshops for general practitioners (GPs) and PTs represented the main implementation activity. Uptake of core treatment (patient education, exercise and weight management) was evaluated using self-reported data from the patient intervention and control group, analysed with logistic regression models. Fidelity was evaluated using six components representing adherence to the content and dose instructions in the implementation strategy and assessed against a-priori criteria for high adherence. RESULTS: Data were collected from 40 GPs, 37 PTs and 393 OA patients. The patient-reported data showed statistically significant higher uptake for exercise, patient education and referral to support for weight reduction, among the intervention group compared to the control group ($P < 0.05$). Evaluation of fidelity showed high adherence to GP and PT workshop attendance and physiotherapy use, partly adherence to PT knowledge after

> workshops, and low adherence to exercise attendance, dose and progression instructions. CONCLUSIONS: The implementation strategy and intervention successfully improved OA patients' access to physiotherapy and uptake of recommended core treatment. However, the strategy was less effective in providing exercise programs with sufficient dose and progression and in supporting patients' adherence to the exercise program. TRIAL REGISTRATION: ClinicalTrials.gov NCT02333656.

Nassar, C. M., Montero, A. et Magee, M. F. (2019). "Inpatient Diabetes Education in the Real World: an Overview of Guidelines and Delivery Models." Curr Diab Rep **19**(10): 103.

> PURPOSE OF REVIEW: Diabetes self-management education and support improves diabetes-related outcomes, yet less than 50% of persons with diabetes in the USA receive this service. Hospital admissions present a critical opportunity for providing diabetes education. This article presents an overview of the current state of inpatient diabetes education. It incorporates a summary of existing guidance relative to content followed by an overarching discussion of existing inpatient diabetes education models and their reported outcomes, when available. RECENT FINDINGS: As diabetes rates continue to soar and adults with diabetes continue to have high hospitalization and readmission rates, hospitals face challenges in assessing and meeting diabetes patients' educational needs. The consensus recommendation for inpatient diabetes teaching is to provide survival skills education to enable safe self-management following discharge until more comprehensive outpatient education can be provided. Established and emerging models for delivery of diabetes survival skills education in the hospital may be broadly grouped as diabetes-specialty care models, diabetes non-specialty care models, and technology-supported diabetes education. These models are often shaped by the availability of diabetes specialists, including endocrinologists and diabetes educators-or lack thereof, and staffing resources for provision of services. Recent studies suggest that all three approaches can be deployed successfully if well planned. This article presents an overview of the current state of inpatient diabetes education. It incorporates a summary of existing guidance relative to content followed by an overarching discussion of existing inpatient diabetes education models and their reported outcomes, when available. The authors seek to make the reader aware of the heterogeneous approaches that are being implemented nationwide for inpatient diabetes education delivery. Meeting inpatient diabetes educational needs will require a sustained effort, diverse strategies based on resources available, and additional research to explore the impact of these strategies on outcomes.

Nilsson, H. (2010). "[Learning to "break bad news" should be included in medical education. The physician's empathy important when informing about cancer, a PubMed search shows]." Lakartidningen **107**(9): 580-582, 584.

O'Dunn-Orto, A., Hartling, L., Campbell, S., et al. (2012). "Teaching musculoskeletal clinical skills to medical trainees and physicians: a Best Evidence in Medical Education systematic review of strategies and their effectiveness: BEME Guide No. 18." Med Teach **34**(2): 93-102.

> BACKGROUND: Musculoskeletal (MSK) complaints make up 12-20% of primary health visits and are a source of significant expenditures and morbidity. Despite this, MSK examination is an area of weakness among practising physicians. Several studies have highlighted the need for increased MSK physical exam teaching. However, increased teaching time alone does not guarantee improvement in these skills. Thus, we aimed to identify interventions that are effective in promoting transfer of MSK clinical skills. METHODS: The review protocol was approved by the Best Evidence in Medical Education (BEME) organization. A comprehensive search was conducted and systematic review methods were applied. Data were not pooled statistically due to heterogeneity. RESULTS: About 5089 titles were screened; 24 studies were included. Eighteen of 24 studies focused on undergraduate medical education. Five of nine studies favoured patient educator. Five of six studies favoured interactive small groups, two of four studies favoured computer-assisted learning, and two of two studies favoured peer learning. Individual studies demonstrated effectiveness of reminder sheets and Gait Arms Legs Spine teaching, respectively. CONCLUSIONS: This study supports the use of different instructional methods that engage learners and provide meaningful learning contexts. The majority of the studies support patient educators and interactive small group teaching.

Ogdie, A. R., Hoch, S., Dunham, J., et al. (2010). "A roadmap for education to improve the quality of care in gout." Curr Opin Rheumatol **22**(2): 173-180.

> PURPOSE OF REVIEW: To describe obstacles to optimum management of gout by primary care physicians and to propose educational interventions to improve care. RECENT FINDINGS: In the past, gout education has been hampered by infrequency of continuing medical education courses, loss of excitement for a disease in which therapies have not changed (until recently), insufficient evidence-based medicine, and the lack of motivation by physicians to re-learn this disease once in active practice. We identify 10 common myths that impede appropriate treatment of gout, identify gaps in evidence-based medicine that perpetuate those myths, and propose opportunities to improve education on these myths. It is through better gout-centered education that quality of care in gout can be enhanced. Residency may be one of the key points of intervention. As more evidence-based medicine publications address the optimum management of gout, national re-education can occur. More outreach by community rheumatologists to primary care physicians through educational programs and improved referral letters can help re-educate practitioners. Lastly, an often overlooked engine to change physician practices is consumer education, but current patient education programs are lacking. SUMMARY: Novel education interventions for physician trainees, primary care physicians, and patients are proposed to improve the care of patients with gout.

Patel, V., Buchanan, H., Hui, M., et al. (2018). "How do specialist trainee doctors acquire skills to practice patient-centred care? A qualitative exploration." BMJ Open **8**(10): e022054.

> OBJECTIVES: The importance of patient-centred care (PCC) has been increasingly recognised. However, there is limited work exploring what doctors actually understand by PCC, and how they perceive they acquire PCC skills in the workplace. The objectives of our study were to explore (1) what UK doctors, in specialist training, perceive to be the essential components of PCC, (2) if/how they acquire these skills, (3) any facilitators/barriers for engaging in PCC and (4) views on their PCC training. DESIGN: Qualitative study using in-depth individual semi-structured interviews with UK specialist trainees. Interview transcripts were thematically analysed. SETTING AND PARTICIPANTS: Thirty-one specialist trainee doctors, with at least 4 years postgraduate experience, were interviewed. Participants worked in various medical specialities within the Medical Directorate of an acute hospital in the East Midlands of England. RESULTS: Interview data were transcribed verbatim and categorised into three main themes. The first theme was 'Understanding PCC' where the doctors gave varied perspectives on what they understood by PCC. Although many were able to highlight key components of PCC, there were also some accounts which demonstrated a lack of understanding. The second theme was 'Learning PCC skills: A work in progress'. Learning to be patient-centred was perceived to be an ongoing process. Within this, trainee doctors reported 'on-the-job' learning as the main means of acquiring PCC skills, but they also saw a place for formal training (eg, educational sessions focussing on PCC, role play). 'Delivering PCC: Beyond the physician' referred to the many influences the doctors reported in learning and delivering PCC including patients, the organisation and colleagues. Observing consultants taking a patient-centred approach was cited as an important learning tool. CONCLUSIONS: Our findings may assist clinical educators in understanding how trainee doctors perceive PCC, and the factors that influence their learning, thereby helping them shape PCC skills training.

Persell, S. D., Brown, T., Lee, J. Y., et al. (2015). "Individualized Risk Communication and Outreach for Primary Cardiovascular Disease Prevention in Community Health Centers: Randomized Trial." Circ Cardiovasc Qual Outcomes **8**(6): 560-566.

> BACKGROUND: Many eligible primary cardiovascular disease prevention candidates are not treated with statins. Electronic health record data can identify patients with increased cardiovascular disease risk. METHODS AND RESULTS: We performed a pragmatic randomized controlled trial at community health centers in 2 states. Participants were men aged >/=35 years and women >/=45 years, without cardiovascular disease or diabetes mellitus, and with a 10-year risk of coronary heart disease of at least 10%. The intervention group received telephone and mailed outreach, individualized based on patients' cardiovascular disease risk and uncontrolled risk factors, provided by lay health workers. Main outcomes included: documented discussion of medication treatment for cholesterol with a

primary care clinician, receipt of statin prescription within 6 months, and low-density lipoprotein (LDL)-cholesterol repeated and at least 30 mg/dL lower than baseline within 1 year. Six hundred forty-six participants (328 and 318 in the intervention and control groups, respectively) were included. At 6 months, 26.8% of intervention and 11.6% of control patients had discussed cholesterol treatment with a primary care clinician (odds ratio, 2.79; [95% confidence interval, 2.25-3.46]). Statin prescribing occurred for 10.1% in the intervention group and 6.0% in the control group (odds ratio, 1.76; [95% confidence interval, 0.90-3.45]). The cholesterol outcome did not differ, and the majority of patients did not repeat lipid levels during follow-up. CONCLUSIONS: Risk communication and lay outreach increased cholesterol treatment discussions with primary care clinicians. However, most discussions did not result in statin prescribing. For outreach to be successful, it should be combined with interventions to encourage clinicians to follow contemporary risk-based cholesterol treatment guidelines. CLINICAL TRIAL REGISTRATION: URL: http://www.clincialtrials.gov. Unique identifier: NCT01610609.

Peytremann-Bridevaux, I., Arditi, C., Gex, G., et al. (2015). "Chronic disease management programmes for adults with asthma." Cochrane Database Syst Rev(5): Cd007988.

BACKGROUND: The burden of asthma on patients and healthcare systems is substantial. Interventions have been developed to overcome difficulties in asthma management. These include chronic disease management programmes, which are more than simple patient education, encompassing a set of coherent interventions that centre on the patients' needs, encouraging the co-ordination and integration of health services provided by a variety of healthcare professionals, and emphasising patient self-management as well as patient education. OBJECTIVES: To evaluate the effectiveness of chronic disease management programmes for adults with asthma. SEARCH METHODS: Cochrane Central Register of Controlled Trials (CENTRAL), Cochrane Effective Practice and Organisation of Care (EPOC) Group Specialised Register, MEDLINE (MEDLINE In-Process and Other Non-Indexed Citations), EMBASE, CINAHL, and PsycINFO were searched up to June 2014. We also handsearched selected journals from 2000 to 2012 and scanned reference lists of relevant reviews. SELECTION CRITERIA: We included individual or cluster-randomised controlled trials, non-randomised controlled trials, and controlled before-after studies comparing chronic disease management programmes with usual care in adults over 16 years of age with a diagnosis of asthma. The chronic disease management programmes had to satisfy at least the following five criteria: an organisational component targeting patients; an organisational component targeting healthcare professionals or the healthcare system, or both; patient education or self-management support, or both; active involvement of two or more healthcare professionals in patient care; a minimum duration of three months. DATA COLLECTION AND ANALYSIS: After an initial screen of the titles, two review authors working independently assessed the studies for eligibility and study quality; they also extracted the data. We contacted authors to obtain missing information and additional data, where necessary. We pooled results using the random-effects model and reported the pooled mean or standardised mean differences (SMDs). MAIN RESULTS: A total of 20 studies including 81,746 patients (median 129.5) were included in this review, with a follow-up ranging from 3 to more than 12 months. Patients' mean age was 42.5 years, 60% were female, and their asthma was mostly rated as moderate to severe. Overall the studies were of moderate to low methodological quality, because of limitations in their design and the wide confidence intervals for certain results.Compared with usual care, chronic disease management programmes resulted in improvements in asthma-specific quality of life (SMD 0.22, 95% confidence interval (CI) 0.08 to 0.37), asthma severity scores (SMD 0.18, 95% CI 0.05 to 0.30), and lung function tests (SMD 0.19, 95% CI 0.09 to 0.30). The data for improvement in self-efficacy scores were inconclusive (SMD 0.51, 95% CI -0.08 to 1.11). Results on hospitalisations and emergency department or unscheduled visits could not be combined in a meta-analysis because the data were too heterogeneous; results from the individual studies were inconclusive overall. Only a few studies reported results on asthma exacerbations, days off work or school, use of an action plan, and patient satisfaction. Meta-analyses could not be performed for these outcomes. AUTHORS' CONCLUSIONS: There is moderate to low quality evidence that chronic disease management programmes for adults with asthma can improve asthma-specific quality of life, asthma severity, and lung function tests. Overall, these results provide encouraging evidence of the potential effectiveness of these programmes in adults with asthma when compared with usual care. However, the optimal composition of asthma chronic disease management programmes and their added value, compared with education or self-management alone that is usually offered to patients with asthma, need further investigation.

Pinnock, H., Fletcher, M., Holmes, S., et al. (2010). "Setting the standard for routine asthma consultations: a discussion of the aims, process and outcomes of reviewing people with asthma in primary care." Prim Care Respir J **19**(1): 75-83.

Globally, asthma morbidity remains unacceptably high. If outcomes are to be improved, it is crucial that routine review consultations in primary care are performed to a high standard. Key components of a review include: * Assessment of control using specific morbidity questions to elucidate the presence of symptoms, in conjunction with the frequency of use of short-acting bronchodilators and any recent history of acute attacks * After consideration of the diagnosis, and an assessment of compliance, inhaler technique, smoking status, triggers, and rhinitis, identification of poor control should result in a step-up of treatment in accordance with evidence-based guideline recommendations * Discussion should address understanding of the condition, patient-centred management goals and attitudes to regular treatment, and should include personalised self-management education Regular review of people with asthma coupled with provision of self-management education improves outcomes. Underpinned by a theoretical framework integrating professional reviews and patient self-care we discuss the practical barriers to implementing guided selfmanagement in routine clinical practice.

Piredda, M., Rocci, L., Gualandi, R., et al. (2008). "Survey on learning needs and preferred sources of information to meet these needs in Italian oncology patients receiving chemotherapy." Eur J Oncol. Nurs **12**(2): 120-126.
http://www.ncbi.nlm.nih.gov/pubmed/18294913

Cancer patient education can be especially important in topics like side effects of chemotherapy. Information needs of oncology patients are scarcely investigated in Italy. This study aimed to identify the learning needs, the amount of information desired and the preferred methods of information delivery of Italian cancer patients receiving chemotherapy. A total of 111 cancer patients completed a questionnaire developed for this study, which was assessed for validity and reliability. Respondents ranked the following priority information: illness, recovery, treatments, chemotherapy side effects and trajectory of illness. The great majority wanted to receive as much information as possible about all these topics. Most patients showed their wish to be informed along with their relatives, but only a few wanted relatives to be informed before them. The preferred method for receiving information about side effects of chemotherapy was oral conversation, followed by written information. Patients preferred receiving information from the oncologist, followed by the oncology nurse and the general practitioner. Most respondents preferred to be informed before receiving the first cycle of chemotherapy. Results are consistent with the existing literature with regard to information priorities, quantity of information desired and preferred methods of information. In contrast with a non-disclosure dominant culture, Italian cancer patients manifest their wish to be informed a great deal and personally about their condition. In order to meet cancer patients' information needs, health professionals' education and practice should be improved

Pynnonen, M. A. et Hawley, S. T. (2014). "A Patient-Centered Approach to Clinical Practice Guidelines in Otolaryngology." Otolaryngol Head Neck Surg **150**(6): 910-913.

Patient education is used to engage patients in their own health care and is relevant in most clinical situations. Shared decision making (SDM) is used to engage patients when a choice needs to be made about a diagnostic or therapeutic procedure and the medical evidence does not indicate which choice is best. American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) clinical practice guidelines (CPGs) include multiple action statements that may benefit from patient education or SDM. In this commentary, we discuss patient education and SDM using examples from AAO-HNS CPGs. We believe that use of patient education and decision support materials for SDM will enhance the effectiveness of SDM and improve the uptake of CPGs. We issue a call to action for all stakeholders to consider how to put these materials into the hands of our patients.

Raats, C. J., van Veenendaal, H., Versluijs, M. M., et al. (2008). "A generic tool for development of decision aids based on clinical practice guidelines." Patient Educ Couns **73**(3): 413-417.

OBJECTIVE: Patient involvement in medical decision making has been suggested to contribute to patients' satisfaction and better patient outcomes. Decision aids are particularly useful for preference-sensitive decisions. Ideally, these should be based on up-to-date evidence-based guidelines. The objective of this project was to develop a generic format for development and maintenance of decision aids based on evidence-based guidelines. METHODS: Decision aids, evidence-based guidelines and IPDAS standards were used for development of a generic format for decision aids. Patient focus groups were used to assess patients' information needs, expectations, personal values and preferences for presentation of information. RESULTS: We developed a generic format for decision aids and six specific decision aids derived from evidence-based guidelines. The decision aids were published on the Dutch national health care portal. Furthermore, we reached formal agreement on ownership and maintenance of the decision aids with all stakeholders. We achieved these results within 12 months. CONCLUSION: Our generic format facilitated the efficient production of specific decision aids based on evidence-based guidelines. PRACTICE IMPLICATIONS: If guidelines and decision aids are developed in parallel, high-quality patient information can be produced within a short time frame. The process of development should include adequate patient involvement and a strategy for maintenance.

Reinders, M. E., Blankenstein, A. H., Knol, D. L., et al. (2009). "Validity aspects of the patient feedback questionnaire on consultation skills (PFC), a promising learning instrument in medical education." Patient Educ Couns **76**(2): 202-206.

OBJECTIVE: A focus on the communicator competency is considered to be an important requirement to help physicians to acquire consultation skills. A feedback questionnaire, in which patients assess consultation skills might be a useful learning tool. An existing questionnaire on patient perception of patient-centeredness (PPPC) was adapted to cover the 'communicator' items in the competency profile. We assessed the face and content validity, the construct validity and the internal consistency of this new patient feedback on consultation skills (PFC) questionnaire. METHODS: We assessed the face validity of the PFC by interviewing patients and general practice trainees (GPTs) during the developmental process. The content validity was determined by experts (n=10). First-year GPTs (23) collected 222 PFCs, from which the data were used to assess the construct validity (factor analysis), internal consistency, response rates and ceiling effects. RESULTS: The PFC adequately covers the corresponding 'communicator' competency (face and content validity). Factor analysis showed a one-dimensional construct. The internal consistency was high (Cronbach's alpha 0.89). For the single items, the response rate varied from 89.2% to 100%; the maximum score (ceiling effect) varied from 45.5% to 89.2%. CONCLUSION: The PFC appears to be a valid, internally consistent instrument. PRACTICAL IMPLICATIONS: The PFC may be a valuable learning tool with which GPTs, other physicians and medical students can acquire feedback from patients regarding their consultation skills.

Renders, C. M., Valk, G. D., Griffin, S., et al. (2001). "Interventions to improve the management of diabetes mellitus in primary care, outpatient and community settings." Cochrane Database Syst Rev(1): Cd001481.

BACKGROUND: Diabetes is a common chronic disease that is increasingly managed in primary care. Different systems have been proposed to manage diabetes care. OBJECTIVES: To assess the effects of different interventions, targeted at health professionals or the structure in which they deliver care, on the management of patients with diabetes in primary care, outpatient and community settings. SEARCH STRATEGY: We searched the Cochrane Effective Practice and Organisation of Care Group specialised register, the Cochrane Controlled Trials Register (Issue 4 1999), MEDLINE (1966-1999), EMBASE (1980-1999), Cinahl (1982-1999), and reference lists of articles. SELECTION CRITERIA: Randomised trials (RCTs), controlled clinical trials (CCTs), controlled before and after studies (CBAs) and interrupted time series (ITS) analyses of professional, financial and organisational strategies aimed at improving care for people with Type 1 or Type 2 diabetes. The participants were health care professionals, including physicians, nurses and pharmacists. The outcomes included objectively measured health professional performance or patient outcomes, and self-report measures with known validity and reliability. DATA COLLECTION AND ANALYSIS: Two reviewers independently extracted data and assessed study quality. MAIN RESULTS: Forty-one studies were included involving more than 200 practices and 48,000 patients. Twenty-seven studies were RCTs, 12 were CBAs, and two were ITS. The studies were heterogeneous in terms of interventions, participants, settings and outcomes. The methodological quality of the studies was often poor. In all studies the intervention strategy was multifaceted. In 12 studies the interventions were targeted at health professionals, in nine they were targeted at the organisation of care, and 20 studies targeted both. In 15 studies patient education was added to the professional and organisational interventions. A combination of professional interventions improved process outcomes. The effect on patient outcomes remained less clear as these were rarely assessed. Arrangements for follow-up (organisational intervention) also showed a favourable effect on process outcomes. Multiple interventions in which patient education was added or in which the role of the nurse was enhanced also reported favourable effects on patients' health outcomes. REVIEWER'S CONCLUSIONS: Multifaceted professional interventions can enhance the performance of health professionals in managing patients with diabetes. Organisational interventions that improve regular prompted recall and review of patients (central computerised tracking systems or nurses who regularly contact the patient) can also improve diabetes management. The addition of patient-oriented interventions can lead to improved patient health outcomes. Nurses can play an important role in patient-oriented interventions, through patient education or facilitating adherence to treatment.

Reinders, M. E., Ryan, B. L., Blankenstein, A. H., et al. (2011). "The effect of patient feedback on physicians' consultation skills: a systematic review." Acad Med **86**(11): 1426-1436.

PURPOSE: The effect of patient feedback interventions as a method of improving physicians' consultation (i.e., communication, interpersonal) skills is equivocal; research is scarce, and methods and rigor vary. The authors conducted this systematic review to analyze the educational effect of feedback from real patients on physicians' consultation skills at the four Kirkpatrick levels. METHOD: The authors searched five databases (PubMed, EMBASE, Cochrane, PsycInfo, ERIC; April 2010). They included empirical studies of all designs (randomized controlled, quasi-experimental, cross-sectional, and qualitative) if the studies concerned physicians in general health care who received formal feedback regarding their consultation skills from real patients. The authors have briefly described aspects of the included studies, analyzed their quality, and examined their results by Kirkpatrick educational effect level. RESULTS: The authors identified 15 studies (10 studies in primary care; 5 in other specialties) in which physicians received feedback in various ways (e.g., aggregated patient reports or educator-mediated coaching sessions), conducted in the United States, the Netherlands, the United Kingdom, Australia, and Canada. All studies that assessed level 1 (valuation), level 2 (learning), and level 3 (intended behavior) demonstrated positive results; however, only four of the seven studies that assessed level 4 (change in actual performance or results) found a beneficial effect. CONCLUSIONS: Some evidence for the effectiveness of using feedback from real patients to improve knowledge and behavior exists; however, before implementing patient feedback into training programs, educators and policy makers should realize that the evidence for effecting actual improvement in physicians' consulting skills is rather limited.

Rockenbauch, K., Geister, C. et Appel, C. (2010). "[Patient involvement: the physician's view--a qualitative survey]." Psychother Psychosom Med Psychol **60**(5): 156-163.

OBJECTIVES: Patient involvement (PI) and shared decision making (SDM) have increasingly come into the focus of (inter-)national research. SDM, however, is not a standard component of standard care so far. Therefore it is of importance to take into consideration all parties concerned. This article points out the barriers physicians see; one group has not been interrogated on this topic often. METHOD: 25 physicians at a clinical centre were interviewed about decision-making processes within their environment, their concerns as well as their ideas towards PI. The consultations were realized with the help of a guideline-oriented questionnaire. The outcome was then interpreted by means of the thematic content analysis. RESULTS: A system of categories was constructed containing 28 categories on the micro-, meso-, and macro-level. From a physician's perspective, changes are necessary on all levels to achieve patient involvement and SDM. Essential points of approach for this are: sufficient time and personnel, sufficient communicative abilities in physicians, and a solid physician-patient relationship as well as changes in healthcare politics. CONCLUSIONS: To consistently improve patient involvement and SDM, physicians' concerns must be taken seriously. Here SDM can only be properly applied by taking into account the meso- and macro-level. Furthermore, it would be helpful to clear up the conceptually vague aspects of SDM, which would also help to communicate the concept more clearly.

Rochfort, A., Beirne, S., Doran, G., et al. (2018). "Does patient self-management education of primary care professionals improve patient outcomes: a systematic review." BMC Fam Pract **19**(1): 163.

BACKGROUND: Patient self-management support is recognised as a key component of chronic care. Education and training for health professionals has been shown in the literature to be associated with better uptake, implementation and effectiveness of self-management programs, however, there is no clear evidence regarding whether this training results in improved health outcomes for patients with chronic conditions. METHODS: A systematic review was undertaken using the PRISMA guidelines using the Cochrane Library, PubMEd, ERIC, EMBASE, CINAHL, PsycINFO, Web searches, Hand searches and Bibliographies. Articles published from inception to September 1st, 2013 were included. Systematic reviews, Meta-analysis, Randomized controlled trials (RCTs), Controlled clinical trials, Interrupted time series and Controlled before and after studies, which reported on primary care health professionals' continuing education or evidence-based medicine/education on patient self-management for any chronic condition, were included. A minimum of two reviewers participated independently at each stage of review. RESULTS: From 7533 abstracts found, only two papers provided evidence on the effectiveness of self-management education for primary healthcare professionals in terms of measured outcomes in patients. These two articles show improvement in patient outcomes for chronic back pain and diabetes based on RCTs. The educational interventions with health professionals spanned a range of techniques and modalities but both RCTs included a motivational interviewing component. CONCLUSIONS: Before and up to 2 years after the incorporation of patient empowerment for self-management into the WONCA Europe definition of general practice, there was a scarcity of high quality evidence showing improved outcomes for patients as a result of educating health professionals in patient self-management of chronic conditions.

Rodin, G., Mackay, J. A., Zimmermann, C., et al. (2009). "Clinician-patient communication: a systematic review." Support Care Cancer **17**(6): 627-644.

GOAL OF WORK: The goal of this work was to identify methods of clinician-patient cancer-related communication that may impact patient outcomes associated with distress at critical points in the course of cancer care. MATERIALS AND METHODS: A systematic review of practice guidelines, systematic reviews, or randomized trials on this topic was conducted. Guidelines for quality was evaluated using the Appraisal of Guidelines for Research and Evaluation Instrument, and the contributive value for recommendations was assessed. Systematic reviews and randomized trials were also evaluated for methodological rigor. RESULTS: Four existing guidelines, eight systematic reviews and nine randomized trials were identified. Two of the guidelines were of high quality, and all systematic reviews reported clear search criteria and support for their conclusions; the randomized trials were of modest or low quality. For all situations and disease stages, guidelines consistently identified open, honest, and timely communication as important; specifically, there was evidence for a reduction in anxiety when discussions of life expectancy and prognosis were included in consultations. Techniques to increase patient participation in decision-making were associated with greater satisfaction but did not necessarily decrease distress. Few studies took cultural and religious diversity into account. CONCLUSIONS: There is little definitive evidence supporting the superiority of one specific method for communicating information compared to another. Evidence regarding the benefit of decision aids or other strategies to facilitate better communication is inconsistent. Since patients vary in their communication preferences and desire for active participation in decision making, there is a need to individualize communication style.

Ruppar, T. M., Dobbels, F., Lewek, P., et al. (2015). "Systematic Review of Clinical Practice Guidelines for the Improvement of Medication Adherence." Int J Behav Med **22**(6): 699-708.

> BACKGROUND: Poor adherence to medications is a significant problem that leads to increased morbidity, mortality, and health care costs. Recommended approaches to address medication adherence vary, and existing practice guidelines are unclear. PURPOSE: This review evaluated clinical practice guidelines designed to help health care providers address patients' medication adherence. METHOD: Multiple search methods were used to identify national or international guidelines addressing medication adherence. We included guidelines published in English, as well as guidelines with an English-language summary or translation. RESULTS: We identified 23 guidelines of varying detail and quality. Recommendations were categorized as assessment strategies (n = 20 guidelines); educational strategies (n = 18); behavioral strategies (n = 17); therapeutic relationship, communication, and provider factors (n = 19); and addressing outside influences/co-morbidities (n = 10). CONCLUSION: Future guidelines should be more clearly guided by research findings and comparative effectiveness methods. When implemented, guidelines will facilitate health care providers and health systems in supporting optimal adherence and improved health outcomes.

Sanders, T., Harrison, S. et Checkland, K. (2010). "Personalizing protocol-driven care: the case of specialist heart failure nurses." J Adv Nurs **66**(9): 1937-1945.

> AIM: This paper is a report of a study conducted to explore how specialist heart failure nurses negotiate treatment advice with patients, in the context of an increasing expectation that clinical staff in the National Health Services will follow guidelines in their daily work. BACKGROUND: The development of specialist nurse roles has given rise to questions about their compatibility with patient-centred care. However, research has revealed little about how specialist nurses balance clinical guidelines with traditional caring tasks. METHODS: Semi-structured interviews (n = 10) were conducted with specialist heart failure nurses in northern England recruited from a heart failure specialist nursing contact list. In addition, non-participant observations were carried out on nurse-patient consultations (n = 16) in one regional nurse-led heart failure clinic. Data were collected between 2003 and 2005, and analysed using a variation of grounded theory. FINDINGS: Heart failure nurses sought to combine traditional caring work with the wider goal of improving patient outcomes by 'personalizing' their advice to patients and presenting their heart failure as 'typical'. They accommodated protocol-driven care into their daily routines, and perceived no disjuncture between evidence-based practice and patient-centredness. However, their approach allowed little space for the exploration of each patient's own priorities about their illness. CONCLUSION: There is a need both to re-examine the appropriateness of traditional caring concepts, and to reflect on the need to incorporate patients' own values into the consultation process.

Santoro, S. L., Martin, L. J., Pleatman, S. I., et al. (2016). "Stakeholder Buy-In and Physician Education Improve Adherence to Guidelines for Down Syndrome." J Pediatr **171**: 262-268.e261-262.

> OBJECTIVES: To assess adherence to the 2011 American Academy of Pediatrics (AAP) health supervision guidelines for Down syndrome, to determine whether pediatrician education improves adherence, and to evaluate stakeholder attitudes toward these guidelines. STUDY DESIGN: Twenty-two pediatric care sites participated in chart review of adherence to the components of the AAP guidelines for Down syndrome in this longitudinal cohort study. We analyzed universal recommendations which apply to all children with Down syndrome. Thirteen pediatric practices caring for 82 patients with Down syndrome received educational information. Frequency calculations with Bonferroni adjustment of the P value threshold (P = .05/9 = .0056) were performed. Adherence rates were compared between cohorts and within the individual before and after intervention using 2 x 2 contingency tables and goodness-of-fit tests. Pediatricians and parents of children with Down syndrome completed an anonymous survey regarding their attitudes toward the guidelines. RESULTS: Statistically significant increases in adherence were seen in 5 of the 8 universal recommendations following pediatrician education (P </= .002), including cardiology and genetics visits, rates of echocardiography, annual audiology testing, and sleep studies by age 4 years. Both physicians and

parents reported generally positive views of the guidelines, yet baseline adherence rates were suboptimal. Pediatrician education preferences include directly integrating the guidelines into an electronic medical record system. CONCLUSION: Stakeholder attitudes reflect a willingness to follow the AAP guidelines for Down syndrome. Providing rapid access to simple, clear reminders of recommended assessments successfully improved adherence to the AAP guidelines for Down syndrome.

Scherer, M., Wollny, A., Vollmar, H. C., et al. (2013). "[The Quality indicator project of the German college of general practice and family medicine (DEGAM): development of indicators based on the guidelines dementia, neck pain and sore throat]." Z Evid Fortbild Qual Gesundhwes **107**(1): 74-86.

A debate on the application of quality indicators (QIs) arose among the members of the German College of General Practitioners and Family Physicians (DEGAM) when two QI systems for ambulatory care (QISA and AQUIK) were published in a short time interval. A research question that emanated from this discussion was whether appropriate QI might be developed based on German general practice guidelines. In spring 2010, the DEGAM guideline committee (SLK) decided to conduct a project on guideline-based development of QIs using the DEGAM guidelines for dementia, neck pain and sore throat. All members of the SLK were invited to participate in the development process which comprised three face-to-face meetings and four paper-pencil ratings. Finally, 17 QIs for the three guidelines on dementia (n=8), neck pain (n=7) and sore throat (n=2) emerged. These QIs received different ratings in the dimensions relevance, practicability, and appropriateness for public reporting as well as for pay for performance. In this project, guideline authors themselves developed QIs based on German general practice guidelines for the first time ever. Not before practice administration systems facilitate the availability of data in the context of clinical documentation, the practicability of the new QIs can be proven in real every-day practice.

Serrano, V., Rodriguez-Gutierrez, R., Hargraves, I., et al. (2016). "Shared decision-making in the care of individuals with diabetes." Diabet Med **33**(6): 742-751.

People with diabetes often live with other chronic conditions and lead complicated lives. Determining what is the best management decision for a patient requires consideration of each individual's personal, social and biomedical context, what he or she values, the reasons he or she has to value the available options, and the relative contribution of each option in terms of benefits, harms, costs and inconveniences. Empathic conversations between patients and clinicians to diagnose the patient situation that necessitates action and the range of evidence-based actions that best address the situation, so-called shared decision-making, are essential to the personalized care of people with diabetes. The aim of the present review was to present key elements of shared decision-making and propose three different approaches for its application. The first approach focuses on transferring information to patients so that they can make decisions. The second approach, choice, focuses on cultivating the individual's ability to give voice to which choice is best for them. The third approach, conversation, establishes an empathic conversational environment through which the individual with diabetes and their clinician think and talk through how to address the problems of living with diabetes and related illnesses. These approaches are manifest in the design of evidence-based decision aids created to support shared decision-making. In randomized trials, decision aids can efficiently improve patient's knowledge, satisfaction, risk awareness, decisional conflict and involvement. Further research, however, is needed to better understand when and how to promote the empathic conversations, patient, clinician and service and policy contexts necessary to routinely implement shared decision-making in different at scale healthcare systems. In the interim, sufficient evidence and tools exist for persons with diabetes and their clinicians to gain expertise in making decisions together.

Shah, S., Toelle, B. G., Sawyer, S. M., et al. (2010). "Feasibility study of a communication and education asthma intervention for general practitioners in Australia." Aust J Prim Health **16**(1): 75-80.

The Physician Asthma Care Education (PACE) program significantly improved asthma prescribing and communication behaviours of primary care paediatricians in the USA. We tested the feasibility and acceptability of a modified PACE program with Australian general practitioners (GP) and measured its impact on self-reported consulting behaviours in a pilot study. Recruitment took place through a local GP division. Twenty-five GP completed two PACE Australia workshops, which incorporated paediatric asthma management consistent with Australian asthma guidelines and focussed on effective communication strategies. Program feasibility, usefulness and perceived benefit were measured by questionnaires before the workshop and 1 month later, and an evaluation questionnaire after each workshop. GP were universally enthusiastic and supportive of the workshops. The most useful elements they reported were communication skills, case studies, device demonstrations and the toolkit provided. GP self reports of the perceived helpfulness of the key communication strategies and their confidence in their application and reported frequency of use increased significantly after the workshops. The PACE program shows promise in improving the way in which Australian GP manage asthma consultations, particularly with regard to doctor-patient communication. The impact ofthe modified PACE Australia program on the processes and outcomes ofGP care ofchildren with asthma is now being measured in a randomised controlled trial.

Shaya, F. T., Gbarayor, C. M., Laird, A., et al. (2011). "Diabetes knowledge in a high risk urban population." Ethn Dis **21**(4): 485-489.

This study explored the impact of an intensive educational intervention to patients on their knowledge and understanding of diabetes. This study was a hypothesis-testing, prospective study, with an experimental two-by-two factorial design. The educational programs were offered to physicians only, patients only, or both patients and their physicians. In the fourth arm, neither patients nor their physicians received any education. Patients with uncontrolled diabetes were enrolled in the study. The outcome was the changes in the score of patients on the diabetes knowledge test. The knowledge test was administered at the time of enrollment and every six months thereafter. The study showed that a total of 622 (75%) patients took the diabetes knowledge test. The mean diabetes knowledge test score increased over time for both insulin and non-insulin users. The mean diabetes knowledge score in patients with patient education only was 11 points higher compared to those in the group of patients and their physicians without education (P=.0104). The study indicated that patients who are exposed to the educational program end up with better knowledge on all counts, than patients who just go through the health care system in the course of usual care for diabetes.

Shu, A. D., Stedman, M. R., Polinski, J. M., et al. (2009). "Adherence to osteoporosis medications after patient and physician brief education: post hoc analysis of a randomized controlled trial." Am J Manag Care **15**(7): 417-424.

OBJECTIVE: To examine whether adherence to osteoporosis medications can be improved by educational interventions targeted at primary care physicians (PCPs) and patients. STUDY DESIGN: Post hoc analysis of data collected as part of a prospective randomized controlled trial to improve initiation of osteoporosis management such as bone mineral density testing or osteoporosis drug initiation. METHODS: The trial was conducted among patients at risk for osteoporosis enrolled in Horizon Blue Cross Blue Shield of New Jersey. For a 3-month period, randomly selected PCPs and their patients received education about osteoporosis diagnosis and treatment. The PCPs received face-to-face education by trained pharmacists, while patients received letters and automated telephone calls. The control group received no education. We assessed medication adherence during 10 months following the start of the intervention using the medication possession ratio (MPR), the ratio of available medication to the total number of days studied. RESULTS: These analyses included 1867 patients (972 randomized to the intervention group and 875 to the control group) and their 436 PCPs. During 10 months following the intervention, the median MPRs were 74% (interquartile range [IQR], 19%-93%) for the intervention group and 73% (IQR, 0%-93%) for the control group (P = .18). The median times until medication discontinuation after the intervention were 85 days (IQR, 58-174 days) for the intervention group and 79 days (IQR, 31-158 days) for the control group. CONCLUSION: The educational intervention did not significantly improve medication compliance or persistence with osteoporosis drugs.

Smith, S. M., Wallace, E., O'Dowd, T., et al. (2016). "Interventions for improving outcomes in patients with multimorbidity in primary care and community settings." Cochrane Database Syst Rev **3**: Cd006560.

BACKGROUND: Many people with chronic disease have more than one chronic condition, which is referred to as multimorbidity. The term comorbidity is also used but this is now taken to mean that there is a defined index condition with other linked conditions, for example diabetes and cardiovascular disease. It is also used when there are combinations of defined conditions that commonly co-exist, for example diabetes and depression. While this is not a new phenomenon, there is greater recognition of its impact and the importance of improving outcomes for individuals affected. Research in the area to date has focused mainly on descriptive epidemiology and impact assessment. There has been limited exploration of the effectiveness of interventions to improve outcomes for people with multimorbidity. OBJECTIVES: To determine the effectiveness of health-service or patient-oriented interventions designed to improve outcomes in people with multimorbidity in primary care and community settings. Multimorbidity was defined as two or more chronic conditions in the same individual. SEARCH METHODS: We searched MEDLINE, EMBASE, CINAHL and seven other databases to 28 September 2015. We also searched grey literature and consulted experts in the field for completed or ongoing studies. SELECTION CRITERIA: Two review authors independently screened and selected studies for inclusion. We considered randomised controlled trials (RCTs), non-randomised clinical trials (NRCTs), controlled before-after studies (CBAs), and interrupted time series analyses (ITS) evaluating interventions to improve outcomes for people with multimorbidity in primary care and community settings. Multimorbidity was defined as two or more chronic conditions in the same individual. This includes studies where participants can have combinations of any condition or have combinations of pre-specified common conditions (comorbidity), for example, hypertension and cardiovascular disease. The comparison was usual care as delivered in that setting. DATA COLLECTION AND ANALYSIS: Two review authors independently extracted data from the included studies, evaluated study quality, and judged the certainty of the evidence using the GRADE approach. We conducted a meta-analysis of the results where possible and carried out a narrative synthesis for the remainder of the results. We present the results in a 'Summary of findings' table and tabular format to show effect sizes across all outcome types. MAIN RESULTS: We identified 18 RCTs examining a range of complex interventions for people with multimorbidity. Nine studies focused on defined comorbid conditions with an emphasis on depression, diabetes and cardiovascular disease. The remaining studies focused on multimorbidity, generally in older people. In 12 studies, the predominant intervention element was a change to the organisation of care delivery, usually through case management or enhanced multidisciplinary team work. In six studies, the interventions were predominantly patient-oriented, for example, educational or self-management support-type interventions delivered directly to participants. Overall our confidence in the results regarding the effectiveness of interventions ranged from low to high certainty. There was little or no difference in clinical outcomes (based on moderate certainty evidence). Mental health outcomes improved (based on high certainty evidence) and there were modest reductions in mean depression scores for the comorbidity studies that targeted participants with depression (standardized mean difference (SMD) -2.23, 95% confidence interval (CI) -2.52 to -1.95). There was probably a small improvement in patient-reported outcomes (moderate certainty evidence) although two studies that specifically targeted functional difficulties in participants had positive effects on functional outcomes with one of these studies also reporting a reduction in mortality at four year follow-up (Int 6%, Con 13%, absolute difference 7%). The intervention may make little or no difference to health service use (low certainty evidence), may slightly improve medication adherence (low certainty evidence), probably slightly improves patient-related health behaviours (moderate certainty evidence), and probably improves provider behaviour in terms of prescribing behaviour and quality of care (moderate certainty evidence). Cost data were limited. AUTHORS' CONCLUSIONS: This review identifies the emerging evidence to support policy for the management of people with multimorbidity and common comorbidities in primary care and community settings. There are remaining uncertainties about the effectiveness of interventions for people with multimorbidity in general due to the relatively small number of RCTs conducted in this area to date, with mixed findings overall. It is possible that the findings may change with the inclusion of large ongoing well-organised trials in future updates. The results suggest an improvement in health outcomes if interventions can be targeted at risk factors such as depression, or specific functional difficulties in people with multimorbidity.

Sofra, D., Delgado, H., Masmont-Berwart, S., et al. (2014). "[The therapeutic education: an awareness program for health professionals]." Rev Med Suisse **10**(433): 1249-1250, 1252-1243.

> The impact of the educational process has been shown to improve the quality of life of patients with chronic disease and their involvement in the management of their daily treatments, particularly in the field of diabetes patients. Usually, several health professionals are involved in the accompaniment of chronic patients. Currently, the health professional has few continuing education training programms that can help to support patients with chronic diseases and to better communicate with colleagues from other disciplines. The purpose of this article is to describe and present a new education program designed for all health care professional working in the filed of the chronic disease.

Springate, R. (2008). "Patient-friendly guidelines." Can Fam Physician **54**(4): 512.
http://www.ncbi.nlm.nih.gov/pubmed/18411376

Straatman, L. et Miller, T. (2013). "Paediatric palliative care: a survey of paediatricians and family practitioners." BMJ Support Palliat Care **3**(3): 366-371.

> BACKGROUND: Paediatric palliative care focuses on the enhancement of the quality of life for a child and family through a combination of active and compassionate therapies intended to comfort and support the child and family who are living with a life-threatening illness. The purpose of this study was to assess the experience with and confidence in providing paediatric palliative care of practicing family/general practitioners (GPs) and paediatricians. In addition, the learning needs, modes of learning and their methods of coping/self-care were questioned. METHODS: Two hundred paediatricians and GPs in the province of British Columbia were randomly selected to participate in a mailed survey. The survey consisted of three categories: demographic information, experience and knowledge of paediatric palliative care, educational needs and preferences for learning and provision of their own self-care. RESULTS: The response rate of completed surveys was 56.5%. Only 40.1% of respondents felt their knowledge and experience were adequate. Overall, 73.5% of the respondents reported that they would like to learn more about paediatric palliative care. Over 53% of those surveyed preferred that learning be offered remotely through either internet or correspondence. Seventy-four per cent of respondents expressed they had adequate or very adequate self-care strategies to meet their own needs of well-being. CONCLUSIONS: The results of the survey will guide the paediatric palliative care community to design programmes that will better educate practicing physicians and future physicians about paediatric palliative and end of life care, healthcare services and family communication and support.

Su, Q., Li, C., Long, F., et al. (2017). "Effects of a health promotion program on medication adherence to antiplatelet therapy among ischemic stroke patients in Hainan Province, China." Vascular **25**(3): 242-248.

> Survivors of ischemic stroke are still at a significant risk for recurrence. Antiplatelet agents are the treatment of first choice for long-term secondary prevention of vascular events. This study aims to assess a health promotion program on medication adherence to antiplatelet therapy among ischemic stroke patients in Hainan province, China. In five hospitals from the intervention group, four highly experienced physicians trained 62 neurologists, who in turn trained 613 stroke patients to improve their awareness and adherence to antiplatelet therapy. Physicians and patients of the control group received usual stroke management programs. After one-year follow-up, the proportion of patients who took the antiplatelet therapy increased significantly in the intervention group, reaching 73.2%, with a pre-post difference between two arms of 22.9% ($P < 0.01$). There was also a significant net increase in the proportion of patients with awareness of antiplatelet therapy (24.4%, $P < 0.01$). Multivariate analysis illustrated health promotion program, higher education, annual household income, insurance, and medical status affected antiplatelet drug use in stroke patients. In conclusion, the health promotion program, based on a train-the-trainer approach, showed positive e ff ects on awareness of and adherence to antiplatelet therapy, which has the potential to be scaled up to other resource-limited areas.

Sullivan, V. H., Hays, M. M. et Alexander, S. (2019). "Health Coaching for Patients With Type 2 Diabetes Mellitus to Decrease 30-Day Hospital Readmissions." Prof Case Manag **24**(2): 76-82.

> PURPOSE/OBJECTIVES: The purpose of this program was to provide health coaching to patients with a primary or secondary diagnosis of Type 2 diabetes mellitus (T2DM) to increase self-management skills and reduce 30-day readmissions. PRIMARY PRACTICE SETTING: The setting was a 273-bed, acute care not-for-profit hospital in the southern region of the United States. FINDINGS/CONCLUSIONS: Health coaching that emphasized self-management, empowered patients to set healthy goals, and provided support through weekly reminders to improve self-management for patients with T2DM in this pilot program. The majority of patients reported accomplishment of goals with 16 out of 20 patients who did not require inpatient stay 30 days after discharge from the acute care facility. IMPLICATIONS FOR CASE MANAGEMENT PRACTICE: The T2DM piloted program can easily be modified to fit other chronic illness that require routine monitoring and complex regimens to remain healthy. Case managers have the opportunity to coach on the importance of lifestyle modification and self-management support for patients with chronic illness with follow-up interactive phone visits after hospital discharge. Motivation and confidence through coaching may increase self-efficacy and better management of self-care and reduce the burden of unplanned hospital readmissions.

Swindell, J. S., McGuire, A. L. et Halpern, S. D. (2010). "Beneficent persuasion: techniques and ethical guidelines to improve patients' decisions." Ann Fam Med **8**(3): 260-264.

> Physicians frequently encounter patients who make decisions that contravene their long-term goals. Behavioral economists have shown that irrationalities and self-thwarting tendencies pervade human decision making, and they have identified a number of specific heuristics (rules of thumb) and biases that help explain why patients sometimes make such counterproductive decisions. In this essay, we use clinical examples to describe the many ways in which these heuristics and biases influence patients' decisions. We argue that physicians should develop their understanding of these potentially counterproductive decisional biases and, in many cases, use this knowledge to rebias their patients in ways that promote patients' health or other values. Using knowledge of decision-making psychology to persuade patients to engage in healthy behaviors or to make treatment decisions that foster their long-term goals is ethically justified by physicians' duties to promote their patients' interests and will often enhance, rather than limit, their patients' autonomy. We describe techniques that physicians may use to frame health decisions to patients in ways that are more likely to motivate patients to make choices that are less biased and more conducive to their long-term goals. Marketers have been using these methods for decades to get patients to engage in unhealthy behaviors; employers and policy makers are beginning to consider the use of similar approaches to influence healthy choices. It is time for clinicians also to make use of behavioral psychology in their interactions with patients.

Thompson, D., Leach, M., Smith, C., et al. (2020). "How nurses and other health professionals use learning principles in parent education practice: A scoping review of the literature." Heliyon **6**(3): e03564.
http://www.sciencedirect.com/science/article/pii/S2405844020304096

> Background Health Professionals (HPs) play an important role in supporting parents to care for their children, by facilitating parents' knowledge and skills development through parent education. This is achieved through teaching, whereby planned strategies, based on principles of how people learn, enable learning. Despite Learning Principles being the fundamental tenets of the learning process, how HPs perceive and use Learning Principles in their practice is neglected in the healthcare literature. Objective To identify, describe and map the existing literature on nurses' and HPs' perceptions and use of Learning Principles in parent education practice. Method A scoping review was performed using the Joanna Briggs Institute approach. A comprehensive search of 10 databases and the grey literature was undertaken between March and June 2017 to identify pertinent English-language publications. The search was limited to literature published between 1998 and 2017. Following a screening and inclusion criteria eligibility check, 89 articles were selected for inclusion. Results HPs' perceptions of Learning Principles were diverse, somewhat disorganised, divergent in meaning and implicit. This was until the Dimensions of Learning construct was applied to guide the analyses and mapping. This revealed that HPs, of whom 60.7% were nurses, used Learning Principles in parent education, but only

referred to them in the context of Adult Learning. Enablers to HPs using Learning Principles included shared partnerships between parents and HPs, while barriers included parents' health beliefs, psychological issues and organisational assumptions about learning. Evaluation of parents' learning also represented implicit use of Learning Principles by HPs. Conclusion This scoping review is the first to examine HPs' perceptions and use of Learning Principles within parent education practice. The findings reveal a significant gap in this body of knowledge. The paucity of studies containing any explicit descriptions of Learning Principles strongly supports the need for further exploration and codification of Learning Principles, through qualitative methods, whereby a deeper understanding of what is happening in healthcare practice can be established.

Wagner, A., Radionova, N., Rieger, M. A., et al. (2019). "Patient Education and Continuing Medical Education to Promote Shared Decision-Making. A Systematic Literature Review." Int J Environ Res Public Health **16**(14).

Background: Over recent years, the use of decision aids to promote shared decision-making have been examined. Studies on patient education and on continuing medical education for physicians are less common. This review analyzes intervention and evaluation studies on patient education and continuing medical education which aim to enhance shared decision-making. The following study parameters are of interest: Study designs, objectives, numbers of participants in the education courses, interventions, primary results, and quality of the studies. Methods: We systematically searched for suitable studies in two databases (Pubmed and the Cochrane Database of Systematic Reviews) from the beginning of April through to mid-June 2016. Results: 16 studies from a total of 462 hits were included: Three studies on patient education and 13 studies on continuing medical education for physicians. Overall, the study parameters were heterogeneous. Major differences were found between the courses; how the courses were conducted, their length, and participants. Conclusions: The differences found in the studies made it difficult to compare the interventions and the results. There is a need for studies that systematically evaluate and further develop interventions in this area to promote shared decision-making.

Tuot, D. S., Velasquez, A., McCulloch, C. E., et al. (2015). "The Kidney Awareness Registry and Education (KARE) study: protocol of a randomized controlled trial to enhance provider and patient engagement with chronic kidney disease." BMC Nephrol **16**: 166.

BACKGROUND: Chronic kidney disease (CKD) is common and is associated with excess mortality and morbidity. Better management could slow progression of disease, prevent metabolic complications, and reduce cardiovascular outcomes. Low patient awareness of CKD and ineffective patient-provider communication can impede such efforts. We developed provider and patient-directed interventions that harness health information technology to enhance provider recognition of CKD and delivery of guideline concordant care and augment patient understanding and engagement in CKD care. METHODS/DESIGN: We report the design and protocol of the Kidney Awareness Registry and Education (KARE) Study, a 2x2 factorial randomized controlled trial that examines the impact of a multi-level intervention on health outcomes among low-income English, Spanish and Cantonese-speaking patients with CKD in a safety net system. The intervention includes: (1) implementation of a primary care electronic CKD registry that notifies practice teams of patients' CKD status and employs a patient profile and quarterly feedback to encourage provision of guideline-concordant care at point-of-care and via outreach; and (2) a language-concordant, culturally-sensitive self-management support program that consists of automated telephone modules, provision of low-literacy written patient-educational materials and telephone health coaching. The primary outcomes of the trial are changes in systolic blood pressure (BP) and the proportion of patients with BP control (</= 140/90 mmHg) after one year. Secondary outcomes include patient understanding of CKD, participation in healthy behaviors, and practice team delivery of guideline-concordant CKD care. DISCUSSION: Results from the KARE study will provide data on the feasibility, effectiveness, and acceptability of technology-based interventions that support primary care efforts at improving health outcomes among vulnerable patients with CKD. TRIAL REGISTRATION: ClinicalTrials.gov, number: NCT01530958.

van der Weijden, T., Boivin, A., Burgers, J., et al. (2012). "Clinical practice guidelines and patient decision aids. An inevitable relationship." J Clin Epidemiol **65**(6): 584-589.

> As health professionals and patients are moving toward shared models of decision making, there is a growing need for integrated decision support tools that facilitate uptake of best evidence in routine clinical practice in a patient-centered manner. This article charts the landscape of clinical practice guidelines (CPGs) and patient decision aids. Decision support tools for medical practice can be mapped on two dimensions. (1) The target user and his or her level of decision making; either for groups of patients or for an individual patient and (2) the level of uncertainty: either supporting more directive decision making (behavior support) in the case of strong recommendations with a single best option or supporting dialog (deliberation support) on the pros and cons of different options in the case of conditional (or weak) recommendations. We conclude that it is important to establish closer links between CPGs and patient decision aids, through collaborative development of both. Such collaboration will encourage the design of decision support tools for professionals and patients who share the same evidence and the aim to increase the quality of decision making between doctor and patient. This could facilitate the implementation of CPGs and shared decision making in clinical practice.

van Dijk-de Vries, A., Moser, A., Mertens, V. C., et al. (2012). "The ideal of biopsychosocial chronic care: how to make it real? A qualitative study among Dutch stakeholders." BMC Fam Pract **13**: 14.

> BACKGROUND: Chronically ill patients often experience psychosocial problems in everyday life. A biopsychosocial approach is considered to be essential in chronic care. In Dutch primary health care the current biomedically oriented clinical practice may conflict with the biopsychosocial approach. This study is aimed to explore the views of Dutch stakeholders on achieving a biopsychosocial approach to the care of patients with chronic diseases. METHODS: In a qualitative explorative study design, we held semi-structured interviews with stakeholders, face-to-face or by telephone. Data were analysed using content analysis. Thirty representatives of Dutch patients with chronic illnesses, primary care professionals, policy makers, health inspectorate, health insurers, educational institutes and researchers were interviewed. RESULTS: Stakeholders were aware that a systematic biopsychosocial care approach is lacking in current practice. Opportunities for effective change are multidimensional. Achieving a biopsychosocial approach to care relates to active patient participation, the training of professionals, high-quality guidelines, protocols and tools, integrated primary care, research and financial issues. CONCLUSIONS: Although the principles and importance of the biopsychosocial model have been recognized, the provision of care that starts from the medical, emotional or social needs of individual patients does not fit in easily with the current Dutch health care system. All parties involved need to make a commitment to realize the ideal of biopsychosocial chronic care. Together they need to equip health professionals with skills to understand patients' multifaceted needs and to reward integrated biopsychosocial care. Patients need to be empowered to be active partners in their own care.

Wagner, A., Radionova, N., Rieger, M. A., et al. (2019). "Patient Education and Continuing Medical Education to Promote Shared Decision-Making. A Systematic Literature Review." Int J Environ Res Public Health **16**(14).

> Background: Over recent years, the use of decision aids to promote shared decision-making have been examined. Studies on patient education and on continuing medical education for physicians are less common. This review analyzes intervention and evaluation studies on patient education and continuing medical education which aim to enhance shared decision-making. The following study parameters are of interest: Study designs, objectives, numbers of participants in the education courses, interventions, primary results, and quality of the studies. Methods: We systematically searched for suitable studies in two databases (Pubmed and the Cochrane Database of Systematic Reviews) from the beginning of April through to mid-June 2016. Results: 16 studies from a total of 462 hits were included: Three studies on patient education and 13 studies on continuing medical education for physicians. Overall, the study parameters were heterogeneous. Major differences were found between the courses; how the courses were conducted, their length, and participants. Conclusions: The differences found in the studies made it difficult to compare the interventions and

the results. There is a need for studies that systematically evaluate and further develop interventions in this area to promote shared decision-making.

Weiss, B. D., Brega, A. G., LeBlanc, W. G., et al. (2016). "Improving the Effectiveness of Medication Review: Guidance from the Health Literacy Universal Precautions Toolkit." J Am Board Fam Med **29**(1): 18-23.

BACKGROUND: Although routine medication reviews in primary care practice are recommended to identify drug therapy problems, it is often difficult to get patients to bring all their medications to office visits. The objective of this study was to determine whether the medication review tool in the Agency for Healthcare Research and Quality Health Literacy Universal Precautions Toolkit can help to improve medication reviews in primary care practices. METHODS: The toolkit's "Brown Bag Medication Review" was implemented in a rural private practice in Missouri and an urban teaching practice in California. Practices recorded outcomes of medication reviews with 45 patients before toolkit implementation and then changed their medication review processes based on guidance in the toolkit. Six months later we conducted interviews with practice staff to identify changes made as a result of implementing the tool, and practices recorded outcomes of medication reviews with 41 additional patients. Data analyses compared differences in whether all medications were brought to visits, the number of medications reviewed, drug therapy problems identified, and changes in medication regimens before and after implementation. RESULTS: Interviews revealed that practices made the changes recommended in the toolkit to encourage patients to bring medications to office visits. Evaluation before and after implementation revealed a 3-fold increase in the percentage of patients who brought all their prescription medications and a 6-fold increase in the number of prescription medications brought to office visits. The percentage of reviews in which drug therapy problems were identified doubled, as did the percentage of medication regimens revised. CONCLUSIONS: Use of the Health Literacy Universal Precautions Toolkit can help to identify drug therapy problems.

Young, H. M., Hudson, N., Clarke, A. L., et al. (2015). "Patient and Staff Perceptions of Intradialytic Exercise before and after Implementation: A Qualitative Study." Plos One **10**(6): e0128995.

INTRODUCTION: Despite guidance and evidence for the beneficial effects of intradialytic exercise (IDE), such programmes are rarely adopted within practice and little is known about how they may best be sustained. The Theoretical Domains Framework (TDF) was used to guide the understanding of the barriers and facilitators to initial and ongoing IDE participation and to understand how these are influential at each stage. MATERIALS AND METHODS: Focus groups explored patient (n=24) and staff (n=9) perceptions of IDE prior to the introduction of a programme and, six months later, face to face semi-structured interviews captured exercising patients (n=11) and staffs' (n=8) actual experiences. Data were collected at private and NHS haemodialysis units within the UK. All data were audio-recorded, translated where necessary, transcribed verbatim and subject to framework analysis. RESULTS: IDE initiation can be facilitated by addressing the pre-existing beliefs about IDE through the influence of peers (for patients) and training (for staff). Participation was sustained through the observation of positive outcomes and through social influences such as teamwork and collaboration. Despite this, environment and resource limitations remained the greatest barrier perceived by both groups. CONCLUSIONS: Novel methods of staff training and patient education should enhance engagement. Programmes that clearly highlight the benefits of IDE should be more successful in the longer term. The barrier of staff workload needs to be addressed through specific guidance that includes recommendations on staffing levels, roles, training and skill mix.

Zanoni, P. H., Parisi, M. C., Admoni, S. N., et al. (2009). "[Diabetes immersion training as teaching method to medical practitioners]." Arq Bras Endocrinol Metabol **53**(3): 355-359.

This study evaluated the effectiveness of theoretical and practical teaching method in diabetes and doctors' position about feasibility of intensive blood glucose control. Forty-eight internal medicine or endocrinology residents participated in a two-day diabetes immersion course. The participants received training on self-blood glucose monitoring, techniques of insulin administration and carbohydrate counting. They were also instructed to behave as patients with diabetes and to follow

> individual medical prescription. They were assessed through questionnaires. In knowledge assessment, a significant increase of 12% was observed between the beginning and the end of the course (61.2% and 73.2%, respectively, with p < 0.0001). Before the course, 70.8% and 89.6% of the participants believed there were complications in performing carbohydrate counting and blood glucose monitoring, respectively. After the experience, 82.9% of them had difficulties in carbohydrate counting and 80.8% in self-monitoring; 40.4% took all medications prescribed and 36.1% monitored blood glucose correctly. These results show that the methodology of this course is an effective way to disseminate knowledge and that it contributes to doctors becoming more sensitive to daily problems faced by patients with diabetes melito concerning the acceptance of medical recommendations.

THESES

Asselin, M. et Université François Rabelais. Tours (2013). Formation médicale continue en éducation thérapeutique du patient : qu'en font les médecins généralistes ? Enquête qualitative à partir d'un questionnaire et de 9 entretiens semi-dirigés. Thèse pour le diplôme d'état de docteur en médecine : 178p.

Attye, M. et Université de Picardie Jules Verne. Amiens (2016). État des lieux de l'attente des patients de médecine générale en matière d'éducation pour la santé : étude qualitative par entretiens individuels semi-directifs en sortie de consultation. Thèse pour le diplôme d'état de docteur en médecine : 54p.

Ayata, Z. et Université de Versailles (2015). Éducation diététique des diabétiques de type 2 en soins primaires : revue de la littérature et proposition d'un outil visuel adapté aux patients diabétiques peu ou non lettrés à la Réunion. Thèse pour le diplôme d'état de docteur en médecine 85p.

Baudinot, L. et Université Claude Bernard Lyon 1 (2015). Perceptions et pratiques de médecins généralistes dans l'éducation thérapeutique concernant l'activité physique des patients diabétiques de type 2 : étude qualitative par focus group. Thèse pour le diplôme d'état de docteur en médecine : 92p.

Bendiab, S. (2017). État des lieux des programmes d'éducation thérapeutique à caractère gériatrique en France hors DOM-TOM, de 2012 à 2014. Lille Université de Lille 2, Université de Lille 2. Lille. FRA. Thèse de Doctorat en Médecine: 73 , tabl.,fig., annexes.
http://pepite.univ-lille2.fr/notice/view/UDSL2-workflow-7705

> Contexte: À l'heure où une réflexion est menée sur l'éducation thérapeutique des patients (ETP) âgés, aucun état des lieux de l'ETP portée par les services de gériatrie en France n'a été réalisé. Objectif: L'objectif du travail était de dresser un état des lieux des programmes d'éducation thérapeutique (ET) gériatriques sur le territoire national de 2012 à 2014. Méthode: Il s'agit d'une étude prospective qui s'est déroulée en deux temps : - Une première enquête par questionnaire en ligne a été faite auprès des membres de la Société française de gérontologie et gériatrie (SFGG), à l'initiative du groupe ETP de la SFGG - Une seconde enquête élargie à tous les professionnels impliqués dans les programmes d'ETP gériatriques en recherchant de manière systématique les programmes d'ETP autorisés sur les sites des Agences régionales de santé (ARS) et en adressant ensuite le même questionnaire aux porteurs identifiés. Résultats: Quatre-vingt programmes d'éducation thérapeutique ont été recensés, dont:25 programmes recensés après les retours de la 1ère enquête auprès des membres de la SFGG, 55 autres programmes après les retours de la 2nd enquête. 15 régions sur 22 selon l'ancien découpage portent ces programmes. Selon le nouveau découpage, ils sont portés par 10 régions sur 13. La population cible réside sur 46 territoires de santé des ARS de France métropolitaine sur les 99 existant. Les thématiques principales sont la prévention des chutes, la maladie d'Alzheimer, le diabète, le médicament et la dénutrition. La plupart des programmes s'adressent à des patients (et leurs aidants) ambulatoires. Un plus petit nombre concerne des patients hospitalisés notamment en Soins de suite et de réadaptation (SSR). Conclusion: Le nombre de programmes reste encore faible, en comparaison du nombre de programmes portés par les autres disciplines médicales, compte tenu du fait que la population âgée atteinte de maladies chroniques est très concernée par l'Education Thérapeutique des Patients.

Bingenheimer Magalon, K. et Université de la Méditerranée Aix-Marseille 2 (2010). Éducation thérapeutique des troubles dépressifs en médecine générale. Thèse pour le diplôme d'état de docteur en médecine : 139p.

Castella, P. et Université Paul Sabatier Toulouse 3. (2016). Éducation thérapeutique en soins primaires : état des lieux d'un programme de proximité dans un bassin de santé. Thèse pour le diplôme d'état de docteur en médecine : 33p.

Cauvin, L. et Université de Picardie Jules Verne. Amiens (2011). Inter relations entre médecins généralistes de la Somme et les structures dédiées à l'éducation thérapeutique du patient : étude qualitative par entretiens semi-dirigés auprès de 11 médecins généralistes de la Somme. Thèse pour le diplôme d'état de docteur en médecine : 46 p.

Cecile, J.-T.-l. et Université de Reims (2011). La place du médecin généralise dans l'éducation du patient asthmatique. Thèse pour le diplôme d'état de docteur en médecine : 100p.

Chaar, B. et Université de Caen. (2016). Éducation thérapeutique du patient et médecine de ville : évaluation des pratiques en 2016 dans le diabète de type 2 des médecins généralistes bas normands. Thèse pour le diplôme d'état de docteur en médecine : 129p.

Chevreuil, R. et Université Paris 7 Denis Diderot (2017). Prise en charge et suivi des patients diabétiques de type 2 inclus dans le protocole de coopération Asalée dans les centres municipaux de santé de la ville de Saint-Ouen (93). Thèse pour le diplôme d'état de docteur en médecine : 51p.

De Lajudie, E. et Université Paris Descartes (2013). Éducation thérapeutique du patient diabétique de type 2 en médecine générale : retour d'expérience d'une proposition d'ETP au sein d'un cabinet de groupe. Thèse pour le diplôme d'état de docteur en médecine : 105p.

Dellaroli Bonneau Desroches, S. et Université de Paris 13. Faculté de médecine de Bobigny Léonard de Vinci. Bobigny (2010). Éducation thérapeutique des patients sous anticoagulants oraux : évaluation du niveau de connaissance de 49 patients lors d'un entretien en médecine générale. Thèse pour le diplôme d'état de docteur en médecine : 118p.

Denis Rudelle, K. et Université de Limoges. Faculté de Médecine. Limoges (2014). L'éducation thérapeutique du patient en médecine générale : analyse des résultats de l'étude ECOGEN. Thèse pour le diplôme d'état de docteur en médecine : 125p.

Deprouw, S. et Université Louis Pasteur Strasbourg 1. (2016). Éducation thérapeutique du patient diabétique de type 2 : entre souhaits du patient et priorités du médecin généraliste. Thèse pour le diplôme d'état de docteur en médecine : 161p.

Detriche, G. et Université Paris Descartes. (2017). Évaluation de la connaissance des facteurs de risque cardiovasculaire chez les patients en médecine générale. Thèse pour le diplôme d'état de docteur en médecine : 61p.

Duffau, N. et Université de Nantes. (2011). L'éducation thérapeutique en consultation de médecine générale : analyse des pratiques de 12 médecins généralistes impliqués en éducation thérapeutique. Thèse pour le diplôme d'état de docteur en médecine : 90p.

Dufour, M. et Université du droit et de la santé Lille 2. (2017). Quel rôle pense avoir le médecin généraliste dans l'éducation nutritionnelle des enfants du littoral du Nord-Pas-de-Calais ? Thèse pour le diplôme d'état de docteur en médecine : 76p.

Estegassy, O. et Université Paris 7 Denis Diderot. (2010). L'éducation des patients asthmatiques en médecine générale. Thèse pour le diplôme d'état de docteur en médecine : 104p.

Fiani, M. et Université de Picardie Jules Verne. (2016). Évaluation des connaissances des internes de médecine générale sur l'éducation thérapeutique du patient : une enquête nationale. Thèse pour le diplôme d'état de docteur en médecine : 86p.

Flandin, M. et Université d'Auvergne Clermont 1. Clermont-Ferrand (2012). Aspect cardiovasculaire de la visite de non contre-indication à la pratique sportive : étude de pratique des médecins généralistes du Puy de Dôme et évaluation de l'impact d'une brochure de rappel des recommandations. Thèse pour le diplôme d'état de docteur en médecine : 155p.

Fleury, D. et Université de Caen. Caen, F. R. A. c. (2016). Identification des facteurs d'amélioration de la couverture vaccinale antitétanique dans la population urbaine caennaise par les médecins généralistes. Thèse pour le diplôme d'état de docteur en médecine : 84p.

Foure, G. et Université Paul Sabatier Toulouse 3 (2016). Utilisation d'une application interactive d'évaluation des compétences des enfants en surpoids par les médecins généralistes du RéPPOPO Midi-Pyrénées. Thèse pour le diplôme d'état de docteur en médecine : 52p.

Fournier, C. (2015). Les maisons de santé pluriprofessionnelles, une opportunité pour transformer les pratiques de soins de premier recours : place et rôle des pratiques préventives et éducatives dans des organisations innovantes. Paris Université Paris 11, Université de Paris 11. Orsay. Thèse de doctorat Santé Publique - sociologie: 337.
https://tel.archives-ouvertes.fr/tel-01149605/

> L'exercice des soins de premier recours en maisons et pôles de santé pluriprofessionnels (MSP) connaît depuis quelques années un développement croissant. Ces modalités d'exercice sont présentées comme une solution aux défis que représentent le vieillissement de la population, l'augmentation de la prévalence des maladies chroniques, l'accentuation des inégalités sociales de santé et l'irrésistible croissance des dépenses de santé. Elles s'inscrivent dans une remise en cause du système de santé français, construit historiquement sur un modèle curatif hospitalo-centré et sur une médecine de ville d'exercice libéral et isolé. L'impératif d'un recentrage du système sur les soins de premier recours devient un objectif partagé par l'Etat et certains professionnels libéraux, associé à celui de leur réorganisation pour en accroître la dimension préventive et éducative, dans une approche de santé publique collective, populationnelle et mieux coordonnée au niveau d'un territoire. Comment les soins primaires se transforment-ils dans les MSP ? Dans les dynamiques observées, quels places et rôles jouent les pratiques préventives et éducatives ? Ces questions sont abordées avec une posture de recherche engagée, inscrite dans une réflexion méthodologique et politique, articulant des approches médicale, de santé publique et sociologique (extrait du résumé de l'auteur).

Gandolphe, M. et Université Paul Sabatier Toulouse 3. (2011). Prise en charge du surpoids chez l'adulte en médecine générale : enjeux et difficultés. Thèse pour le diplôme d'état de docteur en médecine : 92p.

Gaye, T., Mergans, M. et Université Paul Sabatier Toulouse 3. Toulouse, F. R. A. c. (2015). Les représentations de l'éducation thérapeutique du patient : le regard des médecins généralistes sur leur place dans le parcours éducatif : une étude qualitative auprès des médecins généralistes en Midi Pyrénées. Thèse pour le diplôme d'état de docteur en médecine : 78p.

Gayraud, A. et Université Paul Sabatier Toulouse 3. (2011). Hypertension artérielle en médecine générale et éducation thérapeutique : impact de la formation des médecins sur les patients : étude auprès de 15 médecins généralistes et 53 de leurs patients en Midi-Pyrénées. Thèse pour le diplôme d'état de docteur en médecine : 138p.

Ghafir, N. et Université de Nantes. (2012). Attentes, satisfaction et souhaits d'informations des patients diabétiques de type 2 de leur médecin généraliste : étude auprès de 182 patients du RESODIAB44. Thèse pour le diplôme d'état de docteur en médecine : 61p.

Ghionga, P. et Université de la Méditerranée Aix-Marseille 2. (2016). État des lieux de l'accès aux soins pluridisciplinaires en milieu rural corse par le développement des maisons de santé pluridisciplinaires et des pôles de santé. Thèse pour le diplôme d'état de docteur en médecine : 92p.

Godenir, B. et Université Joseph Fourier Grenoble 1. (2011). L'éducation thérapeutique du patient atteint de broncho-pneumopathie chronique obstructive dans le bassin chambérien : évaluation des pratiques en médecine générale et propositions pour l'avenir. Thèse pour le diplôme d'état de docteur en médecine : 118p.

Guengant, A. et Université de Rennes 1. (2013). Le rôle du médecin généraliste dans l'éducation thérapeutique du patient diabétique de type 2 : étude qualitative auprès de médecins généralistes de la région lorientaise. Thèse pour le diplôme d'état de docteur en médecine : 116p.

Hamy Shoshany, S. et Université Claude Bernard Lyon 1. (2015). Freins et dynamiques à la mise en place de programmes d'éducation thérapeutique du patient en soins primaires. Thèse pour le diplôme d'état de docteur en médecine : 112p.

Henriques, P. et Université de Picardie Jules Verne. (2010). Faisabilité d'une intervention d'éducation thérapeutique en médecine générale à l'aide d'internet : à propos de l'étude Lombalnet. Thèse pour le diplôme d'état de docteur en médecine : 70p.

Khelfoun, K. et Université de Picardie Jules Verne. (2014). L'éducation thérapeutique dans la prise en charge de patients souffrant de diabète de type 2 suivis par leur médecin généraliste : étude qualitative par la méthode du focus group. Thèse pour le diplôme d'état de docteur en médecine : 77p.

Labiche, J. et Université de Reims. (2015). Les pratiques d'éducation thérapeutique des médecins généralistes auprès des patients diabétiques de type 2. Thèse pour le diplôme d'état de docteur en médecine.: 169p.

Lafont, H. et Université Paul Sabatier Toulouse 3. (2012). Comment apporter des compétences en éducation thérapeutique aux médecins généralistes ? revue de la littérature et propositions de formation. Thèse pour le diplôme d'état de docteur en médecine : 50p.

Lai Tiong Etave, M. et Université de Limoges. Faculté de Médecine. (2012). L'éducation thérapeutique du patient diabétique de type II : pratiques et faisabilité en soins primaires. Thèse pour le diplôme d'état de docteur en médecine Launay, K. (2012). L'éducation thérapeutique du patient en médecine générale, Bobigny : Université de Paris 13, Faculté de Médecine de Bobigny

> L’éducation thérapeutique se développe en France face à la double nécessité d’améliorer la prise en charge des maladies chroniques et de maitriser les dépenses de santé. C’est un processus éducatif continu, intégré aux soins et centré sur le patient. Cette thèse a pour objectif d’étudier les pratiques et les connaissances de médecins généralistes installés en Seine-Saint-Denis en terme d’éducation thérapeutique. Un questionnaire auto-administré a donc été adressé à 150 médecins généralistes, les interrogeant sur leurs connaissances, leurs pratiques et leurs attentes face à l’ETP. La nature du questionnaire (auto-administré) et la taille restreinte de notre échantillon constituent des limites à cette étude. Les résultats montrent cependant que l’ETP est intégrée aux pratiques quotidiennes des médecins généralistes mais la conception qu’ils en ont reste néanmoins centrée sur l’information sans intégrer ses dimensions pédagogiques et psycho-sociales. Comme dans les autres études sur le sujet, le manque de temps mais aussi le manque de formation et le mode de rémunération représentent les principaux freins à la pratique éducative. Un des défis à relever pour le développement de l’ETP est donc de promouvoir la formation médicale initiale et continue dans ce domaine. Autre défi, la valorisation financière doit inventer un nouveau mode de rémunération en associant par exemple la reconnaissance de consultations longues (diagnostic éducatif et bilan d’évaluation des acquis) à une rémunération forfaitaire pour les séances d’ETP. Ces 2 éléments (formation et valorisation financière) participeront à l’intégration durable de l’ETP à notre système de soins. Le médecin généraliste formé et reconnu pour son rôle d’éducateur sera l’un des principaux garants de ce développement

Lebeau, E. et Université du droit et de la santé Lille 2. (2016). Vécu de la prise en charge du patient lombalgique chronique en médecine générale : étude qualitative. Thèse pour le diplôme d'état de docteur en médecin : 106p.

Leleu, S. et Université Louis Pasteur Strasbourg 1. (2016). Éducation thérapeutique du patient diabétique de type 2 : analyse qualitative d'entretiens semi dirigés réalisés dans un cabinet de médecine générale. Thèse pour le diplôme d'état de docteur en médecine : 159p.

Le Rhun, A. (2008). L'accompagnement psychosocial dans l'éducation thérapeutique du patient : de l'accompagnement soignant/patient à l'accompagnement formateur/soignant. Nantes Université de Nantes,

> L'accompagnement du patient constitue un élément clé dans l'éducation thérapeutique d'une personne atteinte de maladie chronique. Pourtant les concepts d'accompagnement éducatif et d'accompagnement psychosocial souvent retrouvés dans la littérature, sont encore insuffisamment définis. Les objectifs de la recherche consistent à mieux comprendre les pratiques éducatives d’accompagnement psychosocial des soignants et les facteurs influençant celles-ci, afin de pouvoir proposer aux soignants des formations et un accompagnement adaptés pour faciliter le changement de leurs pratiques. La méthodologie de recherche combine une approche qualitative exploratoire dans un premier temps, et une recherche-action dans un deuxième temps réalisée auprès de l’équipe du Centre de Ressources et de Compétences pour la Mucoviscidose (CRCM) pour enfants à Nantes. Cette recherche a mis en évidence auprès de cette équipe (8 soignants) la réalité d un accompagnement psychosocial majeur informel lors du suivi individuel des patients, entourant les temps d’apprentissage bien formalisés des séances individuelles et collectives mises en place pour les enfants atteints de mucoviscidose. Ces pratiques sont nombreuses et variées. Certaines pratiques d’accompagnement du patient restent encore spontanées, intuitives et améliorables. Un accompagnement de l’équipe, proposant des offres de formation variées adaptées à l’équipe et aux professionnels, serait nécessaire pour faciliter le changement des pratiques actuelles.

Lieuze, M. et Université Paul Sabatier Toulouse 3. (2015). Éducation thérapeutique en soins primaires : élaboration de séances pour un programme de proximité dans un bassin de santé. Thèse pour le diplôme d'état de docteur en médecine : 60p.

Lo Pape, G. et Université Jean Monnet Saint-Etienne. Saint-Etienne(2012). Prescription de l'activité physique dans le diabète de type 2 en médecine générale : une revue de la littérature. Thèse pour le diplôme d'état de docteur en médecine : 23p.

Loze, V. et Université Paris 6 Pierre et Marie Curie. Faculté de Médecine. (2017). Compréhension de la maladie et adaptation des règles hygiénico-diététique chez les sujets diabétiques de type 2 précaires : une étude qualitative en médecine générale. Thèse pour le diplôme d'état de docteur en médecine : 83p.

Ly Pung, C. et Université de la Méditerranée Aix-Marseille 2. (2012). Représentations et pratiques de l'éducation thérapeutique en médecine générale : enquête auprès de dix médecins généralistes du 14ème arrondissement de Marseille. Thèse pour le diplôme d'état de docteur en médecine : 128p.

Manon Pradalier, L. et Université Paris Descartes. (2013). Éducation thérapeutique en groupe des patients diabétiques de type 2 au cabinet du médecin généraliste : freins et motivations des patients. Thèse pour le diplôme d'état de docteur en médecine : 50p.

Nicolas, D. et Université de Picardie Jules Verne. (2011). Regards croisés des patients et de leurs médecins généralistes quant à l'éducation thérapeutique dans le diabète de type 2 en médecine générale : étude quantitative par entretiens semi-dirigés en Picardie. Thèse pour le diplôme d'état de docteur en médecine : 287p.

Peytavin, P. et Université Paul Sabatier Toulouse 3. (2012). Le médecin généraliste et l'éducation thérapeutique : enquête de pratique auprès de 224 médecins généralistes de Midi-Pyrénées. Thèse pour le diplôme d'état de docteur en médecine : 49p.

Pinel, C. et Université Paris 7 Denis Diderot. P (2016). Quelles sont les motivations des patients atteints de diabète à participer à un programme d'éducation thérapeutique en ville ? Thèse pour le diplôme d'état de docteur en médecine : 111p.

Rassou, S. et Université Paris Descartes. (2014). Éducation thérapeutique des adultes asthmatiques : impact d'une action en cabinet de médecine générale. Thèse pour le diplôme d'état de docteur en médecine : 123p.

Razafindralambo Gail, S. et Université Paris 7 Denis Diderot. (2012). Perception et pratique des médecins face à l'éducation thérapeutique du patient asthmatique : enquête après de 66 médecins de la commune de Nanterre. Thèse pour le diplôme d'état de docteur en médecine : 110p.

Rodet, F.-L. et Université Claude Bernard Lyon 1. (2012). Obstacles à la réalisation de l'éducation thérapeutique des patients diabétiques de typé 2 en médecine générale. Thèse pour le diplôme d'état de docteur en médecine.: 210p.

Romero, N. et Université de Poitiers. (2012). Représentations et pratiques de l'éducation thérapeutique du patient par les internes en médecine générale de l'académie de Poitiers. Thèse pour le diplôme d'état de docteur en médecine : 227p.

Rousseau, A. et Université d'Angers. (2016). Attentes et besoins des médecins généralistes envers les unités cognitivo-comportementales : étude qualitative auprès de 12 médecins généralistes du Maine et Loire. Thèse pour le diplôme d'état de docteur en médecine : 30p.

Sabourin Jones, A.-L. et Université de Rennes 1. (2013). Niveaux de compétence des internes en médecine générale de Rennes en matière d'éducation, de prévention, et de dépistage : une enquête qualitative. Thèse pour le diplôme d'état de docteur en médecine. Pédagogie médicale : 128p.

Sacco, G. et Université de Nice Sophia Antipolis. (2011). Éducation thérapeutique en médecine générale : comment les patients rendent-ils compte du rôle éducatif de leur médecin généraliste ? : étude descriptive qualitative par focus groups. Thèse pour le diplôme d'état de docteur en médecine : 83p.

Samake, M. et Université Paris 6 Pierre et Marie Curie. Faculté de Médecine. (2011). Analyse comparative du ressenti des patients quant au processus d'éducation thérapeutique en matière de risque cardiovasculaire en médecine générale. Thèse pour le diplôme d'état de docteur en médecine : 150p.

Sauvet, A. et Université Victor Segalen Bordeaux 2. (2013). Les médecins généralistes et le programme SOPHIA : enquête auprès de médecins généralistes de la Gironde. Thèse pour le diplôme d'état de docteur en médecine : 74p.

Sayedoff Puderbeutal, P. et Université Paris Descartes. (2017). Les facteurs qui influencent l'adhésion aux mesures hygiéno-diététiques chez les patients diabétiques de type 2 : une étude qualitative sur 20 patients suivis par des médecins généralistes en Île de France. Thèse pour le diplôme d'état de docteur en médecine : 153p.

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Ressources électroniques

En France

CART'EP
Ce répertoire des programmes d'éducation thérapeutique du patient en Ile-de-France constitue un site d'information pour les médecins et professionnels de santé qui souhaitent prendre connaissance des programmes d'ETP autorisés (éducation thérapeutique du patient) en région pour y référer leurs patients souffrant de pathologies chroniques. Il permet également aux responsables des programmes autorisés d'ETP d'échanger avec les équipes réalisant des programmes ETP dans la même discipline et/ou pour les mêmes catégories de patients. Plusieurs moyens d'accès sont possibles : accès géographique, accès par pathologie. L'accès par la recherche avancée permet de croiser les deux critères précédents ainsi que par typologie de patients et contexte de prise en charge.

Centre régional de ressources et de compétences en éducation thérapeutique du patient
Centre soutenu par l'ARS Hauts de France. Nombreuses ressources documentaires, informations, outils pédagogiques dans le champ de l'éducation thérapeutique, à l'intention des professionnels et des patients.

HAS (Haute Autorité de santé)
La Haute Autorité de santé a mis en ligne sur son site des recommandations et guides en éducation thérapeutique, à destination des patients ou des professionnels de santé.

IPCM
Créé en 1989, l'IPCEM est actuellement la première structure spécialisée en France de formation des soignants à l'éducation thérapeutique des patients atteints de maladies chroniques. Outre la présentation de ses différentes formations, son site propose des outils et ressources d'apprentissage pour l'éducation thérapeutique des patients, une rubrique consacrée à la présentation de l'éducation thérapeutique, aux principaux textes et sites de référence.

Ireps Pays-de-la-Loire
L'Ireps des Pays-de-la-Loire a mis en ligne sur son site trois capsules vidéo de sensibilisation à l'éducation thérapeutique du patient (ETP). Cette série est conçue pour répondre aux questions des professionnels de premier recours sur la pratique de l'ETP dans la prise en charge des patients.

Ireps Occitanie
Bibliographie sélective sur l'ETP

Laboratoire Éducations et Pratiques de Santé (LEPS EA 3412)
Créé en 1977, ce laboratoire de recherche de l'Université de Paris XIII aborde, à partir d'entrées spécifiques l'éducation et les pratiques de santé, les problématiques systémiques de la maladie chronique, les rôles et rapports des soignants et soignés, les nouvelles pratiques de soins et de santé. Le postulat sur lequel le laboratoire se fonde est que les politiques de santé, les systèmes de santé et de soins ne peuvent désormais fonctionner sans la participation active de leurs bénéficiaires (citoyenneté de santé) et que cette alliance passe par une éducation. Il a dirigé une étude d'évaluation des programmes d'éducation thérapeutique autosiées en l'Ile-de-France.

Pratiques en santé
Ce site recense des études sur l'ETP.

Santé Publique France
Santé Publique France reprend les missions de l'Inpes. Il est chargé de mettre en œuvre les politiques de prévention et d'éducation pour la santé dans le cadre plus général des orientations de la politique de santé publique fixées par le gouvernement. Son site offre de nombreuses publications en texte intégral (notamment l'enquête baromètre santé) ainsi qu'une base de données permettant à la fois d'interroger une base documentaire et une base d'outils pédagogiques.

A L'ETRANGER

Cochrane EPOC
Le groupe EPOC (*Effective Practice and Organization of Care review group*), coordonné depuis 1997 par les Prs Jeremy Grimshaw (Ottawa, Canada) et Sasha Shepperd (Oxford, Royaume-Uni) recense l'ensemble des études publiées selon une méthodologie jugée valide qui évaluent une intervention destinée « à promouvoir la pratique professionnelle la plus efficace », qu'il s'agisse d'une intervention sur les professionnels de santé, d'intervention financière, d'une intervention organisationnelle ou d'une intervention sur les patients.

- Liste des reveiws sur la pratique médicale : http://epoc.cochrane.org/our-reviews
- Cochrane France

Evidence in health and social care
Ce site anglais géré par le National Institute for Health and Care Excellence (Nice) permet l'accès à des preuves cliniques et non cliniques faisant autorité et aux meilleures pratiques. Il est destiné aux employés du NHS (National Health Service) et aux professionnels de la santé publique et de l'action sociale.

HSTAT (Health Services/Technology Assessment Text)
Cette base rassemble des documents utiles à la décision médicale en texte intégral : références médicales ou guides de pratiques cliniques, brochures destinées aux consommateurs, rapports sur la médecine basée sur les preuves ou médecine factuelle (evidence based medicine), rapports sur l'évaluation des technologies, conférences de consensus,... Elle a été développée par la National Library of Medicine aux Etats-Unis (NLM) à partir de différentes sources.

National Guideline Clearinghouse
Cette base de données sur les recommandations en pratique clinique est produite par l'Agency for Health Care Policy and Research (AHCPR), en partenariat avec l'American Medical Association (AMA) et l'American Association of Health Plans (AAHP).

Royal collège du Canada
Les Associés du Collège royal des médecins et chirurgiens du Canada (Collège royal) se sont engagés à améliorer la santé des Canadiens et les soins qui leur sont prodigués. Le Collège royal s'acquitte de cette mission en partie par l'établissement de normes élevées pour la formation médicale et la pratique. Ces normes s'appuient sur le Référentiel de compétences CanMEDS pour les médecins qui contribue directement à la prestation de soins de santé de qualité. CanMEDS 2015 représente la troisième édition du référentiel et constitue sa plus importante révision à bien des égards. Le Collège royal a entrepris le processus de renouvellement de CanMEDS dans le contexte d'une autre initiative pluriannuelle connue sous le nom de La compétence par conception (CPC). La CPC est une initiative visant à mettre en oeuvre un modèle amélioré de formation médicale axé sur l'approche par compétences, de la résidence à l'exercice de la médecine spécialisée au Canada. La combinaison du projet CanMEDS 2015 et de la CPC a donné lieu à l'émergence d'un nouveau contenu dans le référentiel, de même que de nouveaux jalons pour marquer la trajectoire de développement de la compétence dans chacun des rôles CanMEDS à toutes les étapes du continuum de la formation médicale.

Santecom
Le Réseau Santécom rassemble les collections documentaires de 35 bibliothèques spécialisées dans le domaine de la santé et des services sociaux, ainsi que les publications de plus de 50 organismes et groupes de recherche québécois.