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Promoting patient uptake and adherence in cardiac rehabilitation

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ABSTRACT

Background
Cardiac rehabilitation is an important component of recovery from coronary events but uptake and adherence to such programs are below recommended levels. In 2010, our Cochrane review identified some evidence that interventions to increase uptake of cardiac rehabilitation can be effective but there was insufficient evidence to provide recommendations on intervention to increase adherence. In this review, we update the previously published Cochrane review.

Objectives
To determine the effects, both harms and benefits, of interventions to increase patient uptake of, or adherence to, cardiac rehabilitation.

Search methods
We performed an updated search in January 2013 to identify studies published after publication of the previous systematic review. We searched the Cochrane Central Register of Controlled Trials (CENTRAL) (Issue 12, 2012), MEDLINE (Ovid), EMBASE (Ovid), CINAHL EBSCO, Conference Proceedings Citation Index - Science (CPCI-S) on Web of Science (Thomson Reuters), and National Health Service (NHS) Centre for Reviews and Dissemination (CRD) databases (Health Technology Assessment (HTA) and Database of Abstracts of Reviews of Effects (DARE)) on The Cochrane Library (Issue 4, 2012). We also checked reference lists of identified systematic reviews and randomised controlled trials (RCTs) for additional studies. We applied no language restrictions.

Selection criteria
Adults with myocardial infarction, coronary artery bypass graft, percutaneous transluminal coronary angioplasty, heart failure, angina, or coronary heart disease eligible for cardiac rehabilitation and RCTs or quasi-randomized trials of interventions to increase uptake or adherence to cardiac rehabilitation or any of its component parts. We only included studies reporting a primary outcome.

Data collection and analysis
At least three authors independently screened titles and abstracts of all identified references for eligibility and obtained full papers of potentially relevant trials. At least two authors checked the selection. Three authors assessed included studies for risk of bias.
Main results

The updated search identified seven new studies (880 participants) of interventions to improve uptake of cardiac rehabilitation and one new study (260 participants) of interventions to increase adherence. When added to the previous version of this review, we included 18 studies (2505 participants), 10 studies (1338 participants) of interventions to improve uptake of cardiac rehabilitation and eight studies (1167 participants) of interventions to increase adherence. We assessed the majority of studies as having high or unclear risk of bias. Meta-analysis was not possible due to multiple sources of heterogeneity. Eight of 10 studies demonstrated increased uptake of cardiac rehabilitation. Successful interventions to improve uptake of cardiac rehabilitation included: structured nurse- or therapist-led contacts, early appointments after discharge, motivational letters, gender-specific programs, and intermediate phase programs for older patients. Three of eight studies demonstrated improvement in adherence to cardiac rehabilitation. Successful interventions included: self monitoring of activity, action planning, and tailored counselling by cardiac rehabilitation staff. Data were limited on mortality and morbidity but did not demonstrate a difference in cardiovascular events or mortality except for one study that noted an increased rate of revascularization in the intervention group. None of the studies found a difference in health-related quality of life and there was no evidence of adverse events. No studies reported on costs or healthcare utilization.

Authors’ conclusions

We found only weak evidence to suggest that interventions to increase the uptake of cardiac rehabilitation are effective. Practice recommendations for increasing adherence to cardiac rehabilitation cannot be made. Interventions targeting patient-identified barriers may increase the likelihood of success. Further high-quality research is still needed.

PLAIN LANGUAGE SUMMARY

Promoting patient uptake and adherence in cardiac rehabilitation

Background

Cardiac rehabilitation programs aid recovery from cardiac events such as heart attacks, coronary stent placement, and bypass surgery and reduce the likelihood of further illness. Cardiac rehabilitation programs vary, but usually include one or more of the following: exercise, education, and psychological counselling/support. Despite the benefits of cardiac rehabilitation, not everyone agrees to participate and, of those who do, many people do not adhere to the program recommended. This review updates a previously published Cochrane review that evaluated trials of strategies to promote the uptake of or adherence to cardiac rehabilitation.

Study characteristics

We searched a wide variety of scientific databases for randomised controlled trials (studies that allocate participants to one of two or more treatment groups in a random manner) in adults (over 18 years of age) who had a heart attack, coronary artery bypass graft (a surgical procedure that diverts blood around narrowed or clogged sections of the major arteries to improve blood flow and oxygen supply to the heart), percutaneous transluminal coronary angioplasty (a procedure that opens up blocked coronary arteries), heart failure, angina, or coronary heart disease who were eligible for cardiac rehabilitation. The search was current to January 2013.

Key results

We found 18 trials that were suitable for inclusion (10 trials of interventions to improve uptake and eight trials of interventions to improve adherence). The studies evaluated a variety of techniques to improve uptake or adherence and, in many studies, a combination of strategies was employed.

Strategies to increase uptake were generally effective and included regular nurse- or therapist-led visits, early appointments after discharge, motivational letters, gender-specific programs, and intermediate phase programs for older patients. We assessed few studies as having low risk of bias (low risk of arriving at wrong conclusions because of favoritism by the researchers). Only a small number of studies demonstrated an improvement in adherence with effective interventions including: daily self monitoring of activity, action planning, and adherence facilitation by cardiac rehabilitation staff. However, the risk of bias in these studies was high. We found no evidence that these interventions improved health-related quality of life or reduce cardiovascular events or total mortality. We found no evidence to suggest that interventions to promote uptake or adherence to cardiac rehabilitation cause harm. We found no studies providing information about costs or resource implications.

Quality of the evidence
There was only weak evidence to suggest that interventions to increase uptake of cardiac rehabilitation were effective. Practice recommendations for increasing adherence to cardiac rehabilitation cannot be made. Further high-quality research is needed, particularly in under-represented groups of people such as women, ethnic minorities, older patients, patients with heart failure, and people with co-morbidities (presence of one or more diseases or conditions other than those of primary interest).

BACKGROUND

Description of the condition
The burden of cardiovascular disease (CVD) remains substantial, and the World Health Organization (WHO) lists CVD as the number one cause of death worldwide (WHO 2011). Progress in therapeutic procedures and pharmacologic therapies has led to dramatic reductions in CVD mortality, and, as a result, a greater number of men and women survive acute CVD events. In this context, there is increasing recognition of the need to build comprehensive, multidimensional prevention strategies to prevent recurrent CVD events.

Description of the intervention
Cardiac rehabilitation is a medically sponsored program offered to individuals after cardiac events to aid recovery and prevent further cardiac illness. It includes specific core components that aim to optimize cardiovascular risk reduction, foster healthy behaviours, promote an active lifestyle, and reduce disability among patients with CVD (Balady 2007). This review evaluates interventions that promote uptake or adherence to a cardiac rehabilitation program.

How the intervention might work
Cardiac rehabilitation has been shown to promote a healthy lifestyle, improve physical health, and decrease subsequent morbidity and mortality among patients with coronary heart disease (CHD) (Heran 2011; Taylor 2004). As a result, cardiac rehabilitation is an integral part of many national guidelines for secondary prevention in cardiac patients (Balady 2007; NICE 2007; Perk 2012; Stone 2005). By promoting uptake or adherence to cardiac rehabilitation, these interventions promote the effectiveness of cardiac rehabilitation.

Why it is important to do this review
Although the beneficial effects of cardiac rehabilitation have been shown, participation and adherence remain suboptimal. Surveys across several countries have shown that only 30% of eligible patients participate in such programs (Bethell 2001; Kotseva 2009; Suaya 2007). Such underutilization can be attributed in part to low referral rates among healthcare providers (Brown 2009). However, even among individuals referred to cardiac rehabilitation, few complete a program and less than 50% maintain an exercise regimen for as long as six months after completion (Daly 2002; Moore 2003). Factors reported as predicting attendance and adherence to cardiac rehabilitation include: illness perception, distance, financial and work constraints, gender, age, social support, and depression (Yohannes 2007).

This review was originally published in 2005 (Beswick 2005) and updated using Cochrane methodology in 2010 (Davies 2010a). The review identified some evidence that interventions to increase uptake of cardiac rehabilitation can be effective but insufficient evidence to provide recommendations on interventions to increase adherence. Since publication of the review, there have been several new studies completed. In this review, we aimed to update the 2010 review and incorporate the most recent additions to the literature.
design. We identified systematic reviews and meta-analyses as a source of additional studies.

Types of participants
Adults (ages 18 years or over) with myocardial infarction (MI), coronary artery bypass graft (CABG), percutaneous transluminal coronary angioplasty (PTCA), heart failure (HF), angina, or CHD who were eligible for cardiac rehabilitation, or any of its constituent components. For studies of uptake, the study population comprised patients who were eligible for cardiac rehabilitation. For studies of increasing adherence, participants were those who had already registered to take part in a cardiac rehabilitation program at the start of the study. We excluded studies of participants with heart transplants and people implanted with either cardiac-resynchronization therapy or implantable defibrillators.

Types of interventions
Any intervention with the specific aim of increasing patient uptake of, or adherence to, cardiac rehabilitation or any of its component parts. Interventions could be targeted to: individuals, groups, partners, caregivers or other family members, or health professionals. We excluded studies evaluating the effects of interventions to improve uptake or adherence to pharmacologic treatments alone (i.e. not in conjunction with any other cardiac rehabilitation activities). We only included studies comparing two or more interventions to increase uptake or adherence if the study included a usual care control arm.

Types of outcome measures

Primary outcomes
Primary outcome measures for this review were 1. measures of the uptake of, or 2. adherence to, cardiac rehabilitation and its exercise, education, and lifestyle components. We defined adherence as the extent to which the participant’s behavior conformed with the advice given by healthcare professionals (e.g. to attend cardiac rehabilitation meetings or to undertake independent exercise). Adherence could be expressed as a dichotomous outcome (i.e. the participant did or did not concord with the advice given) or as a rate (e.g. percentage of weeks during the follow-up period in which the participant did the recommended amount of exercise). We did not consider measures such as frequency of exercise, amount of exercise taken, and measures of exercise capacity (strength, peak oxygen uptake) to be suitable measures of adherence as they do not give an indication of the extent to which participants conformed with the advice given.

Secondary outcomes
Secondary outcomes included:
- all-cause mortality;
- morbidity, modifiable coronary risk factors (smoking behavior, blood lipid levels, blood pressure);
- health-related quality of life;
- harms;
- health service utilization, costs, and any other beneficial or adverse events relevant to the review.

We included only studies that reported at least one primary outcome.

Search methods for identification of studies
A generic search strategy was initially carried out as this review forms part of a broader review that includes four other Cochrane systematic review addressing cardiac rehabilitation (Davies 2010b; Heran 2011; Taylor 2010; Whalley 2011). We then updated this generic search for the purposes of this specific review with detailed search strategies for each electronic database searched.

Electronic searches
In the previous version of the review, RCTs and quasi-randomized controlled trials were identified from a non-Cochrane review (Beswick 2005). The review searched the following databases: Cochrane Central Register of Controlled Trials (CENTRAL) (Issue 4, 2007), MEDLINE DIALOG (2001 to January 2008), EMBASE DIALOG (2001 to January 2008), CINAHL DIALOG (2001 to January 2008), and PsycINFO DIALOG (2001 to January 2008). The review had searched conference proceedings on Web of Science: ISI Proceedings (2001 to April 2008). The authors had located additional studies on National Health Service (NHS) Centre for Reviews and Dissemination (CRD) databases (Health Technology Assessment (HTA) and Database of Abstracts of Reviews of Effects (DARE)), which were both searched from 2001 to January 2008. See Appendix 1 for full details.

We repeated the search in January 2013 as part of the update process by searching the following databases: CENTRAL (Issue 12, 2012), MEDLINE (Ovid, 1946 to January week 2 2013), EMBASE (Ovid, 1980 to 2013 week 03), and CINAHL (EBSCO, 2000 to January 2013). We also searched Conference Proceedings Citation Index - Science (CPCI-S) on Web of Science (Thomson Reuters) (1990 to January 2013). We located additional studies on NHS CRD databases (HTA and DARE), which were both searched from January 2008 to January 2013 on The Cochrane Library (Issue 4, 2012). We limited searches to RCTs (including quasi-randomized), except the searches on The Cochrane Library (Lefebvre 2011). We imposed no language or other limitations. Consideration was given...
to variations in terms used and spellings of terms in different countries so that studies were not missed by the search strategy. We searched reference lists of all eligible trials and systematic reviews for additional studies. We designed search strategies with reference to those of the previous version of this review (Davies 2010a), and in accordance with Cochrane Heart Group methods and guidance. See Appendix 2 for the search strategy employed in the update.

**Data collection and analysis**

**Selection of studies**

In the previous version of this review, two authors (Philippa Davies (PD), Rod Taylor (RT)) independently screened the references identified by the search strategy by title and abstract. In order to be selected, abstracts had to identify the study design, an appropriate population, and relevant components of the intervention clearly as described above. We excluded clearly irrelevant references. We obtained the full-text reports of all remaining trials and two authors (PD, RT) independently assessed them for eligibility based on the defined inclusion criteria. Two authors (PD, Fiona Taylor (FT)) assessed studies included in the non-Cochrane review for inclusion (Beswick 2005). We resolved any disagreements by discussion or, where agreement could not be reached, by consultation with an independent third person (Shah Ebrahim (SE), RT).

For the update, three authors (Kunal N Karmali (KK), FT, Andrew Beswick (AB)) independently screened the references identified by the search strategy by title and abstract. In order to be selected, abstracts had to identify the study design clearly, an appropriate population, and relevant components of the intervention as described above. We excluded clearly irrelevant references. We obtained the full-text reports of all remaining trials and two authors (PD, KK) independently assessed them for eligibility, based on the defined inclusion criteria. We resolved any disagreements by discussion or, where agreement could not be reached, by consultation with an independent third author (FT).

**Data extraction and management**

For the previous version of this review, a data extraction form was re-designed based on that used in the non-Cochrane review (Beswick 2005). Items relating to risk of bias recommended by the Cochrane Handbook for Systematic Reviews of Interventions were added (Higgins 2011). Due to time constraints, a single author (FT) undertook data extraction and a second author (PD) checked entries. We have detailed the excluded studies and reasons for exclusion in the Characteristics of excluded studies table. For the update, we used the previously designed data extraction form. Two authors (KK and PD or FT) independently extracted relevant data regarding inclusion criteria (study design: participants, type of intervention, comparisons, and outcomes), risk of bias, and results. We have detailed the excluded studies and reasons for exclusion in the Characteristics of excluded studies table.

**Assessment of risk of bias in included studies**

In the previous version of this review, the risk of bias in eligible trials was assessed by a single author (FT) and verified by a second (PD) using The Cochrane Collaboration’s recommended tool, which is a domain-based critical evaluation of the following domains: sequence generation, allocation concealment, blinding of outcome assessment, incomplete outcome data, and selective outcome reporting (Higgins 2011). For the update, two authors (KK and PD or FT) independently assessed the risk of bias in included studies.

Because of the nature of the interventions studied, we did not consider it possible to assess the blinding of treatment assignment. Thus, in our risk of bias table we instead reported on the blinding of outcome assessors. One of the authors (KK) re-extracted the domains of incomplete outcome data and selective outcome reporting that were not explicitly delineated in the original review.

**Data synthesis**

Based on prior versions of this review (Beswick 2005; Davies 2010a), it was anticipated that a quantitative synthesis would not be possible. The multiple sources of heterogeneity observed across studies (in terms of participants, interventions, and outcomes), together with the small number of studies identified, meant that undertaking a formal meta-analysis was not appropriate. We explored heterogeneity among included studies qualitatively (by comparing the characteristics of included studies). We grouped studies according to whether the interventions were intended to increase uptake of, or adherence to, cardiac rehabilitation (or any of its components).

**RESULTS**

**Description of studies**

**Results of the search**

The updated electronic search performed in January 2013 yielded 5612 titles after removal of duplicates. After reviewing the titles and abstracts, we retrieved 28 full-text articles for possible inclusion. We excluded 20 studies, two because they were active protocols. Eight studies met the inclusion criteria and had extractable data to assess interventions that promoted the uptake and adherence to cardiac rehabilitation. The study selection process is illustrated in the flow diagram in Figure 1.
The previous version of this Cochrane review (Davies 2010a) included 10 studies (Ashe 1993; Daltroy 1985; Duncan 2002; Hillebrand 1995; Izawa 2005; Jolly 1999; Moore 2006; Oldridge 1983; Sniehotta 2006; Wyer 2001). We identified an additional eight studies in the updated search that met our inclusion criteria (Arrigo 2008; Beckie 2010; Cossette 2012; Dolansky 2011; McPaul 2007; Pack 2013; Parry 2009; Price 2012). Thus, we have included 18 studies in this update. Details of the studies included in the review are listed in the Characteristics of included studies table.
Figure 1. Flow diagram of the study selection for this update.

7079 records identified through database searching

5612 records screened for retrieval after duplicates removed

5584 records excluded on basis of title and abstract

18 full-text articles excluded, with reasons
2 full-text articles excluded because they were protocols

28 full-text articles assessed for eligibility

8 studies included in this update for qualitative synthesis

18 studies included in this update
Included studies

Studies examining uptake of cardiac rehabilitation

In the previous version of this review, we identified three RCTs that evaluated interventions to increase uptake of cardiac rehabilitation with 458 participants (Hillebrand 1995; Jolly 1999; Wyer 2001). The updated search identified seven new studies with 880 participants (Beckie 2010; Cossette 2012; Dolansky 2011; McPaul 2007; Pack 2013; Parry 2009; Price 2012). Thus, we found 10 studies of 1338 participants evaluating interventions to increase uptake of cardiac rehabilitation.

Study design

One study was cluster randomised by general practice (Jolly 1999). Nine studies were parallel-group RCTs (Beckie 2010; Cossette 2012; Dolansky 2011; Hillebrand 1995; McPaul 2007; Pack 2013; Parry 2009; Price 2012). Four studies were conducted in Canada (Beckie 2010; Cossette 2012; Parry 2009; Price 2012), three studies were conducted in the UK (Jolly 1999; McPaul 2007; Wyer 2001), two studies were conducted in the US (Dolansky 2011; Pack 2013), and one study was conducted in Germany (Hillebrand 1995).

Participants were all people who had had an MI in three studies (Hillebrand 1995; McPaul 2007; Wyer 2001). In three studies, participants were hospitalised for acute coronary syndrome (ACS) or angina (Cossette 2012; Jolly 1999; Pack 2013). Four studies examined a mixed CHD population (Beckie 2010; Dolansky 2011; Parry 2009; Price 2012).

Interventions

The studies tested a variety of strategies to increase uptake of cardiac rehabilitation. Five studies utilized a structured telephone call or visit by a nurse or therapist after hospital discharge (Cossette 2012; Hillebrand 1995; Jolly 1999; McPaul 2007; Price 2012). Cossette 2012 studied the effect of a nursing intervention focused on illness perception with a combination of telephone and face-to-face meetings during the 10 days after hospital discharge. In the study by Hillebrand 1995, participants in the intervention group received an in-hospital visit from a social worker and a telephone call at four weeks after discharge (the authors described the content of these contacts as “motivational”). Jolly 1999 evaluated a multifaceted intervention involving liaison nurses who coordinated the transfer of care between hospital and general practice, together with patient-held record cards to prompt and guide follow-up. Price 2012 studied the effects of a nurse-delivered telephone coaching program. McPaul 2007 studied the effects of home visits versus telephone follow-up by an occupational therapist on cardiac rehabilitation attendance. One study examined the use of a peer support group to increase cardiac rehabilitation attendance in patients after surgery (Parry 2009). Pack 2013 studied the effect of an early appointment (within 10 days) rather than standard care (within 35 days) on uptake of cardiac rehabilitation. Wyer 2001 evaluated the effects of motivational letters based on the theory of planned behavior (Ajzen 1986).

Two studies employed novel strategies to increase uptake of cardiac rehabilitation in previously under-represented patient subsets, women and older people (Beckie 2010; Dolansky 2011). Beckie 2010 compared the effect of a gender-tailored cardiac rehabilitation program versus traditional cardiac rehabilitation on attendance in exercise and education sessions. Dolansky 2011 studied the effect of an intermediate phase program consisting of cardiac self management instruction and exercise monitoring for older patients discharged to a skilled nursing or home healthcare facility.

Outcomes

Uptake was variously defined in these studies as enrolment in cardiac rehabilitation (Cossette 2012); attendance at a variety of time points: intake appointment (McPaul 2007; Pack 2013; Price 2012), at least one cardiac rehabilitation session (Jolly 1999; Parry 2009), the first week of cardiac rehabilitation (Wyer 2001), six weeks after discharge (Dolansky 2011), 12 months (Hillebrand 1995), or by number of sessions over a 12-week period (Beckie 2010). Two studies reported on the secondary outcomes of serum cholesterol, blood pressure, and smoking status (Cossette 2012; Jolly 1999). Health-related quality of life was also reported by Parry 2009. Three studies included data on the secondary outcomes.
of death, mortality, CHD events, or hospitalizations (Dolansky 2011; McPaul 2007; Pack 2013).

**Studies examining adherence to cardiac rehabilitation**

In the original review, seven studies evaluated eight interventions to increase adherence to cardiac rehabilitation or its component parts, with 906 participants (Ashe 1993; Daltroy 1985; Duncan 2002; Izawa 2005; Moore 2006; Oldridge 1983; Sniehotta 2006). The updated search identified one study of 261 patients (Arrigo 2008). Thus, we found eight studies involving 1167 patients.

**Study design**

Six studies were randomised (Arrigo 2008; Daltroy 1985; Duncan 2002; Izawa 2005; Moore 2006; Oldridge 1983), and two were quasi-randomized (Ashe 1993; Sniehotta 2006). All eight studies utilized a parallel group design and the unit of allocation was the individual patient. Length of follow-up ranged from two to 12 months. Four studies were conducted in the US (Ashe 1993; Daltroy 1985; Duncan 2002; Moore 2006), and one each in Japan (Izawa 2005), Canada (Oldridge 1983), Germany (Sniehotta 2006), and Switzerland (Arrigo 2008).

**Participants**

Participants were all patients who had had an MI in one study (Izawa 2005), and all patients with HF in another study (Duncan 2002). Six studies included a mix of patients with CHD including MI, CABG, PTCA, angina, and valve problems (Arrigo 2008; Ashe 1993; Daltroy 1985; Moore 2006; Oldridge 1983; Sniehotta 2006). In six studies, over 80% of participants were male (Arrigo 2008; Daltroy 1985; Duncan 2002; Izawa 2005; Oldridge 1983; Sniehotta 2006), 62% were male in one study (Moore 2006), and gender was not reported in one study (Ashe 1993). The mean age of participants in studies ranged from 51 to 66 years.

**Interventions**

In seven of the eight studies, the intervention was designed to increase adherence to exercise (Arrigo 2008; Ashe 1993; Daltroy 1985; Duncan 2002; Izawa 2005; Moore 2006; Sniehotta 2006). In three of these studies, exercise occurred in a supervised setting (Arrigo 2008; Ashe 1993; Daltroy 1985), whereas in four studies participants were given a recommended level of exercise that was carried out unsupervised (Duncan 2002; Izawa 2005; Moore 2006; Sniehotta 2006). In one study, the intervention targeted adherence to supervised cardiac rehabilitation sessions (Oldridge 1983). The intervention involved self monitoring of daily physical activities, body weight and cigarettes smoked, and a written commitment to participate. The interventions evaluated to increase adherence were varied and multifaceted. These interventions included: goal setting (Ashe 1993; Duncan 2002; Moore 2006), action planning (Sniehotta 2006), self monitoring of exercise (Duncan 2002; Izawa 2005; Moore 2006), self monitoring of daily activities (Arrigo 1998; Ashe 1993), body weight (Izawa 2005), heart rate (Izawa 2005), feedback (Duncan 2002; Izawa 2005), problem-solving and coping strategies (Ashe 1993; Daltroy 1985; Duncan 2001; Moore 2006; Sniehotta 2006), written and oral commitments (Daltroy 1985), stress management (Ashe 1993), persuasive written and telephone communication (Daltroy 1985), and small group interaction and peer modeling (Moore 2006). One study targeted the intervention at participants’ spouses in addition to the participants themselves (Daltroy 1985).

**Outcomes**

Adherence was variously defined across studies in terms of number of sessions attended, frequency of exercise, or duration of exercise. In one study, the exact method used to calculate adherence was not clear (Duncan 2002).

In addition to adherence, two studies evaluated health-related quality of life (Arrigo 2008; Duncan 2002), and one reported on CHD event rates (Arrigo 2008).

**Excluded studies**

In the original review, we excluded 18 studies with the most common reason being an inadequate measure of adherence (Aish 1996; Brodie 2005; Carroll 2007; Duncan 2001; Froelicher 2003; Hopper 1995; Hughes 2002; Hughes 2007; Kummel 2007; Luszczynska 2006; Mahler 1999; Moore 2002; Palomäki 2002; Rejeski 2002; Sniehotta 2005; Southard 2003; Stromberg 2006; Vestfold 2003).

In the update, we excluded 18 studies after full-text review (Butler 2009; Carlson 2000; Dankner 2011; Furber 2010; Higgins 2001; Jolly 2009; Leemrijse 2012; Meiliier 2012; Peterson 2012; Powell 2010; Redfern 2009; Reid 2012; Reusch 2011; Richardson 2010; Willmott 2011; Wolkanin-Bartnik 2011; Wu 2012; Zarani 2010). The most common reason for exclusion was an inadequate measure of adherence.

A list of excluded studies, together with reasons for exclusion, can be found in the Characteristics of excluded studies table.

**Ongoing studies**

We identified two RCT protocols in the updated search examining interventions to increase adherence to cardiac rehabilitation. One RCT examined the effect of a telephone-delivered lifestyle intervention on weight management and physical activity among individuals referred to cardiac rehabilitation in Australia (Sangster 2010). Another RCT examined the effect mobile health technologies to deliver personalized and automated messages to improve exercise capacity and self reported physical activity over a 24-week
period (Maddison 2011). Additional details of the studies are provided in the Characteristics of ongoing studies table.

**Risk of bias in included studies**

Limited reporting of the methodology and outcome data in the published papers precluded us, in most cases, from adequately performing a critical evaluation of the following domains: sequence generation, allocation concealment, blinding, incomplete outcome data, selective outcome reporting, and other sources of bias. Nevertheless, we attempted to assess the risk of bias for each of the 18 included studies given the available information in the published trial reports (see Figure 2; Figure 3).

**Figure 2. Methodological quality graph: review authors’ judgments about each methodological quality item presented as percentages across all included studies.**
Figure 3. Methodological quality summary: review authors’ judgments about each methodological quality item for each included study.

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<th>Study</th>
<th>Random sequence generation (selection bias)</th>
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<td>Sniehotta 2006</td>
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<tr>
<td>Wyer 2001</td>
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</tbody>
</table>
Notably, our inclusion of only studies reporting the outcomes of interest (uptake or adherence to cardiac rehabilitation) may have resulted in a biased sample.

**Allocation**

All studies were described as randomised but seven did not report the method of randomization (Arrigo 2008; Daltroy 1985; Duncan 2002; Hillebrand 1995; Izawa 2005; Jolly 1999; McPaul 2007). Two studies employed a weak method of randomization (Ashe 1993; Sniehotta 2006). The remaining nine studies reported an adequate method of randomization (Beckie 2010; Cossette 2012; Dolansky 2011; Moore 2006; Oldridge 1983; Pack 2013; Parry 2009; Price 2012; Wyer 2001). Concealment of allocation prior to entry to the study was not done in two studies (Ashe 1993; Sniehotta 2006), and was unclear in eight studies (Arrigo 2008; Daltroy 1985; Dolansky 2011; Duncan 2002; Hillebrand 1995; Izawa 2005; Jolly 1999; Oldridge 1983). Eight studies adequately described methods used to conceal allocation (Beckie 2010; Cossette 2012; McPaul 2007; Moore 2006; Pack 2013; Parry 2009; Price 2012; Wyer 2001).

**Blinding**

Due to the nature of the intervention, blinding of participants and personnel to treatment allocation was not deemed possible, so blinding of outcome assessors was evaluated instead. Blinding of outcome assessors was only adequately performed in five studies (Cossette 2012; Jolly 1999; Moore 2006; Parry 2009; Price 2012). It could not be determined in nine studies (Ashe 1993; Daltroy 1985; Dolansky 2011; Duncan 2002; Hillebrand 1995; Izawa 2005; Oldridge 1983; Sniehotta 2006; Wyer 2001), and was not satisfactory in four studies (Arrigo 2008; Beckie 2010; McPaul 2007; Pack 2013).

**Incomplete outcome data**

Dropout rates varied from 0% to 50%, but only one study had a dropout rate greater than 24% (Daltroy 1985). Reasons for loss to follow-up and drop-out were rarely reported and intention-to-treat analyses were rarely performed. Only four studies adequately addressed incomplete data (Beckie 2010; Izawa 2005; Jolly 1999; Pack 2013).

**Selective reporting**

The majority of studies reported all outcomes described in the methods section. Only three studies had high-risk of bias in selective reporting of outcomes (Arrigo 2008; Beckie 2010; Dolansky 2011). Due to time constraints, we did not contact authors for clarification of data, thus our review may be at risk of outcome reporting bias. If protocols had been published for the studies included in our review, these would have been identified by our search. Our search identified two protocols of ongoing studies (Maddison 2011; Sangster 2010). Outcome reporting bias most commonly occurs when outcomes are not reported due to no significant effect being found. Given that the interventions evaluated in our study were varied with little overlap between interventions and that most of the adherence studies were negative, we feel that publication bias is unlikely to have changed the conclusions of our review.

**Effects of interventions**

**Interventions to increase uptake of cardiac rehabilitation**

**Uptake**

Of the 10 RCTs (1338 participants) evaluating the effectiveness of interventions to increase uptake of cardiac rehabilitation, eight studies (1206 participants) reported higher rates of cardiac rehabilitation uptake in the intervention group (Beckie 2010; Cossette 2012; Dolansky 2011; Hillebrand 1995; Jolly 1999; Pack 2013; Price 2012; Wyer 2001). Two studies (120 participants) found no difference (McPaul 2007; Parry 2009). Twelve participants who were randomised to an intervention were not analysed. Attendance in the intervention groups ranged from 24% to 90%. Percentage difference in attendance between intervention and comparison groups ranged from 11% to 46%. Successful interventions were varied and included gender-tailored cardiac rehabilitation sessions (Beckie 2010), structured follow-up via either telephone call or visit by a healthcare professional, or both (Cossette 2012; Hillebrand 1995; Jolly 1999; Pack 2013; Price 2012; Wyer 2001). Intermediate phase program (Dolansky 2011), protocolized early appointments to cardiac rehabilitation (Pack 2013), and motivational letters (Wyer 2001). Most studies were assessed as unclear or high risk of bias. Only two studies that demonstrated an improvement in uptake of cardiac rehabilitation were assessed as low risk of bias (Cossette 2012; Price 2012). Results for the individual studies can be found in Table 1.

**Secondary outcomes**

Six studies (827 participants) reported data for secondary outcomes (Cossette 2012; Dolansky 2011; Jolly 1999; McPaul 2007; Pack 2013; Parry 2009). Cardiovascular risk factors such as smoking rates and body mass index (BMI) did not differ between treatment arms in two studies involving 519 participants (Cossette 2012; Price 2012).
Three studies (213 participants) reported on rehospitalization, CHD event, and mortality rates and found no difference between treatment arms (Dolansky 2011; McPaul 2007; Pack 2013). Results are summarized in Table 2, Table 3, and Table 4. One study reported on health-related quality of life and found no difference although there was a trend toward greater improvement in the role-physical domain (t[93] = -1.9; P value = 0.06) and physical component score (t[89] = -1.6; P value = -0.12) in the peer support intervention group (Parry 2009). Additional information on adverse effects were not reported. No studies examined cost-effectiveness.

Interventions to increase adherence to cardiac rehabilitation

Adherence

Eight studies (1167 participants) examined interventions to increase adherence to cardiac rehabilitation or any of its components. Three studies (486 participants) demonstrated significant improvements in adherence to cardiac rehabilitation or any of its components (Arrigo 2008; Duncan 2002; Sniehotta 2006). Five studies (630 participants) showed no difference in adherence to cardiac rehabilitation (Ashe 1993; Daltroy 1985; Izawa 2005; Moore 2006; Oldridge 1983). Fifty-one participants of the 1167 participants who were initially randomised in the eight trials were not analysed. Results for the individual studies can be found in Table 5.

Of the studies that found improvements in adherence to cardiac rehabilitation, one study evaluated adherence in the setting of a supervised exercise session (Arrigo 2008). Two studies examined interventions to increase adherence to unsupervised exercise (Duncan 2002; Sniehotta 2006). Arrigo 2008 utilized a diary monitoring physical activity on a daily basis as well as quarterly physician-supervised exercise sessions to demonstrate an improvement in regular physical activity at one year (227 participants, 70% with diary monitoring versus 37% with usual care, P value < 0.0001). Duncan 2002 evaluated a multifaceted intervention incorporating goal setting, feedback, and problem solving in patients with HF. No significant difference was observed at 12 weeks in adherence to the recommended duration of exercise, but adherence to the recommended frequency of exercise was significantly higher in the intervention group (16 participants, 104% in the intervention group versus 64% in the control group, P value < 0.01). Sniehotta 2006 evaluated two interventions to increase adherence. Participants in the action-planning group were asked to develop three action plans each about when, where, and how they intended to exercise and implement extra everyday activities after discharge. Participants in the combined group were asked to develop three coping plans to overcome anticipated barriers (identified by participants themselves), in addition to the action plans. Although there was no difference in adherence between the 'Action-planning' and control participants (149 participants, 44% adherence in the action-planning group versus 42% adherence in the control group, not statistically significant), those in the 'Combined-planning' group were significantly more adherent than both the 'Action-planning' (130 participants, 71% adherence in the combined-planning group versus 44% adherence in the action-planning group, P value < 0.01) and control groups (143 participants, 71% adherence in the combined-planning group versus 42% adherence in the control group, P value < 0.001). However, all three studies had high risk of bias with differential drop-out in the intervention group for one study (Arrigo 2008), and inadequate randomization and concealment of allocation for two studies (Duncan 2002; Sniehotta 2006). Notably, the findings of Duncan 2002 can be contrasted with those of Moore 2006, a study with lower risk of bias that evaluated a similar intervention but found no strong evidence of effect on adherence (measured at 12 months).

Secondary outcomes

Two studies reported data for secondary outcomes considered by this review (Arrigo 2008; Duncan 2002). Both studies reported on measures of health-related quality of life. In Duncan 2002, health-related quality of life was improved in the intervention group but the evidence was weak. The sample size was small (16 participants) and the study may, therefore, not have been adequately powered. In Arrigo 2008, health-related quality of life scores improved in both groups but there was no significance different between intervention and control. Arrigo 2008 also demonstrated an improvement at one year in the intervention arm for low-density lipoprotein-cholesterol (0.25 mmol/L reduction versus 0.03 mmol/L reduction, P value < 0.05) and BMI (0.1 kg/m² increase versus 0.3 kg/m² increase, p < 0.05). In addition, Arrigo 2008 demonstrated an increase in CHD event rates in the intervention arm but this was attributed to an increase in revascularization (see Table 3). Additional information on adverse effects was not reported. None of the studies identified reported mortality, health service utilization, or costs.

Discussion

Cardiac rehabilitation is an important component of improving from coronary events and reduces the risk of future cardiac events. Despite this, both uptake of cardiac rehabilitation and adherence to such programs are below the recommended levels, especially in certain groups. The aim of this systematic review was to update a previously published Cochrane review (Davies 2010a), and to determine the effects of interventions to increase patient uptake of, or adherence to, cardiac rehabilitation.
Summary of main results

Uptake of cardiac rehabilitation

We identified 10 RCTs (1338 participants) of interventions to improve uptake of cardiac rehabilitation, of which eight demonstrated improvement in the uptake of cardiac rehabilitation (Beckie 2010; Cossette 2012; Dolansky 2011; Hillebrand 1995; Jolly 1999; Pack 2013; Price 2012; Wyer 2001). Successful interventions included structured telephone or home visits by a nurse or therapist after hospital discharge (Cossette 2012; Hillebrand 1995; Jolly 1999; Price 2012), early appointments to cardiac rehabilitation (Pack 2013), and motivational letters (Wyer 2001). Two studies examined novel interventions to improve uptake of cardiac rehabilitation in women and older people, two previously under-represented patient groups (Beckie 2010; Dolansky 2011). Studies did not find a difference in cardiovascular risk factor levels (Cossette 2012; Jolly 1999); event rates such as rehospitalization, CHD events, or mortality (Dolansky 2011; McPaul 2007; Pack 2013); or health-related quality of life (Parry 2009).

Adherence of cardiac rehabilitation

We identified eight RCTs (1167 participants). One RCT examined adherence to a comprehensive cardiac rehabilitation program (Oldridge 1983), and seven RCTs examined exercise only, either supervised (Arrigo 2008; Ashe 1993; Daltroy 1985), or unsupervised (Duncan 2002; Izawa 2005; Moore 2006; Sniehotta 2006). A wide variety of techniques, and combinations of techniques, were evaluated including goal setting, action planning, self monitoring (of exercise, daily activities, body weight, heart rate, smoking, and contact with healthcare professionals), feedback, problem-solving and coping strategies, written and oral commitment, stress management, persuasive written and telephone communication, and small group interaction and peer modeling. Three studies reported improvement on adherence using activity monitoring with daily diary entries, goal setting, and action planning (Arrigo 2008; Duncan 2002; Sniehotta 2006), but adherence to exercise was self reported and follow-up length was limited. We assessed none of the studies as having low risk of bias.

Overall completeness and applicability of evidence

Six of the 10 studies promoting uptake of cardiac rehabilitation recruited people with MI or ACS (Cossette 2012; Hillebrand 1995; Jolly 1999; McPaul 2007; Pack 2013; Wyer 2001). Four studies recruited a mixed CHD population (Beckie 2010; Dolansky 2011; Parry 2009; Price 2012). Six of the eight studies of adherence to cardiac rehabilitation recruited mixed CHD populations including MI, CABG, PTCA, angina, and valve problems (Arrigo 2008; Ashe 1993; Daltroy 1985; Moore 2006; Oldridge 1983; Sniehotta 2006). Only one study identified by the review included people with HF and the sample size was small (13 participants; Duncan 2002). Exercise training is an emerging therapy for people with HF and has been shown to be beneficial in people with mild-to-moderate HF (Davies 2010b), yet such patients may avoid exercise through fear of placing excessive strain on the heart. The identification of effective techniques to increase adherence to exercise recommendations in people with HF may, therefore, be particularly valuable. The majority of participants in the studies included in this review were male. However, two studies identified in the updated search had interventions specifically targeted to women (Beckie 2010; Price 2012). Other groups frequently under-represented in cardiac rehabilitation include older participants, ethnic minorities, and people with co-morbidities (Beswick 2004). Although the majority of participants in the review were middle-aged (age 40 to 60 years), Dolansky 2011 examined the effect of an intermediary stage in cardiac rehabilitation in an older population (ages 65 years or older). Ethnicity was rarely reported within the included studies.

In the majority of the included studies, the intervention was targeted at recruited participants while one study also targeted the intervention at participants’ spouses (Daltroy 1985). Despite the fact that physician endorsement has been found to be a strong predictor of uptake (Jackson 2005), only one study was identified that targeted health professionals as well as patients (Jolly 1999). A range of different techniques to increase uptake or adherence has been evaluated in the studies identified. Interventions were usually multifaceted and many different combinations of techniques were studied. Very few studies evaluated a single intervention strategy. The literature review by Beswick identified a broad range of suggested interventions for increasing uptake and adherence in cardiac rehabilitation, most of which have not been formally evaluated (Beswick 2004).

Interventions rarely targeted barriers to uptake and adherence frequently cited by patients, such as transport difficulties, family commitments, and inconvenient timing (Beswick 2004). Only one study identified in the update targeted participants’ illness perceptions (Cossette 2012).

We used strict definitions of uptake and adherence for the purpose of this review, and only included studies that reported these primary outcomes. Few studies reported secondary outcomes considered in this review. Three studies reported the effects of the intervention on cardiovascular risk factors (serum cholesterol, blood pressure, smoking status) (Arrigo 2008; Cossette 2012; Jolly 1999). Three studies reported on cardiovascular event rates (Arrigo 2008; Dolansky 2011; Pack 2013), with one reporting an increase in cardiovascular events among people randomised to intervention due to an increased rate of revascularization (Arrigo 2008). Three studies included mortality information and found no difference (Dolansky 2011; McPaul 2007; Pack 2013).
reported on measures of health-related quality of life and found no difference (Arrigo 2008; Duncan 2002; Parry 2009). No studies provided information on the costs of the intervention or other resource implications. Lastly, despite the wide definition of cardiac rehabilitation, the studies overwhelmingly studied exercise programs. Therefore, we have little evidence to support these interventions in increasing uptake or adherence in more diverse cardiac rehabilitation programs.

Quality of the evidence
As with the previously published version of this Cochrane review (Davies 2010a), this update reveals limitations in the available RCT evidence examining interventions to promote uptake to, and adherence of, cardiac rehabilitation. Several studies did not provide enough detail to assess their potential risk of bias (Figure 2; Figure 3). Details of allocation concealment and blinding of outcomes assessment were rarely described. Incomplete outcome data (primarily due to losses to follow-up or drop-outs) were insufficiently addressed in most trials and intention-to-treat analyses were rarely reported or performed. Nine studies provided adequate description of the randomization process (Beckie 2010; Cossette 2012; Dolansky 2011; Moore 2006; Oldridge 1983; Pack 2013; Parry 2009; Price 2012; Wyer 2001). Eight studies provided adequate description of allocation concealment (Beckie 2010; Cossette 2012; McPaul 2007; Moore 2006; Pack 2013; Parry 2009; Price 2012; Wyer 2001). The interventions evaluated were varied and often multifaceted limiting the ability to determine consistency of findings. Both uptake and adherence were defined differently from study to study and time-horizons also varied. All eight studies examining interventions to increase adherence to physical activity relied upon self reported exercise levels and these measures may have been affected by social desirability or poor recall (Arrigo 2008; Ashe 1993; Daltroy 1985; Duncan 2002; Izawa 2005; Moore 2006; Oldridge 1983; Sniehotta 2006). Use of pedometers and heart monitors to validate self reported exercise behavior in such trials would have been desirable. The small body of evidence and the multifaceted nature of many of the interventions evaluated means that the consistency of findings could not be determined. Although the quality of reporting tends to be poorer for older studies and improved among studies included from the updated search, it does not appear to have appreciably improved.

Potential biases in the review process
This Cochrane review focused on the uptake or adherence of cardiac rehabilitation. We applied strict inclusion and exclusion criteria for study selection so our review may be biased toward studies that found positive effects. Other outcome measures, such as frequency of exercise, amount of exercise taken, measures of exercise capacity (strength, peak oxygen uptake), cardiac functional status, and potential mediating variables of adherence (e.g. self efficacy, health beliefs) were not considered. It may be the case that some of the interventions evaluated were effective in targeting these outcomes even if the effects on adherence were not significant. Due to the nature of the interventions, blinding of participants and personnel to treatment allocation was not felt to be possible. Instead, we evaluated blinding of outcome assessors. Nevertheless, the potential for lack of blinding of participants and personnel may introduce a potential source of bias in all these studies.

Due to time constraints, we did not contact authors of studies for further information. The primary reason for exclusion of full papers assessed was the lack of a suitable measure of adherence. It may be that adherence rates (or sufficient data to calculate adherence) could have been obtained from study authors had they been contacted, resulting in a greater number of trials of interventions to increase uptake and adherence being included.

A U T H O R S ’ C O N C L U S I O N S

Implications for practice
This update reveals multiple interventions that can increase uptake of cardiac rehabilitation, such as motivational communications by nurse liaisons, therapists, or peers; early appointments after discharge; gender-tailored cardiac rehabilitation; or intermediary rehabilitation programs for older people. There is some evidence that increasing self monitoring of physical activity and action planning can lead to greater adherence to cardiac rehabilitation but these studies were assessed as having high or unclear risk of bias, so there continues to be few practice recommendations that can be made. Coping strategies targeting barriers to adherence may be helpful in improving adherence. Barriers to uptake and adherence in cardiac rehabilitation are many and varied and reasons for non-participation may vary between individuals. Individually tailored approaches may increase the likelihood of success.

Implications for research
As there is a good rationale for increasing uptake and adherence to cardiac rehabilitation, further high-quality research is needed, particularly in under-represented groups such as women, ethnic minorities, older people, people with HF, and people with comorbidities. Interventions should be developed with barriers to uptake and adherence in mind. The evaluation of single strategies will make it easier to identify the ‘active ingredients’ of interventions. The effects of interventions on clinical outcomes such as cardiovascular risk factors (smoking, blood lipid levels, blood pressure), health behaviours, and health-related quality of life should be assessed. Moreover, the beneficial and adverse effects of these interventions should be studied within the context of the costs and resources that they require.
ACKNOWLEDGEMENTS

We would like to thank Rod Taylor for his help and support in the design of the original non-Cochrane review and the selection of studies for inclusion. Margaret Burke is acknowledged for her contribution to the design of the search strategy of the original review. We would also like to thank Karen Rees and Frances Wise, authors of the previous Cochrane review.

REFERENCES

References to studies included in this review

Arrigo 2008 [published data only]

Ashe 1993 [published data only]
Ashe ED. The Effects of a Relapse Prevention Program on Adherence to a Phase II Cardiac Exercise Program [PhD thesis]. Florida: Florida State University, 1993.

Beckie 2010 [published data only]

Cossette 2012 [published data only]

Daltroy 1985 [published data only]

Dolansky 2011 [published data only]

Duncan 2002 [published data only]

Hillebrand 1995 [published data only]

Izawa 2005 [published data only]

Jolly 1999 [published data only]


McPaul 2007 [published data only]

Moore 2006 [published data only]

Oldridge 1983 [published data only]

Pack 2013 [published data only]
References to studies excluded from this review

Aish 1996 (published data only)

Brodie 2005 (published data only)

Butler 2009 (published data only)

Carlson 2000 (published data only)

Carroll 2007 (published data only)

Dankner 2011 (published data only)

Duncan 2001 (published data only)

Froelicher 2003 (published data only)

Furber 2010 (published data only)

Hopper 1995 (published data only)

Hughes 2002 (published data only)

Hughes 2007 (published data only)

Jolly 2009 (published data only)

Kolt 2009 (published data only)
Kummel 2007 *(published data only)*

Leemrijse 2012 *(published data only)*

Luszczynska 2006 *(published data only)*

Mahler 1999 *(published data only)*

Meillier 2012 *(published data only)*

Moore 2002 *(published data only)*

Palomäki 2002 *(published data only)*

Peterson 2012 *(published data only)*

Powell 2010 *(published data only)*

Redfern 2009 *(published data only)*

Reid 2012 *(published data only)*

Rejeski 2002 *(published data only)*

Reusch 2011 *(published data only)*

Richardson 2010 *(published data only)*

Sniehotta 2005 *(published data only)*

Southard 2003 *(published data only)*

Stromberg 2006 *(published data only)*

Vestfold 2003 *(published data only)*

Willmott 2011 *(published data only)*

Wolkamin-Bartnik 2011 *(published data only)*

**Wu 2012** *(published data only)*  

**Zarani 2010** *(published data only)*  

**References to ongoing studies**

**Maddison 2011** *(published data only)*  

**Sangster 2010** *(published data only)*  

**Additional references**

**Ajzen 1986**  

**Balady 2007**  

**Beckie 2008**  

**Bethell 2001**  

**Brown 2009**  

**Daly 2002**  

**Davies 2010b**  

**Heran 2011**  

**Higgins 2011**  

**Jackson 2005**  

**Kotseva 2009**  

**Lefebvre 2011**  

**Marlatt 1980**  

**Moore 2003**  
Moore SM, Dolansky MA, Rudland CM, Pashkow FJ, Blackburn GG. Predictors of women’s exercise maintenance

**NICE 2007**


**Perk 2012**


**Stone 2005**


**Suaya 2007**


**Taylor 2004**


**Taylor 2010**


**Whalley 2011**


**WHO 2011**


**Yohannes 2007**


**References to other published versions of this review**

**Beswick 2004**


**Beswick 2005**


**Davies 2010a**


* Indicates the major publication for the study
### Characteristics of included studies [ordered by study ID]

**Arrigo 2008**

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Details</th>
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<tbody>
<tr>
<td><strong>Methods</strong></td>
<td>Parallel group RCT.</td>
</tr>
<tr>
<td><strong>Participants</strong></td>
<td>261 patients recruited from an inpatient or outpatient cardiac rehabilitation program (129 intervention, 132 control). 227 (105 intervention, 133 control) analysed. 91% with CAD, 42% with previous cardiac surgery, 58% with prior angioplasty. Mean age 61 ± 10 years, 85% male</td>
</tr>
</tbody>
</table>
| **Interventions** | INTERVENTION: participants were instructed on how to use a diary sheet where physical activities were described and quantitated in minutes. They were also invited to take part in quarterly physician-supervised group exercise sessions where diary sheets were collected and questions discussed.
COMPARISON: participants were asked to return after 1 year for re-evaluation without further instructions |
| **Outcomes** | Primary outcome: regular physical activity defined as “being active to noticeably increase pulse rate and breathing ≥ 30 minutes.”
Secondary outcomes: nonfatal cardiac events, exercise capacity, BMI, cholesterol, medication use, quality of life |
| **Notes** | Authors did not report on use of diary or attendance at quarterly group meetings. There was differential drop-out with 23 participants from the intervention arm withdrawing consent and not available for 1-year follow-up compared with 8 participants from the control arm. Participants in the intervention arm had increased rate of nonfatal cardiac events but this was driven by increased rate of revascularization procedures |

### Risk of bias

<table>
<thead>
<tr>
<th>Bias</th>
<th>Authors’ judgement</th>
<th>Support for judgement</th>
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<tbody>
<tr>
<td>Random sequence generation (selection bias)</td>
<td>Unclear risk</td>
<td>Randomized allocation reported but the means by which randomization was performed was not</td>
</tr>
<tr>
<td>Allocation concealment (selection bias)</td>
<td>Unclear risk</td>
<td>Not reported.</td>
</tr>
<tr>
<td>Blind outcome assessment All outcomes</td>
<td>High risk</td>
<td>Not blinded.</td>
</tr>
<tr>
<td>Incomplete outcome data (attrition bias) All outcomes</td>
<td>High risk</td>
<td>31 randomised patients (23 intervention, 8 control) withdrew and were not available for re-evaluation after 1 year. Outcomes only reported on 216 patients. Dropout rate 17%. ITT not performed</td>
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Arrigo 2008  (Continued)

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<th>Bias</th>
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<th>Support for judgement</th>
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<tbody>
<tr>
<td>Selective reporting (reporting bias)</td>
<td>High risk</td>
<td>Did not report on outcomes of diary use or attendance at quarterly meetings</td>
</tr>
<tr>
<td>Other bias</td>
<td>Unclear risk</td>
<td>Groups comparable at baseline including all major prognostic factors. However, primary outcome of physical activity was measured by self report. The intervention arm had additional physician-supervised meetings every 3 months</td>
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</table>

Ashe 1993

<table>
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<tr>
<th>Methods</th>
<th>Parallel group RCT (see notes).</th>
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<tbody>
<tr>
<td>Participants</td>
<td>41 participants recruited from a phase 2 cardiac rehabilitation program. Mixed sample including cardiac patients with MI, CABG, angina, and valve problems. Mean age 62 (range 33-77) years, gender not reported, 95% white</td>
</tr>
</tbody>
</table>
| Interventions                             | INTERVENTION: motivational relapse prevention intervention received during the course of the cardiac rehabilitation program, which consisted of 3 exercise sessions per week of 30-40 minutes’ duration for 2-3 months. The intervention was started after 4 or 5 exercise sessions. The intervention was based on Marlatt and Gordon’s model (Marlatt 1980). Patients received individual sessions, 1 a week for 3 weeks  
Session 1: using pretest information, factors found to interfere with adherence were introduced. Patients discussed their perceptions on the value of exercise, listed their goals for the program and anticipated outcomes  
Session 2: patients were introduced to decision-making concepts and cognitive interference factors. Discussion with regard to coping with ‘slips’ and introduction to appropriate ways to reframe perspectives. Patients filled in daily activity sheets  
Session 3: focused on the importance of lifestyle balance. Patients were asked to refer to daily activity sheets to introduce concepts of shoulds and wants. Stressors were identified that may affect lifestyle balance and discussed, as was the importance of positive thinking and use of medication. Patients also took part in a stress management exercise and relaxation procedure  
COMPARISON: during the course of the exercise program patients received a ‘benign’ education intervention, which covered basic exercise concepts, guidelines for proper exercise participation, exercise tips and handouts, and the benefits of exercise |
| Outcomes                                  | Primary outcome: total adherence to the maximum number of exercise sessions |
| Notes                                     | Weak randomization - allocation to groups by presenting patients with a packet containing a form coded A or B |

Risk of bias

<table>
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<tr>
<th>Bias</th>
<th>Authors’ judgement</th>
<th>Support for judgement</th>
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<tbody>
<tr>
<td>Random sequence generation (selection bias)</td>
<td>High risk</td>
<td>Allocation to groups by presenting patients with a packet containing a form coded A or B</td>
</tr>
</tbody>
</table>
Beckie 2010

Methods
Parallel group RCT

Participants
252 women aged > 21 years old referred to an outpatient cardiac rehabilitation program in the US (141 randomised to a gender-tailored cardiac rehabilitation program, 111 to a traditional program). Mixed CHD population but exact case-mix not defined. Prior publication referred to: 52.7% PCI, 30.8% CABG, 12.1% stable angina, 4.4% MI (Beckie 2008). Mean age 63 (range 31-87) years. 0% male. 82% Caucasian.

Interventions
INTERVENTION: participants were randomised to a gender-tailored cardiac rehabilitation program where participants exercised exclusively with women. The intervention was guided by the TTM of behavioral change and delivered with motivational interviewing counselling style by research nurses and exercise physiologists. The TTM expert prepared an individualized report tailored on TTM constructs to facilitate feedback. Psychologists and nurse specialists provided 1-hr individualized motivational interviewing sessions at weeks 1 and 6 to participants. Psychoeducational classes were held weekly prior to exercise sessions.

COMPARISON: traditional cardiac rehabilitation program following the case management model that was delivered by female nurses and exercise physiologists. The exercise protocol consisted of aerobic and resistance training 3 days/week for 12 weeks. Cardiac rehabilitation personnel provided education classes focusing on CHD risk factor modification at 5 different times weekly.

Outcomes
Primary outcomes: exercise attendance and education attendance
Secondary outcomes: psychosocial predictors of cardiac rehabilitation attendance (perceived health status, quality of life, depression, social support, hope, and optimism), BMI, smoking status, metabolic equivalents on modified Bruce protocol

Notes
The gender-tailored rehabilitation session was a single class time when the traditional rehabilitation facility was closed. The study also studied baseline sociodemographic and clinical predictors of attendance of the exercise and education components of cardiac rehabilitation.
### Risk of bias

<table>
<thead>
<tr>
<th>Bias</th>
<th>Authors’ judgement</th>
<th>Support for judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Random sequence generation (selection bias)</td>
<td>Low risk</td>
<td>Biased coin randomization.</td>
</tr>
<tr>
<td>Allocation concealment (selection bias)</td>
<td>Low risk</td>
<td>Statistician provided treatment assignment sheets that were placed in opaque envelopes, sealed, and delivered to the project director</td>
</tr>
<tr>
<td>Blind outcome assessment</td>
<td>High risk</td>
<td>Cardiac rehabilitation staff not blinded and project director aware of randomization. Only 1 class available for gender-tailored cardiac rehabilitation</td>
</tr>
<tr>
<td>Incomplete outcome data (attrition bias)</td>
<td>Low risk</td>
<td>No drop-outs.</td>
</tr>
<tr>
<td>Selective reporting (reporting bias)</td>
<td>High risk</td>
<td>Primary outcome (attendance) reported but secondary outcomes were not</td>
</tr>
<tr>
<td>Other bias</td>
<td>Low risk</td>
<td>Groups were comparable at baseline including all major prognostic factors. Validated tools used for measurement of psychosocial variables in secondary outcomes</td>
</tr>
</tbody>
</table>

### Cossette 2012

<table>
<thead>
<tr>
<th>Methods</th>
<th>Parallel group RCT.</th>
</tr>
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<tbody>
<tr>
<td>Participants</td>
<td>242 adults hospitalised for suspected acute coronary syndrome at the coronary care unit or medical ward of a specialized cardiac hospital in Montreal (121 randomised to nursing intervention, 121 randomised to control). 59% hospitalised for MI and 41% with unstable angina. Mean age 59 years. 86% male</td>
</tr>
<tr>
<td>Interventions</td>
<td>INTERVENTION: 3 encounters over the 10 days after discharge. The first encounter was face-to-face and occurred before discharge, addressing the patient’s symptoms and physical activity after discharge, their understanding of the illness, and their concerns and worries. The second encounter occurred 3 days post-discharge via telephone call and focused on the patient’s clinical condition, including ability to manage the disease. The third encounter occurred 10 days post-discharge via telephone call or hospital meeting with the focus of addressing risk factors and lifestyle modification including rehabilitation enrolment. COMPARISON: patients were referred to the rehabilitation centre affiliated with academic hospital and encouraged to call the rehabilitation centre themselves to schedule an appointment All study participants received telephone calls from staff to enrol in cardiac rehabilitation and those who accepted were scheduled for a first appointment within 6 weeks of discharge</td>
</tr>
</tbody>
</table>
### Outcomes

<table>
<thead>
<tr>
<th>Primary outcome: enrolment in cardiac rehabilitation program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secondary outcomes: illness perception, family support, anxiety level, medication adherence, and cardiac risk factor levels</td>
</tr>
</tbody>
</table>

### Notes

Study only included patients hospitalised for acute coronary syndrome. Rehabilitation centre was free of charge. Enrollment at surrounding rehabilitation facilities was not ascertained.

### Risk of bias

<table>
<thead>
<tr>
<th>Bias</th>
<th>Authors’ judgement</th>
<th>Support for judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Random sequence generation (selection bias)</td>
<td>Low risk</td>
<td>Randomization carried out in advance by a statistician at the coordinating centre</td>
</tr>
<tr>
<td>Allocation concealment (selection bias)</td>
<td>Low risk</td>
<td>Study nurses provided with sealed opaque envelopes that they opened after each patient had completed the baseline questionnaire</td>
</tr>
<tr>
<td>Blind outcome assessment</td>
<td>Low risk</td>
<td>Enrollment in cardiac rehabilitation assessed by database as well as independent data entry performed by the coordinating centre</td>
</tr>
<tr>
<td>Incomplete outcome data (attrition bias)</td>
<td>Unclear risk</td>
<td>5 lost to follow-up in intervention arm, 17 in control arm. ITT calculations not provided</td>
</tr>
<tr>
<td>Selective reporting (reporting bias)</td>
<td>Low risk</td>
<td>All relevant outcomes described in methods were reported.</td>
</tr>
<tr>
<td>Other bias</td>
<td>High risk</td>
<td>Control group had higher rates of men, obesity, and physical inactivity. The intervention arm had more people with hypertension</td>
</tr>
</tbody>
</table>

### Daltroy 1985

<table>
<thead>
<tr>
<th>Methods</th>
<th>Parallel group RCT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants</td>
<td>174 patients randomised. Mixed CHD patients, 81% MI, 63% with a history of angina, 17% post-CABG. Mean age 53.8 years, 88% men, 95% white</td>
</tr>
<tr>
<td>Interventions</td>
<td>INTERVENTION: oral persuasive communication and education intervention to improve patient adherence to exercise regimens. Intervention developed from interviews with previous patients and their spouses to elicit the most common beliefs of benefits and drawbacks to the exercise program. Patients received an oral persuasive communication on the telephone in scripted counselling format to: convince them of the benefits of regular exercise, warn them of likely drawbacks so that expectations would be realistic, acquaint them with methods used by other patients to cope with drawbacks, and elicit an oral commitment to attend at least 2 classes per week for the first 6 weeks. In addition, patients received a mailed written persuasive communication to reinforce these</td>
</tr>
</tbody>
</table>
points. Spouses also received telephone counselling to encourage the patient to attend and discuss methods that other patients’ spouses found useful. A written communication to reinforce these points was also sent to the spouse to increase the spouses’ support. Patients also received a pamphlet with information on benefits and drawbacks of exercise. All communication was tailored to individual patients based on data collected by questionnaire at baseline.

COMPARISON: patients and spouses received the same pamphlet with information on the benefits and drawbacks of exercise as the intervention group. This was done so all patients would have the same inducement to enter the program. It was thought unlikely that this single intervention would produce lasting behavioral change.

Outcomes

Attendance at exercise sessions over 3 months.

Notes

Subgroup analysis revealed that among the intervention group, attendance was greater among better-educated patients. Spouse participation, age, gender, and occupation were not associated with attendance, although the numbers in these subgroups were likely to be too small to draw firm conclusions.

Risk of bias

<table>
<thead>
<tr>
<th>Bias</th>
<th>Authors’ judgement</th>
<th>Support for judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Random sequence generation (selection bias)</td>
<td>Unclear risk</td>
<td>Not reported.</td>
</tr>
<tr>
<td>Allocation concealment (selection bias)</td>
<td>Unclear risk</td>
<td>Not reported.</td>
</tr>
<tr>
<td>Blind outcome assessment</td>
<td>Unclear risk</td>
<td>Not reported.</td>
</tr>
<tr>
<td>Incomplete outcome data (attrition bias)</td>
<td>High risk</td>
<td>Half of patients stopped at 12 weeks.</td>
</tr>
<tr>
<td>Selective reporting (reporting bias)</td>
<td>Low risk</td>
<td>All relevant outcomes described in methods were reported.</td>
</tr>
<tr>
<td>Other bias</td>
<td>Unclear risk</td>
<td>Cardiac rehabilitation nurse not aware of group assigned to; however, no procedure in place to stop patients telling nurse which letter they had received</td>
</tr>
</tbody>
</table>

Dolansky 2011

Methods

Parallel group RCT

Participants

40 adults ages 65 years or older admitted to a skilled nursing or home healthcare facility following hospitalization for a cardiac event. 38 participants analysed. 55.3% patients with CABG, 23.7% with MI. Mean age 77.1 (SD 6.8) years. 34.2% men. 68.4% Caucasian, 26.3% African American.
**Dolansky 2011 (Continued)**

<table>
<thead>
<tr>
<th>Interventions</th>
<th>INTERVENTION: the Cardiac TRUST program, which consisted of cardiac self-management instruction and exercise monitoring during the postacute care period. The education component consisted of 2 x 30-minute family sessions with a registered nurse to identify values/goals, problem-solving skills, decision-making, and healthcare partnerships. The action component consisted of monitoring the cardiac response to physical therapy. The distance walked was individually tailored and progressively increased each day. Participants were taught to rate their exertion and keep an exercise log. Family members were encouraged to participate in walking sessions. COMPARISON: all participants received usual postacute care services that included daily sessions of physical and occupational therapy as well as discharge instructions on physical activity level, medications, and follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcomes</td>
<td>Primary outcome: outpatient cardiac rehabilitation attendance at 6 weeks' post-discharge Other outcomes: exercise self efficacy, number of steps by pedometer, number of cardiac events</td>
</tr>
<tr>
<td>Notes</td>
<td>Each participants was given USD20 for participation in the study. 9 patients with missing data were excluded from analysis. 68% of participants randomised to intervention did not complete their exercise log</td>
</tr>
</tbody>
</table>

**Risk of bias**

<table>
<thead>
<tr>
<th>Bias</th>
<th>Authors’ judgement</th>
<th>Support for judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Random sequence generation (selection bias)</td>
<td>Low risk</td>
<td>Random numbers table.</td>
</tr>
<tr>
<td>Allocation concealment (selection bias)</td>
<td>Unclear risk</td>
<td>Not reported.</td>
</tr>
<tr>
<td>Blind outcome assessment All outcomes</td>
<td>Unclear risk</td>
<td>Not reported.</td>
</tr>
<tr>
<td>Incomplete outcome data (attrition bias) All outcomes</td>
<td>High risk</td>
<td>5% dropout rate but 24% with missing data and excluded from analysis. ITT analysis not performed</td>
</tr>
<tr>
<td>Selective reporting (reporting bias)</td>
<td>High risk</td>
<td>Satisfaction reported for intervention arm but not control arm</td>
</tr>
<tr>
<td>Other bias</td>
<td>Unclear risk</td>
<td>Groups were comparable across major prognostic factors but more participants in the usual care arm were caregivers, lived with others, and were African Americans</td>
</tr>
</tbody>
</table>
**Duncan 2002**

<table>
<thead>
<tr>
<th>Methods</th>
<th>Parallel group RCT.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants</td>
<td>Patients with heart failure who had completed a supervised exercise program. 16 randomised, results available for 13 (adherence) and 14 (quality of life). Mean age 66 years. 84% male. Duncan 2003 reports 16 patients</td>
</tr>
<tr>
<td>Interventions</td>
<td>INTERVENTION: advice from cardiac rehabilitation staff on home exercise specific to patient’s requirements for 12 weeks. Adherence facilitation (adapted from social learning theory) consisting of goal setting and review of goal setting regarding exercise, graphic feedback, and problem-solving guidance delivered by a research nurse at 3-week intervals. Positive reinforcement provided if goals were not met with follow-up telephone calls. Diaries collecting data on adherence were collected with mailed feedback on progress every 3 weeks. COMPARISON: advice from cardiac rehabilitation staff on home exercise specific to patient’s requirements for 12 weeks. Diaries collecting data on adherence was collected at 12 weeks</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Adherence to exercise regimen at 12 weeks. Quality of life (Minnesota Living with Heart Failure questionnaire)</td>
</tr>
</tbody>
</table>

**Risk of bias**

<table>
<thead>
<tr>
<th>Bias</th>
<th>Authors’ judgement</th>
<th>Support for judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Random sequence generation (selection bias)</td>
<td>Unclear risk</td>
<td>Not reported but participants needed permission from an attending cardiologist to participate</td>
</tr>
<tr>
<td>Allocation concealment (selection bias)</td>
<td>Unclear risk</td>
<td>Not reported.</td>
</tr>
<tr>
<td>Blind outcome assessment All outcomes</td>
<td>Unclear risk</td>
<td>Not reported.</td>
</tr>
<tr>
<td>Incomplete outcome data (attrition bias) All outcomes</td>
<td>Unclear risk</td>
<td>Duncan 2003 reports that 16 patients were randomised, whereas Duncan 2002 reports 13 were randomised. 2 patients died and 2 patients dropped out of the control group. Adherence results reported for 11 participants therefore 1 being unaccounted for</td>
</tr>
<tr>
<td>Selective reporting (reporting bias)</td>
<td>Low risk</td>
<td>All relevant outcomes described in methods were reported.</td>
</tr>
<tr>
<td>Other bias</td>
<td>High risk</td>
<td>Intervention group were older than the control group and had been diagnosed with heart failure for longer (mean of 2.3 years with intervention versus 3.1 years with comparison). Not very clear how the outcome was calculated</td>
</tr>
</tbody>
</table>
### Hillebrand 1995

<table>
<thead>
<tr>
<th>Methods</th>
<th>Parallel group RCT, Germany.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants</td>
<td>94 patients randomised. Post-MI patients attending inpatient cardiac rehabilitation program. Mean age 52 (range 33-60) years, 89% men</td>
</tr>
<tr>
<td>Interventions</td>
<td>INTERVENTION: special outpatient care program to support blue-collar workers (people who have a job with manual labor) after MI to join coronary groups. The program consisted of 4 different conversations between patients and a social worker: at end of rehabilitation program, telephone contact after 4 weeks, home visit after 3 months, and telephone contact after 6 months</td>
</tr>
<tr>
<td>Comparison</td>
<td>no outpatient care program.</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Attendance at cardiac group after 12 months.</td>
</tr>
</tbody>
</table>

#### Risk of bias

<table>
<thead>
<tr>
<th>Bias</th>
<th>Authors' judgement</th>
<th>Support for judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Random sequence generation (selection bias)</td>
<td>Unclear risk</td>
<td>Not reported.</td>
</tr>
<tr>
<td>Allocation concealment (selection bias)</td>
<td>Unclear risk</td>
<td>Not reported.</td>
</tr>
<tr>
<td>Blind outcome assessment</td>
<td>Unclear risk</td>
<td>Not reported.</td>
</tr>
<tr>
<td>Incomplete outcome data (attrition bias)</td>
<td>Unclear risk</td>
<td>4 patients died, 3 refused follow-up. ITT analysis not performed</td>
</tr>
<tr>
<td>Selective reporting (reporting bias)</td>
<td>Low risk</td>
<td>All relevant outcomes described in methods were reported.</td>
</tr>
<tr>
<td>Other bias</td>
<td>Low risk</td>
<td></td>
</tr>
</tbody>
</table>

### Izawa 2005

<table>
<thead>
<tr>
<th>Methods</th>
<th>Parallel group RCT.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants</td>
<td>Patients with MI who had completed a cardiac rehabilitation program. 50 patients randomised. Results available for 45 people. Mean age in intervention group 63.9 (SD 9.7) years and in comparison group 64.5 (SD 10.1) years. 84% male. Percentage white - intervention: 88%, comparison: 67%</td>
</tr>
<tr>
<td>Interventions</td>
<td>All patients received a program of cardiac rehabilitation delivered by a multidisciplinary team customized for each patient. Patients participated in supervised combined aerobic and resistance exercise twice a week for 1 hr. At discharge, all patients were advised of</td>
</tr>
<tr>
<td><strong>Izawa 2005 (Continued)</strong></td>
<td></td>
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<tr>
<td>-----------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Diet and exercise and CVD risk factors</strong></td>
<td></td>
</tr>
<tr>
<td>INTERVENTION: self-monitoring approach based on Bandura's self-efficacy theory. Patients were taught to record body weight, exercise as measured by pedometer, and heart rate. Performance was addressed by written feedback. COMPARISON: cardiac rehabilitation program alone.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Outcomes</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Exercise maintenance at 6 months.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Notes</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Exercise maintenance determined from a readiness to exercise evaluation based on the TTM of exercise behavior change. Self-efficacy for physical activity and mean number of steps taken per day (measured by pedometer) were significantly higher in the intervention group compared with control at 12 months post-MI.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Risk of bias</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bias</strong></td>
</tr>
<tr>
<td>Random sequence generation (selection bias)</td>
</tr>
<tr>
<td>Allocation concealment (selection bias)</td>
</tr>
<tr>
<td>Blind outcome assessment</td>
</tr>
<tr>
<td>Incomplete outcome data (attrition bias)</td>
</tr>
<tr>
<td>Selective reporting (reporting bias)</td>
</tr>
<tr>
<td>Other bias</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Jolly 1999</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Methods</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Participants</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>67 general practices in a specified geographical area randomised. 277 patients from randomised intervention practices and 320 from control practices. Patients admitted to hospital with MI (71%) or with angina of recent onset (&lt;3 months) seen in hospital (29%). Patients were judged well enough to participate by medical and nursing staff on the ward or in clinic. 71% male.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Interventions</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>INTERVENTION: specialist cardiac liaison nurses coordinated the transfer of care between hospital and general practice. The liaison nurse saw patients in hospital and encouraged them to see the practice nurse after discharge. Support was provided to practice nurses by regular contact, including a telephone call shortly before patient discharge to discuss care and book a first follow-up visit to the practice. Practice nurses were encouraged to telephone the liaison nurse to discuss problems or to seek advice on.</td>
</tr>
</tbody>
</table>
Jolly 1999  (Continued)

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Attendance at least 1 outpatient cardiac rehabilitation session, serum cholesterol, blood pressure, smoking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notes</td>
<td>The difference in attendance was most marked in people with angina (42% with intervention vs. 10% with comparison). Serum cholesterol, blood pressure, distance walked in 6 minutes, and smoking cessation did not differ between groups. BMI was slightly lower in the intervention group</td>
</tr>
</tbody>
</table>

**Risk of bias**

<table>
<thead>
<tr>
<th>Bias</th>
<th>Authors' judgement</th>
<th>Support for judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Random sequence generation (selection bias)</td>
<td>Unclear risk</td>
<td>Not reported.</td>
</tr>
<tr>
<td>Allocation concealment (selection bias)</td>
<td>Unclear risk</td>
<td>Not reported.</td>
</tr>
<tr>
<td>Blind outcome assessment All outcomes</td>
<td>Low risk</td>
<td>Follow-up of patients carried out by a nurse not responsible for delivering the intervention to the patient's practice</td>
</tr>
<tr>
<td>Incomplete outcome data (attrition bias)</td>
<td>Low risk</td>
<td>10% of patients lost to follow-up. Similar rates for intervention arm and control</td>
</tr>
<tr>
<td>Selective reporting (reporting bias)</td>
<td>Low risk</td>
<td>All relevant outcomes described in methods were reported.</td>
</tr>
<tr>
<td>Other bias</td>
<td>Low risk</td>
<td></td>
</tr>
</tbody>
</table>

McPaul 2007

<table>
<thead>
<tr>
<th>Methods</th>
<th>Parallel group RCT.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants</td>
<td>25 patients admitted with a diagnosis of MI. 15 randomised to intervention arm, 10 randomised to control. Age range 33-87 years. 84% male</td>
</tr>
<tr>
<td>Interventions</td>
<td>INTERVENTION: a home visit by the researcher (an occupational therapist) to the patient (and relative if required) and a semi-structured discussion format was used during the visit. The visit started with a general discussion about the patient’s physical and mental health since hospital discharge. Counseling was provided about appropriate level of physical activity, medications, diet, and smoking cessation. The researcher invited the participant to attend and encouraged participation in phase 2 cardiac rehabilitation. COMPARISON: a telephone call using the same semi-structured interview format. Patients were invited to attend phase 2 exercise and education classes and were invited to attend a pre-rehabilitation clinic</td>
</tr>
</tbody>
</table>
### Outcomes

Outcomes: attendance at phase 2 cardiac rehabilitation. Anxiety and depression measured using the Hospital Anxiety and Depression Scale. Number of days of rehospitalization with cardiac symptoms. Number of visits to the emergency room with cardiac symptoms.

### Notes

During the study, all patients with ST-elevation MIs were taken to another nearby hospital rather than being admitted to the study hospital. Thus, only patients with non-ST-elevation MI were studied. The control group was invited to a pre-rehabilitation clinic whereas people in the intervention arm were not invited. The control patients who attended the clinic all attended phase 2 cardiac rehabilitation later.

### Risk of bias

<table>
<thead>
<tr>
<th>Bias</th>
<th>Authors’ judgement</th>
<th>Support for judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Random sequence generation (selection bias)</td>
<td>Unclear risk</td>
<td>Envelopes allocating to intervention or treatment were randomly arranged by the researcher</td>
</tr>
<tr>
<td>Allocation concealment (selection bias)</td>
<td>Low risk</td>
<td>Sealed envelopes.</td>
</tr>
<tr>
<td>Blind outcome assessment</td>
<td>High risk</td>
<td>Not blinded.</td>
</tr>
<tr>
<td>Incomplete outcome data (attrition bias)</td>
<td>Unclear risk</td>
<td>4 patients lost to follow-up and excluded from the analysis. Analyses based on the 21 patients who completed the study. ITT analyses not performed</td>
</tr>
<tr>
<td>Selective reporting (reporting bias)</td>
<td>Low risk</td>
<td>1 death reported in the study but cause not reported.</td>
</tr>
<tr>
<td>Other bias</td>
<td>Unclear risk</td>
<td>No significant differences in baseline measurements of anxiety and depression but information on major cardiovascular risk factors not collected</td>
</tr>
</tbody>
</table>

### Moore 2006

<table>
<thead>
<tr>
<th>Methods</th>
<th>Parallel group RCT.</th>
</tr>
</thead>
</table>

| Participants | 259 patients randomised. Results available for 250 patients. Mixed CHD patients, MI 52%, CABG 55%, PTCA 59%. Mean age 62 (range 38-86) years, 62% male. Recruited from 3 outpatient clinics |

| Interventions | All participants received usual cardiac rehabilitation program of structured exercise and individual and group classes (4) on diet modification and stress reduction. At the end, participants were given an exercise prescription that included target heart rate zone and advice to exercise at least 5 times per week for 30 minutes INTERVENTION: CHANGE program (“Change Habits by Applying New Goals and Experiences”), based on several cognitive behavioral frameworks (social problem-solving model, self efficacy theory, expectancy value theory, relapse prevention theory). |
**Moore 2006 (Continued)**

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Adherence to exercise amount (10 hr of moderate intensity exercise a month - 150 minutes/week), adherence to exercise frequency (at least 5 times/week or 20 times/month). Both measured at 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notes</td>
<td>Mean duration of an exercise session among those who exercised was longer than 30 minutes recommended (mean session length 52 minutes). Men were less likely to discontinue exercise than women. Participants with higher comorbidity scores or more muscle and joint pain were more likely to discontinue exercise</td>
</tr>
</tbody>
</table>

**Risk of bias**

<table>
<thead>
<tr>
<th>Bias</th>
<th>Authors' judgement</th>
<th>Support for judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Random sequence generation (selection bias)</td>
<td>Low risk</td>
<td>Computerized minimization stratification randomization program used managed by program director in which participants were stratified on gender and site of recruitment</td>
</tr>
<tr>
<td>Allocation concealment (selection bias)</td>
<td>Low risk</td>
<td>The randomization sequence was concealed until intervention was assigned</td>
</tr>
<tr>
<td>Blind outcome assessment All outcomes</td>
<td>Low risk</td>
<td>Exercise measured using portable wristwatch heart rate monitors, backed up by diaries mailed to investigators. Data collectors were blind to study group</td>
</tr>
<tr>
<td>Incomplete outcome data (attrition bias) All outcomes</td>
<td>Unclear risk</td>
<td>53 (19.4%) lost to follow-up, of which only 30 were included in the final analysis. Those lost to follow-up were older, less fit, and had lower self efficacy scores</td>
</tr>
<tr>
<td>Selective reporting (reporting bias)</td>
<td>Low risk</td>
<td>All relevant outcomes described in methods were reported.</td>
</tr>
<tr>
<td>Other bias</td>
<td>Low risk</td>
<td></td>
</tr>
</tbody>
</table>
Oldridge 1983  (Continued)

| Interventions | INTERVENTION: usual comprehensive cardiac rehabilitation program, plus self management techniques including an agreement to participate in the program for 6 months to be signed by the patient and coordinator, and self report diaries to complete and be discussed with the coordinator at regular intervals. Diaries included 6 graphs for plotting self monitored submaximal heart rates each month, at 33%, 50%, and 75% of the maximum power output achieved in the previous exercise test, and 6 x 24-hr recall questionnaires of daily activities on a randomly chosen day to be completed each month. In addition, a weight loss diary to fill in each week was given to those patients who initially agreed to lose weight, and similar diaries to record number of cigarettes smoked each day. Follow-up at the end of the intervention period of 6 months.

COMPARISON: usual comprehensive cardiac rehabilitation program |

| Outcomes | Compliance (defined as attendance at 60% or more of the scheduled 48 supervised cardiac rehabilitation sessions) |

| Notes | Patients stratified by smoking status, occupation, leisure habits, and number of prior infarctions before randomization. These variables were shown to be predictors of drop-out based on previous experience of this group |

| Risk of bias |

<table>
<thead>
<tr>
<th>Bias</th>
<th>Authors’ judgement</th>
<th>Support for judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Random sequence generation (selection bias)</td>
<td>Low risk</td>
<td>Random number list.</td>
</tr>
<tr>
<td>Allocation concealment (selection bias)</td>
<td>Unclear risk</td>
<td>Not reported.</td>
</tr>
<tr>
<td>Blind outcome assessment All outcomes</td>
<td>Unclear risk</td>
<td>Not reported.</td>
</tr>
<tr>
<td>Incomplete outcome data (attrition bias) All outcomes</td>
<td>Unclear risk</td>
<td>Attendance of drop-outs was similar in the intervention and control groups (21% with intervention vs. 16% with control) and was also similar for compliers (74% with intervention vs. 76% with control). Not all patients in the intervention group signed the agreement to participate. Compliance was significantly higher in the 48 people who signed (65%), than in the 15 who refused (20%).</td>
</tr>
<tr>
<td>Selective reporting (reporting bias)</td>
<td>Low risk</td>
<td>All relevant outcomes described in methods were reported.</td>
</tr>
<tr>
<td>Other bias</td>
<td>Unclear risk</td>
<td>Unclear whether comparison groups were similar at baseline.</td>
</tr>
</tbody>
</table>
Methods

Parallel group RCT.

Participants

150 patients admitted to academic medical centre for a diagnosis of MI, PCI, or angina with documented ischemia on a stress test (76 randomised to early appointment and 74 randomised to control). 17% ST-elevation MI, 47% non-ST-elevation MI, 30% PCI without MI, 6% angina with ischemic stress test. Mean age 61 ± 12 years (early appointment), mean age 59 ± 12 (control). 55% male. 43% white.

Interventions

INTERVENTION: patients were randomised to receive an early appointment for the orientation class for cardiac rehabilitation (within 10 days). COMPARISON: patients randomised to standard care were scheduled for an orientation appointment within 35 days from the index event.

Outcomes

Primary outcome: attendance at orientation class for cardiac rehabilitation
Secondary outcomes: attendance at ≥ 1 exercise and education session of cardiac rehabilitation, total number of exercise sessions attended, completion of cardiac rehabilitation, exercise-related safety events, clinical events.

Notes

Study was terminated early due to relocation of the trial principal investigator. An unplanned interim analysis revealed a statistically significant difference in attendance rate for cardiac rehabilitation so recruitment was terminated early.

Risk of bias

<table>
<thead>
<tr>
<th>Bias</th>
<th>Authors’ judgement</th>
<th>Support for judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Random sequence generation</td>
<td>Low risk</td>
<td>Sequence generation was created using a computerized random number generator</td>
</tr>
<tr>
<td>(selection bias)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allocation concealment</td>
<td>Low risk</td>
<td>Allocation cards kept in opaque sequential sealed envelopes until time of patient randomization</td>
</tr>
<tr>
<td>(selection bias)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blind outcome assessment</td>
<td>High risk</td>
<td>Cardiac rehabilitation staff recorded primary outcomes and were not blinded to treatment allocation</td>
</tr>
<tr>
<td>All outcomes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incomplete outcome data</td>
<td>Low risk</td>
<td>2 patients in intervention group withdrew consent and were excluded. Treated as nonattenders in the analyses. ITT analysis performed</td>
</tr>
<tr>
<td>(attrition bias)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All outcomes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Selective reporting</td>
<td>Low risk</td>
<td>All relevant outcomes described in methods were reported.</td>
</tr>
<tr>
<td>(reporting bias)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other bias</td>
<td>Unclear risk</td>
<td>Trial terminated early due to unplanned interim analysis.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Participants
101 participants with a first time, nonemergency coronary bypass surgery (49 randomised to intervention and 52 to control). 95 participants analysed (45 intervention, 50 control) . 72% with angina and 54% with MI. Intervention arm: mean age 62 (range 40-84) years; control arm: mean age 64 (range 41-85) years. 83% male

### Interventions
INTERVENTION: patients received peer-generated telephone calls for 8 weeks following hospital discharge. Peer volunteers included men and women who had undergone bypass surgery within the previous 5 years, and had attended a cardiac rehabilitation program. The telephone calls focused on pain management, exercise, and encouragement in enrolling in a cardiac rehabilitation program. Peer volunteers attended a 4-hr training session to develop skills required for effective telephone support. Dose and frequency of calls were determined by peer-patient dyad and most telephone calls were peer-initiated. COMPARISON: usual care consisted of standard pre- and postoperative education and visits from in-hospital peer volunteers

### Outcomes
Uptake of cardiac rehabilitation (attendance of at least 1 session), health-related quality of life, pain, pain-related interference with activities

### Notes
There was a wide range in the number of contacts as well as time per contact. Only 17 (18%) patients attended a cardiac rehabilitation program at 9 weeks’ postsurgery

### Risk of bias

<table>
<thead>
<tr>
<th>Bias</th>
<th>Authors’ judgement</th>
<th>Support for judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Random sequence generation (selection bias)</td>
<td>Low risk</td>
<td>Random assignment centrally controlled using an Internet-based randomization service</td>
</tr>
<tr>
<td>Allocation concealment (selection bias)</td>
<td>Low risk</td>
<td></td>
</tr>
<tr>
<td>Blind outcome assessment All outcomes</td>
<td>Low risk</td>
<td>Outcome data collected via telephone interview by research assistant blinded to group allocation</td>
</tr>
<tr>
<td>Incomplete outcome data (attrition bias) All outcomes</td>
<td>Unclear risk</td>
<td>6 drop-outs, balanced between intervention and control arms. Unclear if ITT analysis performed. Text refers to “intention to treat analyses” but figure suggests that excluded patients were not included in the analyses</td>
</tr>
<tr>
<td>Selective reporting (reporting bias)</td>
<td>Low risk</td>
<td>All relevant outcomes described in methods were reported.</td>
</tr>
<tr>
<td>Other bias</td>
<td>Low risk</td>
<td></td>
</tr>
</tbody>
</table>
**Price 2012**

<table>
<thead>
<tr>
<th>Methods</th>
<th>Parallel group RCT.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants</td>
<td>70 women (34 intervention, 36 usual care) hospitalised for a cardiovascular event in a tertiary care hospital in Toronto. 66 women analysed (33 intervention, 33 usual care) . CABG: 44% intervention, 44% control; MI: 29% intervention, 44% control; PCI: 35% intervention, 33% control. Mean age 67 (38-89) years. 100% women</td>
</tr>
<tr>
<td>Interventions</td>
<td>INTERVENTION: usual care plus an individualized, personal coaching program based on social cognitive theory constructs of self efficacy delivered by a registered nurse (the study author). The coaching program consisted of scheduled, coach-generated telephone calls between hospital discharge and cardiac rehabilitation intake appointment to explain the benefits of cardiac rehabilitation, clarify concerns, motivate women to enrol, and overcome any individual barriers to entering a program. Coaching emphasized problem solving, decision making, and confidence building. Interventions were initiated within 1-2 weeks of hospital discharge, calls were scheduled every 2 weeks, and at least 3 telephone calls until an intake appointment. All calls were scheduled and initiated by the investigator. COMPARISON: usual care consisted of a referral to cardiac rehabilitation followed by a letter from the cardiac rehabilitation program informing the patient of their intake appointment</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Primary outcome: attendance at the initial cardiac rehabilitation appointment, assessed 10-12 weeks after discharge Secondary outcomes: self efficacy for exercise and self efficacy to attend cardiac rehabilitation intake</td>
</tr>
<tr>
<td>Notes</td>
<td><strong>Risk of bias</strong></td>
</tr>
<tr>
<td>Bias</td>
<td>Authors’ judgement</td>
</tr>
<tr>
<td>Random sequence generation (selection bias)</td>
<td>Low risk</td>
</tr>
<tr>
<td>Allocation concealment (selection bias)</td>
<td>Low risk</td>
</tr>
<tr>
<td>Blind outcome assessment All outcomes</td>
<td>Low risk</td>
</tr>
<tr>
<td>Incomplete outcome data (attrition bias) All outcomes</td>
<td>Unclear risk</td>
</tr>
<tr>
<td>Selective reporting (reporting bias)</td>
<td>Low risk</td>
</tr>
<tr>
<td>Other bias</td>
<td>Low risk</td>
</tr>
</tbody>
</table>
Methods | Parallel group RCT.
--- | ---
Participants | 246 randomised. Mixed CHD patients: MI 58%, CABG 9%, PTCA 33%. Mean age 59.3 (SD 10, range 31-82) years. 88% male
Interventions | After discharge from residential cardiac rehabilitation program all patients were recommended to engage in regular vigorous exercise (at least 3 times per week for minimum of 30 minutes per unit), and increase their everyday physical activities. Motivation was addressed in psychoeducational classes
INTERVENTION 1: 'Action-planning group' additionally developed 3 action plans each about when, where, and how they intended to exercise and implement extra every day activities after discharge. Treatments were conducted by trained consultants in a 1-to-1 setting and lasted up to 30 minutes
INTERVENTION 2: 'Combined-planning group' additionally developed 3 action plans each about when, where, and how they intended to exercise and implement extra every day activities after discharge and 3 coping plans to overcome anticipated barriers. Treatments were conducted by trained consultants in a 1-to-1 setting and lasted up to 30 minutes
Outcomes | Adherence to exercise (self reported exercise at least 3 times per week for at least 30 minutes. Individuals who adhered were classified as 'achievers'). Follow-up 10 weeks
Notes | Risk of bias

<table>
<thead>
<tr>
<th>Bias</th>
<th>Authors’ judgement</th>
<th>Support for judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Random sequence generation (selection bias)</td>
<td>High risk</td>
<td>Each consultant assigned participants to experimental conditions according to an assignment sheet that followed the order control group, action-planning group, and combined-planning group</td>
</tr>
<tr>
<td>Allocation concealment (selection bias)</td>
<td>High risk</td>
<td>Each consultant assigned participants to experimental conditions according to an assignment sheet that followed the order control group, action-planning group, and combined-planning group</td>
</tr>
<tr>
<td>Blind outcome assessment</td>
<td>Unclear risk</td>
<td>Not reported.</td>
</tr>
<tr>
<td>Incomplete outcome data (attrition bias)</td>
<td>Unclear risk</td>
<td>35 patients excluded. 29 excluded for not returning questionnaire. 6 excluded for unclear reasons</td>
</tr>
<tr>
<td>Selective reporting (reporting bias)</td>
<td>Low risk</td>
<td>All relevant outcomes described in methods were reported.</td>
</tr>
<tr>
<td>Other bias</td>
<td>Low risk</td>
<td>---</td>
</tr>
</tbody>
</table>
Methods

Parallel group RCT, UK.

Participants

87 patients randomised. All patients post-MI. Mean age 63 years. 87% male

Interventions

INTERVENTION: letters based on the theory of planned behavior (Ajzen 1986) designed to increase attendance at outpatient cardiac rehabilitation clinic were given to patients 3 days post-MI and sent 3 weeks post-MI. The first letter was designed to influence acceptance and the second was designed to influence attendance. Patients also received a nominal letter of thanks at 3 days and the standard letter detailing course dates as sent to control patients. After allocation to groups, the cardiac rehabilitation nurse saw all patients for routine assessment and personal invitation to the program. For patients who declined the offer of a place, a brief second letter was sent wishing them well and informing them that they were still welcome to contact the team.

COMPARISON: nominal letter of thanks given to patients at 3 days’ post-MI and the standard letter detailing course dates.

Outcomes

Uptake (defined as attendance at the outpatient cardiac rehabilitation program)

Notes

Women were less likely to attend the program, but neither age nor distance lived from the program predicted attendance. Authors noted that the intervention may have worked by acting as a fear message, rather than through implementation of theory of planned behavior.

Risk of bias

<table>
<thead>
<tr>
<th>Bias</th>
<th>Authors’ judgement</th>
<th>Support for judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Random sequence generation (selection bias)</td>
<td>Low risk</td>
<td>Allocation by random number assignment.</td>
</tr>
<tr>
<td>Allocation concealment (selection bias)</td>
<td>Low risk</td>
<td>Patients were handed a sealed numbered envelope with a nominal letter. Half of the envelopes also contained an intervention letter. Envelope contents known to a research assistant only</td>
</tr>
<tr>
<td>Blind outcome assessment All outcomes</td>
<td>Unclear risk</td>
<td>Uptake defined as saying yes to cardiac nurse. Participants may have mentioned the letter received</td>
</tr>
<tr>
<td>Incomplete outcome data (attrition bias) All outcomes</td>
<td>Unclear risk</td>
<td>13 participants excluded but not told treatment allocation.</td>
</tr>
<tr>
<td>Selective reporting (reporting bias)</td>
<td>Low risk</td>
<td>All relevant outcomes described in methods were reported.</td>
</tr>
<tr>
<td>Other bias</td>
<td>High risk</td>
<td>Cardiac rehabilitation nurse not aware of group assigned to; however, no procedure in place to stop patients telling nurse which letter received</td>
</tr>
</tbody>
</table>
BMI: body mass index; CABG: coronary artery bypass graft; CAD: coronary artery disease; CHD: coronary heart disease; CVD: cardiovascular disease; hr: hour; ITT: intention to treat; MI: myocardial infarction; PCI: percutaneous coronary intervention; RCT: randomised controlled trial; SD: standard deviation; TTM: transtheoretical model.

### Characteristics of excluded studies [ordered by study ID]

<table>
<thead>
<tr>
<th>Study</th>
<th>Reason for exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aish 1996</td>
<td>Adherence to dietary advice not cardiac rehabilitation.</td>
</tr>
<tr>
<td>Brodie 2005</td>
<td>No measure of adherence.</td>
</tr>
<tr>
<td>Butler 2009</td>
<td>No measure of adherence.</td>
</tr>
<tr>
<td>Carlson 2000</td>
<td>Compared different types of cardiac rehabilitation.</td>
</tr>
<tr>
<td>Carroll 2007</td>
<td>No measure of adherence.</td>
</tr>
<tr>
<td>Dankner 2011</td>
<td>Nonrandom allocation to study group.</td>
</tr>
<tr>
<td>Duncan 2001</td>
<td>Adherence to dietary advice not cardiac rehabilitation.</td>
</tr>
<tr>
<td>Froelicher 2003</td>
<td>No intervention to increase adherence.</td>
</tr>
<tr>
<td>Furber 2010</td>
<td>Targeted patients who did not participate in cardiac rehabilitation</td>
</tr>
<tr>
<td>Higgins 2001</td>
<td>No measure of adherence.</td>
</tr>
<tr>
<td>Hopper 1995</td>
<td>No measure of adherence.</td>
</tr>
<tr>
<td>Hughes 2002</td>
<td>No measure of adherence.</td>
</tr>
<tr>
<td>Hughes 2007</td>
<td>No measure of adherence.</td>
</tr>
<tr>
<td>Jolly 2009</td>
<td>No measure of adherence.</td>
</tr>
<tr>
<td>Kolt 2009</td>
<td>Not focused on patients in cardiac rehabilitation.</td>
</tr>
<tr>
<td>Kummel 2007</td>
<td>No measure of adherence.</td>
</tr>
<tr>
<td>Leemrijse 2012</td>
<td>No measure of adherence.</td>
</tr>
<tr>
<td>Luszcynska 2006</td>
<td>No measure of adherence.</td>
</tr>
<tr>
<td>Mahler 1999</td>
<td>No measure of adherence.</td>
</tr>
<tr>
<td>Meillier 2012</td>
<td>Non-random allocation to study group.</td>
</tr>
</tbody>
</table>
Moore 2002  Non-random allocation to study group.
Palomäki 2002  Non-random allocation to study group.
Peterson 2012  Inadequate control arm.
Powell 2010  No measure of adherence.
Redfern 2009  Study targeted adherence to medication and medical appointments not cardiac rehabilitation or any of its components
Reid 2012  Targeted patients who did not participate in cardiac rehabilitation
Rejeski 2002  Not all participants had coronary heart disease.
Reusch 2011  No measure of adherence.
Richardson 2010  No measure of adherence.
Sniehotta 2005  No measure of adherence.
Southard 2003  No measure of adherence.
Stromberg 2006  Study targeted adherence to medication and medical appointments not cardiac rehabilitation or any of its components
Vestfold 2003  No measure of adherence.
Willmott 2011  No measure of adherence.
Wolkanin-Bartnik 2011  No measure of adherence.
Wu 2012  No measure of adherence.
Zarani 2010  No measure of adherence.

### Characteristics of ongoing studies  [ordered by study ID]

**Maddison 2011**

<table>
<thead>
<tr>
<th>Trial name or title</th>
<th>HEART (Heart Exercise And Remote Technologies) trial.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methods</td>
<td>Parallel group RCT.</td>
</tr>
<tr>
<td>Participants</td>
<td>Outpatient cardiac rehabilitation patients.</td>
</tr>
</tbody>
</table>
**Maddison 2011** *(Continued)*

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Personalized, automated package of text and video message components via mobile device and Internet over 24 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcomes</td>
<td>Change in maximum oxygen uptake, self reported physical activity, cardiovascular risk factors, health-related quality of life, cost-effectiveness</td>
</tr>
<tr>
<td>Starting date</td>
<td>1 April 2011.</td>
</tr>
<tr>
<td>Contact information</td>
<td>Ralph Maddison, Clinical Trials Research Unit University of Auckland Private Bag 92019, Auckland Mailing Centre Auckland, New Zealand. Email: <a href="mailto:r.maddison@ctru.auckland.ac.nz">r.maddison@ctru.auckland.ac.nz</a></td>
</tr>
<tr>
<td>Notes</td>
<td></td>
</tr>
</tbody>
</table>

**Sangster 2010**

<table>
<thead>
<tr>
<th>Trial name or title</th>
<th>PANACHE (Physical Activity, Nutrition, And Cardiac HEalth) trial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methods</td>
<td>RCT.</td>
</tr>
<tr>
<td>Participants</td>
<td>Patients referred for cardiac rehabilitation.</td>
</tr>
<tr>
<td>Interventions</td>
<td>Behavioral coaching and goal-setting sessions delivered by telephone over 8 weeks. Coaching sessions focused on weight, nutrition, and physical activity</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Weight change, physical activity, sedentary time, nutrition habits, health-related quality of life</td>
</tr>
<tr>
<td>Starting date</td>
<td>1 March 2010.</td>
</tr>
<tr>
<td>Contact information</td>
<td>Janice Sangster, Wagga Wagga Community Health Centre Docker St, Wagga Wagga, NSW 2650, Australia. Email: <a href="mailto:janice.sangster@gsahs.health.nsw.gov.au">janice.sangster@gsahs.health.nsw.gov.au</a></td>
</tr>
<tr>
<td>Notes</td>
<td></td>
</tr>
</tbody>
</table>

RCT: randomised controlled trial.
DATA AND ANALYSES

This review has no analyses.

ADDITIONAL TABLES

Table 1. Studies of interventions to increase uptake of cardiac rehabilitation

<table>
<thead>
<tr>
<th>Study</th>
<th>No. patients</th>
<th>Intervention</th>
<th>Comparison</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beckie 2010</td>
<td>252</td>
<td>90% - exercise</td>
<td>77% - exercise</td>
<td>P value &lt; 0.001</td>
</tr>
<tr>
<td></td>
<td></td>
<td>87% - education</td>
<td>56% - education</td>
<td>P value &lt; 0.001</td>
</tr>
<tr>
<td>Cossette 2012</td>
<td>242</td>
<td>45%</td>
<td>24%</td>
<td>P value = 0.001</td>
</tr>
<tr>
<td>Dolansky 2011</td>
<td>40</td>
<td>33%</td>
<td>12%</td>
<td>P value = 0.03</td>
</tr>
<tr>
<td>Hillebrand 1995</td>
<td>94</td>
<td>57%</td>
<td>27%</td>
<td>P value &lt; 0.005</td>
</tr>
<tr>
<td>Jolly 1999</td>
<td>277</td>
<td>42%</td>
<td>24%</td>
<td>P value &lt; 0.001</td>
</tr>
<tr>
<td>McPaul 2007</td>
<td>25</td>
<td>67%</td>
<td>78%</td>
<td>n.s.</td>
</tr>
<tr>
<td>Pack 2013</td>
<td>150</td>
<td>77%</td>
<td>59%</td>
<td>P value = 0.022</td>
</tr>
<tr>
<td>Parry 2009</td>
<td>101</td>
<td>25%</td>
<td>12%</td>
<td>P value = 0.11</td>
</tr>
<tr>
<td>Price 2012</td>
<td>70</td>
<td>58%</td>
<td>33%</td>
<td>P value = 0.048</td>
</tr>
<tr>
<td>Wyer 2001</td>
<td>87</td>
<td>86%</td>
<td>57%</td>
<td>P value &lt; 0.0025</td>
</tr>
</tbody>
</table>

n.s.: not significant.

Table 2. Summary of rehospitalization rates between groups

<table>
<thead>
<tr>
<th>Study</th>
<th>Intervention</th>
<th>Comparison</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dolansky 2011</td>
<td>21.67%*</td>
<td>18.4%*</td>
<td>n.s.</td>
</tr>
<tr>
<td>McPaul 2007</td>
<td>0 / 15</td>
<td>0 / 10</td>
<td>n.s.</td>
</tr>
<tr>
<td>Pack 2013</td>
<td>1 / 74</td>
<td>3 / 74</td>
<td>n.s.</td>
</tr>
</tbody>
</table>

* numbers not provided.

n.s.: not significant.
Table 3. Coronary heart disease event rates between groups

<table>
<thead>
<tr>
<th>Study</th>
<th>Intervention</th>
<th>Comparison</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arrigo 2008*</td>
<td>17 / 105</td>
<td>12 / 123</td>
<td>P value &lt; 0.01</td>
</tr>
<tr>
<td>Dolansky 2011</td>
<td>1 / 17</td>
<td>2 / 21</td>
<td>n.s.</td>
</tr>
<tr>
<td>Pack 2013</td>
<td>7 / 74</td>
<td>12 / 74</td>
<td>P value = 0.32</td>
</tr>
</tbody>
</table>

*Authors note the increased rate of revascularization in the intervention group versus control (4 versus 1). n.s.: not significant.

Table 4. Mortality between groups

<table>
<thead>
<tr>
<th>Study</th>
<th>Intervention</th>
<th>Comparison</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dolansky 2011</td>
<td>0 / 17</td>
<td>0 / 21</td>
<td>n.s.</td>
</tr>
<tr>
<td>McPaul 2007</td>
<td>2 / 15</td>
<td>0 / 10</td>
<td>n.s.</td>
</tr>
<tr>
<td>Pack 2013</td>
<td>1 / 74</td>
<td>1 / 74</td>
<td>n.s.</td>
</tr>
</tbody>
</table>

n.s.: not significant.

Table 5. Studies of interventions to increase adherence to cardiac rehabilitation

<table>
<thead>
<tr>
<th>Study</th>
<th>No. of patients/clusters</th>
<th>Intervention</th>
<th>Comparison</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arrigo 2008</td>
<td>261</td>
<td>70%</td>
<td>37%</td>
<td>P value &lt; 0.0001</td>
</tr>
<tr>
<td>Ashe 1993</td>
<td>41</td>
<td>90%</td>
<td>89%</td>
<td>n.s.</td>
</tr>
<tr>
<td>Daltroy 1985</td>
<td>174</td>
<td>64%</td>
<td>62%</td>
<td>n.s.</td>
</tr>
<tr>
<td>Duncan 2002</td>
<td>13</td>
<td>Exercise duration: 109%</td>
<td>Exercise duration: 85%</td>
<td>n.s.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Exercise frequency: 104%</td>
<td>Exercise frequency: 64%</td>
<td>P value &lt; 0.001</td>
</tr>
<tr>
<td>Izawa 2005</td>
<td>45</td>
<td>100%</td>
<td>81%</td>
<td>n.s.</td>
</tr>
<tr>
<td>Moore 2006</td>
<td>250</td>
<td>Exercise amount: 29%</td>
<td>Exercise amount: 27%</td>
<td>n.s.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Exercise frequency: 8%</td>
<td>Exercise frequency: 8%</td>
<td>n.s.</td>
</tr>
<tr>
<td>Oldridge 1983</td>
<td>120</td>
<td>54%</td>
<td>42%</td>
<td>n.s.</td>
</tr>
</tbody>
</table>
Table 5. Studies of interventions to increase adherence to cardiac rehabilitation (Continued)

<table>
<thead>
<tr>
<th>Study</th>
<th>n.</th>
<th>Action planning:</th>
<th>Combined planning:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sniehotta 2006</td>
<td>246</td>
<td>44%</td>
<td>2: 71%</td>
</tr>
</tbody>
</table>

n.s.: not significant.

APPENDICES

Appendix 1. Search strategies 2010

CENTRAL on The Cochrane Library

#1 MeSH descriptor Myocardial Ischemia explode all trees
#2(myocard* NEAR isch*mi*)
#3 isch*mi* NEAR heart
#4 MeSH descriptor Coronary Artery Bypass explode all trees
#5 coronary
#6 MeSH descriptor Coronary Disease explode all trees
#7 MeSH descriptor Myocardial Revascularization explode all trees
#8 MeSH descriptor Myocardial Infarction explode all trees
#9 myocard* NEAR infarct*
#10 heart NEAR infarct*
#11 MeSH descriptor Angina Pectoris explode all trees
#12 angina
#13 MeSH descriptor Heart Failure, Congestive explode all trees
#14 heart and (failure or attack)
#15 MeSH descriptor Heart Diseases explode all trees
#16 heart and disease*
#17 myocard*
#18 cardiac*
#19 CABG
#20 PTCA
#21 stent* AND (heart or cardiac*)
#22 MeSH descriptor Heart Bypass, Left explode all trees
#23 MeSH descriptor Heart Bypass, Right explode all trees
#24 (#1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12 OR #13 OR #14 OR #15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23)
#25 MeSH descriptor Rehabilitation Centers, this term only
#26 MeSH descriptor Exercise Therapy explode all trees
#27 MeSH descriptor Sports, this term only
#28 MeSH descriptor Exertion explode all trees
#29 rehabilitat*
#30 (physical* NEAR (fit* or train* or therap* or activit*))
#31 MeSH descriptor Exercise explode all trees
#32 (train*) near (strength* or aerobic or exercise*)
#33 ((exercise* or fitness) NEAR/3 (treatment or intervent* or program*))
#34 MeSH descriptor Rehabilitation explode all trees
#35 MeSH descriptor Patient Education explode all trees
#36 (patient* NEAR/3 educat*)
#37 ((lifestyle or life-style) NEAR/3 (intervent* or program* or treatment*))
#38 MeSH descriptor Self Care explode all trees
#39 MeSH descriptor Ambulatory Care explode all trees
#40 MeSH descriptor Psychotherapy explode all trees
#41 psychotherap*
#42 psycholog* NEAR intervent*
#43 relax*
#44 MeSH descriptor Mind-Body and Relaxation Techniques explode all trees
#45 MeSH descriptor Counseling explode all trees
#46 counsel*ing
#47 MeSH descriptor Cognitive Therapy explode all trees
#48 MeSH descriptor Behavior Therapy explode all trees
#49 (behavior* or behavio*r*) NEAR/4 (modif* or therap* or rehab* or change)
#50 MeSH descriptor Stress, Psychological explode all trees
#51 stress NEAR manage*
#52 cognitive* NEAR therap*
#53 MeSH descriptor Meditation explode all trees
#54 meditat*
#55 MeSH descriptor Anxiety, this term only
#56 (manage*) NEAR (anxiety or depress*)
#57 CBT
#58 hypnotherap*
#59 goal NEAR/3 setting
#60 (psycho-educat*) or (psychoeducat*)
#61 motivat* NEAR intervat*
#62 MeSH descriptor Psychopathology explode all trees
#63 psychopathol*
#64 MeSH descriptor Autogenic Training explode all trees
#65 autogenic*
#66 self near (manage* or care or motivat*)
#67 distress*
#68 psychosocial* or psycho-social
#69 MeSH descriptor Health Education explode all trees
#70 (nutrition or diet or health) NEAR education
#71 heart manual
#72 (#25 OR #26 OR #27 OR #28 OR #29 OR #30 OR #31 OR #32 OR #33 OR #34 OR #35 OR #36 OR #37)
#73 (#38 OR #39 OR #40 OR #41 OR #42 OR #43 OR #44 OR #45 OR #46 OR #47 OR #48 OR #49 OR #50 OR #51 OR #52 OR #53 OR #54 OR #55 OR #56 OR #57 OR #58 OR #59 OR #60 OR #61 OR #62 OR #63 OR #64 OR #65 OR #66 OR #67 OR #68 OR #69 OR #70 OR #71)
#74 (#72 OR #73)
#75 (#74 AND #24)

MEDLINE DIALOG 1950 to week 1 2008
1. SEARCH: MYOCARDIAL-ISCHEMIA#.DE.
2. SEARCH: MYOCARDS4 NEAR (ISCHAEMI$2 OR ISCHEMI$2)
3. SEARCH: (ISCHAEMI$2 OR ISCHEMI$2) NEAR HEART
4. SEARCH: CORONARY-ARTERY-BYPASS#.DE.
Promoting patient uptake and adherence in cardiac rehabilitation (Review)

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EMBASE DIALOG 1980 to week 1 2008

1. HEART-DISEASE#.DE.
2. (MYOCARD$4 NEAR (ISCHAEMI$2 OR ISCHEMI$2)).TI,AB.
3. ((ISCHAEMI$2 OR ISCHEMI$2) NEAR HEART).TI,AB.
4. CORONARY-ARTERY-DISEASE#.DE.
5. TRANSLUMINAL-CORONARY-ANGIOPLASTY#.DE.
6. (CORONARY NEAR (DISEASE$2 OR BYPASS$2 OR THROMBO$5 OR ANGIOPLAST$2)).TI,AB.
7. HEART-INFARCTION#.DE.
8. (MYOCARDS$4 NEAR INFARCTS$5).TI,AB.
9. (HEART NEAR INFARCTS$5).TL,AB.
10. HEART-MUSCLE-REVASCULARIZATION#.DE.
11. ANGINA-PECTORIS#.DE.
12. ANGINA.TI,AB.
13. CONGESTIVE-HEART-FAILURE#.DE.
14. (HEART NEAR FAILURE).TL,AB.
15. 1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 OR 8 OR 9 OR 10 OR 11 OR 12 OR 13 OR 14
16. (HEART NEAR DISEASE$2).TL,AB.
17. CARDIACS$2.TL,AB.
18. CABG.TL,AB.
19. PTCAR.TL,AB.
20. STENTS$4.TL,AB. AND HEART.TL,AB.
21. EXTRACORPOREAL-CIRCULATION#.DE.
22. 16 OR 17 OR 18 OR 19 OR 20 OR 21
23. 15 OR 22
24. PSYCHOTHERAPY#.W..DE.
25. PSYCHOTHERAP$2.TL,AB.
26. PSYCHOLOG$5 NEAR INTERVENT$5
27. RELAX$6.TL,AB.
28. RELAXATION-TRAINING#.DE.
29. COUNSELING#.W..DE.
30. (COUNSELLING OR COUNSELING).TL,AB.
31. (BEHAVIOR$4 OR BEHAVIOUR$4) NEAR (MODIFY OR MODIFICAT$4 OR THERAPY$2 OR CHANGE)
32. STRESS-MANAGEMENT#.DE.
33. STRESS NEAR MANAGEMENT
34. MEDITATION#.W..DE.
35. MEDITAT$5.TL,AB.
36. MANAGE$5 NEAR (ANXIETY OR DEPRESS$5)
37. CBT.TL,AB.
38. HYPNOTHERAP$2.TL,AB.
39. GOAL$2 NEAR SETTING
40. PSYCHO-EDUCAT$5 OR PSYCHOEDUCAT$5
41. MOTIVAT$5 NEAR INTERVENT$6
42. PSYCHOSOCIAL-CARE#.DE. OR PSYCHOSOCIAL-REHABILITATION#.DE.
43. PSYCHOSOCIAL.TL,AB.
44. HEALTH-EDUCATION#.DE.
45. HEALTH NEAR EDUCATION
46. HEART ADJ MANUAL
47. AUTOGENIC-TRAINING#.DE.
48. AUTOGENIC.TL,AB.
49. REHABILITATION#.W..DE.
50. REHABILITATION-CENTER#.DE.
51. REHABIL$.TL,AB.
52. SPORT#.W..DE.
53. KINESIOTHERAPY#.W..DE.
54. EXERCISE#.W..DE.
55. PHYSIOTHERAPY#.W..DE.
56. PHYSICAL$4 NEAR (FIT OR FITNESS OR TRAIN$5 OR THERAP$5 OR ACTIVITY$5)
57. TRAIN$5 NEAR (STRENGTH$3 OR AEROBIC OR EXERCIS$4)
58. (EXERCISE$4 OR FITNESS) NEAR (TREATMENT OR INTERVENT$4 OR PROGRAM$2 OR THERAPY)
59. AEROBIC$4 NEAR EXERCISE$4
60. (KINESIOtherapy OR PHYSIOTHERAPY).TL,AB.
61. PATIENT-EDUCATION#.DE.
62. PATIENT$2 NEAR EDUCAT$4
63. (LIFESTYLE OR LIFE ADJ STYLE OR LIFE-STYLE) NEAR (INTERVENT$5 OR PROGRAM$2 OR TREATMENT$2)
64. SELF-CARE#.DE.
65. SELF NEAR (MANAGE$5 OR CARE OR MOTIVAT$5)
CINAHL DIALOG 1980 to week 1 2008

1. ((MYOCARDS4 OR HEART) NEAR (ISCHAEMI$2 OR ISCHEMI$2)).TI,AB.
2. CORONARY.TI,AB.
3. ((MYOCARDS4 OR HEART) NEAR INFARC$5).TI,AB.
4. ANGINA.TI,AB.
5. (HEART NEAR FAILURE).TI,AB.
6. (HEART NEAR DISEAS$2).TI,AB.
7. CARDIAC$2.TI,AB.
8. CABG
9. PTCA
10. STENT$4.TI,AB. AND (HEART OR CARDIAC$4).TI,AB.
11. MYOCARDIAL-ISCHEMIA#.DE.
12. MYOCARDIAL-INFARCTION#.DE.
13. CORONARY-ARTERY-BYPASS#.DE.
14. CORONARY-DISEASE#.DE.
15. CARDIAC-PATIENTS#.DE.
16. MYOCARDIAL-DISEASES#.DE.
17. MYOCARDIAL-REVASCULARIZATION#.DE.
18. HEART-DISEASES#.DE.
19. CARDIOVASCULAR-DISEASES#.DE.
20. HEART-FAILURE-CONGESTIVE#.DE.
Promoting patient uptake and adherence in cardiac rehabilitation (Review)
PsycINFO DIALOG 1972 to Jan week 1
1. SEARCH: HEART-DISORDERS#.DE.
2. SEARCH: MYOCARDIAL-INFARCTIONS.DE.
3. SEARCH: ISCHEMIA#.W..DE.
4. SEARCH: HEART-SURGERY.DE.
5. SEARCH: ANGIOPLASTY
6. SEARCH: HEART ADJ BYPASS
7. SEARCH: CORONARY.TI,LAB.
8. SEARCH: (ISCHEMI$3 OR ISCHAEMI$3).TI,LAB.
9. SEARCH: (MYOCARD$5 NEAR INFARCT$5).TI,LAB.
10. SEARCH: (HEART NEAR (INFARC$5 OR FAILURE OR ATTACK)).TI,LAB.
11. SEARCH: ANGINA.TI,LAB.
12. SEARCH: (HEART NEAR DISEASE$2).TI,LAB.
13. SEARCH: MYOCARD$5.TI,LAB.
14. SEARCH: CARDIACS$4.TI,LAB.
15. SEARCH: CABG.TI,LAB.
16. SEARCH: PTCA.TI,LAB.
17. SEARCH: 1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 OR 8 OR 9 OR 10 OR 11 OR 12 OR 13 OR 14 OR 15 OR 16
18. SEARCH: PHYSICAL-ACTIVITY#.DE.
19. SEARCH: SPORTS#.W..DE.
20. SEARCH: PHYSICAL-EDUCATION.DE.
21. SEARCH: HEALTH-BEHAVIOR#.DE.
22. SEARCH: PHYSICAL-FITNESS.DE.
23. SEARCH: (PHYSICAL ADJ EDUCA TION).TI,LAB.
24. SEARCH: EXERTION.TI,LAB.
25. SEARCH: REHABILITAT$6.TI,LAB.
26. SEARCH: (PHYSICAL NEAR (FIT$5 OR TRAIN$5 OR THERAP$5 OR ACTIVIT$4)).TI,LAB.
27. SEARCH: (TRAIN$4 NEAR (STRENGTH$4 OR AEROBIC OR EXERCISE$2)).TI,LAB.
28. SEARCH: ((EXERCISE$3 OR FITNESS) NEAR (TREATMENT OR INTERVENT$5 OR PROGRAM$4 OR THERAP$2)).TI,LAB.
29. SEARCH: (PATIENT WITH EDUCATION).TI,LAB.
30. SEARCH: CLIENT-EDUCATION#.DE.
31. SEARCH: HEALTH-PROMOTION#.DE.
32. SEARCH: ((LIFESTYLE OR LIFE-STYLE) NEAR (INTERVENT$5 OR PROGRAM$2 OR TREATMENT$2)).TI,LAB.
33. SEARCH: OUTPATIENT-TREATMENT#.DE.
34. SEARCH: 18 OR 19 OR 20 OR 21 OR 22 OR 23 OR 24 OR 25 OR 26 OR 27 OR 28 OR 29 OR 30 OR 31 OR 32 OR 33
35. SEARCH: PSYCHOTHERAPY#.W..DE.
36. SEARCH: PSYCHOTHERAP$2.TI,AB.
37. SEARCH: TREATMENT#.W.,DE.
38. SEARCH: (PSYCHOLOG$4 NEAR INTERVENT$5).TI,AB.
39. SEARCH: COUNSELING#.W..DE.
40. SEARCH: COPING-BEHAVIOR#.DE.
41. SEARCH: MEDITATION#.W.,DE.
42. SEARCH: AUTOGENIC-TRAINING.DE.
43. SEARCH: HEALTH-EDUCATION#.DE.
44. SEARCH: RELAX#.TI,AB.
45. SEARCH: (COUNSELLING OR COUNSELING).TI,AB.
46. SEARCH: ((BEHAVIOUR OR BEHAVIOR) NEAR (MODIF$5 OR THERAP$5 OR REHABILIT$5 OR CHANGE)).TI,AB.
47. SEARCH: (STRESS NEAR MANAGE$5).TI,AB.
48. SEARCH: MEDITATE$5.TI,AB.
49. SEARCH: (MANAGE$5 NEAR (ANXIETY OR DEPRESS$5)).TI,AB.
50. SEARCH: (CBT OR COGNITIV$2 NEAR THERAP$3).TI,AB.
51. SEARCH: HYPNOTHERAP$3.TI,AB.
52. SEARCH: (PSYCHO-EDUCAT$6 OR PSYCHOEDUCAT$6).TI,AB.
53. SEARCH: (MOTIVAT$5 NEAR INTERVENT$5).TI,AB.
54. SEARCH: (SELF NEAR MANAG$6).TI,AB.
55. SEARCH: AUTOGENIC$3.TI,AB.
56. SEARCH: (GOAL NEAR SETTING).TI,AB.
57. SEARCH: (HEALTH NEAR EDUCATION).TI,AB.
58. SEARCH: (HEART ADJ MANUAL).TI,AB.
59. SEARCH: 35 OR 36 OR 37 OR 38 OR 39 OR 40 OR 41 OR 42 OR 43 OR 44 OR 45 OR 46 OR 47 OR 48 OR 49 OR 50 OR 51 OR 52 OR 53 OR 54 OR 55 OR 56 OR 57 OR 58
60. SEARCH: 17 AND (34 OR 59)
61. SEARCH: (RANDOM$5 OR PLACEBO$5).TI,AB.
62. SEARCH: (DOUBLE$4 OR SINGLE$4 OR TRIPLE$4).TI,AB. AND (BLIND$4 OR MASK OR SHAM$4 OR DUMMY).TI,AB.
63. SEARCH: RCT.TI,AB.
64. SEARCH: AT=TREATMENT$4
65. SEARCH: 61 OR 62 OR 63 OR 64
66. SEARCH: 60 AND 66
67. SEARCH: LIMIT 66 TO YRS=2001-2008

ISI Proceedings
#5 and #6
Databases=STP Timespan=2001-2008
# 6 TS=(rehab* or educat*)
Databases=STP Timespan=2001-2008
# 5 #4 OR #3 OR #2 OR #1
Databases=STP Timespan=2001-2008
# 4 TS=(angina or cardiac* or PTCA or CABG)
Databases=STP Timespan=2001-2008
# 3 TS=((heart) SAME (infarct* or isch?emia or failure or attack)) Databases=STP Timespan=2001-2008
# 2 TS=((coronary* or heart*) SAME (by?pass or disease*)) Databases=STP Timespan=2001-2008
# 1 TS=((myocard*) SAME (isch?emia or infarct* or revasculari*)) Databases=STP Timespan=2001-2008

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Appendix 2. Search strategies 2013

The Cochrane Library

#1 MeSH descriptor: [Myocardial Ischemia] explode all trees
#2 (myocard* near/3 isch?mi*)
#3 (isch?mi* near/3 heart)
#4 MeSH descriptor: [Coronary Artery Bypass] explode all trees
#5 coronary
#6 MeSH descriptor: [Coronary Disease] explode all trees
#7 MeSH descriptor: [Myocardial Revascularization] explode all trees
#8 MeSH descriptor: [Myocardial Infarction] explode all trees
#9 (myocard* near/3 infarct*)
#10 (heart near/3 infarct*)
#11 MeSH descriptor: [Angina Pectoris] explode all trees
#12 angina
#13 MeSH descriptor: [Heart Failure] explode all trees
#14 (heart near/3 (failure or attack))
#15 MeSH descriptor: [Heart Diseases] explode all trees
#16 (heart near/3 disease*)
#17 myocard*
#18 cardiac*
#19 CABG
#20 PTCA
#21 (sten* near/3 (heart or cardiac*))
#22 MeSH descriptor: [Heart Bypass, Left] explode all trees
#23 MeSH descriptor: [Heart Bypass, Right] explode all trees
#24 #1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12 or #13 or #14 or #15 or #16 or #17 or #18 or #19 or #20 or #21 or #22 or #23
#25 MeSH descriptor: [Rehabilitation Centers] this term only
#26 MeSH descriptor: [Exercise Therapy] explode all trees
#27 MeSH descriptor: [Sports] this term only
#28 MeSH descriptor: [Physical Exertion] explode all trees
#29 rehabilitat*
#30 (physical* near/3 (fit* or train* or therap* or activit*))
#31 MeSH descriptor: [Exercise] explode all trees
#32 (train* near/3 (strength* or aerobic or exercise*))
#33 ((exercise* or fitness) near/3 (treatment or intervent* or program*))
#34 MeSH descriptor: [Rehabilitation] explode all trees
#35 MeSH descriptor: [Patient Education as Topic] explode all trees
#36 (patient* near/3 educat*)
#37 ((lifestyle or life-style) near/3 (intervent* or program* or treatment*))
#38 MeSH descriptor: [Self Care] explode all trees
#39 MeSH descriptor: [Ambulatory Care] explode all trees
#40 MeSH descriptor: [Psychotherapy] explode all trees
#41 psychotherap*
#42 (psycholog* near/3 intervent*)
#43 relax*
#44 MeSH descriptor: [Mind-Body Therapies] explode all trees
#45 MeSH descriptor: [Counseling] explode all trees
#46 counsel?ing
#47 MeSH descriptor: [Cognitive Therapy] explode all trees
Promoting patient uptake and adherence in cardiac rehabilitation (Review)

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10. (heart adj3 infarct*).tw.
11. exp Angina Pectoris/
12. angina.tw.
13. exp Heart Failure/
14. (heart adj3 (failure or attack)).tw.
15. Angioplasty, Balloon, Coronary/
16. CABG.tw.
17. PTCA.tw.
18. ami.tw.
19. (cardia* adj3 infarct*).tw.
20. (acute adj3 infarct*).tw.
21. (heart adj3 bypass*).tw.
22. ((cardiac or mycardial) adj (failure or insufficiency)).tw.
23. or/1-22
24. Patient Compliance/
25. (increase* adj10 participat*).tw.
26. (comply or complian*).tw.
27. remain*.tw.
28. adhere*.tw.
29. (uptake or take up).tw.
30. (sign adj2 (up or on)).tw.
31. effectiv*.tw.
32. follow up.tw.
33. engage*.tw.
34. attend*.tw.
35. or/24-34
36. Rehabilitation Centers/
37. exp Exercise Therapy/
38. Sports/
39. exp Physical Exertion/
40. rehabilitat*.tw.
41. (physical* adj3 (fit* or train* or therap* or activit*)).tw.
42. exp Exercise/
43. (train* adj3 (strength* or aerobic or exercise*)).tw.
44. ((exercise* or fitness) adj3 (treatment or intervent* or program*)).tw.
45. exp Rehabilitation/
46. exp Patient Education as Topic/
47. (patient* adj3 educat*).tw.
48. ((lifestyle or life-style) adj3 (intervent* or program* or treatment*)).tw.
49. exp Self Care/
50. exp Ambulatory Care/
51. exp Psychotherapy/
52. psychotherap*.tw.
53. (psycholog* adj3 intervent*).tw.
54. relax*.tw.
55. exp Mind-Body Therapies/
56. exp Counseling/
57. counsel*ing.tw.
58. exp Cognitive Therapy/
59. exp Behavior Therapy/
60. (behavio*r* adj4 (modif* or therap* or rehab* or change)).tw.
61. exp Stress, Psychological/
62. (stress adj3 manage*).tw.

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63. (cognitive* adj3 therap*).tw.
64. exp Meditation/
65. meditat*.tw.
66. Anxiety/
67. (manage* adj3 (anxiety or depres*)).tw.
68. CBT.tw.
69. hypnotherap*.tw.
70. (goal adj3 setting).tw.
71. (psycho-educat* or psychoeducat*).tw.
72. (motivat* adj3 interv*).tw.
73. exp Psychopathology/
74. psychopatho*.tw.
75. exp Autogenic Training/
76. autogenic*.tw.
77. (self adj3 (manage* or care or motivat*)).tw.
78. distress*.tw.
79. (psychosocial* or psycho-social*).tw.
80. exp Health Education/
81. ((nutrition or diet or health) adj3 education).tw.
82. heart manual.tw.
83. (secondary adj5 prevent$ adj10 (intervent* or program* or treatment* or plan* or regimen*)).tw.
84. or/36-83
85. 23 and 35 and 84
86. randomised controlled trial.pt.
87. controlled clinical trial.pt.
88. randomized.ab.
89. placebo.ab.
90. drug therapy.fs.
91. randomly.ab.
92. trial.ab.
93. groups.ab.
94. 86 or 87 or 88 or 89 or 90 or 91 or 92 or 93
95. exp animals/ not humans.sh.
96. 94 not 95
97. 85 and 96
98. (2008* or 2009* or 2010* or 2011* or 2012* or 2013*).ed.
99. 97 and 98

EMBASE Ovid
1. exp Myocardial Ischemia/
2. (myocard* adj3 isch?mi*).tw.
4. exp Coronary Artery Bypass/
5. coronary.tw.
6. exp Coronary Disease/
7. exp Myocardial Revascularization/
8. exp Myocardial Infarction/
9. (myocard* adj3 infarct*).tw.
10. (heart adj3 infarct*).tw.
11. exp Angina Pectoris/
12. angina.tw.
13. exp Heart Failure/
14. (heart adj3 (failure or attack)).tw.
15. exp Heart Diseases/
16. (heart adj3 disease*).tw.
17. myocard*.tw.
18. CABG.tw.
19. PTCA.tw.
20. (stent* adj3 (heart or cardiac*)).tw.
21. exp Heart Bypass, Left/
22. exp Heart Bypass, Right/
23. or/1-23
24. Rehabilitation Centers/
25. exp Exercise Therapy/
26. Sports/
27. exp Physical Exertion/
28. rehabilitat*.tw.
29. (physical* adj3 (fit* or train* or therap* or activit*)).tw.
30. exp Exercise/
31. (train* adj3 (strength* or aerobic or exercise*)).tw.
32. ((exercise* or fitness) adj3 (treatment or intervent* or program*).tw.
33. exp Rehabilitation/
34. exp Patient Education as Topic/
35. (patient* adj3 educat*).tw.
36. ((lifestyle or life-style) adj3 (intervent* or program* or treatment*)).tw.
37. exp Self Care/
38. exp Ambulatory Care/
39. exp Psychotherapy/
40. psychotherap*.tw.
41. (psycholog* adj3 intervent*).tw.
42. relax*.tw.
43. exp Mind-Body Therapies/
44. exp Counseling/
45. exp Cognitive Therapy/
46. exp Behavior Therapy/
47. (behavior* adj4 (modif* or therap* or rehab* or change)).tw.
48. exp Stress, Psychological/
49. (stress adj3 manage*).tw.
50. exp Meditation/
51. meditat*.tw.
52. Anxiety/
53. (manage* adj3 (anxiety or depres*)).tw.
54. CBT.tw.
55. hypnothearp*.tw.
56. (goal adj3 setting).tw.
57. psychoeducat*.tw.
58. (morivat* adj3 interv*).tw.
59. exp Psychopathology/
60. psychopathol*.tw.
61. exp Autogenic Training/
62. autogenic*.tw.
63. (self adj3 (manage* or care or morivat*)).tw.
64. (heart adj3 (failure or attack)).tw.
CINAHL
S86 S82 AND S85
S85 S83 OR S84
S84 (MH "Randomized Controlled Trials") OR (MH "Single-Blind Studies") OR (MH "Triple-Blind Studies") OR (MH "Double-Blind Studies")
S83 (random* or blind* or allocat* or assign* or trial* or placebo* or crossover* or cross-over*)
S82 S22 AND S69 AND S81
S81 S70 OR S71 OR S72 OR S73 OR S74 OR S75 OR S76 OR S77 OR S78 OR S79 OR S80
S80 attend*
S79 engage*
S78 “follow up”
S77 effectiv*
S76 “sign up” or “sign on”
S75 uptake or “take up”
S74 adhere*
S73 remain*
S72 comply or complian*
S71 (increase* N10 participat*)
S70 (MH “Patient Compliance”)
S69 S23 or S24 or S25 or S26 or S27 or S28 or S29 or S30 or S31 or S32 or S33 or S34 or S35 or S36 or S37 or S38 or S39 or S40 or S41 or S42 or S43 or S44 or S45 or S46 or S47 or S48 or S49 or S50 or S51 or S52 or S53 or S54 or S55 or S56 or S57 or S58 or S59 or S60 or S61 or S62 or S63 or S64 or S65 or S66 or S67 or S68
S68 (heart manual)
S67 ((nutrition or diet or health) N3 education)
S66 (MH “Health Education+”)  
S65 (psychosocial* or psycho-social*)
S64 (distress*)
S63 (autogenic*)
S62 (MH “Autogenic Training (Iowa NIC)”)  
S61 (psychopathol*)
S60 (MH “Psychopathology”)  
S59 (motivat* N3 interv*)
S58 (psycho-educat* or psychoeducat*)  
S57 (goal N3 setting)  
S56 (hypnotherap*)
S55 CBT
S54 (manage* N3 (anxiety or depres*))
S53 (MH “Anxiety”)  
S52 (meditat*)
S51 (MH “Meditation”)  
S50 (cognitive* N3 therap*)
S49 (stress N3 manage*)
S48 (MH “Stress, Psychological+”)  
S47 (behavio*r* N4 (modif* or therap* or rehab* or change))
S46 (MH “Behavior Therapy+”)
S45 (MH “Cognitive Therapy”)  
S44 (counseling)
S43 (MH “Counseling+”)  
S42 (MH “Mind Body Techniques+”)  
S41 (relax*)
S40 (psycholog* N3 intervent*)
S39 (psychotherap*)
S38 (MH “Psychotherapy+”)  
S37 (MH “Ambulatory Care”)  
S36 (MH “Self Care+”)  
S35 (lifestyle or life-style) N3 (intervent* or program* or treatment*)
S34 (patient* N3 educat*)
S33 (MH “Patient Education+”)  
S32 (MH “Rehabilitation+”)  
S31 (exercise* or fitness) N3 (treatment or intervent* or program*)
S30 (train* N3 (strength* or aerobic or exercise*))
S29 (MH “Exercise+”)
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Web of Science

#40 #39
#39 #38 AND #37 AND #34 AND #7
#38 TS=((random* or blind* or allocat* or assign* or trial* or placebo* or crossover* or cross-over*))
#37 #36 OR #35
#36 TS=(comply or complian* or remain* or adhere* or uptake or "take up" or "sign up" or "sign on" or effectiv* or "follow up" or engage* or attend*)
#35 TS=(increase* near/10 participat*)
#34 #33 OR #32 OR #31 OR #30 OR #29 OR #28 OR #27 OR #26 OR #25 OR #24 OR #23 OR #22 OR #21 OR #20 OR #19
OR #18 OR #17 OR #16 OR #15 OR #14 OR #13 OR #12 OR #11 OR #10 OR #9 OR #8
#33 TS=heart manual
#32 TS=((nutrition or diet or health) near/3 education))
#31 TS=((psychosocial* or psycho-social*))
#30 Topic=((distress*))
#29 Topic=((self near/3 (manage* or care or motivat*)))
#28 Topic=((self near/3 (manage* or care or motivat*)))
#27 TS=((psychopathol* OR autogenic*))
#26 Topic=((motivat* near/3 interv*))
#25 Topic=((psycho-educat* or psychoeducat*))
#24 Topic=((goal near/3 setting))
#23 Topic=((hypnotherap*))
#22 Topic=(CBT)
WHAT'S NEW

Last assessed as up-to-date: 23 January 2013.

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 October 2013</td>
<td>New citation required but conclusions have not changed</td>
<td>Eight new trials were identified but the conclusions remains unchanged</td>
</tr>
<tr>
<td>23 January 2013</td>
<td>New search has been performed</td>
<td>Search was updated in January 2013.</td>
</tr>
</tbody>
</table>

CONTRIBUTIONS OF AUTHORS

Karmali K was responsible for coordinating the update, selecting studies for inclusion, data extraction and risk of bias assessment, data management and analysis, and drafting the manuscript.

Davies P was responsible for the design of the review, selecting studies for inclusion, data extraction and risk of bias assessment, data management and analysis, and drafting the manuscript.

Taylor F was responsible for the design of the review, data extraction and risk of bias assessment, commenting critically on the intellectual content of drafts of the manuscript, and final approval prior to publication.

Beswick A was responsible for the design of the review, selecting studies for inclusion, commenting critically on the intellectual content of drafts of the manuscript, and final approval prior to publication.

Martin N was responsible for the design of the search strategy, commenting critically on the intellectual content of drafts of the manuscript, and final approval prior to publication.
Ebrahim S was responsible for the design of the review, providing methodologic and clinical advice, commenting critically on the intellectual content of drafts of the manuscript, and final approval prior to publication.

**DECLARATIONS OF INTEREST**

None known.

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**INDEX TERMS**

**Medical Subject Headings (MeSH)**
Angina Pectoris [rehabilitation]; Angioplasty, Balloon, Coronary [rehabilitation]; Coronary Artery Bypass [rehabilitation]; Coronary Disease [*rehabilitation]; Exercise; Heart Failure [rehabilitation]; Myocardial Infarction [rehabilitation]; Patient Acceptance of Health Care [*statistics & numerical data]; Patient Compliance [statistics & numerical data]; Randomized Controlled Trials as Topic

**MeSH check words**
Adult; Humans; Middle Aged