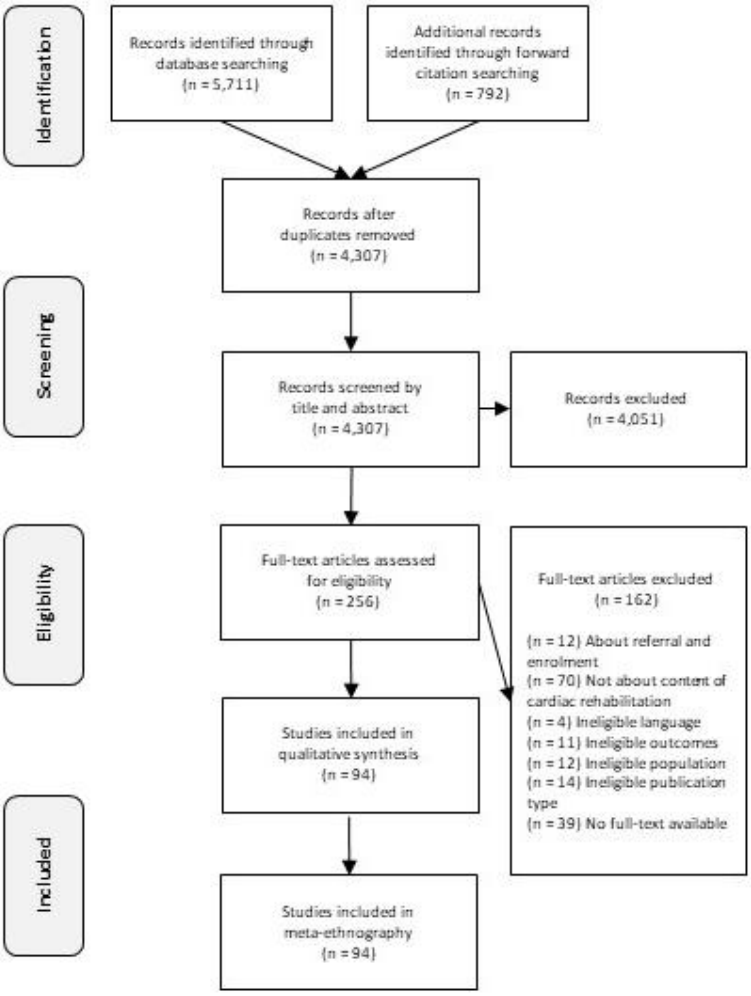
Bijlagen bij module C.2 'Volhouden en voltooien van de hartrevalidatie'

Bijlage C.2-1 Details zoekstrategie

Ovid MEDLINE, December 2023, 1,071 results
Patients
Exp Coronary Disease/ OR Exp Heart Failure/ OR Exp Dissection, Thoracic Aorta/ OR Cardiovascular Disease/ OR ("Coronary Disease*" OR "Coronary Heart Disease*" OR "Coronary Aneurysm*" OR "Coronary Artery Disease*" OR "Left Main Disease*" OR "Coronary Arterioscleros*" OR "Coronary Occlusion*" OR "Coronary Stenos*" OR "Coronary Artery Stenos*" OR "Coronary Restenos*" OR "Coronary Thrombos*" OR "Myocardial Ischemia*" OR "Myocardial Infarction*" OR "Ischemi* Heart Diseas*" OR "Acute Coronary Syndrome" OR "Angina Pectoris" OR "Myocardial Reperfusion*" OR "Coronary Reperfusion*" OR CABG OR "Heart Stent" OR "Cardiac Stent" OR "Heart Failure*" OR "Cardiac Failure*" OR "Heart Decompensatio*" OR "Cardiac Decompensatio*" OR "Decompensatio* Cordis" OR "Myocardial Failure*" OR HFNEF OR HFPEF OR HFREF OR "Thoracic Aorta Dissection*" OR "Thoracic Aortic Dissection*" OR "Descending Aorta Dissection*" OR "Aortic Arch Dissection*" OR "Ascending Aorta Dissection*" OR "Ascending Aortic Dissection*" OR "Aortic Root Dissection*").ti,ab,kf.
Intervention
Cardiac Rehabilitation/ or Aneurysm, Dissecting/rh or Aortic Aneurysm, Thoracic/rh or Aortic Aneurysm/rh or Aortic Rupture/rh or Rehabilitation/ or Telerehabilitation/ or Exp Exercise Therapy/ OR Rehabilitation Centers/ OR (Rehabilitat* OR Telerehabilitation OR Telemedicine OR "Exercis* Therap*" OR "Physical Therap*" OR Physiotherap* OR Kinesiotherapy* OR "Movement Therap*").ti,ab,kf.
Outcome
Needs assessment/ OR (Needs OR Valu* OR View* OR Thought* OR Factor* OR Belief* OR Attitude* OR Perception* OR Experience* OR Facilitator* OR Barrier* OR Perspective* OR Preference* OR Requirement* OR Necessit* OR Requisit* OR Demand* OR Prerequisit*).ti,ab,kf.
Study type
Qualitative Research/ OR Focus Groups/ OR Interview.pt OR Interviews as Topic/ OR Narration/ OR Personal Narratives as Topic/ OR Grounded Theory/ OR Observational Studies as Topic/ OR Observational Study.pt OR Tape Recording/ OR thematic analys*.ti,ab,kf OR content analys*.ti,ab,kf OR focus group*.ti,ab,kf OR ethnograph*.ti,ab,kf OR ethnograf*.ti,ab,kf OR etnograf*.ti,ab,kf OR field stud*.ti,ab,kf OR phenomenolog*.ti,ab,kf OR narration*.ti,ab,kf OR narrative.ti,ab,kf OR qualitative stud*.ti,ab,kf OR qualitative analys*.ti,ab,kf OR qualitative research*.ti,ab,kf OR qualitative method*.ti,ab,kf OR multimethodolog*.ti,ab,kf OR mixed method*.ti,ab,kf OR observation*.ti,ab,kf OR grounded theory.ti,ab,kf OR audio recording*.ti,ab,kf OR tape recording*.ti,ab,kf OR audiotape*.ti,ab,kf OR ((semi-structured.ti,ab,kf OR semistructured.ti,ab,kf OR unstructured.ti,ab,kf OR informal.ti,ab,kf OR in-depth.ti,ab,kf OR indepth.ti,ab,kf OR face-to-face.ti,ab,kf OR structured.ti,ab,kf OR guide*.ti,ab,kf) AND (interview*.ti,ab,kf OR discussion*.ti,ab,kf OR questionnaire*.ti,ab,kf))

Bijlage C.2-2 Stroomdiagram selectieproces studies



Bijlage C.2-3 Redenen voor exclusie van full-text artikelen

Author and year	Reasons for exclusion
(Abramsohn et al., 2013)	Not about content of cardiac rehabilitation
(Afrasiabi-Far et al., 2009)	Ineligible language
(Ahmed et al., 2022)	Ineligible population
(Aiping et al., 2023)	No full-text available
(Albatini et al., 2023)	No full-text available
(Allsup et al., 2016)	No full-text available
(Amos et al., 2023)	No full-text available
(Andersen et al., 2021)	Ineligible population
(Andersson & Skar, 2017)	No full-text available
(Annable, 2009)	Ineligible publication type
(Anttila et al., 2019)	Not about content of cardiac rehabilitation
(Anttila et al., 2021)	Not about content of cardiac rehabilitation
(Arndt et al., 2009)	Ineligible population
(Arthur et al., 2001)	Ineligible outcomes
(Beasley & Dixon, 2013)	Ineligible population
(Bennett, 1992)	No full-text available
(Benson et al., 1997)	No full-text available
(Biswas et al., 2018)	Ineligible outcomes
(Blackwell et al., 2024)	Not about content of cardiac rehabilitation
(Blakoe et al., 2021)	Not about content of cardiac rehabilitation
(Blokzijl et al., 2021)	Not about content of cardiac rehabilitation
(Borah et al., 2023)	Not about content of cardiac rehabilitation
(Brugin & Cordero, 2023)	No full-text available
(Cacciata et al., 2022)	Not about content of cardiac rehabilitation
(Chauhan et al.)	Not about content of cardiac rehabilitation
(Cooper et al., 2005)	Ineligible outcomes
(D'Eath et al., 2013)	Not about content of cardiac rehabilitation
(Dalal et al., 2015)	Ineligible publication type
(Dale et al., 2015)	Not about content of cardiac rehabilitation
(Daw et al., 2022)	No full-text available
(Dawkes & Brown, 2018)	No full-text available
(Delmar et al., 2012)	Not about content of cardiac rehabilitation
(Desveaux et al., 2020)	Not about content of cardiac rehabilitation
(Dhaliwal et al., 2017)	Not about content of cardiac rehabilitation
(Dickerson, 1998)	Ineligible population
(Dinesen et al., 2019)	Not about content of cardiac rehabilitation
(Erban et al., 2022)	No full-text available
(Evans & Crust, 2015)	No full-text available
(Faller, 1989)	Ineligible language
(Falter et al., 2022)	Ineligible publication type
(Falter et al., 2021)	No full-text available
(Fernandez et al., 2008)	Ineligible population
(Finkelstein et al., 2022)	Not about content of cardiac rehabilitation
(Fitzpatrick et al., 2011)	No full-text available
(Fredriksson-Larsson et al., 2013)	Not about content of cardiac rehabilitation
(Fuda et al., 2024)	Ineligible outcomes

(Gallagher et al., 2008)	Not about content of cardiac rehabilitation
(Gassner et al., 2002)	Not about content of cardiac rehabilitation
(Gerbild et al., 2021)	Not about content of cardiac rehabilitation
(Gonzi & Cassar, 2017)	No full-text available
(Goodman et al., 2009)	Ineligible population
(Gregory et al., 2006)	Not about content of cardiac rehabilitation
(Griffiths et al., 2009)	Not about content of cardiac rehabilitation
(Groninger & Fischer, 2016)	No full-text available
(Hagan et al., 2007)	About referral and enrolment
(Hamborg et al., 2023)	Not about content of cardiac rehabilitation
(Henriksen & Rosenqvist, 2002)	Ineligible outcomes
(Henriksen & Rosenqvist, 2003)	Ineligible population
(Herber et al., 2017)	Ineligible outcomes
(Hilt et al., 2020)	Not about content of cardiac rehabilitation
(Hird et al., 2004)	About referral and enrolment
(Holder et al., 2015)	Not about content of cardiac rehabilitation
(Hutton & Perkins, 2008)	Not about content of cardiac rehabilitation
(Isselhard et al., 2022)	Not about content of cardiac rehabilitation
(Jaarsma et al., 2018)	Ineligible publication type
(Jackson et al., 2011)	No full-text available
(Jackson et al., 2000)	Not about content of cardiac rehabilitation
(Jillings, 2007)	No full-text available
(Johannsdottir et al., 2021)	Not about content of cardiac rehabilitation
(Jokar et al., 2017)	Not about content of cardiac rehabilitation
(Jones, 2014)	Ineligible publication type
(Jones et al., 2019)	Not about content of cardiac rehabilitation
(Jones et al., 2007)	Not about content of cardiac rehabilitation
(Kalantarzadeh et al., 2022)	Not about content of cardiac rehabilitation
(Karner et al., 2004)	Not about content of cardiac rehabilitation
(Kärner et al., 2004)	Not about content of cardiac rehabilitation
(Kaushal et al., 2022)	Not about content of cardiac rehabilitation
(Kerins et al., 2011)	Ineligible outcomes
(Khodneva et al., 2023)	No full-text available
(Klompstra et al., 2017)	Not about content of cardiac rehabilitation
(Knudsen et al., 2021)	Not about content of cardiac rehabilitation
(LaCharity, 1999)	Not about content of cardiac rehabilitation
(Lesage-Moussavou-Nzamba et al., 2020)	Not about content of cardiac rehabilitation
(Lidell et al., 1998)	Not about content of cardiac rehabilitation
(Lie et al., 2012)	Not about content of cardiac rehabilitation
(Lindback & Nordgren, 2015)	Not about content of cardiac rehabilitation
(Linnea Almstedt et al., 2016)	No full-text available
(Lundgren et al., 2018)	Not about content of cardiac rehabilitation
(MacInnes, 2005)	About referral and enrolment
(Madden et al., 2011)	About referral and enrolment
(Maiorana et al., 2015)	No full-text available
(Maleki et al., 2022)	About referral and enrolment
(Manderson & Warren, 2010)	Not about content of cardiac rehabilitation
(Manning et al., 2017)	No full-text available
(Marcellino et al., 2018)	No full-text available

(McAnirn et al., 2015)	No full-text available
(McCarthy et al., 2015)	Not about content of cardiac rehabilitation
(McCorry et al., 2009)	About referral and enrolment
(McHale et al., 2023)	No full-text available
(McLean & Timmins, 2007)	Ineligible population
(McPhillips et al., 2021)	Not about content of cardiac rehabilitation
(McPhillips et al., 2019)	Not about content of cardiac rehabilitation
(Mead et al., 2016)	Ineligible population
(Medich, 1995)	Ineligible publication type
(Medved & Brockmeier, 2011)	Ineligible outcomes
(Mehrpoya et al., 2018)	Not about content of cardiac rehabilitation
(Mitchell et al., 2014)	Not about content of cardiac rehabilitation
(Mitoff et al., 2005)	About referral and enrolment
(Nadarajah, 2012)	Ineligible publication type
(Ngeno et al., 2021)	No full-text available
(Northrup-Snyder, 2002)	Ineligible publication type
(O'Driscoll et al., 2007)	Ineligible outcomes
(Okwose et al., 2020)	Not about content of cardiac rehabilitation
(Pakrad et al., 2022)	No full-text available
(Pattenden et al., 2007)	Not about content of cardiac rehabilitation
(Pedersen et al., 2018)	Ineligible outcomes
(Piamjariyakul et al., 2012)	Not about content of cardiac rehabilitation
(Pourghane et al., 2013)	Ineligible language
(Pullen et al., 2009)	No full-text available
(Quigley, 2002)	Ineligible publication type
(Raisi et al., 2023)	Not about content of cardiac rehabilitation
(Rankin et al., 2002)	Not about content of cardiac rehabilitation
(Ravn et al., 2022)	Not about content of cardiac rehabilitation
(Regan-Moriarty et al., 2023)	Not about content of cardiac rehabilitation
(Robertson et al., 2010)	Not about content of cardiac rehabilitation
(Rolfe, 2012)	Ineligible publication type
(Rouleau et al., 2015)	No full-text available
(Rouleau et al., 2018)	About referral and enrolment
(Sanaie, Darvishpoor-Kakhki, & Ahmadi, 2021)	Not about content of cardiac rehabilitation
(Sanaie, Kakhki, & Ahmadi, 2021)	Not about content of cardiac rehabilitation
(Sawyer, 2022)	Ineligible population
(Schou et al., 2008)	Not about content of cardiac rehabilitation
(Scott & Allen, 2004)	About referral and enrolment
(Serves et al., 2023)	Not about content of cardiac rehabilitation
(Simony et al., 2015a)	No full-text available
(Simony et al., 2015b)	No full-text available
(Solano-Ruiz et al., 2021)	Not about content of cardiac rehabilitation
(Soleimani et al., 2009)	Ineligible language
(Stewart Eadie & Tane, 2010)	No full-text available
(Su et al., 2023)	Ineligible outcomes
(Sukeri et al., 2013)	Ineligible publication type
(Svedlund & Axelsson, 2000)	Not about content of cardiac rehabilitation
(Sweet et al., 2019)	Not about content of cardiac rehabilitation
(Talty et al., 2023)	No full-text available

(Taylor et al., 2010)	Ineligible publication type
(Theobald, 1997)	Ineligible population
(Tingstrom et al., 2015)	No full-text available
(Tod et al., 2002)	About referral and enrolment
(Turner et al., 2017)	Not about content of cardiac rehabilitation
(Vila & Rossi, 2008)	Not about content of cardiac rehabilitation
(Vistisen & Rodkjaer, 2014)	No full-text available
(Waterhouse et al., 2022)	No full-text available
(White et al., 2009)	No full-text available
(White et al., 2010)	No full-text available
(Wieslander et al., 2013)	No full-text available
(Winchester, 2000)	Ineligible publication type
(Wyer et al., 2001)	About referral and enrolment
(Xie et al., 2022)	About referral and enrolment
(Yang et al., 2023)	Not about content of cardiac rehabilitation
(Yang et al., 2024)	Not about content of cardiac rehabilitation
(Young, 1997)	Ineligible publication type
(Zhang et al., 2023)	Not about content of cardiac rehabilitation

Bijlage C.2-4 Kenmerken van de geïncludeerde studies

Authors, year, country	Study aim	Methodological approach	Sampling strategy	Data collection methods	Data analysis methods	Population (sample size)	Type of cardiac rehabilitation	Type of outcomes
Alavi et al., 2013, Iran	To provide an insight into the nature of these barriers in an Iranian context from the perspective of health care providers and users of cardiac rehabilitation services.	Not reported	Purposive	Individual semi-structured interviews	Thematic analysis	Healthcare professionals (n=10), patients with acute coronary syndrome (n=13), and family members (n=2)	Supervised center-based cardiac rehabilitation	Perceptions and experiences
Ammouri et al., 2017, Jordan	To describe the experiences of Jordanian patients when they suffered a myocardial infarction attack.	Hermeneutical approach	Purposive	Individual semi-structured interviews	Content analysis	Patients admitted with a first-time acute myocardial infarction diagnosis (n=5)	Supervised center-based cardiac rehabilitation	Experiences
Andersson et al., 2013, Sweden	To elucidate the meaning of the experience of younger people during their first year following a myocardial infarction.	Phenomenology	Purposive	Individual semi-structured interviews	Phenomenological–analysis according to Lindseth and Norberg	Younger people (< 55 years) with an initial myocardial infarction diagnosis within 12 months (n=17)	Supervised center-based cardiac rehabilitation	Experiences
Andersson et al.,	To describe the cardiac care	Not reported	Purposive	Individual semi-structur	Content analysis	Younger people (< 55	Supervised center-based	Experiences

2020, Sweden	experiences of post-myocardial infarction younger people and their next of kin.			ed interviews		years) with an initial myocardial infarction diagnosis within 12 months (n=13) and their next of kin (n=13)	cardiac rehabilitation	
Anttila et al., 2021, Sweden	To explore the different meanings patients give to the rehabilitation process.	Grounded theory	Purposeful	Focus group semi-structured interviews	Grounded theory	Cardiac patients after coronary angioplasty, coronary artery bypass grafting, or no operation (n=30).	Supervised center-based and web-based cardiac rehabilitation	Experiences
Astin et al., 2008, United Kingdom	To examine participants' experiences of cardiac rehabilitation and the nature of family support across a sample of South Asian and white cardiac patients and their carers.	Not reported	Convenience	Individual semi-structured interviews	Framework analysis	White (n=20) and South Asian (n=45) patients aged over 30 years with unstable angina (n=21), myocardial infarction (n=27) or coronary artery bypass graft (n=17); and their	Supervised center-based cardiac rehabilitation	Experiences

						carers (n=54).		
Bäck et al., 2017, Sweden	To explore aspects that influence patients' attendance at exercise-based cardiac rehabilitation after acute coronary artery disease.	Not reported	Relevance	Individual semi-structured interviews	Content analysis	Patients with ST-elevation myocardial infarction, non-ST-elevation myocardial infarction, or instable angina pectoris (n=16).	Supervised center-based cardiac rehabilitation	Experiences and aspects
Bäck et al., 2020, Sweden	To explore patients' perceptions of kinesiophobia in relation to physical activity and exercise two to three months after an acute myocardial infarction.	Not reported	Not reported	Individual semi-structured interviews	Content analysis	Patients with ST-elevation myocardial infarction or non-ST-elevation myocardial infarction (n=21).	Supervised center-based cardiac rehabilitation	Experiences and perceptions
Banerjee et al., 2010, Canada	To explore the potential cultural factors that facilitate participation in on-site cardiac rehabilitation sessions among South Asian patients living in Canada.	Not reported	Purposive	Individual semi-structured interviews	Thematic analysis	South Asian patients with a clinical diagnosis of angina, atherosclerosis, ischemic heart disease, myocardial infarction, or	Supervised center-based cardiac rehabilitation	Factors and facilitators

						congestive heart failure (n=16).		
Bardsgjerde et al., 2019, Norway	To explore patient participation in the myocardial infarction pathway.	Narrative approach	Purposive	Individual semi-structured interviews	Analytic lenses	Patients diagnosed with acute myocardial infarction living in areas more than 300 km away from a cardiac intervention hospital (n=10).	Supervised center-based cardiac rehabilitation	Experiences
Bardsgjerde et al., 2020, Norway	To explore nurses' perceptions of patient participation in different phases of the myocardial infarction pathway.	Hermeneutical approach	Purposive	Focus group semi-structured interviews	Hermeneutic analysis	Nurses working in cardiac care with at least one year of experience (n=22).	Supervised center-based cardiac rehabilitation	Perceptions and experiences
Bergman and Berterö, 2001, Sweden	To gain increased knowledge and understanding of what it means to be afflicted with coronary artery disease.	Hermeneutical approach	Purposeful	Individual semi-structured interviews	Hermeneutic analysis	Interviewees had to have coronary artery disease (n=8).	Supervised center-based cardiac rehabilitation	Experiences and factors
Bernt Jorgensen et al., 2023, Denmark	To improve our understanding of factors shaping the return-to-work process	Phenomenology	Purposive	Individual semi-structured interviews	Thematic analysis	Being diagnosed with heart failure within six and twenty-four	Supervised center-based cardiac rehabilitation	Experiences, needs, factors, barriers, and facilitators

	following a diagnosis of heart failure.					months; aged ≤60 years; and being employed at the time of diagnosis (n=18).		
Birtwistle et al., 2021, United Kingdom	To explore how family might contribute to patients' physical activity related rehabilitation from the perspective of cardiac rehabilitation professionals.	Pragmatist paradigm	Convenience	Individual semi-structured interviews	Thematic analysis	Cardiac rehabilitation professionals who had experience of working with myocardial infarction patients (n=14).	Supervised center-based cardiac rehabilitation	Experiences and views
Blackwell et al., 2024, United Kingdom	To explore the experiences of cardiac patients and significant others who participated in cardiac rehabilitation, dropped out, or declined.	Ethnography	Purposive	Two individual semi-structured interviews	Thematic analysis	Patients referred to the cardiac rehabilitation service at the supporting Trust (n=10) and significant others (n=7).	Supervised center-based cardiac rehabilitation	Experiences and reasons
Boothby et al., 2021, Canada	To characterize the experience of reengaging in sexual activity post-acute coronary syndrome.	Framework approach	Criterion	Dyadic semi-structured interviews	Thematic analysis	Patients who were post-acute coronary syndrome (n=6) and their partners (n=6).	Supervised center-based cardiac rehabilitation	Experiences and needs
Bourke et al.,	To identify the major factors	Not reported	Purposeful	Individual semi-structur	Thematic analysis	Current cardiac rehabilit	Supervised center-based	Experiences and factors

2022, Ireland	influencing participants' adherence and early drop-out from cardiac rehabilitation.			ed interviews		ation participants (n=14).	cardiac rehabilitation	
Clark et al., 2004, United Kingdom	To compare decision-making in relation to cardiac rehabilitation attendance in users, nonusers and patients with high attrition rates from a cardiac rehabilitation program in the West of Scotland.	Not reported	Purposive	Focus group semi-structured interviews	Thematic analysis	Patients who were diagnosed with myocardial infarction and treated with coronary artery bypass grafting (n=44).	Supervised center-based cardiac rehabilitation	Experiences and views
Crowley, 2010, Ireland	To determine the effect of the cardiac rehabilitation program on physical, functional and quality of life outcomes and to evaluate the clients' perspectives on the program.	Mixed-methods	Convenience	Focus group semi-structured interviews	Thematic analysis	Patients after coronary artery bypass grafting, percutaneous coronary intervention, aortic valve replacement, or mitral valve replacement (n=12).	Supervised center-based cardiac rehabilitation	Experiences and perspectives
Damlund et al., 2022, Denmark	To explore the reasons why patients drop out during the	Hermeneutical approach	Purposeful	Individual semi-structured interviews	Inductive systematic text condensations analysis	Informants had been diagnosed with a chronic	Supervised center-based cardiac rehabilitation	Experiences and reasons

	transition from a hospital-based cardiac rehabilitation program to local healthcare facilities.					heart disease and assigned to cardiac rehabilitation (n=12).		
De Oliveira Nascimento et al., 2021, Brazil	To examine the perception of patients with coronary artery disease about their participation in two cardiac rehabilitation models.	Not reported	Convenience	Individual semi-structured interviews	Grounded theory analysis	Patients with the following cardiac diagnoses or procedures: coronary artery disease, post-myocardial infarction, percutaneous coronary intervention, or coronary artery bypass grafting (n=28).	Supervised center-based cardiac rehabilitation (exercises versus exercise and education)	Experiences and perceptions
Dechaine et al., 2018, United States of America	To articulate the experiences of women in Phase II cardiac rehabilitation.	Not reported	Convenience	Individual semi-structured interviews	Content analysis	Patients after heart attack, myocardial infarction, heart surgery, or planned cardiac procedures (n=40).	Supervised center-based cardiac rehabilitation	Experiences, barriers, and facilitators
Desveaux et al., 2017, Canada	To explore the experiences of older	Not reported	Purposive	Individual semi-structured	Thematic analysis	Older adults with heart	Supervised center-based cardiac	Experiences and preferences

	adults with heart failure and chronic obstructive pulmonary disease with respect to maintaining physical activity following completion of cardiac or pulmonary rehabilitation			interviews		failure and chronic obstructive pulmonary disease (n=11).	rehabilitation	
Devi et al., 2014, United Kingdom	To explore patients' views regarding the acceptability and feasibility of a new web-based cardiac rehabilitation program.	Generic approach	Purposive	Individual semi-structured interviews	Thematic analysis	Patients diagnosed with coronary heart disease and treated with medication only, angioplasty, percutaneous coronary intervention, or coronary bypass surgery (n=16).	Unsupervised web-based cardiac rehabilitation	Thoughts, feelings, and experiences
Dreyer et al., 2021, United States of America	To characterize patients' experience of acute myocardial infarction and treatment.	Phenomenology	Not reported	Individual semi-structured interviews	Not reported	Patients with an acute myocardial infarction in the past 24 months (n=42).	Supervised center-based cardiac rehabilitation	Experiences
Dunckley et al., 2008, United	To identify post-discharge facilitators	Not reported	Purposive	Individual semi-structured	Thematic analysis	Patients who had undergone	Supervised center-based cardiac	Experiences

Kingdom	and barriers to recovery after coronary artery bypass grafting.			interviews		coronary artery bypass grafting (n=11) and health professionals experienced in caring for these patients (n=11).	rehabilitation	
East et al., 2004, United Kingdom	To explore myocardial infarction survivors' experiences of their heart attack.	Not reported	Random	Individual semi-structured interviews	Thematic analysis	Patients from southeast Nottingham with myocardial infarction (n=20).	Supervised center-based cardiac rehabilitation	Experiences, views, and ideas
Elbrond et al., 2022, Denmark	To explore how men experience and manage their health while suffering from ischaemic heart disease.	Phenomenology	Criterion	Individual semi-structured interviews	Phenomenological analysis according to Ricoeur	Male patients with ischemic heart disease and a referral for coronary artery bypass graft or percutaneous coronary intervention (n=21).	Before participating in cardiac rehabilitation	Experiences
Ellis et al., 2019, United States of America	To provide a prototypical patient narrative of the cardiac rehabilitation experience for providers	Narrative approach	Not reported	Individual semi-structured interviews	Thematic framework analysis	Cardiac rehabilitation participants with myocardial infarction, heart failure, coronary	Supervised center-based cardiac rehabilitation	Experiences

	and prospective patients.					artery bypass graft, or percutaneous coronary intervention (n=17).		
Eriksson et al., 2009, Sweden	To describe the patient's and his/her partner's experiences after hospital discharge following acute myocardial infarction.	Not reported	Purposive	Individual semi-structured interviews	Content analysis	Patients with a first-time acute myocardial infarction (n=15) and their partner (n=15).	Not reported	Experiences
Feinberg et al., 2018, United States of America	To examine the feasibility and acceptability of an adapted cardiac rehabilitation program for the home care setting	Mixed-methods	Not reported	Individual semi-structured interviews	Thematic analysis	Patients with heart failure or coronary artery disease (n=28) and home care clinicians (n=11).	Supervised home-based cardiac rehabilitation	Experiences
Fletcher et al., 2014, Australia	To evaluate a community-based, cardiac rehabilitation program.	Not reported	Convenience	Focus group semi-structured interviews	Content analysis	Patients with a diagnosis of cardiovascular disease and stable medical condition (n=18).	Supervised community-based cardiac rehabilitation	Experiences
Fletcher and McBurney, 2016, Australia	To explore decision-making drivers for attendance or nonattendance at	Not reported	Convenience	Individual semi-structured interviews	Thematic analysis	Attenders and nonattenders with coronary artery disease	Supervised center-based or unsupervised community-based cardiac	Experiences

	cardiac rehabilitation programs.					or heart failure in rural Victoria, Australia (n=10).	rehabilitation	
Fors et al., 2014, Sweden	To explore patients' experiences of acute coronary syndrome during their hospital stay.	Hermeneutical approach	Strategic	Individual semi-structured interviews	Phenomenological–analysis according to Lindseth and Norberg	Patients with acute myocardial infarction or unstable angina pectoris (n=12).	Not reported	Lived experiences
Galdas and Kang, 2010, Canada	To explore the experiences of Punjabi Sikh patients with post myocardial infarction.	Grounded theory	Theoretical	Individual semi-structured interviews	Grounded theory analysis	Patients with myocardial infarction, self-identified as Sikh and Punjabi speaking (n=15).	Supervised center-based cardiac rehabilitation	Experiences
Galdas et al., 2012, Canada	To describe Punjabi Sikh patients perceived barriers to engaging in physical exercise following myocardial infarction.	Hermeneutical approach	Theoretical	Individual semi-structured interviews	Thematic analysis	Patients with myocardial infarction, self-identified as Sikh and Punjabi speaking (n=15).	Supervised center-based cardiac rehabilitation	Experiences
Ghezeljeh et al., 2013, Iran	To explore how Iranian patients with coronary heart disease experience their lives.	Grounded theory	Purposive	Individual semi-structured interviews	Grounded theory analysis	Patients with angina pectoris living in Iran (n=24).	Not reported	Experiences
Hellem and Bruusgard,	To explore the impact the cardiac event has on	Phenomenology	Purposive	Focus group and individual semi-	Phenomenological analysis according to Giorgi	Women who had experienced an acute	Supervised center-based cardiac	Experiences

2020, Norway	emotional and bodily experiences.			structured interviews		myocardial infarction and/or cardiac surgery and/or PCI, age ≥40, and living at home (n=20).	rehabilitation	
Hudson et al., 2001, United Kingdom	To examine the experiences of cardiac rehabilitation patients within the framework of psychological loss.	Not reported	Purposive	Individual semi-structured interviews	Content analysis	Patients who experienced at least one myocardial infarction during the previous five years (n=12).	Supervised center-based cardiac rehabilitation	Experiences
Hwang et al., 2017, Australia	To describe patient experiences of a group-based heart failure telerehabilitation program.	Mixed-methods	Purposeful	Self-report surveys and individual semi-structured interviews	Thematic analysis	Patients with stable chronic heart failure (n=17).	Supervised web-based cardiac rehabilitation	Experiences and perspectives
Jackson et al., 2012, United Kingdom	To understand non-participation in cardiac rehabilitation and coronary heart disease self-help groups from the perspectives of the non-participants.	Not reported	Stratified	Individual semi-structured interviews	Grounded theory analysis	Patients with myocardial infarction not participating in cardiac rehabilitation (n=27) and their significant others (n=17).	Supervised center-based cardiac rehabilitation	Experiences

Jones et al., 2009, United Kingdom	To compare the views of patients who had completed a home or hospital-based cardiac rehabilitation program.	Randomized controlled trial	Purposive	Focus group semi-structured interviews	Thematic analysis	Patients with myocardial infarction or after revascu-larization (n=26).	Unsupervised home-based or supervised center-based cardiac rehabilitation	Experiences and views
Junehag et al., 2014a, Sweden	To describe individual perceptions of their lifestyle and support one year after an acute myocardial infarction.	Not reported	Consecutive	Individual semi-structured interviews	Content analysis	Patients one year after an acute myocardial infarction with and without a mentor (n=20).	Not reported	Perceptions
Junehag et al., 2014b, Sweden	To describe individuals' perceptions of the psychosocial consequences of an acute myocardial infarction.	Not reported	Purposeful	Individual semi-structured interviews	Content analysis	Patients after first-time acute myocardial infarction (n=20).	Not reported	Perceptions and experiences
Kenny et al., 2023, Northern Ireland	To explore the experiences of patients who participated in digital cardiac rehabilitation programs.	Critical realist approach	Convenience	Individual semi-structured interviews	Thematic analysis	Patients with cardiovascular disease (n=11).	Supervised web-based cardiac rehabilitation	Experiences
Koivunen et al., 2005, Finland	To describe the experience of rehabilitation reported by coronary artery	Not reported	Not reported	Thematic questionnaires	Content analysis	Patients after coronary artery bypass grafting (n=14).	Supervised center-based cardiac rehabilitation	Experiences

	disease patients.							
Kristoffer zon et al., 2008, Sweden	To describe experiences of present everyday life after a myocardial infarction.	Not reported	Not reported	Individual semi-structured interviews	Content analysis	Swedish women and men 4–6 months after a myocardial infarction (n=39).	Supervised center-based cardiac rehabilitation	Experiences and expectations
Lee L.S. et al., 2022, Canada	To explore the experiences and attitudes of women with coronary artery disease with respect to attending cardiac rehabilitation.	Randomized controlled trial	Purposive	Focus group semi-structured interviews	Thematic analysis	Post-menopausal women with coronary artery disease (n=9).	Supervised center-based cardiac rehabilitation	Experiences and attitudes
Lee M. et al., 2022, Canada	To identify and understand factors impacting cardiac rehabilitation program dropout.	Not reported	Purposive	Individual semi-structured interviews	Thematic analysis	Patients with cardiovascular disease who dropped out from a cardiac rehabilitation program (n=23).	Supervised center-based cardiac rehabilitation	Experiences
Liljeroos et al., 2022, Sweden	To explore the self-perceived cognitive status and cognitive challenges associated with lifestyle changes in cardiac rehabilitation.	Not reported	Purposive	Individual semi-structured interviews	Thematic analysis	Myocardial infarction patients over 65 years old (n=9).	Supervised center-based cardiac rehabilitation	Perceptions and experiences

Lotto et al., 2022, United Kingdom	To gain a contemporary understanding of the experiences of South Asian patients as they navigate their cardiac rehabilitation journey.	Not reported	Purposeful	Individual semi-structured interviews	Grounded theory	South Asian patients with coronary heart disease (n=6).	Supervised center-based cardiac rehabilitation	Experiences
Maddocks and Cobbing, 2017, South Africa	To explore and describe patients' experiences and perceptions of phase 1 cardiac rehabilitation.	Naturalistic approach	Purposive	Focus group semi-structured interviews	Not reported	Patients who had undergone coronary artery bypass graft (n=9).	Phase 1 supervised center-based cardiac rehabilitation	Experiences
McAuliffe et al., 2021, Ireland	To identify the active ingredients of a community-based cardiac rehabilitation program.	Multimethod design	Convenience	Observations and focus group semi-structured interviews	Thematic analysis	Cardiac rehabilitation patients with a subgroup myocardial infarction patients (n=42).	Supervised community-based cardiac rehabilitation	Perceptions and experiences
McIntosh et al, 2017, United States of America	To better understand the contextual factors that influence patient participation in cardiac rehabilitation.	Not reported	Not reported	Individual semi-structured interviews	Grounded theory	Cardiac rehabilitation eligible patients with coronary heart diseases (n=16) and cardiac rehabilitation providers and	Supervised center-based cardiac rehabilitation	Perceptions and experiences

						staff (n=15).		
McSweeney and Crane, 2001, United States of America	To explore the factors that have influenced continuation of the cardiac rehabilitation program of women.	Naturalistic approach	Purposive	Questionnaires and two individual semi-structured interviews	Content analysis	Women who had experienced their first myocardial infarction within the previous 6 weeks to 12 months (n=40).	Supervised center-based cardiac rehabilitation	Experiences
Mendell et al., 2019, Canada	To understand needs and challenges patients have with cardiac rehabilitation and the virtual cardiac rehabilitation program in particular.	Randomized controlled trial	Consecutive	Chat sessions	Not reported	Patients admitted for acute coronary syndrome, residing in areas with no outpatient cardiac rehabilitation program (n=21).	Supervised web-based cardiac rehabilitation	Experiences, needs, and challenges
Merritt et al., 2017, United Kingdom	To understand how a sample of men under 45 adjusted to and made sense of myocardial infarction.	Phenomenology	Purposive	Individual semi-structured interviews	Interpretative phenomenological analysis	Patients with myocardial infarction aged under 45 (n=10).	Supervised center-based cardiac rehabilitation	Experiences
Mohammadi et al., 2019, Iran	To analyze the concept of care needs in phase 1 cardiac rehabilitation.	Hybrid approach	Purposive	Individual semi-structured interviews	Content analysis	Patients with coronary artery disease (n=6), nurses (n=5), and a	Phase 1 supervised center-based cardiac rehabilitation	Experiences and needs

						surgeon (n=1).		
Mooney et al., 2007, Ireland	To describe patients' experience of a pre-operative program of cardiac rehabilitation.	Phenomenology	Purposive	Individual un-structured interviews	Framework analysis	Patients who had completed a 12-week pilot program of cardiac rehabilitation, designed for patients awaiting coronary artery bypass grafting (n=7).	Pre-operative supervised center-based cardiac rehabilitation	Experiences
Murray et al., 2000, Canada	To identify experiences and needs of women with coronary artery disease.	Not reported	Semi-random	Focus group semi-structured interviews	Grounded theory	Women with coronary artery disease and who were within two years of their most recent cardiac event (n=17).	Supervised center-based cardiac rehabilitation	Experiences and needs
Nadarajah et al., 2017, United States of America	To explore the lived experiences of cardiac recovery in cardiac rehabilitation individuals with a predominantly positive outlook in the context of an acute	Phenomenology	Purposive	Individual semi-structured interviews	Phenomenological analysis according to Colaizzi	Patients that had experienced an acute cardiac event, had completed phase two cardiac rehabilitation, and had reported a	Phase 2 supervised center-based cardiac rehabilitation	Lived experiences

	cardiac event.					predominantly positive outlook post cardiac event (n=10).		
Nilsson et al., 2023, Sweden	To describe patients' perceptions of performing exercise-based cardiac telerehabilitation after a myocardial infarction.	Not reported	Purposive	Individual semi-structured interviews	Content analysis	A diagnosis of myocardial infarction and age ≤ 80 years with access to internet or a device (n=15).	Supervised web-based cardiac rehabilitation	Perceptions and experiences
O'Shea et al., 2020, Ireland	To explore participants' views and experiences of an eHealth phase 3 cardiac rehabilitation intervention.	Randomized controlled trial	Not reported	Questionnaires	Framework analysis	Patients referred to cardiac rehabilitation after cardiac intervention or surgery (n=43).	Unsupervised web-based cardiac rehabilitation	Views and experiences
Pâquet et al., 2005, Canada	To describe how cardiac patients experience the first three months following a cardiac event requiring hospitalization.	Not reported	Purposeful	Focus group semi-structured interviews	Content analysis	People hospitalized for a myocardial infarction, angina pectoris or percutaneous coronary angioplasty (n=20).	Supervised center-based cardiac rehabilitation	Experiences and needs
Pedersen et al., 2017, Denmark	To explore the patient experience of barriers to	Hermeneutical approach	Purposeful	Individual or dyadic semi-structur	Framework analysis	Patients with acute coronary syndrom	Supervised phase 2 center-based cardiac	Experiences and barriers

	completion of phase 2 cardiac rehabilitation.			ed interviews		e (n=24) and their close-relatives (n=12).	rehabilitation	
Pedersen et al., 2021, Denmark	To explore mastery of everyday life and social support needs in older, vulnerable women with myocardial infarction and their relatives.	Not reported	Purposive	Individual or dyadic semi-structured interviews	Thematic analysis	Myocardial Infarction survivors (n=21) and their close-relatives (n=13)	Supervised center-based cardiac rehabilitation	Experiences and needs
Pryor et al., 2014, Australia	To identify the issues that require support for individuals who have experienced a cardiac event and completed a cardiac rehabilitation program	Not reported	Purposive and convenience	Individual semi-structured interviews	Grounded theory analysis	Patients with myocardial infarction of ischemic chest pain (n=9).	Supervised phase 2 center-based cardiac rehabilitation	Experiences and needs
Resurrección et al., 2018, Spain	To explore women's perceptions about the reasons they faced for dropout from cardiac rehabilitation programs.	Grounded theory	Theoretical	Individual and focus group semi-structured interviews	Grounded theory analysis	Women with cardiovascular disease, having dropped out of cardiac rehabilitation (n=10); and professionals (n=7).	Supervised center-based cardiac rehabilitation	Experiences and reasons
Rolfe et al., 2010, Canada	To explore how the principle of ''accessible programs'' is	Not reported	Purposive and random	Individual semi-structured interviews	Grounded theory analysis	Women with cardiovascular disease or at risk	Supervised center-based cardiac rehabilitation	Experiences

	experienced by women.					for cardiovascular disease (n=14).		
Seto Nielsen et al., 2012, Canada	To examine how and under what circumstances immigrants combine diabetes self-care with cardiac rehabilitation recommendations.	Ethnography	Purposeful	Two individual semi-structured interviews and an activity journal	Not reported	Long-term immigrants in Canada with type 2 diabetes and coronary heart disease in the first three months of their enrolment in cardiac rehabilitation (n=18).	Supervised center-based cardiac rehabilitation	Experiences
Simonÿ and Pedersen et al., 2015, Denmark	To investigate patients' lived experiences of exercise-based cardiac rehabilitation.	Phenomenology	Not reported	Individual and focus group semi-structured interviews and field notes	Phenomenological analysis according to Ricoeur	Patients with unstable angina pectoris or myocardial infarction (n= not reported).	Supervised center-based cardiac rehabilitation	Lived experiences and needs
Simonÿ and Dreyer et al., 2015, Denmark	To understand how patients afflicted by a minor heart attack experience their life situation when following cardiac	Ethnography	Not reported	Individual and focus group semi-structured interviews and field notes	Phenomenological analysis according to Ricoeur	Patients with unstable angina pectoris or myocardial infarction (n=11).	Supervised center-based cardiac rehabilitation	Lived experiences

	rehabilitation.							
Simonÿ et al., 2017, Denmark	To understand how patients afflicted by a minor heart attack experience their life situation when following cardiac rehabilitation.	Phenomenology	Not reported	Individual and focus group semi-structured interviews	Phenomenological analysis according to Ricoeur	Patients with unstable angina pectoris or myocardial infarction (n=11).	Supervised center-based cardiac rehabilitation	Experiences
Sloots et al., 2011, The Netherlands	To explore treatment experiences in patients from Moroccan and Turkish origin regarding an adapted cardiac rehabilitation program.	Not reported	Not reported	Individual semi-structured interviews	Grounded theory analysis	Turkish, Moroccan and Dutch patients diagnosed with coronary artery disease (n=11); and native Dutch physical therapists and social workers (n=5).	Adapted and regular supervised center-based cardiac rehabilitation	Experiences
Smith et al., 2017, Ireland	This study investigated experiences of women with a primary diagnosis of acute coronary syndrome.	Case study	Purposive	Individual semi-structured interviews and diaries	Modified analytic induction	Women with a primary presentation of acute coronary syndrome in the six-eight week period following discharge from	Supervised center-based cardiac rehabilitation	Experiences

						hospital (n=30).		
Strömbäck et al., 2020, Sweden	To describe patients' expressed needs during cardiac rehabilitation after suffering a second myocardial infarction in comparison to personnel's descriptions of how they work with these patients.	Not reported	Not reported	Individual semi-structured interviews	Content analysis	Patients diagnosed with having a second myocardial infarction (n=8) and healthcare professionals working in cardiac rehabilitation (n=11).	Supervised center-based cardiac rehabilitation	Needs and experiences
Sutantri et al., 2019a, Indonesia	To explore factors that influence women's attendance of a phase two cardiac rehabilitation program in Indonesia.	Not reported	Purposive	Individual semi-structured interviews	Framework analysis	Indonesian women who had experienced a cardiac event within the last three months (n=23).	Supervised phase 2 center-based cardiac rehabilitation	Experiences, factors, and needs
Sutantri et al., 2019b, Indonesia	To understand how gender shapes Indonesian women's experiences of living with heart disease in their daily lives.	Feminist approach	Purposive	Individual semi-structured interviews	Framework analysis	Indonesian women who had undergone cardiac surgery (n=26).	Supervised center-based cardiac rehabilitation	Experiences
Sutton et al., 2012, Canada	To explore the multidimensionality of safety in cardiac rehabilitati	Not reported	Random	Individual semi-structured interviews	Thematic analysis	Women that participated in a women's only cardiac	Supervised center-based cardiac rehabilitation	Experiences

	on programs as perceived by women.					rehabilitation program (n=14).		
Svedlund and Danielson, 2004, Sweden	To illuminate the meaning of lived experiences in daily life after an acute myocardial infarction.	Hermeneutical approach	Not reported	Four individual narrative interviews	Phenomenological analysis according to Ricoeur	Women aged under 60 years with an acute myocardial infarction (n=9) and their partners (n=9).	Supervised center-based cardiac rehabilitation	Lived experiences
Thompson et al., 2022, United Kingdom	To understand barriers and facilitators to cardiac rehabilitation enrollment and long-term exercise training.	Critical realist approach	Convenience	Individual and dyadic semi-structured interviews	Thematic analysis	Post-acute myocardial infarction patients (n=10) and their significant others (n=10).	Supervised phase 3 center-based cardiac rehabilitation	Experiences, views, and opinions
Tolmie et al., 2006, United Kingdom	To explore patients' perspectives on the effects of coronary artery bypass surgery on health and well-being over time.	Mixed-methods	Not reported	Individual semi-structured interviews	Thematic analysis	Patients who had undergone coronary artery bypass grafting over 7 years ago (n=62).	Supervised center-based cardiac rehabilitation	Experiences
Tulloch et al., 2020, Canada	To assess the intervention needs and desires of patients with cardiovascular disease and their partners.	Not reported	Purposive	Focus group semi-structured interviews	Content analysis	Patients who experienced a cardiovascular event and were in a couple relationship	Supervised center-based cardiac rehabilitation	Needs, desires, and experiences

						(n=16), and their partners (n=16).		
Tully et al., 2010, Ireland	To explore patients' experiences of structured heart failure programs.	Not reported	Not reported	Focus group semi-structured interviews	Content analysis	Participants had been diagnosed with heart failure for at least one year (n=15).	Supervised center-based cardiac rehabilitation	Experiences
Velvin et al., 2021, Norway	To explore the experiences on physical exercise before and after being diagnosed with hereditable thoracic aortic disease.	Not reported	Convenience and purposive	Focus group semi-structured interviews	Inductive systematic text condensations analysis	Participants were diagnosed with Marfan syndrome (n=14), vascular Ehlers-Danlos syndrome (n=11), or Loeys-Dietz syndrome (n=11).	Supervised center-based cardiac rehabilitation	Experiences, barriers, facilitators, and strategies
Visram et al., 2008, United Kingdom	To describe experiences and perceptions of cardiac rehabilitation among a sample of women from South Asian communities.	Not reported	Not reported	Two individual and one focus group semi-structured interview	Thematic analysis	Clients with coronary heart disease (n=9) and community health development workers (n=4).	Supervised center-based cardiac rehabilitation	Experiences and perceptions
Walthall et al., 2020, United Kingdom	To deliver an adapted cardiac rehabilitation program for people entering the advanced stages of	Intervention study	Convenience	Individual semi-structured interviews	Thematic analysis	Patients with a diagnosis of chronic heart failure and an expected	Adapted supervised hospice-based cardiac rehabilitation	Experiences

	heart failure trajectory in a day hospice.					survival greater than 10 weeks from the start of the program (n=12).		
Webster et al, 2002, United Kingdom	To explore the experiences and needs of Gujarati Hindu myocardial infarction patients and their partners.	Not reported	Theoretical	Individual semi-structured interviews	Content analysis	Gujarati Hindu myocardial infarction patients in the first month after diagnosis (n=35) and their partners (n= not reported).	Supervised center-based cardiac rehabilitation	Experiences and needs
Wieslander et al., 2016, Sweden	To explore how women's recovery process is promoted after a first myocardial infarction	Not reported	Purposive	Individual semi-structured interviews	Content analysis	Women suffering a first myocardial infarct (n=26).	Supervised center-based cardiac rehabilitation	Experiences and needs
Wingham et al., 2006, United Kingdom	To explore patients' experience of myocardial infarction.	Phenomenology	Purposive	Individual semi-structured interviews	Interpretive phenomenological analysis	Patients with a recent myocardial infarction (n=17).	Supervised center-based versus unsupervised home-based cardiac rehabilitation	Experiences
Wong et al., 2016, Hong Kong	To examine the attitudes of Chinese patients with coronary heart disease	Not reported	Purposeful	Individual semi-structured interviews	Content analysis	Chinese adults diagnosed with coronary heart disease (n=22).	Supervised center-based cardiac rehabilitation	Attitudes and experiences

	toward the outpatient cardiac rehabilitation program.							
Yang and Sun et al., 2023, China	To explore a conceptual model of home-based cardiac rehabilitation exercise adherence.	Grounded theory	Purposive and theoretical	Individual semi-structured interviews	Grounded theory analysis	Patients with chronic heart failure (n=21).	Unsupervised home-based cardiac rehabilitation	Experiences and values
Yang and Zheng et al., 2023, China	To explore perceived barriers to adherence to home-based cardiac rehabilitation exercise in patients with chronic heart failure.	Not reported	Purposive	Individual semi-structured interviews	Thematic analysis	Patients with chronic heart failure (n=16).	Unsupervised home-based cardiac rehabilitation	Experiences and barriers
Yates et al., 2018, United States of America	To examine patients' and partners' perceptions of phase 2 cardiac rehabilitation.	Randomized controlled trial	Purposive	Individual semi-structured interviews	Content analysis	Patients had undergone coronary artery bypass graft surgery (n=11) and their partners (n=11).	Phase 2 supervised center-based cardiac rehabilitation	Experiences

Bijlage C.2-5 Beoordeling individuele studiekwaliteit

De opmaak van de richtlijn laat het niet toe om deze bijlage te presenteren. Graag verwijzen we nu naar Appendix H van het wetenschappelijke artikel.

Bijlage C.2-6 GRADE-CERQual Evidence Profile

Objective: To synthesize the needs of patients with coronary heart disease, heart failure, or thoracic aortic dissection regarding cardiac rehabilitation
Context: Needs of patients, close-relatives, and healthcare professionals regarding phase 0-4, both home-based and center-based, both unsupervised and supervised, cardiac rehabilitation.

Summarized review finding	Studies	Cerqual rating	
		Confidence	Explanation
Patients need safety by learning to manage symptoms, being in a safe environment, and receiving clear exercise instructions; however, patients also experience overprotection by significant others	[28-35, 39, 42, 45, 48-51, 53, 57, 60-63, 65-67, 70, 71, 73, 77-81, 84-88, 90, 96-98, 100, 101, 103, 106, 108-111, 113-115, 117, 119]	⊕⊕⊕⊕ High confidence	No/Very minor concerns regarding methodological limitations, coherence, adequacy, and relevance.

Methodological limitations No/Very minor concerns	Explanation: This review finding is interpretive and explanatory in nature. There are 24 interpretive studies and explanatory studies (e.g., interpretive phenomenological analysis and grounded theory analysis) that support the nature of this review finding. The aspects of safety, symptoms, and exercise instructions are hardly mentioned in research questions, objectives, and topic lists. However, participants are sufficiently invited to share perspectives on safety and, therefore, the aspects of safety are thoroughly studied.
Coherence No/Very minor concerns	Explanation: There is some data that patients do not have to learn to cope with their symptoms. They accept or ignore symptoms and then move on. This contradicts our third-order construct "learning to manage symptoms". Furthermore, telerehabilitation and home-based rehabilitation are also considered safe environments. In addition, some patients actually need pushing by significant others, although not in the context of safety but more in the context of motivation. The data are clear and we have found no plausible alternative explanations.
Adequacy No/Very minor concerns	Explanation: This review finding is interpretive and explanatory in nature. There are 54 studies contributing to this finding. Ten of these studies explained explicitly the need for symptom management, 5 the safe environment, 9 clear exercise instructions and 7 avoiding overprotection. The data are very rich; both about the need for safety and the third-order constructs themselves.
Relevance No/Very minor concerns	Explanation: The supporting studies fully reflect the context of the review, i.e., patients with coronary artery disease, heart failure, or thoracic aortic dissection regarding cardiac rehabilitation. For safety, supervised cardiac rehabilitation versus unsupervised cardiac rehabilitation seems especially important in terms of context. In addition, safety has been specifically studied in subgroups, such as women and minorities. Data from all contexts are included in this review finding.

Summarized review finding	Studies	Cerqual rating	
		Confidence	Explanation
Patients need significant others to be involved; partly to get support from the significant others and partly to get support for the significant others	[26-29, 31, 33, 34, 37, 39, 41, 46, 47, 49, 50, 52, 53, 55, 57, 62, 65-67, 69-71, 76, 77, 83-86, 88-93, 95, 96, 99, 102, 106, 108, 111, 113, 114, 116, 119]	⊕⊕⊕⊕ High confidence	No/Very minor concerns regarding methodological limitations, coherence, adequacy, and relevance.

Methodological limitations No/Very minor concerns	Explanation: The perspective of significant others and the concept of 'involvement' are explicitly studied in four studies. In fourteen studies, significant others participate in the study. In these studies, the perspective of partners is most strongly represented. However, the perspective of other family members or caregivers is also studied. Both duo and individual interviews are performed with patients and significant others.
Coherence No/Very minor concerns	Explanation: There is some concern about too much involvement of significant others, which makes patients feel their autonomy or privacy is compromised. This contradicts our third-order construct "support from significant others". The data are clear and we have found no plausible alternative explanations.
Adequacy No/Very minor concerns	Explanation: This review finding is relatively descriptive in nature. There are 48 studies contributing to this finding. 24 of these studies explicitly describe the need for support from significant others, and 32 the need for support for significant others. The data are very rich; both on the need for significant others to be involved and on the third-order constructs themselves.
Relevance No/Very minor concerns	Explanation: The supporting studies fully reflect the context of the review, i.e., patients with coronary artery disease, heart failure, or thoracic aortic dissection regarding cardiac rehabilitation. The "others" included in the studies are relevant to the research question, and there is much diversity in "others" (partners, family members, caregivers, friends, neighbours, employers, or workmates).

Summarized review finding	Studies	Cerqual rating	
		Confidence	Explanation
Patients need support from people with whom they can identify such as peers with the same age, sex, disease or fitness level	[26, 29, 30, 38, 39, 42-48, 50, 54, 57, 60, 63-67, 70, 71, 73, 74, 76, 78, 80, 84-86, 88, 89, 91-94, 98, 99, 102, 104, 107-112, 114-116]	⊕⊕⊕◯ Moderate confidence	Minor concerns regarding methodological limitations, because triangulation of participants and data are limited. Minor concerns regarding coherence, because of plausible alternative explanations, No/Very minor concerns regarding adequacy and relevance.

Methodological limitations Minor concerns	Explanation: Minor concerns regarding methodological limitations because the concept of 'peer support' is not explicitly mentioned in the study objectives. Three studies do focus on support, after which peer support is studied in depth. However, these studies have performed no purposive recruitment to explore other perspectives on peer support. It is possible that a specific perspective is understudied, such as peers with the same culture, or a different perspective, such as peers becoming too involved. Moreover, there are no observations performed in the studies, which might have led to improved knowledge about group dynamics and peer support.
Coherence Minor concerns	Explanation: Minor concerns regarding coherence because contradictory data have been found that there are patients who resist group training or group dynamics; these patients prefer individual rehabilitation. In addition, there are data that patients do not need to have patients with the same disease around them. They identify with peers with a different characteristic. This contradicts our third-order construct "peers with the same disease." The data are clear. We have found some plausible alternative explanations for the need for peer support, such as information exchange, sharing experiences and effective use of resources. These are different concepts than identify.
Adequacy No/Very minor concerns	Explanation: This review finding is relatively descriptive in nature. There are 50 studies contributing to this finding. Six of these studies explicitly described the need for peers with the same age, ten same sex, five same disease, and four same fitness level. The data supporting the need for peers with the same disease are less rich; however, we have found no grounds for concern.
Relevance No/Very minor concerns	Explanation: The supporting studies fully reflect the context of the review, i.e., patients with coronary artery disease, heart failure, or thoracic aortic dissection regarding cardiac rehabilitation. For peer support, group-based versus individual cardiac rehabilitation seems especially important in terms of context. Data from both contexts are included in this review finding. The "peers" included in the studies are specified in the review finding.

Summarized review finding	Studies	Cerqual rating	
		Confidence	Explanation
Patients need personalized care with personal attention, personalized goals, aftercare and culture-sensitive professionals	[28, 29, 31, 33, 34, 44, 49, 51, 57-60, 66, 69, 71, 72, 76, 78, 81, 87, 88, 90, 92, 94, 96, 100, 109-111, 116]	⊕⊕⊕◯ Moderate confidence	Minor concerns regarding methodological limitations, because few studies specifically inquired personalized care. No/Very minor concerns regarding coherence, adequacy, and relevance

Methodological limitations Minor concerns	Explanation: Minor concerns regarding methodological limitations because there is no specific research on personalized care or tailored care needs. This might leave specific perspectives underexposed, for example why professionals choose one size fits all programs or what economic considerations are important. However, within the methodology used, sufficient attention has been paid to identifying the needs of specific subgroups such as Punjabi Sikh, South Asian and younger populations.
Coherence No/Very minor concerns	Explanation: The data contain no contradictions and are clear. However, there are plausible alternative explanations for needs related to personalized care, such as alignment with personal values, beliefs and shared decision-making.
Adequacy No/Very minor concerns	Explanation: This review finding is relatively explanatory in nature. There are 30 studies contributing to this finding. Eleven of these studies explicitly explore the need personal attention, five personalized goals, 12 aftercare, and 3 culture-sensitive professionals. The data supporting the need for personalized goals are less rich; however, we have found no grounds for concern.
Relevance No/Very minor concerns	Explanation: The supporting studies fully reflect the context of the review, i.e., patients with coronary artery disease, heart failure, or thoracic aortic dissection regarding cardiac rehabilitation. The need for personalized care is often explicitly described in specific groups (e.g., age- or culture-specific groups). Nevertheless, there is no indirect relevance or partial relevance, because the need for personalized care applies to the wider cardiac rehabilitation population.

Summarized review finding	Studies	Cerqual rating	
		Confidence	Explanation
Patients need help redesigning a meaningful future so they can regain control of their lives, reflect on their recovery and learn to cope with their changed identity	[27-30, 37, 38, 43, 46, 47, 49-51, 53-55, 61-64, 66, 69, 70, 72, 74, 77, 82, 83, 85, 90, 92, 93, 96, 97, 102, 103, 105, 111, 113, 114, 118]	⊕⊕⊕⊕ High confidence	No/Very minor concerns regarding methodological limitations, coherence, adequacy, and relevance.

Methodological limitations No/Very minor concerns	Explanation: Meaning of heart disease for the future is explicitly studied in three studies and implicitly in 38 studies. The review finding is of an interpretative and explanatory nature. This is well supported by ten interpretative phenomenological, hermeneutic, and grounded theory studies. A sufficient number of participants has been recruited who live a longer time after the onset of the heart disease.
Coherence No/Very minor concerns	Explanation: The data contain some contradictions. First, there is a contradiction regarding the term "help," because some patients indicate that they do not need help to redesign their future. Second, there is a contradiction regarding the term "future," because some patients indicate that they are not concerned with the future and are just getting on with it. The data are clear and we have found no plausible alternative explanations.
Adequacy No/Very minor concerns	Explanation: This review finding is relatively explanatory in nature. There are 41 studies contributing to this finding. 12 of these studies explain explicitly the need for control, 9 reflecting on recovery, and 11 coping with identity. The data are very rich; both about the need for redesigning a meaningful future and the third-order constructs themselves.
Relevance No/Very minor concerns	Explanation: The supporting studies fully reflect the context of the review, i.e., patients with coronary artery disease, heart failure, or thoracic aortic dissection regarding cardiac rehabilitation.

Bijlage C.2-7 'Karakteristieken en resultaten van de geïncludeerde studies overgenomen uit het systematisch literatuuronderzoek van Santiago de Araújo Pio et al.'

Study & study characteristics	Patient characteristic	Intervention	Control	Outcome
(Ashe 1993) RCT USA N analysed: total: 41; intervention: 21; comparator: 20	Inclusion criteria: patients referred to CR programmes following a variety of heart problems: angina, MI, valve problems, CABG, and coronary artery disease. Exclusion criteria: NR Age (mean ± SD): intervention: 62.6 ± 13.1; comparator: 62.7 ± 16.5 Sex (% women): intervention: 30.4%; comparator: 31.2% Race/ethnicity (% white): 95% intervention: 82.6%; comparator: 83.0%	The trial offered a motivational relapse prevention intervention that was delivered during the course of the CR programme. The intervention was started after 4 or 5 exercise sessions. The intervention was based on Marlatt and Gordon's model. Participants received individual sessions, once a week for 3 weeks Session 1: based on pretest information, factors found to interfere with adherence were introduced. Participants discussed their perceptions on the value of exercise, listed their goals for the programme, and anticipated outcomes. Session 2: participants were introduced to decision-making concepts and cognitive interference factors. Discussion with regard to coping with "slips" and introduction to appropriate ways to re-frame perspectives. Participants filled in daily activity sheets. Session 3: focused on the importance of lifestyle balance. Participants were asked to refer to daily activity sheets to introduce concepts of should and wants. Stressors were identified that may affect lifestyle balance and were discussed, as was the importance of positive thinking and use of medication	During the course of the exercise programme, participants received a 'benign' education intervention, which covered basic exercise concepts, guidelines for proper exercise participation, exercise tips and handouts, and the benefits of exercise	Adherence - defined as total number of prescribed sessions completed. Completion - defined as completion of the programme after a follow-up assessment
(Beckie 2010) RCT USA	Inclusion criteria: women aged > 21 years old referred to an outpatient CR programme with multiple CHD conditions/procedures (MI, angina, or CABG) and able to read, write, and speak English	Gender-tailored CR programme in which participants exercised exclusively with women. Psychologists and nurse specialists provided to participants 1-hour individualised motivational interviewing sessions at weeks 1 and 6 based on the transtheoretical model (TTM) of behaviour change.	Traditional CR programme based on the case management model that was delivered by female nurses and exercise physiologists. The exercise protocol consisted of aerobic and resistance training for 3 days/week for 12 weeks. CR personnel provided	Adherence - defined as exercise session attendance and educational session attendance

N analysed: total: 252; intervention: 141; comparator: 111	Exclusion criteria: lack of insurance coverage for 36 exercise sessions, cognitive impairment, inability to ambulate, implantation of internal cardiac defibrillator in the last year Age (mean ± SD): intervention: 63.0 ± 11.0; comparator: 64.0 ± 11.0 Sex (% women): intervention: 100%; comparator: 100% Race/ethnicity (% white): overall: 82%	Psychoeducational classes were held weekly before exercise sessions Tailoring: participants received 1-hour individualised motivational interviewing (MI) sessions at weeks 1 and 6 with a clinical psychologist or a clinical nurse specialist formally trained in motivational interviewing focussed on factors affecting women's CR utilisation	educational classes focussed on CHD risk factor modification at 5 different times weekly	
(Bertelsen 2017) RCT Denmark N analysed: total: 190; intervention: 97; comparator: 93	Inclusion criteria: > 18 to 80 years of age, angiographically documented coronary thrombosis or stenosis, resident in one of the participating municipalities: Aarhus, Viborg, Silkeborg, Skive, Samsø, Favrskov, or Skanderborg; no previous CR. Exclusion criteria: MI on a non-thrombotic basis, ejection fraction < 40%, lack of physical or mental ability to participate in CR, inability to write and understand Danish without help, other disease causing severe disability. Age, mean (range) : intervention: 60 (40 to 79); comparator: 60 (30 to 78) Sex (% women): intervention: 29.2%; comparator: 20.7.5% Race/ethnicity (% white): NR	CR delivered through shared care. The general practitioner was responsibility for CR components not delivered in the community, as well as for pharmacological treatment and risk factor management after the initial visit to the hospital outpatient clinic. Municipal health care centres provided courses on smoking cessation, nutrition, and exercise training, along with patient education and psychosocial support	CR was delivered entirely within hospital outpatient clinics. CR was terminated upon consultation with a cardiologist concerning risk factors and future medication	Adherence - defined as a composite of participation in different components of the programme (smoking cessation, dietary advice, exercise training, clinical assessment by a doctor, and patient education)
(Farias-Godoy 2013) RCT Canada	Inclusion criteria: Men and women with risk factors for IHD (primary prevention) or documented IHD (secondary prevention) accepted into CR; secondary prevention patients classified as low or moderate risk according to AACVPR risk stratification criteria.	Reduced (i.e., shorter) CR programme. The programme was designed to include the core elements of standard CR, with fewer hospital-based exercise sessions (10 sessions). The first 2 weeks was the same for both groups (a total of 2 in-hospital exercise sessions/week),	Comparison: hospital-based CR over 4 months (32 sessions)	Adherence - defined as per cent attendance at prescribed sessions

N analysed: total: 102; intervention: 50; comparator: 52	Exclusion criteria: presence of poorly controlled metabolic risk factors; scheduled revascularisation procedures; unlikely to survive due to non-cardiac causes; psychiatric diagnosis that would interfere with compliance; congenital heart disease with no IHD risk factors. Age (mean ± SD): intervention: 61.6 ± 10.5; comparator: 60.6 ± 10.7 Sex (% women): intervention: 18.0%; comparator: 20.0% Race/ethnicity (% white): NR	and during this time, participants were able to learn exercise routines and were evaluated by staff		
(Focht 2004) RCT USA N analysed: total: 142; intervention: 68; comparator: 74	Inclusion criteria: older adults between 50 and 80 years of age; documented MI, PCI, chronic stable angina, stable HF, or cardiovascular surgery (coronary artery or valvular heart disease) in the past 6 months; self-reported disability and not actively engaging in exercise or CR for preceding 6 months. Exclusion criteria: psychiatric illness (major depression within past 5 years); severe symptomatic heart disease (unstable angina, unstable HF, or exercise-induced complex ventricular arrhythmias); severe systemic disease; active treatment for cancer; hearing or sight impairment; alcoholism; inability to speak or read English; judgement of clinical staL; current participation in another medical intervention study Age (mean ± SD): intervention: 64.7 ± 7.2; comparator: 64.9 ± 6.8 Sex (% women): intervention: 45.2%; comparator: 50.0%	Group-delivered cognitive–behavioural physical activity programme, designed to gradually wean participants from dependency on the CR staL and group programme toward independent self-regulation of physical activity. For the first and second months, participants engaged in centre-based CR 2 times each week. During the third month, centre-based training was reduced to 1 time per week. In each of these months, self-planned home-based activity by participants provided additional sessions of exercise for a frequency equivalent to control treatment. Following each exercise therapy session, participants engaged in a 20- to 25-minute period of instruction and discussion regarding learning and using self-regulatory tools to maintain long-term physical activity	Participants received 3 months of centre-based CR 3 days/week. In addition to exercise therapy, weekly educational lectures were given on topics that related to modification of risk factors for cardiovascular disease	Adherence - defined as percentage of the total number of sessions attended during the first 3 months of the trial. Completion - defined as the number completing the CR programme and follow-up assessment

	Race/ethnicity (% white): NR			
(Grace 2016) RCT Canada N analysed: total: 58; women-only CR: 21; home-based CR: 18; traditional mixed-sex CR: 19	Inclusion criteria: women residing in proximity to CR programmes; proficiency in the English language; written approval to participate in CR provided by the patient's cardiac specialist or general practitioner (in the case of inpatient recruitment); eligibility for home-based CR (i.e., low to moderate risk as demonstrated by (1) lack of complex ventricular dysrhythmia, (2) NYHA class of 1 or 2 and left ventricular ejection fraction (LVEF) > 40%, or (3) CCS class 1 or 2) Exclusion criteria: musculoskeletal, neuromuscular, visual, cognitive, or non-dysphoric psychiatric condition; any serious or terminal illness not otherwise specified that would preclude CR eligibility based on CR guidelines; physician deemed patient not suitable for CR at time of intake exercise stress test (i.e., < 3 minutes completed on Bruce protocol treadmill stress test, or < 6 minutes on modified Bruce protocol treadmill stress test, or workload < 300 kpm on a cycle ergometer test, or significant ST segment depression, uncontrolled dysrhythmias, abnormal heart rate or blood pressure measurements in response to exercise); planning to leave the area before the anticipated end of the study; being discharged to a long-term care facility; previous participation in CR; participation in another clinical trial with behavioural interventions; in the case of inpatient recruitment, having been referred to a CR programme by their healthcare provider before study randomisation was completed	Women-only or home-based CR	Traditional hospital-based mixed-sex CR. The only differences between site-based programme models were sex composition and some educational session content	Adherence - defined as percentage of prescribed sessions attended. Completion - defined as attended at least some of the CR intervention components and underwent formal re-assessment by the CR team at the conclusion of the CR intervention

	Age (mean ± SD): women-only: 66.2 ± 10.2; home-based: 63.1 ± 10.9; mixed-sex comparator: 61.5 ± 9.7 Sex (% women): women-only: 100.0%; home-based: 100.0%; comparator: 100.0% Race/ethnicity (% white): women-only: 59.1%; home-based: 65.3%; comparator: 62.7%			
(Hwang 2017) RCT Australia N analysed: total: 102; intervention: 23; comparator: 26	Inclusion criteria: HF, over 18 years of age Exclusion criteria: did not meet safety screening criteria as outlined by the Australian exercise guidelines for patients with chronic HF, such as symptomatic severe aortic stenosis and significant ischemia at low exercise intensity, lived in an institution such as a nursing home; lived more than an hour driving distance from the treating hospital; had no support person at home Age (mean ± SD): intervention: 68.0 ± 14.0; comparator: 67.0 ± 11.0 Sex (% women): intervention: 20.8%; comparator: 27.5% Race/ethnicity (% white): intervention: 92%; comparator: 93%	Short-term, real-time, group-based HF rehabilitation programme delivered at each participant's home via an online telerehabilitation system. The programme was delivered via a synchronous videoconferencing platform across the Internet to groups of up to 4 participants within the home. Two-way audiovisual communication enabled interaction of all parties, and the physiotherapist guided participants through an exercise programme similar to the control. This approach enabled the physiotherapist to watch participants performing the exercises and to provide real-time feedback and modification, as required, as well as to facilitate peer support from other participants. Participants were provided with additional home exercises similar to those in the control group. Participants were encouraged to watch the designated presentation individually or with their support person, in their own time, in preparation for subsequent online group discussions. A 15-minute interaction period was held at the start of each telerehabilitation session to facilitate these discussions	The control group received a centre-based rehabilitation programme based on current recommended guidelines encompassing education, aerobics, and strength training exercise. This traditional HF rehabilitation programme was led by physiotherapists over a 12-week period; it consisted of 60 minutes of exercise per session, 2 sessions per week, at the treating hospital. Each session consisted of a 10-minute warm-up, 40 minutes of aerobic and strength exercises, and a 10-minute cool-down. Exercise prescription was tailored to the participant's goal, and the treating physiotherapist continuously reviewed it to ensure appropriate progression. The control group attended educational sessions at the hospital on the same day as the exercise sessions	Adherence - defined on basis of the proportion of prescribed sessions attended (in person or online)
(Kraal 2014) RCT The Netherlands	Inclusion criteria: patients who entered CR after hospitalisation for MI, unstable angina, or a revascularisation procedure (PCI or CABG); low to moderate risk of future cardiac events according to the Dutch CR guidelines.	The FIT@HOME intervention combined motivational interviewing in the initial CR phase with ongoing objective feedback on training progression. After 3 supervised training sessions in the outpatient clinic, participants started training in their home environment. The coach remotely supervised the	Group-based training sessions on a treadmill or cycle ergometer, supervised by physical therapists and exercise specialists. The programme lasted for 12 weeks, with at least 2 training sessions per week. Participants were instructed to exercise for 45 to 60	Adherence - defined as percentage of prescribed sessions completed. Notes

N analysed: total: 50; intervention: 25; comparator: 25	Exclusion criteria: NR Age (mean ± SD): intervention: 60.6 ± 7.5; comparator: 56.1 ± 8.7 Sex (% women): intervention: 12.0%; comparator: 16.0% Race/ethnicity (% white): NR	training sessions performed at home and offered appropriate support via telephone using a semi-structured interview	minutes per session at 70 to 85% of their maximal heart rate	
(Lynggaard 2017) RCT The Netherlands N analysed: total: 825; intervention: 413; comparator: 412	Inclusion criteria: aged 18 years and older, discharged from hospital with ischemic heart disease or HF; assigned and motivated for CR Exclusion criteria: acute coronary syndrome less than 5 days before randomisation; active peri-, myo-, or endocarditis; symptomatic and untreated valve disease; severe hypertension with blood pressure > 200/110 mmHg; other severe cardiac or extracardiac disease; planned revascularisation; senile dementia. assessed as having low compliance, former participation in the study Age (mean ± SD): intervention: 63.0 ± 10.0; comparator: 63.0 ± 11.0 Sex (% women): intervention: 24.0%; comparator: 24.0% Race/ethnicity (% white): NR	Based on learning and coping strategies. The intervention group received individual clarifying interviews before and after the CR programmes. Participants had an initial interview to help clarify their needs before CR and to prepare them to learn how to cope with living with a chronic heart disease. In the finishing interview, the patient and the health professional in partnership clarified what benefits the patient had derived from CR and discussed future strategies for coping with their chronic heart disease. Narratives told by experienced patients were used as good learning examples	The control group received group-based CR lasting 8 weeks, with exercise training sessions 3 times a week and education once a week	Adherence - defined as percentage of prescribed sessions completed
(McGrady 2014) RCT USA	Inclusion criteria: patients admitted to Phase II of the CR after MI, CABG surgery, stable angina, chronic heart failure (CHF, NYHA class I or II), or other procedure (stent placement, valve replacements, aortic aneurism repair, atrial fibrillation, and heart transplant)	The intervention consisted of four 30-minute sessions conducted during the first weeks of CR. Participants participated in groups of 2 to 6. Sessions rotated so that a participant could begin at any time in the 4 sessions. Each session consisted of about 15 minutes of motivational interviewing and about 15 minutes of relaxation. The motivational interviewing portions	The historical control group received group-based CR lasting 12 weeks, with exercise training sessions 3 times a week and education once a week	Adherence - defined as percentage of prescribed sessions completed

N analysed: total: 304; intervention: 136; comparator: 168	Exclusion criteria: NR Age (mean ± SD): intervention: 60.3 ± 11.7; comparator: 62.8 ± 13.1 Sex (% women): intervention: 34.0%; comparator: NR Race/ethnicity (% white): NR	focused on participants' personal goals, fostering an optimistic view of the benefits of rehabilitation, decreasing negative self-talk, and overcoming barriers to completing the exercise programme. The relaxation portion comprised mindful breathing, progressive relaxation, and simple imagery		
(Oldridge 1983) RCT Canada N analysed: total: 120; intervention: 63; comparator: 57	Inclusion criteria: all male patients admitted with a documented diagnosis of coronary heart disease (MI, CABG, and angina) and referred to CR Exclusion criteria: NR Age (mean ± SD): overall: 51.5 ± 8.7 Sex (% women): 0% Race/ethnicity (% white): NR	Usual comprehensive CR programme plus self-management techniques, including an agreement to participate in the programme for 6 months to be signed by the participant and the coordinator, and self-report diaries to be completed and 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 × 24-hour recall questionnaires of daily activities on a randomly chosen day to be completed each month. In addition, a weight loss diary to be filled in each week was given to participants who initially agreed to lose weight, and similar diaries were used to record the number of cigarettes smoked each day (as applicable). Follow-up was provided at the end of the intervention period of 6 months	Usual comprehensive CR programme	Completion - defined as percentage of those who attended 60% or more of the 48 scheduled supervised CR sessions
(Pack 2013) RCT USA N analysed: total: 148; intervention: 74;	Inclusion criteria: patients > 18 years of age with a qualifying diagnosis for referral to CR (MI, PCI, or angina with an ischemic stress ECG, stress echocardiogram, or stress myocardial perfusion imaging study) Exclusion criteria: patients who have undergone recent CABG, valve surgery, or cardiac transplantation	Early appointment for orientation class for CR (within 10 days)	Participants randomized to standard care were scheduled for an orientation appointment within 35 days from the index event	Adherence - defined as total number of exercise sessions attended Completion - defined as completion of CR

comparator: 74 (for attendance)	Age (mean ± SD): intervention: 61.0 ± 12.0; comparator: 59.0 ± 12.0 Sex (% women): intervention: 39.2%; comparator: 50.0% Race/ethnicity (% white): intervention: 45.0%; comparator: 42.0%			
(Varnfield 2014) RCT Australia N analysed: total: 72; intervention: 46; comparator: 26 (6-week assessment)	Inclusion criteria: patients admitted for MI and referred to CR Exclusion criteria: unable to participate in self-management programmes or to operate smartphone for purposes of trial due to medical care needs (e.g., vision, hearing, cognitive or dexterity impairment). attending CR or being involved in another behavioural trial; or had no experience with mobile/smartphones Age (mean ± SD): intervention: 54.9 ± 9.6; comparator: 56.2 ± 10.1 Sex (% women): intervention: 31.6%; comparator: 31.1% Race/ethnicity (% white): NR	The CAP-CR platform used a smartphone for health and exercise monitoring and delivered motivational and educational materials to participants via text messages and pre-installed audio and video files (including understanding cardiovascular disease, symptoms, and management). The platform included a Web portal with participant data for mentors to provide weekly consultations	Community centres	Adherence - defined as attendance for 4 weeks (8 or more gym sessions) for the traditional CR group, or upload of 4 weeks' exercise data for the CAP-CR group Completion - defined as completion of the 6-week CR programme
AACVPR = American Association of Cardiovascular and Pulmonary Rehabilitation, CABG = Coronary artery bypass graft, CCS = Canadian Cardiovascular Society Angina Score, CHD = coronary heart disease, CR = cardiac Rehabilitation, HF = heart failure, LVEF = left ventricular ejection fraction: MI = myocardial infarction, N = number of participants, NR = not reported, NYHA = New York Heart Association, PCI = percutaneous coronary intervention, RCT = randomized controlled trial, SD = standard deviation, USA = United States of America				

Bijlage C.2-8 'Risk-of-biastabel: beoordeling van het risico op vertekening voor het geïncludeerde systematic review'

Voor de beoordeling van de methodologische kwaliteit van het systematische literatuuronderzoek is gebruik gemaakt van de AMSTAR 2 (Shea 2017).

AMSTAR 2 score (Santiago de Araújo Pio 2019)					
Item		Yes	Partial yes	No	No meta-analysis/ Includes only
1	Did the research questions and inclusion criteria for the review include the components of PICO?	x			
2	Did the report of the review contain an explicit statement that the review methods were established prior to the conduct of the review and did the report justify any significant deviations from the protocol?			x	
3	Did the review authors explain their selection of the study designs for inclusion in the review?			x	
4	Did the review authors use a comprehensive literature search strategy?			x	
5	Did the review authors perform study selection in duplicate?	x			
6	Did the review authors perform data extraction in duplicate?	x			
7	Did the review authors provide a list of excluded studies and justify the exclusions?	x			
8	Did the review authors describe the included studies in adequate detail?		x		
9	Did the review authors use a satisfactory technique for assessing the risk of bias (RoB) in individual studies that were included in the review?	x			
10	Did the review authors report on the sources of funding for the studies included in the review?	x			
11	If meta-analysis was performed did the review authors use appropriate methods for statistical combination of results?	x			
12	If meta-analysis was performed, did the review authors assess the potential impact of RoB in individual studies on the results of the meta-analysis or other evidence synthesis?	x			
13	Did the review authors account for RoB in individual studies when interpreting/ discussing the results of the review?	x			
14	Did the review authors provide a satisfactory explanation for, and discussion of, any heterogeneity observed in the results of the review?	x			
15	If they performed quantitative synthesis did the review authors carry out an adequate investigation of publication bias (small study bias) and discuss its likely impact on the results of the review?	x			
16	Did the review authors report any potential sources of conflict of interest, including any funding they received for conducting the review?	x			

Bijlage C.2-9 'Risk-of-biastabel: beoordeling van het risico op vertekening voor de geïncludeerde studies overgenomen uit het systematisch literatuuronderzoek van Santiago de Araújo Pio et al.'

Bijlage C.2-10 ‘Oriënterende zoekactie

Search: (("Cardiac Rehabilitation"[Mesh]) AND ("Exercise"[Mesh])) AND (comply OR complian* OR Completion OR drop?out OR adherence OR non?attendance OR non?completion OR engage* OR attend*) Filters: Systematic Review Sort by: Publication Date

("Cardiac Rehabilitation"[MeSH Terms] AND "Exercise"[MeSH Terms] AND ("complied"[All Fields] OR "complies"[All Fields] OR "comply"[All Fields] OR "complying"[All Fields] OR "complian*"[All Fields] OR ("complete"[All Fields] OR "completed"[All Fields] OR "completely"[All Fields] OR "completeness"[All Fields] OR "completer"[All Fields] OR "completers"[All Fields] OR "completes"[All Fields] OR "completing"[All Fields] OR "completion"[All Fields] OR "completions"[All Fields]) OR ("drop"[All Fields] AND "out"[All Fields]) OR ("adherance"[All Fields] OR "adhere"[All Fields] OR "adhered"[All Fields] OR "adherence"[All Fields] OR "adherences"[All Fields] OR "adherent"[All Fields] OR "adherents"[All Fields] OR "adherer"[All Fields] OR "adherers"[All Fields] OR "adheres"[All Fields] OR "adhering"[All Fields]) OR ("non"[All Fields] AND ("attend"[All Fields] OR "attendance"[All Fields] OR "attendances"[All Fields] OR "attendant"[All Fields] OR "attendant s"[All Fields] OR "attendants"[All Fields] OR "attended"[All Fields] OR "attendence"[All Fields] OR "attendents"[All Fields] OR "attender"[All Fields] OR "attenders"[All Fields] OR "attending"[All Fields] OR "attendings"[All Fields] OR "attends"[All Fields])) OR ("non"[All Fields] AND ("complete"[All Fields] OR "completed"[All Fields] OR "completely"[All Fields] OR "completeness"[All Fields] OR "completer"[All Fields] OR "completers"[All Fields] OR "completes"[All Fields] OR "completing"[All Fields] OR "completion"[All Fields] OR "completions"[All Fields])) OR "engage*"[All Fields] OR "attend*"[All Fields])) AND (systematicreview[Filter])

Translations

comply: "complied"[All Fields] OR "complies"[All Fields] OR "comply"[All Fields] OR "complying"[All Fields]

Completion: "complete"[All Fields] OR "completed"[All Fields] OR "completely"[All Fields] OR "completeness"[All Fields] OR "completer"[All Fields] OR "completers"[All Fields] OR "completes"[All Fields] OR "completing"[All Fields] OR "completion"[All Fields] OR "completions"[All Fields]

adherence: "adherance"[All Fields] OR "adhere"[All Fields] OR "adhered"[All Fields] OR "adherence"[All Fields] OR "adherences"[All Fields] OR "adherent"[All Fields] OR "adherents"[All Fields] OR "adherer"[All Fields] OR "adherers"[All Fields] OR "adheres"[All Fields] OR "adhering"[All Fields]

attendance: "attend"[All Fields] OR "attendance"[All Fields] OR "attendances"[All Fields] OR "attendant"[All Fields] OR "attendant's"[All Fields] OR "attendants"[All Fields] OR "attended"[All Fields] OR "attendence"[All Fields] OR "attendents"[All Fields] OR "attender"[All Fields] OR "attenders"[All Fields] OR "attending"[All Fields] OR "attending's"[All Fields] OR "attendings"[All Fields] OR "attends"[All Fields]

completion: "complete"[All Fields] OR "completed"[All Fields] OR "completely"[All Fields] OR "completeness"[All Fields] OR "completer"[All Fields] OR "completers"[All Fields] OR "completes"[All Fields] OR "completing"[All Fields] OR "completion"[All Fields] OR "completions"[All Fields]

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