June 2017

Review of best practice in cardiac rehabilitation for women

Osaimi Alosaimi  
*Faculty of Rehabilitation Medicine, University of Alberta, Canada, alosaimi@ualberta.ca*

Angelica N. Reyes MScOT  
*Faculty of Rehabilitation Medicine, University of Alberta, anreyes@ualberta.ca*

Cary A. Brown PhD  
*Faculty of Rehabilitation Medicine, University of Alberta, cary.brown@ualberta.ca*

Follow this and additional works at: [http://nsuworks.nova.edu/ijahsp](http://nsuworks.nova.edu/ijahsp)  
Part of the [Occupational Therapy Commons](http://nsuworks.nova.edu/ijahsp) and the [Physical Therapy Commons](http://nsuworks.nova.edu/ijahsp)

**Recommended Citation**  
Review of best practice in cardiac rehabilitation for women

**Purpose:** Cardiovascular disease is defined as damage to, or narrowing of, arteries due to atherosclerosis and is the leading cause of mortality and morbidity among women worldwide. Cardiovascular disease is recognized to be both a leading cause of mortality and an undertreated condition for women. The goals of this review manuscript are to present the current background literature specific to cardiac rehabilitation programs for women and serve as a knowledge translation strategy to help raise therapists’ awareness of the need for cardiac rehabilitation programs specifically designed for female patients. **Methods:** A review of best practice literature in cardiac rehabilitation for women. **Results:** With current increasing trends in risk factors, including stress, obesity, poor diet, smoking, and a sedentary lifestyle, the future burden could be overwhelming from the perspective of individuals’ health and health authorities’ resources. **Conclusions:** Emerging research clearly demonstrates the need for cardiac rehabilitation programs tailored for women and highlighting the unique features of program delivery that can reduce the risk of under-referral and treatment program dropout.

**Author Bio(s)**
Osaimi Alosaimi, BPT, is a physiotherapist and MSc student with diverse experience in cardiac rehabilitation.

Angelica Reyes, MScOT is a clinical occupational therapist/researcher with experience in a range of patient populations, currently working in Edmonton, Alberta.

Cary Brown, PhD is a professor in the Faculty of Rehabilitation Medicine, University of Alberta.

**Acknowledgements**
We would to acknowledge Osaimi Alosaimi’s sponsors for supporting his advanced studies in cardiac rehabilitation.

This manuscript is available in Internet Journal of Allied Health Sciences and Practice:
http://nsuworks.nova.edu/ijahsp/vol15/iss3/8
Review of Best Practice in Cardiac Rehabilitation for Women

Osaimi Alosaimi, BPT
Angelica N. Reyes, MScOT
Cary Brown, PhD
University of Alberta
Canada

ABSTRACT

Purpose: Cardiovascular disease is defined as damage to, or narrowing of, arteries due to atherosclerosis and is the leading cause of mortality and morbidity among women worldwide. Cardiovascular disease is recognized to be both a leading cause of mortality and an undertreated condition for women. The goals of this review manuscript are to present the current background literature specific to cardiac rehabilitation programs for women and serve as a knowledge translation strategy to help raise therapists’ awareness of the need for cardiac rehabilitation programs specifically designed for female patients. Methods: A review of best practice literature in cardiac rehabilitation for women. Results: With current increasing trends in risk factors, including stress, obesity, poor diet, smoking, and a sedentary lifestyle, the future burden could be overwhelming from the perspective of individuals’ health and health authorities’ resources. Conclusions: Emerging research clearly demonstrates the need for cardiac rehabilitation programs tailored for women and highlighting the unique features of program delivery that can reduce the risk of under-referral and treatment program dropout.

BACKGROUND

Prevalence of Cardiovascular Disease in Women

Cardiovascular disease (CVD) is a class of diseases that involve the damage to, or narrowing of, arteries due to atherosclerosis.1 Cardiovascular disease includes, but is not limited to myocardial infarct (MI), angina, atherosclerotic disease, valvular disease, cardiomyopathy, hypertensive heart disease, heart failure, acute coronary syndrome, and asymptomatic coronary heart disease.1 Procedures related to CVD include coronary artery bypass graft, percutaneous coronary intervention, and cardiac valve repair.1 Although CVD is the leading cause of mortality and morbidity among women worldwide, CVD is a major health problem in developed nations as it is the primary cause of morbidity, mortality, and low quality of life in Canada, the United States (US), and Europe.2-4 CVD is a leading cause of death for many women in the US and other western countries.5 Statistics have shown that CVD declined in the US by 29.2% from 1996 to 2006. During 2006, 433,000 women in the US were affected with CVD, which constitutes a larger number compared to other serious health problems, such as respiratory diseases, cancer, Alzheimer’s, and accidents.5,7

CVD has demographic and regional differences that stem from hospitalization and treatment methods as well as variability in risk factors.4 The Public Health Agency of Canada (2009) statistics indicate that in 2007, the incidence of heart disease was 2.7% and 6.4% in the Northwest Territories and Nova Scotia, respectively. Eastern Canada was found to have a higher prevalence of CVD compared to northern and western regions. Ethnicity also plays a role.4 For example, CVD in Canada has been found to be highly prevalent among South Asian, African-Caribbean, and Aboriginal patients, who are at higher risk of morbidity and mortality compared to those of European origin.5

For the past three decades, the CVD mortality rate in the United States has been higher for women than for men.9 In Canada, CVD is the second leading cause of death among women, at the rate of 2.4 and 3,082.8 per 100,000 in those aged 25 to 34, and 85 years or more, respectively.4 With current increasing trends in risk factors which include stress, obesity, poor diet,
smoking, and a sedentary lifestyle, the future burden could be overwhelming from the perspective of individuals’ health and governments’ budgets.

CVD Risk Factors in Women

There are several risk factors of CVD identified in the literature. These include being post-menopausal, age, obesity, smoking, heredity, hyperlipidemia, sedentary lifestyle, diabetes, stress, and hypertension. Gender-specific research highlights the necessity to conduct more studies that focus on gender differences with respect to pathophysiology, clinical presentation, and outcomes. With respect to risk factors, studies suggest that some are more prominent among women than men. These include hypertension, type 2 diabetes mellitus (DM), depression, and psychosocial factors.

Hypertension is more prevalent in women than in men over 65 years of age and is significantly associated with MI in women. Cardiac death increases 3-fold in women with systolic blood pressure levels greater than 185 mm/Hg compared to those at or below 135 mm/Hg. Evidence shows that women with Type 2 DM are at higher risk of CVD death than men with Type 2 DM. DM is considered a strong risk factor in young women, where it increases their chances of coronary heart disease 4- to 5-fold. In addition, high levels of total cholesterol and low-density lipoprotein (LDL) cholesterol are considered to be risks for cardiac death in middle-aged (<65) and elderly (>65) women. A study of 32,826 postmenopausal women found that high-density lipoprotein (HDL) cholesterol eliminated the high risk of chronic heart disease. Estrogen levels also may play a role because as women reach menopause, their LDL levels increase significantly.

Depression is almost two times more prevalent in women than in men in the general population and has been shown to elevate women’s risk for MI and cardiac-related death by at least 50%. Depression is also linked to cardiac death in middle-aged and elderly women. Additionally, stress derived from home, work, and major life events have been shown to be a risk factor for MI in women as demonstrated by a study reporting higher perceived stress scores among young women with MI compared to young men with MI. Furthermore, Albert et al followed 1,701 women aged 30 to 55 years, between the years 1976-1998 and observed 224 cardiac-related deaths. They concluded that the risk of cardiac arrest increases as women age. Sixty-nine percent of women in the study with sudden cardiac death were reported to lack a prior history of cardiac disease. However, 94% of them reported one or more risks factors, including smoking, diabetes, and hypertension.

CARDIAC REHABILITATION AND CVD

Cardiac Rehabilitation (CR) is a comprehensive service that entails medical assessment, prescription, modification of cardiac disease risk factors, education, and counseling. The goal of CR is to relieve cardiac symptoms, improve patients’ physical function, and increase their quality of life. CR usually consists of four phases beginning with the patient’s hospitalization following an acute cardiac incident (Phase I), followed by Phases II-IV which include ongoing and specific assessment, in-clinic interventions, and home programs for long-term cardiac health. The importance of CR programs as preventive strategies in cardiovascular incident recurrence is acknowledged and endorsed globally.

Cardiac Rehabilitation Program Components

Balady et al have highlighted various components of CR programs designed to reduce CVD-related risk factors, improve quality of life and physical function, and prevent future cases of CVD. These components include exercise prescription, diet counseling, body lipid pharmacological management, physical examination including blood pressure, weight and body mass index (BMI), medical history review, evaluation and education programs for comorbid diabetes and other chronic health conditions, evaluation and treatment of psychological and social problems, and programs to address smoking and addictions. Additionally, the consensus statements of the American Heart Association, American Association of Cardiovascular and Pulmonary Rehabilitation, and the Agency for Health Care Policy and Research underscore that CR programs should offer a multidisciplinary approach to achieve CVD risk reduction and that programs consisting of exercise training alone are not considered CR.

Benefits of Cardiac Rehabilitation

Empirical studies illustrate that CR programs provide extensive benefits to eligible populations. These benefits include improvement in physical capacity, cardiovascular profile (e.g., lipids, blood pressure, and diabetes), depression, anxiety, quality of life, and weight reduction, in addition to reductions in morbidity and mortality rates, hospital readmissions, and psychological disorders. Studies also have shown that women derive the same benefits as do men.

Exercise is considered the cornerstone of CR programs. Oldridge’s review of six independent, exercise-based CR meta-analyses, published since 2002, included 71 randomized clinical trials with a total of 13,824 participants. The findings revealed significantly positive outcomes related to reductions in cardiac mortality, nonfatal re-infarction, and hospitalization rates, as well as favorable changes in total cholesterol, triglycerides, and systolic blood pressure. Another recent Cochrane systematic review and meta-analysis of the effectiveness of exercise-based CR included a total of 63 studies with 14,486 participants. It showed...
that exercise-based CR reduced cardiovascular mortality, hospital readmission, and contributed to major improvements in quality of life. A further 2016 meta-analysis investigated the effect of exercise on high sensitive c-reaction protein (hsCRP). This meta-analysis included 43 studies with 3,575 participants. It concluded that exercise interventions contributed to reductions in hsCRP levels in healthy adults and adults with CVD. Moreover, exercise training reduces clinical depression, anxiety, and hostility among patients with CVD.

Other components of CR programs include education and psychological interventions. Brown et al. conducted a systematic review of 13 studies and 66,556 participant that examined the effects of cardiac psycho-educational programs as a primary intervention versus typical care on morbidity, mortality, quality of life, and health costs. The authors reported that, while there was no strong evidence that psycho-educational programs as a primary intervention contributes to reductions in morbidity or mortality, there is evidence to support that they improve quality of life and reduce health care costs. Similarly, Whaleley et al. carried out a systematic review of the independent effect of psychological interventions on CVD-related morbidity, mortality, quality of life, and psychological outcomes. A total of 24 studies and 9,296 participants were included. The authors concluded that, while there was no clear evidence of a positive effect of psychological interventions on morbidity, mortality, and quality of life, there was a slight to moderate improvement in depression and anxiety.

Overall, CR offers patients a long-term program of medical evaluation, prescribed exercise, cardiac risk factor modification, education, and counseling. CR has shown to improve survival rate, quality of life, functional status/aerobic fitness, cardiovascular risk profile, psychological status, and reduce hospital readmissions. Cardiac rehabilitation is also considered cost effective.

CARDIAC REHABILITATION AND WOMEN

Despite the numerous benefits previously described, evidence shows that with respect to referral, participation, and adherence, CR is generally underutilized by all patients, and most markedly in women. According to a study by Colella et al, which examined sex differences in referral to CR, the referral rate to CR for women was almost 10% lower than for men. In accordance with these findings, a subsequent retrospective cohort study that included 25,958 participants (24.6% women) also revealed lower CR referral rates for women compared to men (31.1% vs. 42.2%). As for women’s enrollment in CR, a meta-analysis included 26 observational studies conducted between 2000 and 2011 with 797,719 participants (43.2% women) showed that women were 36% less likely to be enrolled in CR programs. Moreover, evidence shows that after enrollment, women appear to have lower adherence to CR compared to men. A recent meta-analysis that investigated sex differences in adherence included 14 studies and 8,176 participants (27.3% women) and concluded that some gender-based differences do exist in adherence to CR, in that after enrollment, adherence to the prescribed sessions was 64.2% and 68.6% in women and men, respectively.

Barriers to Women’s Use of Cardiac Rehabilitation

Barriers that hinder eligible women from participating in, and adhering to, CR programs are categorized as: 1) patients’ behavior/beliefs, 2) attitudes of health professionals (e.g., physicians/nurses/physiotherapists, etc.), and 3) contextual factors such as employment, self-esteem, family support, and transportation. Barriers attributable to patients’ behavior/beliefs include: smoking, sedentary lifestyle, obesity, marital status, perceived program characteristics and suitability, anxiety, perceived self-efficacy and self-esteem, and perceptions that exercise is painful.

Low rates of physician referrals and CR endorsement are also principal barriers contributing to low participation and adherence among women. Contextual factors that contribute to low participation in, and adherence to, CR include age, gender roles such as primary caregiver and mother, low socioeconomic status, lack of transportation, low social support, and comorbidities such as depression and musculoskeletal limitations.

STRATEGIES TO ENHANCE WOMEN’S USE OF CARDIAC REHABILITATION

Although CR has been proven to be a beneficial and safe method of secondary prevention, it is often underutilized for women with CVD. Many strategies have been proposed in attempts to overcome the multifactorial obstacles that hinder women’s use of CR and to increase referrals to, enrollment in, and adherence to CR. These strategies will be explored in the following section.

Referral Strategies to Enhance Enrollment in Cardiac Rehabilitation

Inadequate referral of eligible female participants is one of the primary factors in low participation in CR. Automatic referral has been proposed to avoid referral gender bias. Automatic, system generated, referral is defined as the implementation of standing referral orders to CR based on eligible diagnoses supported by clinical guidelines without requiring the physician to generate a referral for each specific patient. However, simply initiating a referral does not guarantee participation in CR. The joint policy statement of the Canadian Association of Cardiac Rehabilitation and Canadian Cardiovascular Society, based
on a synthesis of data available in the literature recommends using multiple referral strategies to enhance participation in CR. A systematic review and meta-analysis were carried out on 14 studies published prior to 2009. This review examined various referral strategies including usual referrals, system generated referrals, a liaison strategy, and other strategies (providing patients with educational materials and motivational letters). The studies included reported that enrollment following these referral strategies ranged from 6% to 32% for usual referral, 19% to 54% for system-generated referral, 35% to 56% for liaison strategy, 53% to 78% for the combination of system generated and liaison strategy, and 58% to 86% for system generated or liaison strategy combined with patient letters. The rate of enrollment in CR by referral strategy after the synthesis was 73% for patient letters, 66% for combined system generated and liaison strategy, 45% for system generated alone, and 44% for liaison strategy alone.

**Alternative Models to Traditional, Hospital-based Cardiac Rehabilitation Programs**

To overcome or eliminate barriers that affect female patients' participation and adherence to CR programs, alternative models to hospital-based CR have been promoted. These alternative models include community, home, internet, and telephone-based CR programs. According to Dalal et al., home and community-based programs are structured programs that include monitoring and follow-up visits. Nurses can provide home-based programs to monitor and supervise the care and progress of their patients or ensure that healthcare is provided. Internet and telehealth-based programs that use information technologies help reach patients in remote areas and ensure modification of risk factors, education, guidance, and instruction in physical activities. These alternative models have yielded clinical outcomes as favorable as those achieved by hospital-based CR programs. A meta-analysis of 17 trials including 2,172 male and female participants concluded that home and hospital-based CR were equally effective in the clinical and health quality of life-related outcomes. Rawstorn et al conducted a meta-analysis to investigate the relative effectiveness of telehealth and hospital-based programs. A total of 11 trials that included 1,189 participants showed that telehealth CR programs were at least as effective as those based in hospitals with respect to clinical outcomes such as cardiovascular risk management and functional capacity.

With the dramatic evolution in technology, Smartphone applications may offer an alternative and inexpensive model to deliver CR that integrates monitoring, education, language translation, and motivational features. However, this technology will require collaboration on the part of health professionals, researchers, and apps developers to exploit apps' advantages in providing credible, evidence-based health content. Some of this work has begun. For example, Varnfield et al. conducted a non-blinded, randomized controlled trial that included 120 post-MI participants to compare the outcome of Smartphone-based home-CR versus traditional center-based CR on program for improved program adherence and other health-related metrics. Varnfield et al found that Smartphone-based CR showed better uptake and adherence outcomes than did traditional CR and yielded physiological, psychological, and quality of life outcomes as effective as those of traditional CR. Although the trial by Varnfield et al provided insight into the feasibility of Smartphone-based CR, large-scale randomized controlled trials (RCT) that examine a range of CR outcomes in various settings are required to draw solid conclusions about the effectiveness of Smartphone-based CR programs.

Even though the alternative models above support wider access to CR services and some patients prefer them to hospital-based programs, there is no specific, significant evidence of improvements in women's uptake and adherence, as women have been underrepresented notably in trials of alternatives.

**Other Strategies**

A Cochrane systematic review by Karmali et al was conducted to examine interventions that reported enhanced uptake and adherence to CR. A total of 18 RCT trials were included (10 studies that evaluated CR uptake and 8 that evaluated adherence). The authors reported that useful interventions included gender-tailored programs, structured follow-up via telephone call or visit by health professionals, intermediate phase programs, early referral to CR as a standing order in CVD management protocols, and motivational letters. With respect to adherence to CR, interventions that showed improvement included action planning, goal setting, and activity monitoring through daily diary entries. However, women were notably underrepresented in these studies evaluating interventions to increase uptake and adherence to CR. In the past two decades, emerging evidence in the literature has suggested that gender-tailored CR programs may help overcome the barriers that prevent women from obtaining the optimal benefits of CR. However, only two studies were identified that focused specifically on women.

The first study by Price was a RCT including 70 women that concluded a telephone-coaching strategy was effective in improving attendance in CR among women after hospital discharge. Despite the limited sample size, this study provides insight into the efficacy and feasibility of a telephone coaching strategy to enhance women's attendance in CR. Price's study was based on Social Cognitive Theory constructs of self-efficacy. Social Cognitive Theory regards human behavior as a dynamic reciprocal
relationship among three factors: behavior, personal (cognitive, affective, and biochemical), and socio-environmental. Cognitive personal factors include self-efficacy (i.e., an individual's confidence in performing a behavior or overcoming a barrier to behavior performance), and self-regulatory behavior (i.e., the ability to adjust behavior to achieve the desired results).

A second study by Beckie proposed a motivational, enhanced, gender-tailored CR program for women (TCRP-W) including exercise, psycho-educational interventions guided by the Transtheoretical model (TMM) of behavior change, and motivational interviewing. The TTM is considered to be a beneficial central organizing construct, as it guides the interventions by stage of change. Prochaska and Velicer propose that the TTM assists therapists in understanding and predicting how and when individuals will abandon high-risk behaviors and adopt healthy ones. This model integrates five stages of change: precontemplation, contemplation, preparation, action, and maintenance. The model involves constructs related to weighing pros versus cons in decision making, self-efficacy, and psychological influences on cognitive-behavioral change (e.g., experiential learning, consciousness raising, self-reflection, social norms, counterconditioning, helping relationships, reinforcement management, stimulus control, and self-management).

According to Prochaska and Velicer, individuals in the precontemplation stage deny the need to change their behavior because either they are unaware of its significant negative consequences or they have abandoned the idea of changing because they are demoralized. These individuals often become defensive and resistant if pressured to take action. Individuals in the precontemplation stage tend to believe that the difficulties outweigh the benefits of changing a behavior and are less confident that they can achieve their goal. In the transition from the precontemplation to the contemplation stage, their perception of the benefits increases and perception of the difficulties decreases.

In contrast, individuals in the contemplation stage are more aware of the benefits of changing risky behaviors but tend to overestimate the costs of doing so, which makes them ambivalent and unprepared to take action. In the preparation stage, the benefits begin to outweigh the difficulties and individuals have greater confidence that helps them take the action necessary to change their behavior. At this stage, individuals have decided to make a change and have begun to take steps towards their goal(s). Individuals in the action stage are engaged actively in changing their undesirable behaviors and developing healthy ones, while individuals in the maintenance stage have been able to sustain change and resist relapse for at least 6 months.

Individuals’ progress through the stages of behavior change occurs primarily in cyclic patterns as they may suffer relapses; however, the gains made prior to relapse are preserved and subsequent attempts to engage in action are more likely to be successful. In clinical settings, TTM expert system assessment can be used to assess individuals for multi-behavioral, staged-matched interventions. Beckie used the TTM expert system assessment to generate three computer reports (baseline, 3, and 9 months) for each of the three behaviors (healthy eating, physical activity, and stress management). The reports for each behavior are divided into sections with the first section focusing on the stage of change and readiness to change behavior. The second section explores pros and cons of changing. The third section provides participants with feedback relevant to their stage of change. The fourth section offers guidance on ways to enhance self-efficacy in difficult situations. The final section offers small, step-wise strategies to progress between stages.

A second key component guiding TCRP-W interventions is motivational interviewing. Motivational interviewing is defined as “a client-centered, directive method for enhancing intrinsic motivation by exploring and resolving ambivalence.” The motivational interviewing philosophy is that the counselor should foster a collaboration with the patient and employ techniques designed to enhance the patient’s willingness to change behavior and develop insight about what is intrinsically motivating to support desired changes. Expressing a sense of acceptance and empathy towards the patient is an overriding principle of motivational interviewing. A second principle is to help the patient realize the difference between present maladaptive behaviors and their coping style and the potential afforded by assuming adaptive and active coping behaviors. The key to developing intrinsic motivation is that the patient, not the counselor, assumes the primary role in identifying the reasons for positive action and lifestyle. The third principle concerns going with the flow of resistance. Attempting face-to-face arguments or other direct forms of persuasion is unproductive in overcoming any patient defensiveness and resistance to change. A final principle is to support the patient in developing a stronger sense of self-efficacy. The patient is acknowledged to be in charge of his or her own individual change.

In the TCRP-W trials conducted by Beckie, each patient received three, 1-hour individualized face-to-face motivational interview sessions with a cardiovascular nurse specialist trained in behavioral intervention. The first took place before group exercises and psycho-educational sessions began. The second session began halfway through the study and the third occurred at the end of the study. The nurse helped the patients identify their maladaptive behaviors with respect to self-confidence, the importance of change, and readiness for change by guiding patients to recognize and articulate their mental arguments against
change. The nurse used non-judgmental behaviors and agreed that the patients had the right and ability to self-direct their own goals and facilitated their confidence to overcome barriers to reach their goals.95

According to Beckie, TTM and motivational interviewing principles and approaches were also used to guide the psycho-educational sessions. In those sessions, participants were first taught the TTM behavior change strategies and then offered evidence–based guidelines to help them practice the strategies of behavioral change.95 For example, in the contemplative stage, the TTM suggests that increasing emotional awareness is a useful intervention that can be accomplished by assigning the participant homework that includes strategies to enhance self-reevaluation and environmental reevaluation. The psycho-educational sessions discussed topics such as CVD risk factors, medications, communication skills, stress management, and dietary and exercise guidelines. The sessions were conducted in a group format that provided opportunities for social support, role-playing, and group brainstorming discussions that generated ideas to create positive change and allow each participant to hear new ideas and build new strategies.95

Since introducing the TCRP-W approach, Beckie et al. have carried out rolling studies of the programs and concluded that, in comparison to traditional CR interventions, TCRP-W produces superior physiological and psychological outcomes.70,95,101 A significant shortcoming of the TCRP-W is that there appears to be no outcomes studies with this technique by researchers who are not aligned with Beckie et al.

CONCLUSION
As early as 1976, researchers identified that CVD program adherence and dropout were problematic.102 In the subsequent 50 years, we have learned that increasing women’s access and participation in CR is complex. Access issues such as childcare, timing of programs when women are freer from domestic and paid work, and the problems with certain program equipment being too large and uncomfortable for women maybe just as important as the type of programming offered. Delivering rehabilitation via tele-link has been an option partially addressing these concerns for nearly two decades but is ineffective when used in isolation.103 Along with pharmaceutical interventions, CR is a key strategy in treatment and prevention of CVD which is the leading cause of morbidity and mortality among women worldwide. The bulk of the evidence in the literature demonstrates that CR contributes to significant improvement in physiological and psychological clinical outcomes. Despite this, studies have shown that there are barriers that lead women to underutilize CR. Alternative referral strategies (e.g., automatic referral), methods of delivery (e.g., home/community/internet-based CR), and modification of CR program components (e.g., follow-up visit with health professional) have addressed some of the system-created challenges.73 However, much work remains to be done to develop best-practice evidence for this high need and the growing area of women’s health. As all stakeholders work toward this high level goal, clinicians can act within their own practices to identify opportunities in their CR interventions for female patients to reduce contextual barriers (e.g. transportation, childcare needs, cultural beliefs) and incorporate motivational interviewing and stages of change theory to build insight, motivation for change, and self-efficacy in a safe, non-judgmental environment.

REFERENCES


on Exercise, Cardiac Rehabilitation, and Prevention) and the Council on Nutrition, Physical Activity, and Metabolism (Subcommittee on Physical Activity), in collaboration with the American Association of Cardiovascular and Pulmonary Rehabilitation. Circulation. 2005;111(3):369-76. [PMID: 15668354]


52. Daly J, Sindone AP, Thompson DR, Hancock K, Chang E, Davidson P. Barriers to participation in and adherence to cardiac rehabilitation programs: A critical literature review. Prog Cardiovasc Nurs. 2002;17(1):8-17. [PMID: 11872976]


77. King KM, Teo KK. Cardiac rehabilitation referral and attendance: Not one and the same. Rehabilitation Nursing. 1998;23(5):246-51. [PMID: 10067639]


© The Internet Journal of Allied Health Sciences and Practice, 2017