

SA Health Cardiac Rehabilitation Services Model of Care

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The cardiac rehabilitation model of care outlines the core components and best-practice approach for delivering cardiac rehabilitation services across SA Health.



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Introduction

Coronary heart disease (CHD) remains a leading cause of death in South Australia, reflecting national trends. In 2022, CHD was responsible for nearly 19,000 deaths across Australia, accounting for 9.8% of all deaths [1]. While mortality rates from CHD have declined over recent decades, the prevalence of CHD remains high, and the burden of cardiovascular disease is ongoing. South Australia is not exempt, with many local regions experiencing higher-than-average rates of CHD, highlighting the need for sustained prevention and chronic disease management.

The burden of CHD is not evenly distributed. In 2017-18, Aboriginal and Torres Strait Islander adults were more than twice as likely to report CHD compared to non-Aboriginal and Torres Strait Islander adults. During the same period, adults living in the most socioeconomically disadvantaged areas were 1.6 times more likely to report CHD than those in the least disadvantaged areas [1].

Up to 80% of CHD cases are linked to modifiable risk factors such as poor diet, physical inactivity, smoking, and high blood pressure [2]. Alarming, approximately half of hospital admissions for CHD in Australia are repeat events [3], underscoring the critical need for **effective secondary prevention**. Cardiac rehabilitation (CR) programs offer a proven and cost-effective solution [4]. Despite its proven benefits, referral and participation rates remain suboptimal, reinforcing the need for consistent, statewide approaches to improve access and delivery. Through structured exercise, lifestyle modification, and education, CR supports long-term self-management and significantly improves clinical outcomes, including preventing secondary occurrence and further hospital admissions [5]. South Australian studies using clinical audit data demonstrate that participation in CR is associated with lower mortality, reduced cardiovascular readmissions, and higher rates of CR program completion [6,7]. In particular, Astley et al. (2020) reported that attending CR was associated with a 32% reduction in cardiovascular readmission [7]. The goals of CR are to promote secondary prevention and to enhance quality of life for cardiac patients. By reducing readmissions and re-presentations through effective secondary prevention, CR not only improves patient outcomes but also delivers significant long-term cost savings for the health system.

The Australian Cardiovascular Health and Rehabilitation Association (ACRA) and the National Heart Foundation recommend participation in CR after a cardiac event to reduce the risk of rehospitalisation and death. The recommendation is reinforced in the recently released *Australian Clinical Guideline for Diagnosing and Managing Acute Coronary Syndromes (ACS) 2025* [8], which advises that all patients with ACS should be referred to a multidisciplinary, exercise-based CR program prior to hospital discharge. Furthermore, medical societies rate CR class IA, the highest level of evidence. Evidence shows that CR programs addressing multiple risk factors – such as physical inactivity, smoking, poor diet, and medication adherence – or that include the prescription and monitoring of cardioprotective medications can reduce all-cause mortality (27% and 65% respectively) [9,10]. Programs that promote and achieve high levels of exercise adherence are associated with significant reductions in both all-cause (19%) and cardiovascular (28%) mortality [10,11]. In contrast, CR programs that do not include these components tend to have limited impact [10].

It is important to consider factors such as convenience, accessibility, flexibility, and personal preferences when designing CR programs. Tailoring programs to individual needs can improve access and participation by reducing barriers. Research shows that only about 30% of eligible patients participate in structured CR programs in Australia [12] and globally [13]. This is also demonstrated by South Australian clinical audit data investigating CR utilisation and effectiveness in the state. The study showed clear gaps in CR take-up, with 31% of eligible patients referred, and of those who received a referral, 36% commenced the program, and 77% completed it [6]. Rural and remote populations face significantly higher rates of cardiac mortality and morbidity but have poorer access to these programs [14]. The Country Heart Attack Prevention (CHAP) Research Program showed that tailoring services to address consumer barriers can improve attendance and completion rates for CR in regional South Australia [15].

In South Australia, implementing a more structured and systematic approach to CR and improving access to high-quality, comprehensive yet flexible CR programs – particularly in rural, remote, and Aboriginal communities – is essential to reducing the burden of CHD and improving health outcomes.

The Model of Care for SA Health Cardiac Rehabilitation Services outlines the core components of CR service delivery within SA Health facilities. Supporting resources will be developed to support consistent implementation. Appendix 1 provides an overview of the current state of CR in South Australia, which has informed the development of this Model of Care.

Objective

To ensure CR services in South Australia are guided by standardised, evidence-based approaches that are tailored and adaptable to local needs and culturally responsive.

The aim is to enable equitable access, optimise patient recovery and quality of life, and reduce cardiovascular morbidity and mortality through multidisciplinary care, patient education, and ongoing monitoring and evaluation.

Definition of Cardiac Rehabilitation

CR is a secondary prevention program delivered by a multidisciplinary team aimed at halting cardiovascular disease progression and optimising patient function [16]. It includes exercise training, health behaviour change, education on lifestyle and medical risk factor management, psychosocial support, and monitoring of cardioprotective medications.

CR services typically include:

- Physical activity and structured exercise
- Health education and counselling
- Behaviour change strategies / addressing modifiable risk factors
- Support for self-management.

CR is provided across the continuum of care and delivered across three distinct phases [17]:

- **Phase I – Inpatient:** From hospital admission to discharge, focusing on early mobilisation, risk factor education (e.g. smoking cessation, medication use, dietary choices and overweight/obesity), chest pain management, psychosocial support, and referral to an appropriate structured CR service. Access to the My Heart My Life (MHML) patient education package during admission.
- **Phase II – Outpatient:** Commences following hospital discharge and involves supervised exercise and lifestyle education through individual or group sessions, including options for home-based delivery. Ongoing assessment and referral to additional services occur as required. In some cases, patients may not require the full program; this is determined by the clinician after the initial assessment on a case-by-case basis.
- **Phase III – Maintenance:** After completion of the core CR program a patient moves into the (ongoing) secondary prevention phase. Focuses on long-term self-management and sustaining healthy behaviours. May include weekly group exercise sessions and lifestyle support, often provided in the primary health setting, via a Primary Health Network, Non-Government Organisation, or community organisations.

Cardiac Rehabilitation Model of Care

CR programs are multidisciplinary services that deliver personalised care plans focused on disease management, case coordination, self-management support, and physical rehabilitation.

This Model of Care streamlines the referral process for practitioners (central referral process) and is designed to be flexible, allowing patients to receive varying levels of support as they progress from inpatient care to Phase II CR – ranging from a light-touch approach to more intensive intervention, depending on individual needs. The central CR portal¹ aims to serve as a unified system for recording and monitoring patient and service data across CR programs.

Each program is typically led by a clinician with expertise in cardiac care, however a multidisciplinary approach is essential for delivering evidence-based CR programs. The essential components of CR are outlined in Table 1, based on guidance from the National Heart Foundation [18], ACRA, and supported by the European Society of Cardiology [19].

Essential elements of Cardiac Rehabilitation

Table 1. Essential elements of Cardiac Rehabilitation programs

Element	Description
Universal access to the Heart Foundation <i>My Heart My Life</i> (MHML) resource	Provide access to the online or printable resource during hospital admission (Phase I). Making it available before discharge ensures patients have the information and support they need as they transition home. It also empowers patients to take an active role in their recovery while waiting to commence CR (Phase II).
Choice and flexibility of delivery mechanism	Offer patients a choice in how they complete their CR (e.g. face-to-face, telehealth/video, hybrid etc.).
Initial assessment	Comprehensive assessment using the CR portal. Individual patient focused goal setting and tailored care plan shared with patient and GP. Determination of suitable CR delivery mode.

¹ The CR Portal described in this document is intended as a centralised data system that enables CR programs across SA to record and monitor patient-level and service-level information. It supports consistent reporting, quality improvement, and evaluation of CR services, while also facilitating streamlined referral tracking and service planning. Depending on its configuration, it could also capture referrals. Refer to Appendix 1 for limitations of the current data application.

Element	Description
Heart education and self-management	Educate patients about strategies for managing their heart health independently.
Medication education and review	Provide education on medications, their benefits, and support adherence strategies.
Managing medical risk factors	Equip patients to manage and prevent overweight/obesity, hypertension, diabetes, and dyslipidaemia through self-care skills.
Exercise and physical activity	Deliver tailored, supervised exercise programs based on FITT (frequency, intensity, time/duration, and type of exercise) principles and promote general physical activity and reduce sedentary behaviour.
Healthy eating and weight management	Address nutrition and physical activity as key modifiable risk factors for overweight/obesity and cardiovascular disease. Encourage sustainable lifestyle changes through healthy dietary choices, regular physical activity, and individualised dietetic support where available.
Tobacco cessation and alcohol reduction	Offer brief interventions for smoking cessation and alcohol reduction, with referrals to support services, such as Quitline.
Psychosocial wellbeing	<p>Screen for depression/anxiety at initial and post program assessment, measure Quality of Life at initial and post program assessment, provide emotional support, and education about depression and mood disorders.</p> <p>Facilitate opportunities for peer support, recognising its role in reducing isolation and improving motivation (e.g. Face-to-face group classes or online via the Heart Foundation's website online communities).</p>
Activities of daily living	Address concerns about driving, sleep, energy conservation, returning to work, and resuming sexual activity following a cardiac event.
Reassessment and completion	Conduct post-program assessment on the CR portal, review goals on completion of the program, and provide a discharge summary and ongoing management plan to the client and GP. Collect Patient Reported Measures (PRMs) through a survey at program completion to support continuous quality improvement.

Priority populations and equity

Tailored approaches are needed to address barriers to participation, ensure equity of access, and improve outcomes for priority population groups. These include Aboriginal and Torres Strait Islander peoples; culturally and linguistically diverse communities; women; people living in rural and remote areas; older adults; and individuals experiencing socioeconomic disadvantage. While this Model of Care does not provide detailed strategies for these groups, it recognises that bespoke approaches will be required. It is recommended that CR sites partner with Aboriginal Community Controlled Health Organisations to support culturally safe CR care for Aboriginal and Torres Strait Islander peoples, and work with local multicultural health services or community organisations to tailor CR delivery for other priority populations.

Timing of Cardiac Rehabilitation

Evidence shows that early CR assessment increases enrolment and participation in CR, which in turn improves quality of life and reduces hospital readmissions [6,7,19]. Within SA Health, referrals to CR should be made within 3 days of patient hospital discharge. The target is to complete the CR assessment within 28 days of discharge for public inpatients, or within 28 days of receiving the referral for non-public inpatients [10].

Flexibility in timing is essential to account for clinical factors. Patients who are not suitable to commence CR within 28 days, such as those with postoperative restrictions or complications (e.g. CTSU patients), should have commencement deferred based on clinical judgement, while maintaining clear distinction from standard timeframes. For example, surgical patients need to delay starting CR until at least six weeks after surgery to allow adequate recovery.

Referrals and inclusion criteria for Cardiac Rehabilitation services

Patients can be referred to CR from inpatient or outpatient settings, through primary care/GPs, or via self-referral. CR is recommended for all patients hospitalised with a cardiac event as part of their recovery and ongoing cardiac care. All SA Health clinicians can generate referrals to send patients to Phase II CR services via the centralised CR portal. Timely referrals support best practice and underpin this model of care.

Referral process

A key principle of this Model of Care is to ensure timely referrals, as early referral improves patient engagement with CR services, increases overall referral rates, and supports better outcomes. A central referral process brings all referrals to a central location to support better data capture and streamlined health administration.

- Referral should be made within 3 days of hospital discharge.
- All patients should be referred during Phase I (inpatient stay).
 - If a referral is not made, the reason should be documented in the CR portal using the available options. For example, patients may not be referred due to physical limitations, cognitive impairment, or because they live in a residential aged care facility.
- Patients may opt out of the CR program after completing their initial assessment (opt-out process).

Inclusion criteria

As outlined by the ACRA and recommended by the Heart Foundation, CR is appropriate for patients with [20]:

- Acute myocardial infarction (MI) – both ST and Non-ST elevation; including patients with and without post-MI revascularisation
- Revascularisation procedures:
 - Coronary artery bypass graft (CABG) surgery
 - Percutaneous coronary intervention (PCI)
- Medically managed coronary artery disease (CAD), e.g., stable angina
- Other ACS presentations including MINOCA, SCAD, coronary spasm, etc.

While the focus of this model of care document is the Acute Coronary Syndrome (ACS) patient cohort, patients with the following conditions will also benefit from CR:

- Heart failure and cardiomyopathy conditions
- Valve surgery or device implantation (replacement or repair)
- Permanent pacemaker and implantable defibrillator insertion
- Heart transplant and ventricular assist device (VAD)
- Atrial fibrillation
- Those at high risk of coronary artery disease
- Other vascular or heart conditions and interventions
- Familial hypercholesterolaemia.

Consideration of patient safety should apply in the inclusion criteria for participation in the Phase II exercise component.

Cardiac Rehabilitation Assessment (pre- and post-program)

A comprehensive assessment is required for all public CR patients and should be completed using the CR portal. This is in line with the CR Quality Indicators (Refer to Table 2 – QI-3).

- Access: Clinicians can request access to the CR portal when identified as a SA Health CR service clinician.
- Documentation: Assessment records are auto-generated and can be uploaded into the CR portal.
- Private CR programs use their own assessment and documentation processes.

Assessment includes:

- Socio-demographic details
- Clinical history
- Exercise capacity (e.g., Graded Exercise Test, Six-minute Walk Test [6MWT] and other functional measures. Refer to the CSANZ position statement for a list of detailed exercise assessments [21])
- Lifestyle risk factors (physical activity, diet, smoking, alcohol use, overweight/obesity)
- Psychosocial screening using a validated scale:
 - Depression and anxiety (e.g. PHQ-4)
 - Quality of Life (e.g. AQOL or Short QOL)
- Medication review.

Completion of a comprehensive reassessment at the end of the CR program is also necessary to support identifying how effective a program has been, as per the CR Quality Indicators (Refer to Table 2 - QI-9).

Modes of delivery

CR programs should be flexible in design to accommodate diverse patient needs and preferences. Delivery may occur in various formats depending on individual circumstances and local resources, including in-person at health centres or the patient's home, and via telehealth through video or phone. Telehealth can also be used to support patient follow-up reviews. Services can be provided through group programs or individual appointments.

The mode of delivery at each site should be standardised to ensure consistency of care. Program delivery methods and details should be recorded at each site.

A CR program should provide all essential elements as outlined in Table 1.

Model of care options

Education and exercise remain the most effective and evidence-based components of CR [20].

Exercise program

CR programs typically provide a minimum of 12 supervised sessions, with patients exercising at least twice per week, over a six to 12-week period. Research shows that 12 sessions represent the minimum effective dose to reduce all-cause mortality [22]. Therefore, participation in a minimum of 12 supervised CR exercise sessions is recommended, with additional sessions encouraged to further support physical activity outcomes and behaviour change. For example, higher doses (such as 36 sessions) have been shown to further reduce the need for percutaneous coronary interventions in patients with cardiovascular disease [22].

While a minimum of 12 supervised sessions is recommended, this Model of Care recognises the need for flexibility to accommodate individual patient needs rather than a prescribed, one-size-fits-all approach. A variety of delivery modes are available (see diagram on page 12).

It is expected allied health professionals will design and prescribe the exercise and physical activity program based on a comprehensive initial assessment of the patient's exercise capacity, regular review of the patient's response to the program and sign off on any appropriate increases to ensure continual improvements [21]. Before conducting any exercise assessments, clinicians must review all absolute and relative contraindications to exercise as outlined in the CSANZ Position Statement [21].

Additional resources will be developed to guide exercise prescription and physical activity in cardiac disease patients. It is encouraged to review the CSANZ Position Statement (2023), 'A clinical guide for assessment and prescription of exercise and physical activity in cardiac rehabilitation' [21] to understand the exercise prescription guidelines for CR.

CR services are encouraged to record session frequency, duration, and mode of delivery in the CR portal, in addition to the start and end dates and total sessions attended. This data will support evaluation and help determine the optimal dosage to improve patient outcomes across South Australia.

Education program and other supports

Education is always delivered as part of Phase II CR programs and can be captured via a variety of delivery modes (see diagram on page 14). This may involve a self-directed education program when the patient reviews clinician directed education content in their own time and at their own pace, such as via a web platform education hub, and video resources. This can include the National Heart Foundation's My Heart My Life resource, which is an expected deliverable from the initial assessment (in addition to its provision in Phase I).

At times, further referrals are required to allied health or specialist staff (e.g. psychologist, occupational therapist) to support patients to achieve their goals. For example, patients screened as positive for depression or anxiety should be referred for stepped, collaborative care [20]. Local referral processes will determine the approach to generating these referrals. The outcomes of these referrals should be documented in the CR portal.

Patients can also be encouraged to connect with peer support as part of their longer-term recovery and transition between CR phases. Programs offered by the Heart Foundation, Heart Support Australia and Heartbeat South Australia provide valuable opportunities for ongoing support and connection.

Discharge from Cardiac Rehabilitation

CR programs should manage patient flow to maintain capacity for new referrals. Discharge should occur when:

- The patient has achieved their individual goals, and
- They have completed an optimal dosage of CR sessions.

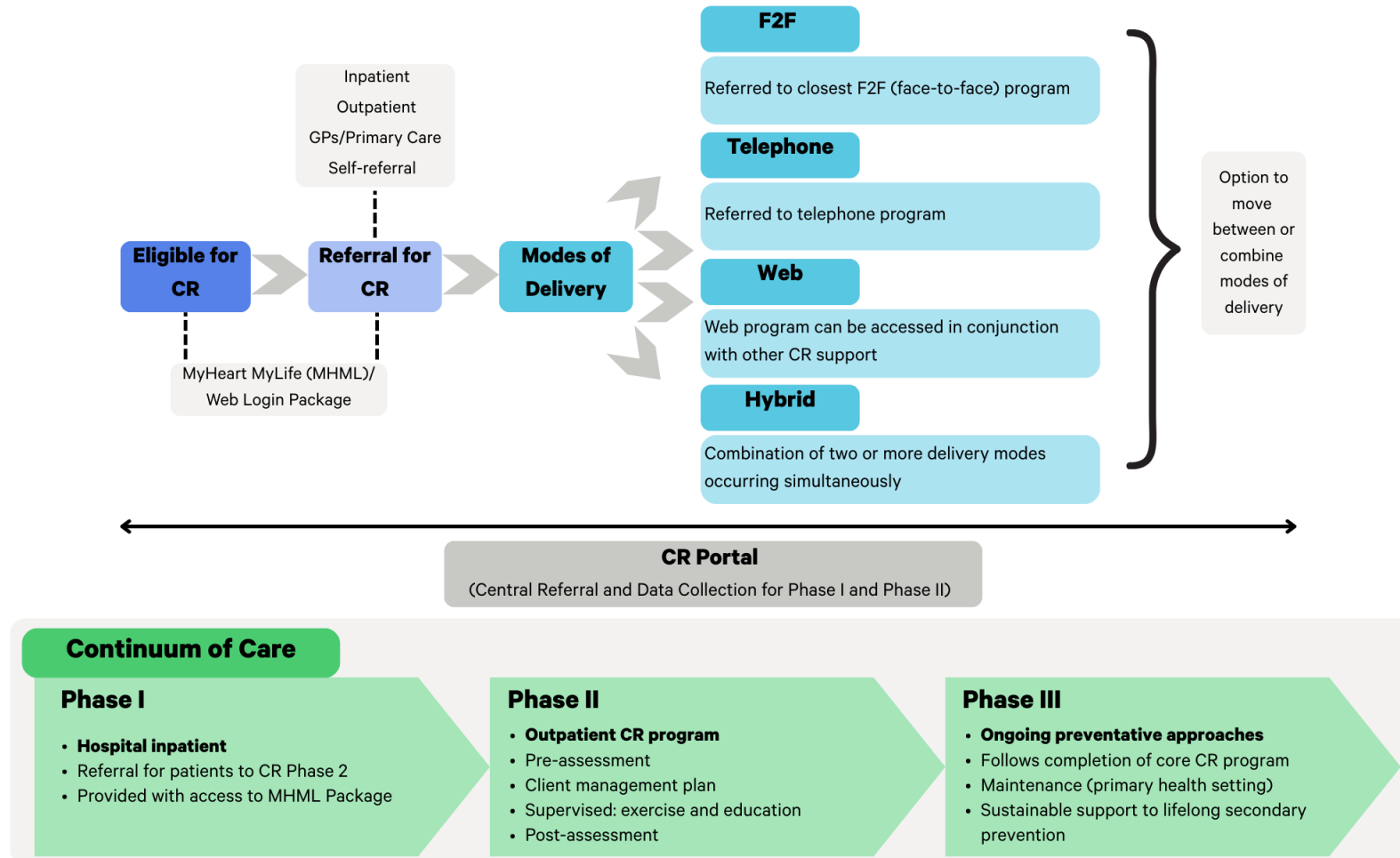
Before discharge, all patients (and/or their caregivers) should:

- Be able to self-manage their condition, recognise worsening symptoms, and know how to follow an action plan,
- Understand how to exercise safely based on their cardiac condition and maintain lifelong physical activity,
- Know how to manage cardiovascular risk factors (e.g., diet, smoking, overweight and obesity, sedentary behaviours and medication adherence),
- Be under the care of a GP and specialist, if ongoing follow-up is required.

In addition, health professionals should check that a comprehensive reassessment has been undertaken, as per the CR Quality Indicators (Refer to Table 2 – QI-9).

Model of Care Pathway

Statewide Cardiac Rehabilitation (CR) Model of Care (MoC)



Acknowledgement: Adapted from the Country Heart Attack Prevention (CHAP) Project: 2019 - 2023

Benchmarking and Outcomes

By using the CR portal, clinicians and health administrators in SA Health CR programs automatically contribute to a statewide collection of key data on referrals, timeliness, program performance, and clinical outcomes. This also supports the National Quality Indicators for CR [10].

Key features of the Cardiac Rehabilitation portal

The portal should encompass a robust IT system that can track data and generate reports or live dashboards of the quality indicators (key performance measures), so CR programs can assess progress and monitor performance.

Key features of the portal include:

- Clinicians enter patient data electronically via the CR portal.
- Access to all assessment documents, service data, and quarterly reports is available without duplicate data entry.
- Patient-reported outcomes, pathology results, and functional assessments are recorded at both initial and post-program stages, allowing measurement of patient progress following CR participation.

Reporting and performance monitoring

- Clinical indicator reports track referral rates, assessment completion, and timeliness of the patient journey.
- Outpatient summary reports provide monthly data on referrals, demographics, and assessment outcomes by CR site.
- Both reports are distributed quarterly to CR service contacts.
- An annual statewide report summarises activity and performance and is publicly available on the SA Health website.

Purpose of measurement

Process and outcome indicators (see Table 2) monitor both the quality-of-care processes and patient outcomes following CR. Table 2 provides a summary of the 10 quality indicators for CR, aligning to the National Cardiac Rehabilitation Quality Indicators. These data guide ongoing discussions between the Cardiac Care Statewide Clinical Network (SCN) and Local Health Networks (LHNs) to ensure patients receive optimal care.

Table 2. Overview of cardiac rehabilitation quality indicators

Overview of cardiac rehabilitation quality indicators [10]
QI-1. Referral to CR - Eligible in-patients are referred to cardiac rehabilitation within 3 calendar days after hospital discharge
QI-2. Time to enrolment - Eligible in-patients commence cardiac rehabilitation within 28 calendar days after hospital discharge
QI-3. Comprehensive assessment - Patients who commence cardiac rehabilitation receive a comprehensive assessment of cardiovascular risk factors
QI-4. Depression screening - Patients who commence cardiac rehabilitation are screened for depression at initial and re-assessment and offered counselling (or referral to counselling) if symptoms are identified
QI-5. Assessment of smoking - Patients who commence cardiac rehabilitation are assessed for smoking use at initial and re-assessment and offered smoking cessation counselling (or referral to counselling) if they are a current or recent smoker
QI-6. Assessment of medication adherence - Patients who commence cardiac rehabilitation are assessed for medication adherence at initial and re-assessment
QI-7. Assessment of exercise capacity - Patients who commence cardiac rehabilitation have an initial assessment and re-assessment to determine exercise capacity change
QI-8. Assessment of health-related quality of life - Patients who commence cardiac rehabilitation have an initial assessment and re-assessment to determine health-related quality of life change
QI-9. Re-assessment - Patients who participate in cardiac rehabilitation receive a comprehensive re-assessment of their cardiovascular risk factors
QI-10. Care transition - Patients and ongoing care providers are provided with a report which outlines patient risk factors and an individualised ongoing management plan

Key:

Blue = Process indicator

Green = Outcome indicator

Workforce for Cardiac Rehabilitation

Patients must have timely access to a **multidisciplinary** CR team. A multidisciplinary team is integral to CR to achieve optimal outcomes as CR is a complex, evidence-based clinical intervention whose benefits (reduced cardiovascular mortality, fewer readmissions, improved function and quality of life) are achieved only when exercise, education, medical and dietary review, and psychosocial care are delivered together by appropriately trained health professionals. This Model of Care emphasises the multidisciplinary approach and importance of allied health as central to achieving best-practice outcomes in CR. The composition of each CR team may differ, but it is essential that the service is multidisciplinary. Access to the full range of specialised staff and services is essential to provide comprehensive CR care. There should also be dedicated administrative support.

Clinical roles in Cardiac Rehabilitation

Medical Specialist

Most CR programs do not have a medical specialist in attendance. However, maintaining a strong working relationship with referring specialists and treating clinicians is essential.

- Contact the specialist when there is uncertainty about referral information, patient stability for CR entry, or if adverse events occur during the program.
- Communicate at CR discharge to ensure the specialist and GP receive an ongoing management plan, supporting transition of care.

Nursing

Nurses provide clinical expertise in comprehensive assessment, care planning, and management of patients with cardiac disease. Their role includes:

- Considering complex patient needs and comorbidities.
- Interpreting relevant investigations.
- Offering clinical advice and education to patients and carers, helping them to understand their cardiac condition, how to modify their cardiac risk factors, and develop self-management skills to support their heart health.

Allied Health

Allied health professionals are an essential part of the core CR team. When patients require expertise beyond the skills of the core team, timely referral to additional allied health professionals must be provided. Evidence consistently shows that specialised interdisciplinary care involving allied health is critical to achieving optimal patient outcomes in CR.

Physiotherapist / Accredited Exercise Physiologist

- Conduct comprehensive assessments and interpret relevant investigations.
- Evaluate exercise capacity, considering the patient's complex needs and comorbidities.
- Prescribe tailored individual and group exercise programs based on evidence-based guidelines.
- Educate patients and carers about physical activity and exercise specific to their needs.

In addition, **allied health assistants** support the multi-disciplinary team in delivering exercise components, and other cardiac rehabilitation activities.

Pharmacist

- Take medication histories and perform medication reviews.
- Manage cardiac medication.
- Assess and resolve medication-related problems.
- Support medication titration, especially for heart failure patients, following evidence-based guidelines.
- Provide education to patients and carers about medications.
- Promote medication adherence.
- Liaise with community health providers to ensure continuity of care.

Dietitian

- Conduct diet histories, estimate dietary intake and fluid needs.
- Compare actual intake to recommended guidelines.
- Screen for malnutrition.
- Prescribe specific diets tailored to individual needs.
- Provide education to support dietary changes.

Occupational therapist

- Support patient independence through personal goal setting.
- Educate patients on energy conservation and work simplification techniques.
- Recommend and facilitate home modifications to improve function, safety, and prevent falls.

Social worker

- Offer advice and assistance with practical, financial, and legal matters.
- Support end-of-life planning.
- Provide interventions such as stress management, relaxation techniques, counselling, and emotional support.

Psychologist

- Provide psychological support for patients experiencing distress, including depression and anxiety related to chronic disease.
- Deliver motivational support and behaviour change strategies.

Coordination and support roles

Clinical Administration Support

Administration support may include telephone reception, scheduling of patients, data entry, clinical letters and minute taking.

Statewide Cardiac Rehabilitation Program Advisor

The Statewide CR Program Advisor is responsible for coordinating cardiac rehabilitation services across South Australia. Their role is to ensure high standards of practice and promote ongoing service development. This includes supporting quality care by developing and maintaining evaluation systems, leading service improvement initiatives, overseeing workforce training and education, and guiding service planning and development. The role could also encompass tracking referral patterns, including public vs private referrals.

Appendix 1: Current State

CR sites across SA have different inclusion criteria and service options which are available depend on patient location. There are currently 23 public CR services in SA, with each service operating independently with significant variability in program content and delivery. Service level outcomes therefore vary significantly.

Current average wait times from referral to commencement of CR is 40 days in SA, however it can extend to up to 8 months. Australian CR quality indicators recommend referral to rehabilitation within 3 days of discharge and commencement of CR within 28 days of discharge. Approximately 4500 referrals are processed each year through SA's current central referral application, with 4800 referrals on track for 2025. Only 38% of total referrals commence a CR program.

Barriers to patient attendance persist. Data analysis from SA referrals shows telehealth options are associated with increased commencement and completion rates and patients are more likely to participate if they are referred quickly and there is a group component to the CR program. They were less likely to participate if they have risk factors such as depression, smoking, and drinking.

Health system resourcing challenges can result in allied health staff being prioritised for inpatient activities and redirected away from CR, while limited space and constrained facilities are reported as barriers to effective CR delivery in public health settings. Furthermore, there is no central capability framework for clinicians delivering CR care, leaving clinicians without robust support outside of the central CR sites.

The primary data collection application, CATCH (Country Access to Cardiac Health), which enables CR programs across country and metropolitan programs to record patient level data, needs upgrades to improve usability and engagement with clinicians and health administrators. Integration with the Electronic Medical Record (EMR) would further enhance data quality and workflow.

In this context, the Model of Care has been developed to establish a more standardised and consistent approach, including a streamlined referral process for practitioners and flexible delivery options to improve patient engagement with CR.

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