**SDC Table. Intervention Characteristics of Included Studies**

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| **Study** | **Length** | **Follow-up** | **Measure** | **Units** | **Intervention Description** | **Results** |
| Aliabad et al (2014)33 | 3 sessions | 4 mo after end of CR | Godin Leisure-Time Exercise Question-naire | METs/wk | HAPA-based training in 3 sessions; booklet designed based on HAPA with family support; HAPA is a health behavior change model which distinguishes between pre-intentional motivational processes leading to behavioral intention and post-intentional volitional processes leading to actual health behavior. | PA in the intervention group was significantly higher than the control group after the intervention. |
| Antypas et al (2014)31 | 12 wk | 12 wk  | IPAQ | METs/wk | Tailored internet- and mobile-based intervention which contained general information about CVD and self-management, including information about diet, physical activity, smoking, and medication, as well as access to an online discussion forum and tailored content; participants in the tailored group were required to answer more online questions than the control group, usually every 2 wk and they were reminded to log-in through email and SMS text messages and answer the questionnaires. | Intervention group had a significantly higher median level of overall physical activity than the control group. |
| Arrigo et al (2008)34 | 1 yr | 1 yr after end of CR | Exercise diary | Physically active (Y/N) | Diary in which PA had to be described and quantified in min; physician-supervised exercise session once every 3 mo where diary was discussed; not well described.  | Intervention showed a significant impact on regular physical activity at follow-up.  |
| Butler et al (2009)35 | 18 wk | 6 mo | Active Australia Survey | Sessions/wk | The intervention group was given a pedometer, step calendar, and walking safety sheet after the baseline questionnaire was completed; participants were trained in the use of the pedometer and were instructed to record daily steps for 6 wk; telephone calls to participants were made 1 wk after receiving the pedometer and step calendar and at weeks 3, 12, and 18; key features of the intervention included use of verbal reinforcement, individualized goal-setting, and objective feedback from the pedometer to support the adoption and maintenance of a physically active lifestyle; outcome expectancies, goal-setting and barrier identification were also addressed.  | Physical activity sessions and minutes were significantly greater in the intervention group than the control group at follow-up.  |
| Duncan et al (2002)18 | 12 wk | 12 wk | Exercise diary | Sessions/wk | Unsupervised home-based program + adherence facilitation intervention including goal-setting, graphic feedback and problem-solving guidance delivered to each patient at 3-wk intervals provided by a nurse researcher. | Exercise frequency and duration was significantly higher in the intervention group at follow-up.  |
| Duncan et al (2003)19 | 12 wk | 24 wk | Exercise diary | Sessions/wk | Adherence facilitation intervention including goal-setting, graphic feedback and problem-solving guidance delivered to each patient at 3-wk intervals during unsupervised home-based phase provided by a nurse researcher. | Exercise adherence significantly higher in the intervention group at follow-up. |
| Frederix et al (2015)28 | 12 wk | 18 wk | Triaxial accelero-meter | Steps/d | Motion sensor, online patient account, and weekly personalized automated feedback by SMS text messaging or email. Program was designed to encourage the patient to increase their daily step count to reach the recommended daily step count of 6500-8000 steps/d. |  peak increased significantly in the intervention group, and was significantly correlated with daily steps.  |
| Frederix et al (2015)27 | 24 wk | 24 wk | Triaxial accelero-meter | Steps/d | The telerehabilitation included an online program and tailored exercise prescription; participants were instructed to wear accelerometer continuously and to regularly transmit their registered activity data to the telerehabilitation center’s local server; these data enabled a semiautomatic telecoaching system to provide the patients with feedback via email and SMS text messaging (once weekly), encouraging them to gradually achieve predefined exercise training goals; content of the feedback messages changed over time based on how well the patient changed prior lifestyle behavior.  | Daily steps increased in the intervention group from baseline to follow-up; however, was not significant. Self-reported PA significantly increased in the intervention group.  |
| Giallauria et al (2009)29 | 2 yr | 2 yr | Question-naire | Exercise intensity categories | Multifactorial continuing education and behavioral program. Patients were seen in hospital once/mo throughout the 24-mo follow-up each patient received a booklet for exercise, diet, and smoking cessation to help patients assume a greater role in their healthcare, summarizing ideal lifestyle and risk factor targets, aiming to empower patients to manage each risk factor and lifestyle behavior; in addition, patients received, at each monthly visit, dietary advice, reinforcement on maintaining a correct lifestyle, a session of exercise training. Intervention team was made up of a psychologist, dietitian, cardiac specialist nurse, and a physiotherapist supported by a lead cardiologist. | At follow-up, only 27% of the control group compared with 58% of the intervention groupreported moderate or high level of LTPA (*P* < .001). |
| Giannuzzi et al (2008)30 | 3 yr | 3 yr | Question-naire | LTPA score | The multifactorial, continuing educational and behavioral program was performed by a cardiac rehabilitation team composed of a specialist cardiac nurse, a physiotherapist, and a cardiologist (who was the supervisor); comprehensive sessions with 1-to-1 support were held monthly from Month 1 to Month 6, then every 6 mo for 3 yr; each session consisted of 30 min of supervised aerobic exercise, plus lifestyle and risk factor counseling lasting at least 1 hr and reinforcement of preventive interventions lasting approximately 30 min; booklets explaining how to deal with exercise, diet, smoking cessation, and stress management were distributed.  | The improvement in PA scores was significantly greater in the intervention group. |
| Guiraud et al (2012)34 | 8 wk | 8 wk | Single-axis accelero-meter | Kcal/wk | The kinesiologist insisted on the importance of wearing the accelerometer from first thing in the morning to last thing at night; to motivate the patients, the kinesiologist called them every 15 d; during the telephone interview, the kinesiologist gave standard feedback on the amount of PA performed and counseled patients to identify potential barriers encountered to achieve PA recommendations and to implement strategies to increase the daily amount of moderate-intensity PA. | The intervention group had a significantly higher total active energy expenditure compared to the control group.  |
| Hofman-Bang et al (1999)37 | 11 mo | 24 mo | Question-naire | Sessions/wk | Regular follow-up contacts were established between the patient and the nurse; these contacts were based on the agreed individual goal and consisted of continued self-observation and recording of important aspects on everyday life in a diary, monitoring of behavioral changes, and, when needed, problem-solving and replanning discussions; at discharge from the rehabilitation center, a referral note was sent to the family physician with information on achieved lifestyle changes; this maintenance program was successively stepped down over the 11-mo period, leaving the patients on their own during the 2nd yr of follow up. | Exercise improved significantly in the intervention group compared to the control group.  |
| Hopper (1995)20 | 12 mo | 15 mo | 13-item question-naire | Score for “current exercise habit” | The intervention group received monthly telephone calls from rehabilitation staff (ie, health care professionals) to provide social support and encourage their adherence to the exercise regime established during rehabilitation; a cardiac nurse or exercise physiologist contacted each participant of the intervention group and, during a structured telephone interview, addressed the following areas: (1) consistent exercise, (2) maintenance of a healthy diet, (3) consistency with medication, (4) knowledge of current blood pressure and cholesterol levels, and (5) symptoms that required medical attention and/or physician awareness. | The intervention group demonstrated significantly greater exercise adherence at follow-up than the control group.  |
| Hughes et al (2007)38 | 9 mo | 12 mo | Uniaxial accelero-meter | Activity counts/wk | Participants received an exercise consultation after baseline and 6-mo assessments and a support phone call 3 mo after each consultation; control participants received a phone call on topics unrelated to exercise at 3 and 9 mo after the baseline assessment; exercise consultations involved a 30-min 1-to-1 discussion with a trained researcher; strategies included: assessing current physical activity status, exploring pros and cons of being active, problem-solving barriers, social support, exploring activity options, setting realistic activity goals (for 1, 3 and 6 mo) and preventing relapse; support phone calls 3 mo after each consultation lasted approximately 10 min and involved a discussion on barriers to activity, achieving activity goals and remaining active. | Activity counts did not significantly change in intervention group; however, they were exceeding PA guidelines at baseline and maintained that level. Activity decreased in the control group but was not significant. |
| Izawa et al (2005)39 | 6 mo  | 6 mo after end of CR | Pedometer | Steps/d | Patients were asked to continue self-monitoring after CR by recording body weight, objective physical activity derived from the pedometer, blood pressure, and heart rate; the goal in the self-monitoring approach group was to promote self-efficacy for physical activity in relation to exercise maintenance and LTPA; the self-monitoring approach used in this study was based on Bandura’s self-efficacy theorya and was designed to enhance confidence for exercise maintenance; performance accomplishments were addressed by written feedback on exercise, muscle strength test results, body composition test results (% body fat), and discussion of the self-monitoring log. | Mean objective PA was significantly higher in the intervention group than control group at follow-up.  |
| Janssen et al (2014)40  | 19 wk | 15 mo postCR | Pedometer | Steps/d | The intervention was a self-regulation program focused on maintenance of lifestyle change; the program started with an individual 1-hr motivational counseling session with a health psychologist (Week 1); during the interview, important (life) goals for the patients were explored, on the basis of which personal health goal was set; potential barriers to goal achievement and costs and benefits of change were examined; patients then attended five 2-hr group sessions (Week 3, 5, 7, 9 and 11) and two 2-hr follow-up sessions (Week 15 and 19) at the cardiac rehabilitation center led by the same health psychologist; group sessions were structured around the self-regulatory phases of goal pursuit, in particular the maintenance phase, and focused on enhancing the relevant self-regulation skills; patients were also encouraged to bring their partner (or a significant other) to 1 of the sessions in order to increase social support.  | Steps significantly increased from baseline to follow-up in the intervention group compared to control.  |
| Kaminsky et al (2013)21 | 8 wk | 8 wk | Pedometer | Steps/d | Participants wore a pedometer daily for the entire study period, whereas the control group only wore the pedometer during initial assessment week and during Week 8; with each week of pedometer use, participants completed a PA log form to report pedometer wear-time on a given day. All participants, regardless of group, were given the same recommendation to obtain a minimum of 30-40 min/d MVPA, on days they did not attend CR; following baseline assessment, intervention participants received individualized daily step count goals that increased by 10% from baseline steps/d for Week 2-8. | Intervention participants significantly increased steps/d from baseline to follow-up. There was no difference in control participants. |
| Lear et al (2003)25 | 9 mo | 1 yr | 4-wk; modified Minnesota Leisure Time Physical Activity question-naire | Kcal/wk | ELMI was designed so that each participant was contacted at least once/mo using a case management model based on principles of behavioral change; during these sessions, participants were counselled to establish a home-based exercise program with each participant received a logbook for exercise, diet and medications at the study’s onset to aid in lifestyle adherence; telephone follow-up calls were conducted by the case manager to identify any new or change in symptoms, follow-up on goal progress, and assess and counsel on lifestyle behaviors and risk factors; ELMI lifestyle and risk factor counselling sessions were held at Month 6 and 9; participants received a ELMI Lifestyle and Risk Factor Report upon entry. | There were no significant differences between the 2 groups.  |
| Luszczynska et al (2006)41 | 10-15 min | 8 mo after MI | Question-naire | Exercise sessions/wk | Patients received instructions about what implementation intentions should include, completed the intervention form, screened the intervention form together with an interviewer and received supportive feedback from an interviewer regarding their implementation intentions, and were complimented by an interviewer regarding successful implementation of their intentions; the intervention was given on an individual basis and lasted 10-15 min; patients were instructed that they would be asked to form a plan regarding their physical activity and that their plans should always include the information about when, where, and how to exercise.  | Patients in the intervention group exercised more frequently than the control group at follow-up. |
| Madssen et al (2014)32 | 12 mo | 12 mo | Question-naire | Exercise sessions/wk | Patients in the maintenance program group received a written exercise program with the aim of 3 sessions of high-intensity interval-training (HIIT) per wk, and were invited to attend a monthly supervised exercise session at the hospital; the HIIT program consisted of 8-10 min of warmup, followed by 4 bouts of 4-min intervals, with an active pause of 3 min in-between intervals and at the end; physiotherapists or exercise physiologist motivated the patients on how to perform HIIT and asked about their home training. | There was no difference in physical activity levels between groups after 12 mo.  |
| Millen et al (2009)26 | 3 mo | 3 mo | Modified Physical Activity Scale for the Elderly  | Exercise sessions/wk | A Social Cognitive Theory-Based Resistance Training Manual was a 30-page instructional resistance-training manual designed for the cardiac patients in the intervention group; the content of the manual was based on fundamental strength training principles for cardiac patients and social cognitive theory constructs targeting self-efficacy and outcome expectancies; patients were also provided Thera-Band resistive bands and a logbook; all participants were given an orientation to exercises.  | There was no difference between groups at follow-up.  |
| Moore et al (2006)48 | 2 mo | 12 mo | Portable wristwatch heart rate monitor | Exercise sessions/mo | “Change Habits by Applying New Goals and Experiences” (CHANGE) intervention consisted of 5 small-group (6-8 people) counseling and behavior modification sessions for participants attending a CR program in which they were taught self-efficacy enhancement, problem-solving skills, and relapse prevention strategies to address their identified exercise maintenance problems; the CHANGE intervention is based on several cognitive-behavioral theoretical frameworks; the intervention was provided in 3 1½-hr sessions once a wk during the last 3 wk of the CR program and 2 sessions were held at 1 and 2 mo following completion of the CR program. | No significant differences between groups at follow-up.  |
| Pinto et al (2011)23 | 6 mo | 12 mo | 7-day Physical Activity Recall validated by triaxial accelero-meter | Min of MVPA/wk | The participants were given home logs to monitor exercise participation and a pedometer to wear during exercise activities that involved walking; each participant received calls over 6 mo (weekly over the fırst 2 mo, biweekly for the next 2 mo, and monthly for the last 2 months - a total of 14 calls) from the Intervention Coordinator to promote adherence to prescribed aerobic exercise, incorporating components of social cognitive theory, motivational interviewing, and transtheoretical theory; participants were mailed an information sheet for each call and received feedback letters throughout. | The intervention group reported significantly higher exercise participation at 12 mo than the control.  |
| Sniehotta et al (2005)17 | 4 mo | 4 mo after end of CR | Modified Kaiser Physical Activity Survey | Exercise sessions/wk | Planning intervention: participants received a planning booklet with 2 sheets for action plans and for coping plans.Personalized Weekly Diary Intervention: participants in the planning plus diary group received the planning booklet and they also received by mail 6 weekly diaries after discharge, tailored to individual requirements; in each diary, participants received copies of their own personal plans previously formulated in the planning intervention. | The planning plus diary group reported the highest levels of PA at follow-up; however, it did not reach statistical significance.  |
| Yates et al (2005)24 | 9 wk | 6 mo | Question-naire | Exercise sessions/wk | The intervention was by telephone and was guided by Bandura’sa self-efficacy theory; during booster sessions, the subject’s individualized goals, negotiated in CR, were used as a basis for intervening; subjects who reported progress toward goal achievement received praise and were encouraged to attribute accomplishments to their own abilities; factors inhibiting achievement of target goals were also discussed to deal with areas of relapse; 4 BSN-prepared nurses with expertise in CR provided the booster intervention; participants met with a nurse at 3 and 9 wk after CR. | Intervention group had greater exercise at follow-up compared to baseline; however, there were no significant differences between groups.  |

Abbreviations: CR, cardiac rehabilitation; CVD, cardiovascular disease; ELMI, Extensive Lifestyle Management Intervention; HAPA, Health Action Process Approach; HIIT, high-intensity interval-training; IPAQ, International Physical Activity Questionnaire; LTPA, leisure-time physical activity; PA, physical activity; SMS, short message service; , oxygen uptake.

aBandura A. Self-efficacy mechanism in human agency. *Am Psychol*. 1982;37:122-147.