

A Clinical Guide for Assessment and Prescription of Exercise and Physical Activity in Cardiac Rehabilitation. A CSANZ Position Statement

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Patients with cardiovascular disease benefit from cardiac rehabilitation, which includes structured exercise and physical activity as core components. This position statement provides pragmatic, evidence-based guidance for the assessment and prescription of exercise and physical activity for cardiac rehabilitation clinicians, recognising the latest international guidelines, scientific evidence and the increasing use of technology and virtual delivery methods. The patient-centred assessment and prescription of aerobic exercise, resistance exercise and physical activity have been addressed, including progression and safety considerations.

Keywords

Cardiac rehabilitation • Secondary prevention • Coronary disease • Cardiovascular disease • Exercise assessment • Exercise prescription • Physical activity • Position statement

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Introduction

Cardiovascular disease (CVD) is the leading cause of death and disease burden globally [1]. Improvements in diagnosis, treatment and long-term management have improved survivorship and reduced hospitalisations following a cardiac event, however they have also greatly increased the number of patients requiring ongoing and lifelong CVD risk management [2,3]. To reduce the risk of future events, international guidelines recommend all eligible patients have access to, and participate in, secondary prevention programs, including cardiac rehabilitation [4,5]. Cardiac rehabilitation is a comprehensive, multidisciplinary intervention consisting of patient assessment and individualised risk profile management, dietary advice, exercise prescription and physical activity counselling and psychosocial support [6]. The National Heart Foundation of Australia, the Australian Cardiovascular Health and Rehabilitation Association (ACRA) and the National Heart Foundation of New Zealand all promote cardiac rehabilitation and have online resources that can provide referrers with a list of local services available for their patients. Exercise-based cardiac rehabilitation has demonstrated effectiveness for reducing hospitalisations and myocardial infarction rates, whilst improving risk profile, exercise capacity and quality of life in patients with coronary disease [7,8]. Exercise programming also benefits patients with other cardiovascular conditions such as heart failure (both reduced and preserved ejection fraction) [9,10], atrial fibrillation [11], peripheral vascular disease [12], congenital heart disease [13], valve disease [14], pulmonary hypertension [15] and, more recently, with cardio-oncology patients [16].

A graduated program of structured exercise and physical activity is a core component of comprehensive cardiac rehabilitation [17]. Recent studies have described new exercise training techniques, which have improved our understanding of the physiological adaptations from exercise training across diverse patient groups. Furthermore, recent data have also provided a greater understanding of technology and virtual delivery methods for the prescription of exercise and physical activity within cardiac rehabilitation programs. A patient-centred approach is important, and communication with patients should be non-judgemental and respectful. Shared decision making, where patients and their carers are actively involved in the care process, results in personalised interventions that are more likely to improve engagement, treatment adherence, and clinical outcomes [18]. Concomitantly, health professionals should consider evidence, guidelines and behaviour change theories, techniques, and tools when collaborating with patients, identifying their individual exercise and physical activity needs, values and preferences. Realistic short- and medium-term goal setting may be considered, and follow-up should be discussed and supported by the entire multidisciplinary team as they are central to the patient's rehabilitation journey [18].

The objective of this position statement is to provide pragmatic, evidence-based guidance for the assessment and prescription of exercise and physical activity by all clinicians

working within cardiac rehabilitation (e.g., exercise physiologists, nurses, physiotherapists) in the Australian and New Zealand context. Specifically, the aim is to summarise the assessment and prescription recommendations for aerobic exercise, resistance exercise and physical activity for all patients referred for secondary prevention of their recent cardiac event or a new diagnosis. To do this, a multidisciplinary writing group was convened comprising of experts from relevant disciplines, with regional, gender and cultural representation to ensure diversity. A consensus process was then followed to draft, review, and refine the document. The position paper was then submitted to the Cardiac Society of Australia and New Zealand, ACRA, Exercise and Sports Science Australia, and the Australian Physiotherapy Association for endorsement.

Aerobic Exercise

Aerobic exercise is defined as any activity that uses large muscle groups that can be maintained continuously and is rhythmic in nature [19]. Common forms of aerobic exercise include walking, jogging, cycling, rowing and swimming. The benefits of aerobic exercise training within cardiac rehabilitation are well established [7,8]. Cardiometabolic benefits include (but are not limited to) improved insulin sensitivity and glycaemic control, reduction in inflammatory markers, reduced visceral fat, improved vascular function and blood pressure control, improved lipid metabolism, improved skeletal muscle structure and function and modest improvements in left ventricular function [10,20,21].

Assessment

The ACRA cardiac rehabilitation core components state that all patients should receive “an individualised initial assessment that includes physical, psychological and social parameters” [17]. This assessment enables the development and implementation of an individualised exercise program based on the aerobic exercise or functional capacity of the patient.

An aerobic exercise assessment should be conducted to assess the patient's aerobic exercise capacity. Prior to performing any exercise assessment, it is imperative that clinicians consider all relevant contraindications (Table 1). The gold-standard assessment for aerobic exercise capacity is a cardiopulmonary exercise test (CPET) conducted on either a treadmill or cycle ergometer with gas analysis. However, this test is limited to predominantly tertiary centres in Australia and New Zealand due to the cost and specialised equipment and staff required to conduct it. Several methods for assessing aerobic exercise capacity and functional exercise capacity, and the pros and cons of each are summarised in Table 2.

Prescribing and Progressing Aerobic Exercise

Figure 1 summarises the recommended clinician workflow in relation to assessment, prescription and progression of

Table 1 Absolute and relative contraindications to exercise and physical activity.*

Absolute Contraindications	Relative Contraindications [#]
Progressive worsening of exercise tolerance or dyspnoea at rest or on exertion over previous 3–5 days (uncompensated heart failure)	2 kg increase in body mass over previous 1–3 days [†]
Unstable angina	Concurrent continuous or intermittent dobutamine therapy
Blood glucose <4.0 mmol/L or >15.0 mmol/L with symptoms of weakness/tiredness, or with ketosis	Decrease in systolic blood pressure with exercise
Acute systemic illness or fever	NYHA functional class IV
Recent embolism (<4 weeks)	Complex ventricular arrhythmia at rest or appearing with exertion
Thrombophlebitis	Supine resting heart rate ≥ 100 bpm
Active pericarditis or myocarditis*	Moderate aortic stenosis
Severe symptomatic aortic stenosis	Blood pressure >180/110 mmHg (evaluated on a case-by-case basis)
Regurgitant valvular heart disease requiring surgery	Sternal Instability Scale grade 1–2 (minimally to partially separated sternum)
Previously undiagnosed atrial fibrillation	
Sternal Instability Scale grade 3 (completely separated)	
Resting heart rate >120 bpm	
Orthostatic blood pressure drop of >20 mmHg with symptoms	
Third-degree atrioventricular block without pacemaker	

*Adapted from HeartOnline [52]; American College of Sports Medicine Guidelines for Exercise Testing and Prescription [22]; El-Ansary et al. [34].

*During recovery, limit to light to moderate intensity exercise until left ventricular dysfunction has resolved.

[#]Relative contradictions are a guide only and should be combined with clinical judgement at every session. If in doubt, medical advice should be sought before commencing an exercise or physical activity assessment or session.

[†]Rapid weight gain may be a red flag for heart failure.

Abbreviation: NYHA, New York Heart Association.

aerobic exercise training. Informed by a comprehensive clinical history and exercise assessment, the fundamental principles of exercise prescription should be applied: Frequency, Intensity, Time, Type, Volume and Progression (FITT-VP) [22]. Frequency (F) considers how often the patient completes the exercise. Intensity (I) is the level of effort the patient should be exercising at based on assessment of their exercise capacity. Absolute intensity refers to the energy required to perform an activity (e.g., caloric expenditure, absolute oxygen uptake, metabolic equivalent of task). Whereas relative intensity refers to the energy cost of the activity relative to the individual's maximal capacity (e.g., % maximum oxygen consumption or heart rate reserve, perceived exertion). For individualised exercise prescription, a relative measure of intensity is recommended, especially for deconditioned individuals [22]. Time (T) is the duration of each exercise session. Type (T) is the mode of exercise to be completed. Volume (V) is the total amount of exercise training, a product of frequency, intensity and time. Progression is the commencement, advancement and progression of intensity or volume over time [15]. It is important to

highlight that rest or recovery within and between sessions should also be promoted for patients to maximise their overall health status and adaptations to exercise. Table 3 provides FITT-VP recommendations for an individually tailored aerobic exercise prescription at a moderate-high intensity. Table 4 provides a summary of the definitions of light, moderate, high, and very-high intensities when assessing or prescribing exercise or physical activity.

Moderate-Intensity Continuous Training Versus High-Intensity Interval Training

In Australia and New Zealand, exercise prescription guidelines for cardiac rehabilitation have historically been more conservative compared to those in Europe and America, focussing on low-to-moderate intensity exercise, with less technical assessment of aerobic capacity [23]. Moderate-intensity continuous training (MICT) is beneficial and safe for all patients with coronary disease and is strongly recommended [6,24]. More recently, high-intensity interval

Table 2 Types of aerobic exercise, muscle strength and physical activity assessments.

Type of assessment	Description	Pros	Cons
Aerobic Capacity			
Cardiopulmonary Exercise Test (CPET)	Incremental treadmill (Modified Bruce, Naughton, Balke protocols [52]), or leg/arm ergometer test (Ramp protocol) with concomitant expired air analysis.	Gold standard Valid and reliable Tailored exercise prescription Investigates the physiology of exercise intolerance [53] Assesses ventilatory responses to exercise Assesses ventilatory thresholds (VT1 and VT2) Heart rate response to peak exercise Blood pressure response Peak VO ₂ prognostic marker Assessment of haemodynamic response to exercise Tailored exercise prescription Easy to implement Lower cost than CPET Peak METs prognostic	Requires supervision by an allied health professional with extensive experience and training in the ability to interpret an electrocardiogram [54] Medical Practitioner on site [55] Generally limited to tertiary medical centres, often with specialist cardiac services Expensive equipment required
Graded Exercise Test	Treadmill or leg/arm ergometer test following a standardised protocol (e.g., Balke, Naughton or Bruce Protocols [56]). Test may be ceased once the patient reaches 85% of their age predicted HR _{max} (65% for those with beta-blockade therapy who are well rate controlled during exercise), or if clinically indicated; e.g., chest pains, dyspnoea, light-headedness, or fatigue [22,55,56]		Requires qualified supervision Inability to walk on slowest treadmill speed
Functional Exercise Capacity/Field Tests	Incremental Shuttle Walk Test: Incremental walking test between the two cones 10 m apart timed to an audio signal (beep). Patient walks as long as possible or can no longer keep up with the beeps [57]. Six-Minute Walk Test (6MWT): Low-resource test that involves walking as far as possible in 6 minutes, along a 20–30m flat track. Calculate average speed (km/hr) to guide exercise prescription = (6MWT distance x10)/1000.	Valid and reliable Externally paced Low-cost requiring minimal equipment Assessment of physiological indices Tailored exercise prescription Well established [17] Prognostic Easy to comprehend and perform Suitable for the less agile Assessment of physiological indices Tailored exercise prescription Minimal resources Blood pressure and heart rate monitoring	External audible timed signal More complex than 6MWT Unsuited for those unable to walk at least 1.8 km/hr Submaximal test as patient unlikely able to reach higher intensities Limited tool to prescribe exercise intensity targets Sensitivity

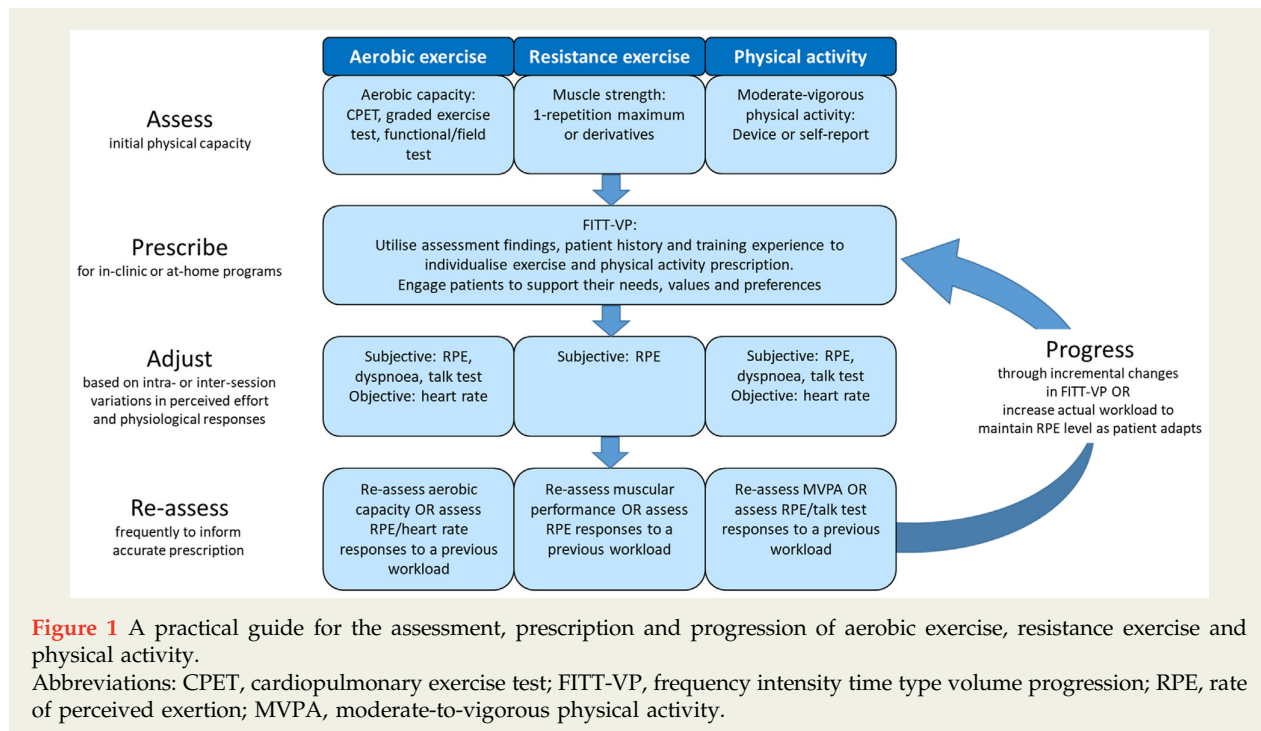
Table 2. (continued).

Type of assessment	Description	Pros	Cons
Muscle Strength 1RM assessments	Defined as the maximum weight that can be lifted for one-repetition, through the full available range of motion and with an acceptable level of technical proficiency Completed for any major muscle group and requires either machine weights or free weights Test terminated when patient is unable to perform one acceptable repetition on two consecutive attempts Uses validated prediction equations [62] to estimate 1RM based on a multiple repetition test Multiple repetition test = the highest weight that can be lifted for a specified number of repetitions to failure (e.g., a 3–6-repetition maximum test) Higher reliability with lower repetition tests (≤ 6 reps) Same equipment, range of motion, technical proficiency and termination criteria as standard 1RM test	Good—excellent test-retest reliability regardless of age, sex, experience level or muscle group [58] Safe and tolerable for cardiac rehabilitation patients [59,60] May limit the haemodynamic excursions seen in higher repetition assessments [61] Results can directly inform exercise prescription	Requires machine or free weights with adequate available loading, which can be costly Requires supervision of appropriately trained and experienced clinicians Risk of musculoskeletal complications
Estimated 1RM assessments	The general principle of these assessments is for patients to either: (1) complete a specified number of repetitions in the fastest possible time (e.g., 5 sit-to-stands for fastest time), or (2) complete the highest number of repetitions in a specified period of time (e.g., maximum number of sit-to-stands in 30 seconds)	Lower loads may suit equipment limitations or patient/clinician hesitancy Safe and tolerable for cardiac rehabilitation patients [59,60] Results can directly inform exercise prescription	Some error associated when population-level estimation equations used to predict individual outcomes Requires machine or free weights with adequate available loading, which can be costly Requires supervision of appropriately trained and experienced clinicians
Low-resource assessments		Easily implemented across most CR settings Minimal equipment requirements Repeatable, objective measurement of muscular strength or endurance	Outcome not transferrable to resistance exercise equipment for prescription

Table 2. (continued).

Type of assessment	Description	Pros	Cons
Physical Activity			
Pedometers	Research vs consumer pedometers Range in functionality and accuracy and are often found in smartphones or smartphone apps	Less prone to recall error and bias [63] Output (steps) is simple to understand Consumer pedometers have reasonable accuracy for steps [64]	Unable to determine context of activity Insensitive to non-ambulatory and water activities (e.g., cycling, swimming) [63] Output does not capture intensity
Accelerometers	Research vs consumer accelerometers Capture acceleration of movement in one or more planes, as well as steps	Provides a measure of intensity, allowing an overall measure of activity volume (i.e., MVPA minutes/week)	Accelerometer intensity thresholds may not be appropriate for cardiac populations
Inclinometers	Research vs consumer inclinometers Measure postural transitions, recording time in sitting/lying, standing and stepping	Considered the most accurate measure of sedentary behaviour	
Physical activity and Sedentary Behaviour questionnaires	Long-format International Physical Activity Questionnaire [65] (group level measure) Active Australia Survey [66] (group level measure) Physical Activity Vital Sign [67] (clinically feasible, individual level measure) Past-day Adults' Sedentary Time questionnaire [68] (group level measure) At an individual level, activity diaries can also be used	More practical due to their low cost and ease of use in the clinical setting Past-day Adults' Sedentary Time questionnaire has been validated in the cardiac rehabilitation setting	More likely to under or over-estimate physical activity and sedentary time due to recall bias Tend to show low correlations with objective measures No physical activity questionnaires have been validated in the cardiac rehabilitation setting
Activity diaries			Labour intensive for participants [69]

Abbreviations: METs, metabolic equivalents; VT1, ventilatory threshold 1; VT2, ventilatory threshold 2; VO₂, volume of oxygen consumption; 1RM, 1 repetition-maximum; MVPA, moderate-to-vigorous physical activity.



training (HIIT) has also been recommended and deemed safe by international authorities for various patients with stable cardiac disease and may provide superior outcomes compared to MICT [25–27].

If appropriate, moderate- and high-intensity training can be prescribed interchangeably as patients progress, while considering patients' preferences and ability, and can be a good combination to improve a patient's aerobic exercise capacity [28]. MICT is recommended for those patients with low aerobic exercise capacity and, where appropriate, patients could be progressed to high intensity sessions as their aerobic exercise capacity improves. Select patients with stable coronary disease, and a good level of aerobic exercise capacity, may progress to high-intensity exercise after a brief period of moderate-intensity exercise training. The most commonly used HIIT model is a warm-up, followed by 4x4-min intervals at 75%–90% peak heart rate (HR_{peak}) with an active recovery phase of 3-min between bouts at approximately 60% HR_{peak} , followed by a cool-down [28]. However, a flexible approach, tailored to individual requirements is judicious in practice, such as shorter intervals and/or a lower intensity for patients who have a reduced aerobic capacity and who may be unable to complete a full 4-min workload [28].

Resistance Exercise

Resistance exercise requires the contraction of one or more muscle groups against an external resistance (e.g., weights)

with the intention to enhance muscular adaptations such as strength, mass and endurance [22]. Participation in structured resistance exercise sessions, known as resistance training, also improves functional performance and prognosis for patients with heart failure [29] or coronary artery disease [30].

Resistance training is an important aspect of an exercise program for the diverse and ageing cardiac rehabilitation population, offering unique benefits that are not provided by aerobic exercise training. Specifically, resistance training can prevent or reverse the loss of muscle mass (sarcopenia) that occurs after coronary artery bypass grafting and with older age, and can also benefit comorbid metabolic, vascular, cognitive, frailty and mental health conditions [31]. Moreover, the addition of resistance training to aerobic exercise programs enhances both muscular strength and aerobic capacity adaptations in patients with coronary disease [32]. Despite historical concerns regarding safety, resistance exercise is well tolerated by patients with cardiovascular conditions, with very few adverse cardiovascular events reported [32] and acute haemodynamic changes comparable to aerobic exercise [33].

Assessment

The objective assessment of muscle strength in cardiac rehabilitation is important to determine and quantify baseline muscle strength, guide individual prescription, and evaluate changes in muscular strength. It is critical that clinicians consider all relevant contraindications before conducting any resistance exercise testing (Table 1), including

Table 3 FITT-VP Recommendations for prescribing aerobic exercise, resistance exercise and physical activity in cardiac disease patients.

	Aerobic Exercise	Resistance Exercise	Physical Activity
<i>All recommendations should primarily be based on patient need and preference and individual risk assessment</i>			
Frequency	3 or more days per week [6]. For patients completing HIIT, at least two of these sessions per week are recommended to be high intensity.	2–3 sessions per week. Recommend 48 hours between sessions, where possible, to maximise muscular recovery	MVPA should be completed on most days per week, which includes exercise as a subset.
Intensity	Moderate-to-high intensity (Table 4; e.g., 55%–90% HRmax, RPE 12–16) based on assessment of aerobic capacity (Table 2)	Moderate-to-high intensity (Table 4; e.g., 50%–80% 1RM or 5–7 RPE based on assessment of muscular performance. Initial prescriptions recommended at moderate intensity for patients not experienced in resistance training	MVPA is recommended to meet the physical activity guidelines. Patients can use the Borg RPE. Modified RPE or the Talk Test to monitor how hard they are working (Table 4)
Time	Session duration >30 min of total aerobic exercise. For patients who are severely deconditioned or have symptoms at low workloads, it is recommended to start with bouts of light-moderate continuous exercise of 5–10 min in duration with breaks as required, to allow full recovery and repeat 2–3 times, progressing towards 30 min of continuous activity. Once moderate intensity activities are tolerated, patients should be encouraged to exercise at higher intensities	Session duration: >20 min Duration of muscle contraction >4 second per repetition (>1 s concentric phase, >3 s eccentric phase) Rest between sets: 60 s [70]	150–300 min moderate intensity, or 75–150 min vigorous intensity, or a combination of both, per week is the aim. This does not need to be accumulated in 10-minute bouts. Additionally, break up long periods of sedentary time, replacing with any intensity of physical activity, including light intensity.
Type	A variety of aerobic modes of exercise are recommended that use large muscle groups such as walking, jogging, cycling, swimming, rowing, stair climbing. Arm-ergometry can also be used if there are underlying musculoskeletal issues affecting lower limb use.	Whole body, single- or multi-joint exercises, performed bilaterally where possible. May include a range of modalities including bodyweight, free-weights, machine weights and elastic resistance bands. Altering the type of resistance training performed can be a useful way to manipulate intensity through changes in body position and loading, particularly in low-resource settings	A variety of MVPA is recommended including domestic, occupational, transportation and leisure activities. Explore opportunities to increase physical activity within the individual's existing daily routines, encouraging activities that the individual enjoys. Be aware of local physical activity referral opportunities (e.g., Heart Foundation walking groups, Parkrun), if appropriate.
Volume	A minimum of 150 minutes of moderate-high intensity aerobic exercise, with an ideal target of >210 min per week for increased cardiometabolic benefit [71]	Total session volume per major muscle group = 15–36 repetitions, arranged as 1–3 sets of 8–15 repetitions. Initial prescriptions can consider lower volumes to allow patient familiarisation prior to progressing towards higher volumes	≥150 min MVPA per week; ≥7,500 steps/day [72]

Table 3. (continued).

	Aerobic Exercise	Resistance Exercise	Physical Activity
Progression	Start slowly and progress gradually, increasing duration to meet 30 min before increasing intensity. Increases in intensity and duration of 5%–10% every 1–2 weeks are typically well-tolerated within cardiac patients.	Clinicians should progress at least one of the following to optimise resistance training adaptations: volume (reps, sets), intensity, type, frequency. Volume and intensity should be progressed before other training variables. E.g., Progress repetitions before sets or intensity, up to a maximum of 15. Once 15 reps can be completed with ease, then intensity should be progressed to 4–6 on RPE scale at a new target of 8–10 reps. Intensity should then be progressed towards the highest tolerable intensity and sets progressed towards 3 per major muscle group.	Start slowly and progress gradually, increasing duration before intensity. If appropriate, individuals may start with as little as 2–5 minutes of activity, 3–4 times a day. Progress towards 30 min of moderate intensity physical activity or 7,500 steps on most days, noting any activity is better than none

Abbreviations: HIIT, high-intensity interval training; MICT, moderate-intensity continuous training; HR_{max} , Maximal heart rate; MVPA, moderate-to-vigorous physical activity; RPE, rate of perceived exertion; reps, repetitions.

the sternal stability of post-sternotomy patients prior to commencing upper body resistance training [34].

Muscle strength should be assessed or estimated relative to the 1-repetition maximum (1RM) outcome measure. Several alternative methods for the assessment of muscle strength are summarised in Table 2, where individual service-level factors like equipment availability and clinician experience may limit the accessibility of 1RM assessment. It is important to note these alternative methods are limited in their ability to inform exercise prescription.

Prescribing and Progressing Resistance Exercise

Figure 1 summarises the recommended clinician workflow in relation to assessment, prescription and progression of aerobic exercise training. Prescription of resistance training during cardiac rehabilitation should be informed by the results of a comprehensive assessment and align with the dual principles of resistance training programming: individualisation and progression [26]. Individualisation refers to tailoring the resistance exercise prescription specific to a patient's physical capacity, experience, preference and cardiac history. Progression is the application of the progressive overload principle and it refers to the increases in intensity or volume over time that is essential for promoting muscle adaptations to exercise. Prescription recommendations for resistance training are summarised in Table 3 and exercise intensities in Table 4.

An objective measurement of muscular strength (e.g., 1RM) for each of the available equipment types or movements facilitates accurate initial exercise intensity prescription [26]. In the absence of objective data for all movements, the most relevant subjective measurement to inform prescription and progression of resistance exercise is the rating of perceived exertion (RPE) (Table 4). Scales include the Borg and Omnibus Resistance Exercise Scale (OMNI-RES) for rating perceived exertion that allow patients to rate their own perceived level of exertion from 1–10 (10 is maximal) using a number or pictorial tool that have been validated against other subjective scales for use specifically in resistance exercise [35].

Many patients will have had limited exposure to resistance exercise prior to cardiac rehabilitation enrolment. Thus, it is important for patients to develop good technical proficiency during the initial training sessions, to set the technical foundation and allow for the safe progression of resistance exercise load and volume throughout the program [26]. Clinicians are encouraged to initially provide a demonstration and then communicate with and coach the patient throughout the exercise delivery to facilitate skill acquisition and body awareness. Thus, clinicians should embed clear, concise instructions for each exercise and simple, consistent feedback at the conclusion of each set. Patients should also be advised that: (1) breath-holding (Valsalva manoeuvre) should be avoided during resistance exercise to limit blood pressure excursions; (2) muscle tension during resistance exercise is a normal sensation; and (3) muscle soreness is

Table 4 Aerobic exercise, physical activity and resistance training intensities.

	Light Intensity	Moderate Intensity	High/Vigorous Intensity	Very High Intensity
Aerobic exercise/physical activity				
VO _{2max} [26] (%)	<40	40–69	70–85	>85
HR _{max} (%)	<55	55–74	75–90	>90
HRR (%)	<40	40–69	70–85	>85
6MWT average speed* [73] (%)		80	100	
Borg RPE	10–11	12–13	14–16	17–19
Modified RPE	2–3	4–6	7–8	9
Talk test [74]	Able to sing	Able to talk in full sentences/ unable to sing	Unable to talk comfortably	
Resistance training				
1RM (%)	<50	50–69	70–84	≥85
OMNI-RPE [35]	<5	5	6–7	≥8

*These intensities may be an underestimate in fitter individuals in whom the test is submaximal.

Abbreviations: VO_{2max}, maximal oxygen capacity; HR_{max}, Maximal heart rate; HRR, heart rate reserve; 6MWT, 6-minute walk test; RPE, rate of perceived exertion; 1RM, 1 repetition maximum.

common in the first few days after resistance exercise but is reduced with subsequent exposures [26]. The recommendation for preliminary sessions is to commence at lower ranges of the recommended intensity so that patients can primarily focus on technique without being hampered by muscular fatigue [26].

Physical Activity

Physical activity is defined as any bodily movement produced by skeletal muscles that result in energy expenditure such as walking for transport, dancing, housework, or gardening; with exercise as a subset [36]. Sedentary behaviour is any waking behaviour characterised by an energy expenditure ≤1.5 metabolic equivalents (METs), while in a sitting, reclining, or lying posture [37]. In people with coronary disease, physical inactivity and sedentary behaviour are risk factors for cardiovascular and all-causes of death [38,39]. Active people with coronary disease have a 50% lower risk of mortality, compared to inactive counterparts [38]. Additionally, sufficient physical activity reduces the impact of coronary disease, slows its progress and improves modifiable risk factors for recurrent CVD and other chronic disease [40]. Consequently, individuals undertaking cardiac rehabilitation and secondary prevention interventions are encouraged to meet the public health physical activity guidelines to improve health outcomes [17].

The World Health Organization physical activity guidelines for adults with chronic disease recommend that individuals should complete 150–300 minutes of moderate intensity aerobic physical activity; or 75–150 minutes of vigorous intensity aerobic physical activity or a combination of both per week [41]. Muscle strengthening should be completed on at least two days per week and varied functional balance and strength activities should be completed three days per week. In addition, long periods of sedentary time should be avoided, replacing sedentary time with any intensity of physical activity, including light intensity, and, for those who find it difficult to meet guidelines, any activity is better than none [41,42].

Assessing Physical Activity

Physical activity and sedentary behaviour can be assessed subjectively (e.g., questionnaire) or objectively (e.g., pedometer, accelerometer) to determine whether an individual is inactive (i.e., not meeting the physical activity guidelines). The most common metrics used to measure physical activity are minutes of moderate-to-vigorous physical activity (MVPA) and step counts. Table 2 outlines methods for assessing physical activity and sedentary behaviour in clinical practice.

Prescribing and Progressing Physical Activity

Figure 1 summarises the recommended clinician workflow in relation to assessment, prescription and progression of

physical activity. Following a comprehensive assessment of an individual's physical activity levels and their safety to increase these levels (Table 1), physical activity can be prescribed according to the FITT-VP principle. An individual's goals, motivation and confidence to increase physical activity in everyday life should be reviewed as part of a comprehensive assessment, with each patient receiving an individually tailored physical activity program based on these findings. Recommendations for physical activity prescription and counselling at a moderate-vigorous intensity (Table 4) are outlined in Table 3.

Clinicians (e.g., nurses, allied health professionals, medical doctors) are well placed to provide general physical activity advice on the types and amount of activity appropriate for the individual's goals, needs, abilities, preferences, functional limitations, medication regimes and treatment. For more specific physical activity advice, exercise specialists such as physiotherapists and exercise physiologists should be consulted. A medical review is generally unnecessary prior to beginning light-to-moderate intensity physical activity within cardiac rehabilitation and the community, unless there are known contraindications (Table 1) [41]. For vigorous or high intensity physical activity (e.g., jogging, tennis singles), a full clinical assessment and medical review is recommended [15].

Safety and Monitoring

Regardless of diagnosis, whether there has been an acute cardiac event or procedure, comorbidities or age, all individuals should be encouraged to increase their exercise and physical activity levels safely, starting slowly at an appropriate level and progressing gradually [6,41]. It is recommended that when conducting centre-based exercise sessions there are basic safety standards and procedures in place, such as a defibrillator, resuscitative and first-aid equipment on-site. Prior to each supervised exercise session, it is recommended to assess the patient's contraindications to exercise, measuring pre-exercise heart rate and blood pressure, to ensure that they are within an acceptable range at rest (Table 1). However, as patients progress and their cardiac disease is stable with no symptoms, these pre-exercise measurements are not necessary and may be counterproductive to the patient's feelings around exercise and physical activity in an unsupervised state. Clinical risk may increase over time due to disease progression or clinical deterioration. When in doubt, seek medical advice or support before commencing the exercise session. During exercise it is recommended to monitor the patient's heart rate and RPE (or Borg Scale for Dyspnoea in patients with heart failure) to ensure they are reaching their target intensity during their aerobic bout of exercise and responding to exercise appropriately (Figure 1). ECG monitoring during exercise is not essential for patients within the supervised setting; however, in certain circumstances (e.g., atrial fibrillation, history of significant ventricular arrhythmias), it is beneficial to use for patients showing

signs or symptoms necessitating further investigation. For most asymptomatic patients, continuous ECG monitoring can be counterproductive by exacerbating feelings of anxiety around exercise that delays development of patient self-efficacy. A warm-up and cool-down should be included in all exercise sessions and physical activity for 5–10 minutes, gradually increasing and lowering the heart rate and blood pressure to limit rapid haemodynamic changes.

For resistance exercise in people with underlying musculoskeletal conditions, correct technique and modifying intensity or volume are important for reducing the risk of aggravating these conditions [32]. Special consideration should also be given to recent median sternotomies; however, evidence supports early initiation of upper body movements within safe limits of pain [43,44]. "Keep your move in the tube" is a paradigm shift that promotes upper limb activity and exercise using short lever arms by performing activities close to the body. This encourages clinicians to engage patients in early active recovery by educating on what they *can safely do*, in contrast to prescribing overly restrictive precautions not supported by current evidence [43,44]. More recently, early post-sternotomy resistance exercise inclusive of individualised upper limb exercise has been reported as safe and resulted in significant improvement in muscular strength and cognitive recovery [45].

Within the community, patients should be advised to wear comfortable clothing and footwear, have adequate fluid intake and avoid activity after heavy meals, if they are suffering from an illness, and in extreme temperatures. During unsupervised exercise and physical activity, individuals should monitor their intensity (e.g., talk test, RPE; Table 4) and symptoms (i.e., chest pain, dizziness, nausea, feeling unwell, excessive sweatiness). If patients experience any warning signs of a cardiac event, then they should be encouraged to call an ambulance immediately. To improve adherence to the exercise and physical recommendations, interventions using mHealth (e.g., text messages, smartphone apps) and wearable activity trackers should be considered [46].

Wearable Activity Trackers

There is emerging evidence that the use of free-living wearable activity trackers (e.g., smartwatches, wristbands, chest strap, clothing and shoe-embedded sensors, smartphone pedometers and accelerometers) leads to increased physical activity levels and aerobic capacity in cardiac rehabilitation participants [47]. The increasing self-initiated use of wearable activity trackers by patients provides an opportunity for clinicians to promote physical activity using these devices. The use of wearable activity trackers can be successfully incorporated within clinical settings after reviewing some device and individual factors [48]. Clinicians should consider device availability, usability (e.g., battery life, metrics available (step count, MVPA, heart rate)), clarity of the interface and management of the devices (e.g., downloading and

interpreting the data). Reliability and validity of the device is important, as well as data security and management. At an individual level, clinicians should determine whether patients are motivated to use a wearable activity tracker and have matching levels of digital literacy. Clinicians can maximise the effectiveness of wearable activity trackers, over the short and long term, through encouraging, educating, monitoring, and providing effective feedback loops to promote individual engagement and autonomy beyond the structured, supervised cardiac rehabilitation setting.

Using Telehealth to Assess and Prescribe Exercise and Physical Activity

Over the past decade telehealth has emerged as an alternative and effective model for delivering cardiac rehabilitation, with its utilisation increasing markedly during the COVID-19 pandemic due to widespread restrictions to face-to-face delivery [49]. Ideally, it is recommended that exercise and physical activity assessments are done in-person to ensure a safe and standardised assessment. However, for a variety of reasons, including patient preference, this may not be possible, in which case telehealth exercise assessments are recommended to allow individually tailored exercise and physical activity prescription.

Before assessing exercise and physical activity using telehealth, safety needs to be considered, including verifying the patient's location in case you need to call an ambulance or checking whether they have an action plan and medications nearby if required. Some patients may not be suitable for a telehealth assessment and will need an in-person review, including those with cognitive impairments and low digital literacy. Before commencing the assessment, clinicians should determine what monitoring equipment is available (e.g., blood pressure or heart rate monitors) and conduct a virtual tour to check if the space is safe for exercising. Also, a standard subjective history should be taken, followed by a virtual exercise test. Selection of a suitable exercise test is dependent on the space and equipment available, ensuring that the test can be repeated at the end of the program using the same methods. To assess functional exercise capacity, the 6-minute walk test (6MWT) [50], 1-minute sit-to-stand test [51] and Timed Up and Go [50] could be used. To assess muscle strength, the 5x sit-to-stand evaluates functional quadriceps strength [50]. Consumer pedometers, accelerometers, or questionnaires can be used to assess physical activity (Table 2). Prescription of aerobic exercise, resistance exercise and physical activity should follow the FITT-VP principle (Table 3). Effective virtual assessment, prescription and progression of exercise and physical activity may be challenging; however, the assessment and prescription of exercise and physical activity via telehealth is preferable to generic untailored programs, providing new opportunities to ensure programs can remain individually tailored when in-person assessment is not possible.

Summary of Recommendations

- A comprehensive individual assessment of aerobic exercise capacity, muscle strength and physical activity allows limiting factors to be identified, guiding the safe prescription of aerobic and resistance exercise and physical activity that is personalised to the patient's abilities, needs, preferences and goals.
- Aerobic exercise capacity, muscle strength and physical activity assessments should be conducted at enrolment and at discharge to allow for a more detailed analysis of a patient's response to exercise and physical activity, which can guide the target intensities during their program, and allow for measurement of program effectiveness.
- Cardiac rehabilitation should incorporate a range of exercise and physical activity options, with the aim to achieve moderate-to-vigorous intensity exercise and physical activity to receive the optimal health benefits and prevent recurrent CVD events.
- MICT is well established as being safe and effective for cardiac patients, with increasing evidence that HIIT is well-tolerated for selected cardiac patients and can offer improvements to aerobic exercise capacity exceeding those resulting from MICT in some patient cohorts.
- Making use of available resources, including wearable activity trackers and telehealth, will potentially allow increased support for exercise and physical activity resulting in increased health benefits, including improvement of quality of life, supporting and empowering patients to self-monitor and manage their symptoms, and increasing their confidence to be active over the longer term.

Conclusion

Patients with cardiovascular disease benefit from cardiac rehabilitation, which includes structured exercise and physical activity as core components. This position statement provides up-to-date evidence-based guidance for the assessment and prescription of exercise and physical activity for cardiac rehabilitation clinicians within the Australian and New Zealand context. With ongoing research in this area, it is important for clinicians to be aware of current guidelines and recommendations from other global cardiac bodies.

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