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POSTER ABSTRACT

Developing a national Cardiac Rehabilitation Clinical Action Guide enabling person-centred care delivery closer to or at home

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Background: The Integrated Model of Care, Prevention and Management of Chronic Disease (1), ECC programme and Model of Care for Integrated Cardiac Rehabilitation, 2023 (2), have enabled cardiac rehabilitation (CR) expansion in Ireland to community-based chronic disease hubs. Historically CR was only delivered in hospitals. An Overview of CR Services in Ireland, 2024 (3), evidenced service delivery variation, including interdisciplinary staffing. The Clinical Action Guide (CAG) will provide a practical resource for national implementation of the Model of Care, end-to-end implementation and evaluation across Integrated Health Areas: (HSE West and North West) and standardised care for patients, in hospitals, hubs or online.

Approach: The CAG is being developed by a CR Clinical Action Guide Working Group, including CR and cardiology HCPs with subject matter expert guidance from the National Institute for Preventative Cardiology. Content includes referral management, improving participation, person-centred interdisciplinary team assessment, CR content, delivery methods (in-person/virtual/hybrid), staff training, monitoring, audit and evaluation. Members are utilising digital platforms to collaborate, share resources and meet regularly. The CAG will be reviewed by the National Prevention Sub-Group, including patient representatives.

Results: •Shifting to interdisciplinary team delivery, from single professional and multi-disciplinary working, requires clear guidance to enable implementation
•Including both hospital and hub staff in design, is essential to ensure the CAG meets the needs of all and will support implementation.
•Supporting collaboration between multiple stakeholders is challenging, especially as many involved are front-line workers. Strong leadership and organisational support is essential.
•The lack of unified EHR across hospitals and communities continues to present challenges, especially for audit and evaluating CAG impact.

Implications: The CAG will standardise delivery, improve integration between hospitals, hubs and interdisciplinary team members at CR sites, and improve patient quality care and choice. While a short-term IT solution is required to examine the impact of the CAG and CR pilots, long-term the national electronic health record will integrate audit and evaluation into standard clinical practice.

This will support effective business cases to fill staffing gaps.

Abbreviations

CAG – Clinical Action Guide
CR – Cardiac Rehabilitation
ECC – Enhanced Community Care
EHR – Electronic Health Record
HCP – Health Care Professionals
ICPCD - Integrated Care Programme for Prevention and Management of Chronic Disease
MOC – Model of Care

References

1. HSE. National Framework for the Integrated Prevention and Management of Chronic Disease in Ireland 2020–2025. Dublin, Ireland: Health Service Executive. 2020.
2. HSE. Model of Care for Integrated Cardiac Rehabilitation. Dublin, Ireland: Health Service Executive. 2020.
3. HSE. An Overview of CR Services in Ireland. Dublin, Ireland: Health Service Executive. 2024