Background: The HARP Cardiac Coach program at Royal Melbourne Hospital has evolved to include a Greek and Italian service, developed in response to the diverse local community and supported by evidence that Culturally and Linguistically Diverse (CALD) groups both perceive health and respond to health care services and information differently.

Methods: We retrospectively analysed cardiovascular risk profiles at recruitment in to and discharge from the program. Patients (n = 383) were recruited after an acute coronary event or intervention between June 2011 and June 2013. Recruitment was into the English (n = 301 patients (79%)) Greek (40 (10%)) or Italian (42 (11%)) model. Data was collected on demographic information and risk factor status at entry and discharge from the program; waist circumference, weight, height, lipid profile, HbA1C, smoking status and physical activity. A comparison of the proportion of patients meeting the defined targets across the English, Italian and Greek cohorts was performed, with multivariate logistic regression analysis applied to adjust for differences in baseline variables.

Results: There were baseline differences in age, smoking history, total cholesterol and cholesterol fractions, diastolic blood pressure, weight and physical activity between the cohorts. At discharge, the proportion of patients meeting targets within each cohort were similar.

Conclusion: A phone based integrated disease management program can be adapted to CALD patients, achieving comparable outcomes as compared with an English speaking cohort. Health services need to respond to their local needs and be flexible in program delivery in order to benefit as many patients as possible.

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A Randomised Study of Triggered Acute Risk Prevention (TARP) for Risk Reduction

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Background: Prior studies have shown that acute cardiovascular disease (CVD) may be triggered by external stressors; however, it remains uncertain how to use this information for disease prevention.

Aim: To determine, using a randomised controlled study design, whether it is feasible for individuals with ≥2 risk factors or known CVD, to take targeted medication using customised packaging for specific stressors. Assessments include haemodynamics, lipids and inflammatory markers, and questionnaires of self-mastery and quality of life.

Methods: Subjects initially recorded episodes of heavy physical exertion, anger and anxiety, heavy meals and respiratory infection over 2 weeks. After baseline measures and questionnaires were obtained, subjects were randomised to control (usual therapy) or a treatment strategy for 4 months, during which they were additionally instructed to take either aspirin 100 mg and propranolol 10 mg (for episodes of significant physical and emotional stress), or aspirin alone (for respiratory infection and heavy meal).

Results: In this ongoing study, 20 subjects have completed the protocol. Using Likert scales, subjects randomised to treatment reported that the medication packaging was convenient, and they were confident in taking the medication and sustaining the strategy into the future. Feedback included a greater insight into their health and improved dealing with anxiety and anger. Ongoing subject enrolment will enable evaluation of other study endpoints.

Conclusions: Initial data suggest that it is feasible to conduct a randomised-controlled trial for individuals at increased CVD risk to identify potential triggers of acute CVD and take targeted medication at the time of these triggers.

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Angina Management is Poor After Percutaneous Coronary Intervention

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Background and aim: Self-management of coronary heart disease (CHD) is critical after elective percutaneous coronary intervention (PCI). While elective PCIs should reduce patients' stable angina symptoms, recurring pain is a common problem post-procedure and effective self-management of this seemed poor. The aims of the study were to identify how patients self-managed their angina symptoms after undergoing PCI and to explore barriers to their effectiveness in this.

Methods: This mixed methods study used an explanatory, sequential design. In phase one quantitative data were collected from a convenience sample (n=93) approximately three months after elective PCI using a validated self-administered survey tool. Quantitative data were subject to univariate, bivariate and multi-variate analysis. Phase one findings were used to purposively select ten participants from the original sample for interview in phase two of the study. Thematic analysis was used to analyse qualitative data.

Results: Participants had a mean age of 66.25 years (SE±10.56), were mostly male (n=70/75.3%) and Caucasian (n=80/86%). After PCI, 74.2% (n=69) of participants managed their angina symptoms inappropriately. Around 17% (n=16) would summon an emergency ambulance to help them deal with any recurrence of symptoms, however slight or short-lived. Older age, the existence of co-morbidities, low self-efficacy, lack of support from healthcare providers, less threatening perceptions of CHD and fear compromised participants' effective self-management of angina symptoms.

Conclusion: Self-management of angina symptoms is suboptimal after elective PCI and a plethora of factors contribute to that. Careful evaluation of patients' self-management skills is required to inform effective self-management strategies.

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