

ACE Workgroup
GAP/Barrier Analysis
Awareness and Action

WHAT THE RESEARCH SAYS

Reasons for delay

- 66% of delay is attributable to patient delay (average is ≥ 2 hours) (Zerwic JJ. Patient delay in seeking treatment for acute myocardial infarction symptoms. J. Cardiovasc Nurs. 1999 Apr; 12(3): 21-32)
- Delay relates to:
 - Misinterpretations or lack of awareness of symptoms (particularly gender differences)
 - Lack of patient/individual awareness of time factor
 - Lack of patient/individual awareness of EMS capabilities
 - Patient/individual reluctance to use EMS (embarrassment/cost)

Strategies that work

- Information from a number of sources, sustained over time
- Interventions, not just materials
- Focus on individuals with risk
- Emotional/cognitive appeal
- Peer messages/support
- Culturally appropriate (women, ethnic groups)

Messages that work

- Risk factors
- Early recognition of symptoms (especially subtle or unexpected, not just chest)
- Call 911
 - Urgency and reason for urgency
 - OK to call EMS—Essential to call EMS

CURRENT STRENGTHS AND BARRIERS IN MAINE

Assets/Available Resources

- A number of organizations are working on improving individual awareness and action as it relates to cardiovascular disease. These efforts are sustained over time
- There does not appear to be a specific focus on patients at risk
- There does not appear to be a specific focus on providers (EMS, PCPS, Specialists, Case/care Managers) to inform individuals and encourage individual action.
- Emotional/cognitive appeal is incorporated in existing strategies

- Peer support is incorporated in some strategies but could be strengthened
- There is a need culturally appropriate approaches (women, ethnic minorities, Native American Indians)
- The most significant behavioral change is achieved through education of youth. [Need citations] There is one school program for youth (elementary and middle school) through the American Heart Association) targeted to behavior/risk factors. It is not specific to AMI.

Target Audiences, Messages/Material:

- Messages/material exists for individuals for CV disease in general.
- There are models for AMI specific messages for individuals that should be consolidated and disseminated broadly (MCVHP slide show, CMMC early symptom recognition are examples)
- Providers: messages/materials have been developed to some extent (Healthy Maine Communities Program works with PCPs and EMS for example). These
- Culturally appropriate messages/materials
 - Women: Information on early symptoms exists, could be expanded. [Danielle and Carrie, should we say anything about treatment—some evidence suggests that treatment for women should differ somewhat (i.e. tubing size) but I don't think it's best practice yet]
 - Ethnic groups (Somalians, Asian communities, Native American Indians): No specific messages/materials are used in Maine for these groups. Messages/materials should be developed.

Delivery Mechanisms

- Maine has a variety of existing delivery mechanisms, including:
 - Individuals (AHA volunteers)
 - Community based organizations (HMP, Healthy Maine Communities, women's groups)
 - Medical providers (Hospital/PCI program outreach, EMS, Primary Care Physicians (PCPs), FQHCs)
 - State level organizations and programs (AHA, MCVHP)
 - Some school-based programs targeted to healthy behavior, but not use of EMS
- Providers (PCPs, specialists, Case/Care Managers, EMS) could be used more frequently, particularly for patients at risk.
- Media
 - Television: Stroke Awareness Campaign – Doug Rafferty PSAs aired on WGME between May 1 and June 5, 2006. (Do any of the PCI centers have TV spots?)
 - Radio: Stroke Awareness Campaign – Two radio spots ran state-wide during May 2005. (Do PCI Centers have radio spots?)
 - Print media
 - State level: MQF has distributed a flyer via major regional newspapers.
 - Local level: None currently

- Internet
 - Media campaign materials/resources are available on the MCVHP and AHA websites, however there are no internet-based media campaigns in place at this time.

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