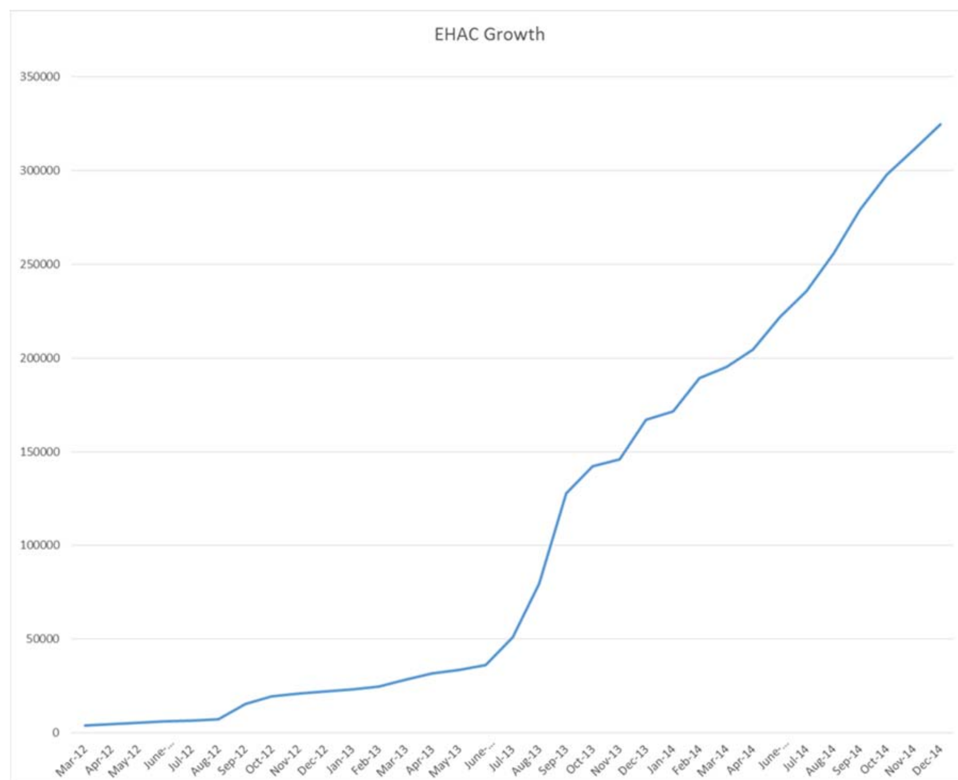
EHAC Strategy Update: Early Heart Attack Care Reaches 300,000 Pledges in 18 Months!

December 2014

In October, the EHAC count reached 300,000 pledges. What's astounding about this accomplishment is that it took a little over 18 months for SCPC accredited facilities and the community-at-large to help us achieve this number. If you look at the EHAC growth chart, you can see how people began to spread the message that heart attacks have beginnings and, together, we can change the cardiovascular mortality rate.



Think about it another way – if each of the 300,000 pledges saves one life, we are successfully achieving the founding mission of the Society and Early Heart Attack Care education.

Science supports our mission.

Chest Pain Centers were developed in the 1980s to improve the variable heart attack care in the United States. Part of this development included the formation of the Society of Chest Pain Centers (today it is called Society of Cardiovascular Patient Care) to create the necessary guidelines for a process of improvement. Performance could be measured to track the reduction of the morbidity and mortality rate.

In addition to performance, the chest pain center's mission was to discover a heart attack in the early stages – when prevention was still possible. In over 50% of heart attacks, it was discovered that, "heart attacks had beginnings," and these early stages had been documented in medical literature for over 100

years. In his NEJM editorial, *The Value of Being Prepared*, Dr. E. Braunwald coined the phrase "Heralded Heart Attacks," in order to discuss the frequent occurrence of the early symptoms.

Although the early stages were well documented, the problem was that these beginnings were occurring in the community – not in the hospital. The Society developed a comprehensive strategy to shift the paradigm from late care to early care. Late care included patients with cardiac arrest, congestive heart failure and acute myocardial infarction (STEMI). Although reducing door to balloon time did improve patient survival rates, EHAC proved to have the greater impact on the patient's life *and quality of life* because a heart attack never occurred – thus preventing any damage to the muscle.

EHAC became the Key Element 1 in the Society's mission to significantly reduce heart attack deaths in the United States and is a national public service message.

EHAC as a System of Care

Early Heart Attack Care (EHAC) is early symptom recognition of an oncoming heart attack and the action steps required to prevent the heart attack from doing damage to the heart muscle and causing cardiac arrest. EHAC education consists of more than just the knowledge of these early signs and symptoms, but consists of a system of care that addresses the stumbling blocks that confronts the patient, the bystander, the EMS paramedics and the ER physicians from acting on these early symptoms. Early Heart Attack Care, to be effective, has to develop into a level of care that offsets these stumbling blocks. In this sense of the word, it has to become a new level of care, one that is needs to be, but is currently not practiced on a consistent basis.

EARLY RECOGNITION AND RESPONSE

EHAC Definition

EHAC = Early Heart Attack Care
EHAC is not just education awareness.
It's a new level of heart attack care with action steps that involve the Patient, the Bystander, the Emergency Medical System and the Hospital.
Addressing these stumbling blocks helps EHAC succeed.

Onset of Symptoms:

1. Early: Central Miled Chest Discomfort
   a. Chest Pressure
   b. Chest Fullness
   c. Chest Burning
   d. Chest Ache
2. These symptoms may come & go (stuttering)
3. During this EHAC timeframe, there is little to no damage to the heart muscle.
4. These symptoms then become more frequent and painful.
5. When the Big One occurs, the patient is in severe pain, weak, cold and clammy. The necessity for hospitalization is obvious.

Stumbling Blocks

A. Patient Denial - "This is just indigestion or the flu"

B. Enabler or Bystander Denial - "You are okay and will be fine in a few minutes."

C. Emergency Personnel - "The patient may not look sick and symptoms don't sound like a heart attack."

D. Hospital - "GOMER mentality."

EHAC Symptoms

New onset of centrally located mild chest discomfort that is often described as a chest pressure, a chest fullness, chest burning, chest discomfort or a chest ache. These are called Chest Pressure, a Chest Fullness, a Chest Burning, a Chest Discomfort or a Chest Ache. These are considered "soft" symptoms and may come and go in the early phase. Sometimes referred to as "a stuttering heart attack," the chest symptoms get worse and become more frequent until the chest symptoms become severe chest pain that does not go away but stays and becomes prolonged. Now, it is called the "Big One." The patient will liken it to a "Mack Truck" or "Elephant" sitting on the chest. At this time, the patient is very weak and has started to become cold, clammy, and sweating and can't wait to get to the hospital.

"Soft" symptoms are deceiving and present problems

When symptoms are described as "soft chest discomfort," there is a tendency for the patient to put such symptoms on the back burner until they become more severe. Since the patient may not look sick, the person may not be recognized as having a problem If a friend is with the person, the friend may easily be talked into agreeing with the thinking of the patient and putting off doing something about these symptoms. The friend often becomes an enabler rather than a caregiver and this happens in 80% of the cases. If 911 is called and paramedics arrive upon the scene, there is a natural tendency for the paramedics to be deceived by the looks of the patient "not looking that sick" and give their own reasons why the patient does not have to go to the hospital. To make it even worse, when the early symptom patient arrives in the ER, the GOMER mentality in the ER Physician often surfaces - "Get Out Of My Emergency Room" unless you have severe chest pain!

The Activated EHAC Response is the Deputy Program

The EHAC Deputy Educational Program addresses these stumbling blocks and teaches ways to get around them. The person taking this program is tested to see if they truly understand the issues stated above. The person then pledges that, once they recognize such a patient, they will not leave them until they can get them into the hospital. Converting enablers into caregivers is the essence in making this strategy work. The GOMER mentality is replaced by the TUFCIE mentality — "Thank You For Coming In Early!" When all of this comes together, we begin to develop a virtual coronary care unit into the community.

How can a Community Coronary Care begin?

Previously, community outreach for the heart attack problem was deemed mission impossible. Now, we are beginning to see progress taking place to address some of the needs. We can see this with the results being obtained from the survivors of cardiac arrest occurring in the community. For example, Witnessed Sudden Cardiac Arrest in Cook County, Seattle, has a success survival rate of 62%. They report 70% bystander participation. In many other cities, the survival rate is less than 20% with only 20-30% bystander participation.

Using this success, we can accomplish the same by providing for an increase in the number of EHAC Deputies in the community to identify and capture early symptom patients and get them to the hospital. We need to change the culture of America to one of action. Converting enablers into Early Heart Attack caregivers would help bring about this Community Coronary Care!

With this evolving strategy, the Society has been able to Deputize 300,000 individuals over the last 18 months. We believe that if we can reach a critical mass (1-3 million) that the message will resonate with the audience and continue to expand.

The reasons that we are optimistic in that EHAC will continue to grow!

1. EHAC has been moved to Key Element Number ONE because it mirrors the mission of the Society of Cardiovascular Patient Care.
2. Accreditation of new chest pain centers includes the requirement that all hospital employees become certified in EHAC education.
3. EHAC education is required to run in conjunction with CPR and ACLS programs.
4. The Society has standardized the EHAC course and makes it available for free to all hospitals on the Deputy Web Site.
5. An EHAC counter on the Deputy Heart Attack website and is updated as people take the course.
6. The Standard EHAC course is offered free to hospitals on their HealthStream LMS or other LMS and makes it easy for their employees to maintain their competency.
7. Apex Innovations has added the Standard EHAC course to their Educational Learning System.
8. As new chest pain centers come on board, they will be able to add between 3000-5000 to the EHAC count. It is projected that the present 850 Chest Pain Centers will swell to 1000 CPCs in the next year. Do the Math! We are talking about adding 750,000 to the 300,000 and want to increase to one million pledges.
9. There is a value-added aspect to the EHAC Strategy and that comes from creating the power of ***"An Idea whose time has come."*** This phenomenon is similar to the rapid growth of CCUs in the 1960s.
10. When many of the above kicks in, EHAC will ***"Go Wild"*** and we think that we can change the Culture of America so people recognize and respond to the importance of Early Heart Attack Care in order to make a significant dent in heart attack mortality in the United States.

Summary

The Success of community cardiopulmonary resuscitation in the Seattle experience (62% Survival) has been attributed to increasing the number of bystander participation (70%) in witnessed cardiac arrest. Using EHAC and following the success in the Seattle study, we can convert "Enablers" into "Caregivers." Just think about it. If the 300,000 individuals who have been EHAC certified can identify one person having a heart attack and stay with that person until they reach the hospital, how many lives can be saved with this new level of Early Heart Attack Care?