The State of Stroke in Washington: Data Metrics, Best Practices, & Challenges from Emergency Cardiac & Stroke Regions through our State

• Smoking Cessation Counseling
• Door to CT Times
• Door to Needle Times

Presented By:
Matt Nelson
Kelly Boardley, BSN, RN, CEN
Julie Berdis, RN, BSN, CNRN
Valerie Lyttle, RN, MSN, CEN, SCRN
Moderated By: Karen Young, RN, CPHQ
The Past...

- 5 year CDC Grant in 2008 for Heart Disease and Stroke Prevention Program
- 2010 Legislation to create ECS System
  - Voluntary Categorization
  - EMS Guidelines
  - ECS Technical Advisory Committee
- Funding ended in June 2013
The Present...

- 96% hospitals now categorized
- Most counties have defined County Operating Procedures
- Statewide Triage Destination tool
- Regional Patient Care Procedures
- Quarterly ECS TAC meetings
- Re-categorization
The Future...

- Continue with ECS TAC and Re-categorization
- Funding sources
  - Legislation?
  - Collaboration?
Thank you!
Smoking Cessation

Kelly Boardley BSN, RN, CEN
Washington State Stroke Forum
September 18, 2014
Objectives

• Identify evidence based best practices in stroke care and discuss current practice from regions across Washington State.
• Identify strategies to implement meaningful education and follow up for patients regarding smoking cessation.
• Provide a list of smoking cessation resources
Why Quitting is so Hard

• Smoking is a physical and behavioral challenge
  – Physical Challenge- it can be addictive
  – Behavioral Challenge- people develop smoking routines into their daily lives that are difficult to change

• Most people try to quit 6-9 times before they are successful

• Need a support system in place
  – Physician
  – Family
  – Friends
  – Co-workers

• Need to be committed to the life style change
### TABLE. Prevalence of past year quit attempt, and recent smoking cessation among adult smokers aged ≥18 years, by selected characteristics — National Health Interview Survey, United States, 2010–2011

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Past year quit attempt (n = 12,681)</th>
<th>Recent smoking cessation (n = 12,260)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% (95% CI)</td>
<td>% (95% CI)</td>
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<tr>
<td>Total (n = 60,171)</td>
<td>51.8 (50.6, 53.0)</td>
<td>6.3 (5.1, 7.6)</td>
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<tr>
<td>Age group (years)</td>
<td></td>
<td></td>
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<tr>
<td>18–24</td>
<td>62.1 (58.9, 65.4)</td>
<td>7.3 (5.7, 8.9)</td>
</tr>
<tr>
<td>25–44</td>
<td>55.3 (53.6, 56.9)</td>
<td>7.1 (6.1, 8.1)</td>
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<td>45–64</td>
<td>45.9 (44.2, 47.7)</td>
<td>5.1 (4.2, 5.9)</td>
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<tr>
<td>≥65</td>
<td>43.7 (40.3, 47.2)</td>
<td>6.8 (5.1, 8.5)</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
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<tr>
<td>Male</td>
<td>51.0 (49.5, 52.6)</td>
<td>6.3 (5.5, 7.0)</td>
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<tr>
<td>Female</td>
<td>52.7 (51.2, 54.3)</td>
<td>6.4 (5.6, 7.2)</td>
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<tr>
<td>Race/ethnicity</td>
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<tr>
<td>American Indians/Alaska Natives (non-Hispanic)</td>
<td>50.7 (40.2, 61.2)</td>
<td>**</td>
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<tr>
<td>Asians, non-Hispanic</td>
<td>49.5 (43.3, 55.7)</td>
<td>6.9 (3.8, 9.9)</td>
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<tr>
<td>Blacks, non-Hispanic</td>
<td>59.1 (56.4, 61.7)</td>
<td>4.0 (3.0, 5.1)</td>
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<td>Hispanics</td>
<td>57.0 (54.2, 59.9)</td>
<td>9.1 (7.2, 11.0)</td>
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<td>Whites, non-Hispanic</td>
<td>49.9 (48.4, 51.3)</td>
<td>6.2 (5.5, 6.9)</td>
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<td>Education</td>
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<td>GED Diploma</td>
<td>49.3 (45.1, 53.5)</td>
<td>3.9 (2.2, 5.6)</td>
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<td>9–11 years</td>
<td>45.9 (42.5, 49.4)</td>
<td>4.6 (3.2, 6.0)</td>
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<td>High School Diploma</td>
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<tr>
<td>Undergraduate College Degree</td>
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<td>10.0 (7.7, 12.4)</td>
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<td>Postgraduate College Degree</td>
<td>54.5 (47.7, 61.4)</td>
<td>10.5 (6.5, 14.5)</td>
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<tr>
<td>Poverty</td>
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<tr>
<td>Below Poverty Level</td>
<td>51.3 (50.0, 52.7)</td>
<td>6.6 (6.0, 7.3)</td>
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<tr>
<td>At or Above Poverty Level</td>
<td>53.7 (51.3, 56.1)</td>
<td>5.1 (4.2, 6.1)</td>
</tr>
</tbody>
</table>
About 443,000 U.S. Deaths per Year Attributable to Cigarette Smoking

- Ischemic Heart Disease: 126,000
- Chronic Obstructive Pulmonary Disease: 92,900
- Lung Cancer: 128,900
- Other Cancers: 35,500
- Stroke: 15,900
- Other Diagnoses: 44,000

Every year:
- $96 billion in medical costs
- $97 billion in lost productivity


About 443,000 U.S. Deaths per Year Attributable to Cigarette Smoking
U.S. Smoking-Attributable Morbidity

• For every person who dies of a smoking-attributable disease, 20 suffer from a serious smoking-related illness

• At least 8.6 million Americans live with one or more serious smoking-related illnesses

The Good News

• Seven in ten smokers want to quit
• More than half try to quit each year
• Even a 3 minute physician intervention can help a patient quit
• Treatment can double to triple quit rates
  – Prescription medication, support groups, follow up
• Simple office systems and state quit lines can lighten your load
  – 1-800-QUIT-NOW- directs patients to their state quit lines

• CDC. Quitting smoking among adults – United States, 2001 -2010. MMWR 2011;60:1513-1519.
Current Practice

• Smoking Cessation Counseling
  – CMS
  – GWTG
  – Stroke Prevention

• Check the Box-
  – Was it done ... Yes or No

• Where do we go from there ??
  – Any follow up?
  – Primary physician involvement?
  – Resources provided?
## TABLE. Tobacco use screening, and cessation assistance during outpatient visits to office-based physicians among adults aged ≥18 years, by selected demographic characteristics — National Ambulatory Medical Care Survey, United States, 2010

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Visits with tobacco screening* (n = 17,015)</th>
<th>Visits with current tobacco use† (n = 3,056)</th>
<th>Visits with current tobacco use with tobacco counseling‡ (n = 570)</th>
<th>Visits with current tobacco use with tobacco counseling and/or cessation medication§ (n = 627)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% (95% CI)</td>
<td>% (95% CI)</td>
<td>% (95% CI)</td>
<td>% (95% CI)</td>
</tr>
<tr>
<td><strong>Total (n = 25,757)</strong></td>
<td>65.6 (62.1, 69.1)</td>
<td>16.9 (15.5, 18.2)</td>
<td><strong>19.1 (16.3, 22.0)</strong></td>
<td><strong>20.7 (17.9, 23.5)</strong></td>
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<tr>
<td><strong>Age group (years)</strong></td>
<td></td>
<td></td>
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<tr>
<td>18–24</td>
<td>69.8 (64.8, 74.7)</td>
<td>18.9 (15.7, 22.2)</td>
<td>18.6 (11.0, 26.2)</td>
<td>18.8 (11.1, 26.5)</td>
</tr>
<tr>
<td>25–44</td>
<td>68.5 (64.7, 72.2)</td>
<td>20.4 (18.2, 22.6)</td>
<td>17.7 (13.5, 21.9)</td>
<td>19.5 (15.1, 23.9)</td>
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<tr>
<td>45–64</td>
<td>64.7 (60.8, 68.5)</td>
<td>20.1 (18.1, 22.1)</td>
<td>21.1 (17.2, 25.1)</td>
<td>23.2 (19.4, 27.0)</td>
</tr>
<tr>
<td>≥65</td>
<td>63.5 (59.1, 67.8)</td>
<td>9.5 (8.2, 10.9)</td>
<td>17.1 (11.2, 23.1)</td>
<td>17.7 (11.8, 23.7)</td>
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<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Male</td>
<td>64.4 (60.7, 68.1)</td>
<td>20.7 (18.9, 22.6)</td>
<td>19.7 (16.5, 22.8)</td>
<td>21.1 (17.9, 24.2)</td>
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<tr>
<td>Female</td>
<td>66.4 (62.8, 70.0)</td>
<td>14.4 (13.0, 15.8)</td>
<td>18.7 (14.6, 22.7)</td>
<td>20.4 (16.4, 24.4)</td>
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<tr>
<td><strong>Race/ethnicity</strong></td>
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<tr>
<td>White, non-Hispanic</td>
<td>67.0 (63.5, 70.5)</td>
<td>17.5 (16.0, 19.0)</td>
<td>18.2 (15.1, 21.2)</td>
<td>20.0 (17.0, 23.9)</td>
</tr>
<tr>
<td>Black, non-Hispanic</td>
<td>62.5 (58.0, 69.0)</td>
<td>18.8 (16.0, 21.6)</td>
<td>25.6 (15.9, 35.2)</td>
<td>25.7 (16.1, 35.4)</td>
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<tr>
<td>Hispanic</td>
<td>60.1 (51.9, 68.3)</td>
<td>16.6 (8.5, 12.7)</td>
<td>20.2 (18.8, 23.5)</td>
<td>20.9 (12.7, 29.9)</td>
</tr>
<tr>
<td>Other Race/Multiple Race, Non-Hispanic</td>
<td>60.2 (45.4, 74.0)</td>
<td>11.6 (7.9, 15.3)</td>
<td>**</td>
<td>**</td>
</tr>
<tr>
<td><strong>Poverty%</strong></td>
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</tr>
<tr>
<td>Less than 5%</td>
<td>65.2 (60.8, 69.6)</td>
<td>13.0 (11.6, 14.5)</td>
<td>19.4 (12.5, 26.3)</td>
<td>22.0 (14.7, 29.2)</td>
</tr>
<tr>
<td>5.00% - 9.99%</td>
<td>66.8 (62.3, 71.2)</td>
<td>16.0 (13.9, 18.1)</td>
<td>20.9 (16.4, 25.4)</td>
<td>22.6 (18.1, 27.2)</td>
</tr>
<tr>
<td>10.00% - 19.99%</td>
<td>67.6 (63.4, 71.7)</td>
<td>19.6 (17.5, 21.7)</td>
<td>19.2 (15.0, 23.5)</td>
<td>20.1 (15.8, 24.4)</td>
</tr>
<tr>
<td>20% or more</td>
<td>60.6 (54.0, 67.2)</td>
<td>19.3 (16.0, 22.5)</td>
<td>16.2 (12.0, 20.5)</td>
<td>17.9 (13.7, 22.1)</td>
</tr>
</tbody>
</table>
What Can We Do As Nurses?

- Advocate for our patients
  - Follow up with PCP
  - Print off information for the patient prior to D/C
- Provide resources
  - Websites
  - Handouts
  - Support groups
- Provide words of Encouragement
  - You can do this!
  - Celebrate small victories
START

• **S** = Setting a quit date. Pick a date within the next 2 weeks. That gives you enough time to get ready, but not so much time that you lose your determination.

• **T** = Telling others about your plan to quit. Quitting is easier to do with support from others. Tell family, friends, and co-workers how they can help you.

• **A** = Anticipating the challenges you will face. Most people who return to smoking do it within the first 3 months. Be prepared for situations when you will be tempted to smoke and plan for how you will deal with them.

• **R** = Removing cigarettes from your home, car, and work. Getting rid of things that remind you of smoking will help you get ready to quit. Clean your car, get rid of lighters and ashtrays, and have your teeth cleaned to get rid of smoking stains.

• **T** = Talking to your doctor about getting help to quit. Some people need help to manage the withdrawal from nicotine. Ask your health care provider if a medicine might help you. You can buy some of these medicines on your own, like the nicotine patch or nicotine gum. Others require a prescription.
Tools for Providers

Quitting takes hard work and a lot of effort, but—

You Can Quit Smoking
SUPPORT AND ADVICE FROM YOUR CLINICIAN

A PERSONALIZED QUIT PLAN FOR:

WANT TO QUIT?
- Nicotine is a powerful addiction.
- Quitting is hard, but don’t give up. You can do it.
- Many people try 2 or 3 times before they quit for good.
- Each time you try to quit, the more likely you will be to succeed.

GOOD REASONS FOR QUITTING:
- You will live longer and live healthier.
- The people you live with, especially your children, will be healthier.
- You will have more energy and breathe easier.
- You will lower your risk of heart attack, stroke, or cancer.

TIPS TO HELP YOU QUIT:
- Get rid of ALL cigarettes and ashtrays in your home, car, or workplace.
- Ask your family, friends, and coworkers for support.
- Stay in non-smoking areas.
- Breathe in deeply when you feel the urge to smoke.
- Keep yourself busy.
- Reward yourself often.

QUIT AND SAVE YOURSELF MONEY:
- At over $5.00 per pack, if you smoke 1 pack per day, you will save more than $1,500 each year and more than $13,500 in 10 years.
- What else could you do with this money?

Five Keys for Quitting

1. GET READY.
   - Set a quit date and stick to it—not even a single puff!
   - Think about past quit attempts. What worked and what didn’t work?

2. GET SUPPORT AND ENCOURAGEMENT.
   - Tell your family, friends, and coworkers you are quitting.
   - Talk to your doctor or other health care provider.
   - Get group or individual counseling.
   - For free help, call 1-800-QUIT NOW (784-8769) to be connected to the Quitline in your state.

3. LEARN NEW SKILLS AND BEHAVIORS.
   - When you feel the urge to smoke, change your routine.
   - Reduce stress.
   - Distraction from urges to smoke.
   - Plan something enjoyable to do every day.
   - Drink a lot of water and other fluids.
   - Replace smoking with low-calorie food such as carrots.

4. GET MEDICATION AND USE IT CORRECTLY.
   - Talk with your health care provider about which medication will work best for you.
   - Bupropion SR—available by prescription.
   - Nicotine gum—available over the counter.
   - Nicotine patch—available by prescription.
   - Nicotine nasal spray—available by prescription.
   - Nicotine lozenge—available over the counter.
   - Varenicline—available by prescription.

5. BE PREPARED FOR RELAPSE OR DIFFICULT SITUATIONS.
   - Avoid alcohol.
   - Be careful around other smokers.
   - Impose some rules to replace old habits with new ones.
   - Eat a healthy diet, and stay active.

Your Quit Plan

1. YOUR QUIT DATE
   ____________________________________________________________

2. WHO CAN HELP YOU:
   ____________________________________________________________

3. SKILLS AND BEHAVIORS YOU CAN USE:
   ____________________________________________________________

4. YOUR MEDICATION PLAN:
   Medications:
   ____________________________________________________________
   Instructions:
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

5. HOW WILL YOU PREPARE?
   Avoid alcohol.
   ____________________________________________________________
   Be careful around other smokers.
   ____________________________________________________________
   Impose some rules to replace old habits with new ones.
   ____________________________________________________________
   Eat a healthy diet, and stay active.
   ____________________________________________________________

Quitting smoking is hard. Be prepared for challenges, especially in the first few weeks.

Follow-up plan: _______________________________________________________
Other information: _______________________________________________________
Referral: _______________________________________________________________

Clinician __________________________ Date ____________

Plan to Quit Cards

How Ready Are You to Quit?
This tool can help you understand how important quitting is to you. And how confident you are about succeeding. Be sure to share this with your doctor. The way you think and feel about your quit can have an impact on your success.

Circle a number that corresponds to how you feel about quitting.

<table>
<thead>
<tr>
<th>How important is it to you to quit?</th>
</tr>
</thead>
<tbody>
<tr>
<td>not at all important</td>
</tr>
<tr>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How confident are you that you can quit?</th>
</tr>
</thead>
<tbody>
<tr>
<td>not at all confident</td>
</tr>
<tr>
<td>0</td>
</tr>
</tbody>
</table>

How to Think About These Numbers.
First, there are no wrong answers. But whichever number you chose, ask yourself why didn’t I choose a lower number? For example, if you chose a 5 for how confident you feel about quitting, how come you didn’t choose a 4?

Write down the reason(s) below: You may realize you’re more confident about quitting than you thought. And that may help you feel even more ready to quit.

I chose a _____ on the importance scale.
It wasn’t a lower number because:
________________________
________________________
________________________

I chose a _____ on the confidence scale.
It wasn’t a lower number because:
________________________
________________________
________________________
Successful Cessation

- A quit program needs to be multifaceted and address all elements of the addiction
  - Identify their reasons to quit
  - Assess their readiness/commitment to quit
  - Identify what their daily habits are
    - When do they reach for a cigarette?
    - Is it feelings, situations, times of day etc
  - Identify their support groups
  - Address the need for dealing with urges to light up again.
  - Understanding the signs of nicotine withdrawal and how to deal with it.
  - Celebrate Successes
Resources

• Center for Disease Control

• Surgeon General

• Pfizer- Chantix (Varenicline) website

• 1-800-QUIT-NOW
  – Free telephone support service that can help individuals who want to stop smoking or using tobacco. Callers are routed to their state quit lines.
Resources

• My time to Quit website:

• Agency for Health Care Research and Quality

• Betobaccofree.gov
  – http://betobaccofree.hhs.gov/

• Gethealthystayhealthy.com
Door to CT

Julie Berdis Stroke Coordinator
Providence Sacred Heart Medical Center
Spokane WA
Target Stroke

Treatment Goal: Door to IV tPA $\leq$ to 60 minutes

At least 50% of eligible patients receive IV tPA in 60 minutes or less
Joint Commission

As of March 1, 2015: IV thrombolytics within 60 minutes to eligible patient presenting for stroke care at least 50% of the time

Effective July 1, 2014
• ED physician assessment ≤ 15 minutes
• Door to CT ≤ 25 minutes
• CT to result ≤ 20 minutes (Interpretation/Documentation by a physician)
• MRI/MRA/CTA interpreted within 2 hours of completion, if ordered to be completed ASAP
Target Stroke

- EMS Pre-Notification
- Stroke Tools
- Rapid Triage Protocol and Stroke Team Notification
- Single Call Activation System
- Transfer Directly to CT Scanner
- Rapid Acquisition and Interpretation of Brain Imaging
- Rapid Laboratory Testing (Including Point of Care Testing if Indicated)
- Mix tPA Ahead of Time
- Rapid Access and Administration if Intravenous tPA
- Team-Based Approach
- Prompt Data Feedback
Barriers:
“Lack of systematic cooperation, streamlined processes, and concerns for misdiagnosis”

TPA- 5 minute Door to Needle-

YouTube

https://www.youtube.com/watch?v=FdSIwvYIQRU
OSF-Saint Francis Medical Center, Peoria Illinois Joint Commission Designated Comprehensive Stroke Center “Strategy to a 5 minute Door-to-Needle Time” NSA Webinar June 18, 2014

Best Practice Strategies:

• **Inclusion: 0-4.5 hour window**

• **Exclusion: Symptomatic Intracranial Hemorrhage**
Three Questions:

• Does the patient take Warfarin (if yes, wait for PT/INR), Dabigatran, Rivaroxaban or Apixaban?
• Has the patient been using heparin or low molecular weight heparin?
• Is the patient on hemodialysis?
Best Practice Strategies:
• Direct to CT
• EMS discussion in CT. Request family cell #’s
• Required lab: blood glucose
• Register while in CT
• Floor scale weight
• tPA available in Pyxis
• Stroke box tPA dose worksheet, IV tubing syringes/flushes)
• Competencies for tPA mixing
• Neurology/Neuro Resident present
• Time out to check tPA dose
Performance Improvement:
2007 Door to Needle 65.5 minutes
2012 Door to Needle Time: 35 minutes (2-5 minutes cases)

2013
• 26% of all stroke alerts received tPA
• 62% of stroke alerts that were ischemic strokes received tPA
  • ≤ 60 minutes 87%
  • ≤ 45 minutes 63%
  • ≤ 30 minutes 46%
  • ≤ 20 minutes 30%
Washington State Door To CT <3 Hour

Time from triage (ED arrival) to initial imaging work-up for all patients who arrive < 3 hours from time Last Known Well

Time Period: 01/2010 - 12/2014

Data is generated from the Get With The Guidelines® Stroke Patient Management Tool and reflects what has been entered by each individual participating hospital.
Door To CT <3 Hour Note: Time periods/Categories at the end of the graph and data table have been omitted because there were no patient records during that time.

<table>
<thead>
<tr>
<th>Benchmark Group</th>
<th>Time Period</th>
<th>0-15 min.</th>
<th>16-25 min.</th>
<th>26-35 min.</th>
<th>36-45 min.</th>
<th>46-55 min.</th>
<th>56-65 min.</th>
<th>66-90 min.</th>
<th>91-120 min.</th>
<th>&gt;=121 min.</th>
<th>Total</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Median</th>
<th>Range</th>
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</thead>
<tbody>
<tr>
<td>All WA Hospitals</td>
<td>2010</td>
<td>243 (18.2%)</td>
<td>354 (26.5%)</td>
<td>249 (18.7%)</td>
<td>142 (10.6%)</td>
<td>83 (6.2%)</td>
<td>71 (5.3%)</td>
<td>78 (5.8%)</td>
<td>57 (4.3%)</td>
<td>58 (4.3%)</td>
<td>1335</td>
<td>45.1</td>
<td>86.1</td>
<td>28</td>
<td>0 - 1539</td>
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<tr>
<td></td>
<td>2011</td>
<td>298 (20.3%)</td>
<td>373 (25.4%)</td>
<td>266 (18.1%)</td>
<td>145 (9.9%)</td>
<td>99 (6.7%)</td>
<td>72 (4.9%)</td>
<td>91 (6.2%)</td>
<td>51 (3.5%)</td>
<td>76 (5.2%)</td>
<td>1471</td>
<td>51.3</td>
<td>128.2</td>
<td>28</td>
<td>0 - 1782</td>
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<tr>
<td></td>
<td>2012</td>
<td>356 (21.2%)</td>
<td>440 (26.2%)</td>
<td>290 (17.3%)</td>
<td>186 (11.1%)</td>
<td>91 (5.4%)</td>
<td>69 (4.1%)</td>
<td>107 (6.4%)</td>
<td>55 (3.3%)</td>
<td>83 (4.9%)</td>
<td>1677</td>
<td>44</td>
<td>80.9</td>
<td>27</td>
<td>0 - 1437</td>
</tr>
<tr>
<td></td>
<td>2013</td>
<td>557 (27.8%)</td>
<td>561 (28%)</td>
<td>299 (14.9%)</td>
<td>152 (7.6%)</td>
<td>94 (4.7%)</td>
<td>73 (3.6%)</td>
<td>110 (5.5%)</td>
<td>57 (2.8%)</td>
<td>100 (5%)</td>
<td>2003</td>
<td>61.6</td>
<td>489</td>
<td>23</td>
<td>0 - 14421</td>
</tr>
<tr>
<td></td>
<td>2014</td>
<td>373 (34.7%)</td>
<td>289 (26.9%)</td>
<td>140 (13%)</td>
<td>71 (6.6%)</td>
<td>44 (4.1%)</td>
<td>40 (3.7%)</td>
<td>54 (5%)</td>
<td>17 (1.6%)</td>
<td>47 (4.4%)</td>
<td>1075</td>
<td>444.9</td>
<td>13299.2</td>
<td>20</td>
<td>0 - 436268</td>
</tr>
</tbody>
</table>
Resources/References

• TPA- 5 minute Door to Needle-YouTube
• National Stroke Association/MER Webinar “Strategy to a 5 minute Door-to-Needle Time” June 18 2014
• AHA/ASA Target Stroke Best Practice Strategies
• The Joint Commission Disease Specific Care 2014 Requirements for Primary Stroke Center Certification
• Get With The Guidelines® Stroke Patient Management Tool
Door-to-Needle Times by Level

Valerie Lyttle, RN, MSN, CEN, SCRN
Stroke Program Coordinator
MultiCare Good Samaritan Hospital
Door-to-Needle times in WA

• Have been steadily improving in the last 5 years
• As a state Washington State has met Target Stroke initiative times since 2013
• By Level:
  – Level III hospitals have met this since 2012
  – Level I’s and II’s have met this since 2013
Time to Intravenous Thrombolytic Therapy

Percent of acute ischemic stroke patients receiving intravenous tissue plasminogen activator (tPA) therapy during the hospital stay who have a time from hospital arrival to initiation of thrombolytic therapy administration (door-to-needle time) of 60 minutes or less.

Time Period: 01/2010 - 12/2013; Site: Good Samaritan Hospital - Puyallup (22162)
## Data For: Time to Intravenous Thrombolytic Therapy

<table>
<thead>
<tr>
<th>Benchmark Group</th>
<th>Time Period</th>
<th>Numerator</th>
<th>Denominator</th>
<th>% of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>All WA Hospitals</td>
<td>2010</td>
<td>110</td>
<td>331</td>
<td>33.2%</td>
</tr>
<tr>
<td>All WA Hospitals</td>
<td>2011</td>
<td>114</td>
<td>383</td>
<td>29.8%</td>
</tr>
<tr>
<td>All WA Hospitals</td>
<td>2012</td>
<td>161</td>
<td>393</td>
<td>41.0%</td>
</tr>
<tr>
<td>All WA Hospitals</td>
<td>2013</td>
<td>274</td>
<td>470</td>
<td>58.3%</td>
</tr>
</tbody>
</table>

Date of report: 07/31/2014 13:39:14 GMT-07:00 run by User: Valerie Lyttle (lyttlev) at Site: Good Samaritan Hospital - Puyallup (22162)

Please note: GWTG aggregate comparative data is intended for internal quality improvement. Permission is required from the American Heart Association and Outcome Sciences, Inc. d/b/a Outcome for external presentation or publication of benchmark data.
Time to Intravenous Thrombolytic Therapy

Percent of acute ischemic stroke patients receiving intravenous tissue plasminogen activator (tPA) therapy during the hospital stay who have a time from hospital arrival to initiation of thrombolytic therapy administration (door-to-needle time) of 60 minutes or less.

Time Period: 01/2010 - 12/2013; Site: WA State DOH (70145)
# Time to IV Thrombolytics, all Levels

<table>
<thead>
<tr>
<th>Benchmark Group</th>
<th>Time Period</th>
<th>Numerator</th>
<th>Denominator</th>
<th>% of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>WADOH ECS Level I</td>
<td>2010</td>
<td>59</td>
<td>150</td>
<td>39.3%</td>
</tr>
<tr>
<td>WADOH ECS Level I</td>
<td>2011</td>
<td>55</td>
<td>165</td>
<td>32.1%</td>
</tr>
<tr>
<td>WADOH ECS Level I</td>
<td>2012</td>
<td>63</td>
<td>156</td>
<td>40.4%</td>
</tr>
<tr>
<td>WADOH ECS Level I</td>
<td>2013</td>
<td>113</td>
<td>164</td>
<td>68.9%</td>
</tr>
<tr>
<td>WADOH ECS Level II</td>
<td>2010</td>
<td>44</td>
<td>163</td>
<td>27.9%</td>
</tr>
<tr>
<td>WADOH ECS Level II</td>
<td>2011</td>
<td>54</td>
<td>212</td>
<td>25.5%</td>
</tr>
<tr>
<td>WADOH ECS Level II</td>
<td>2012</td>
<td>64</td>
<td>219</td>
<td>30.4%</td>
</tr>
<tr>
<td>WADOH ECS Level II</td>
<td>2013</td>
<td>151</td>
<td>274</td>
<td>55.1%</td>
</tr>
<tr>
<td>WADOH ECS Level III</td>
<td>2010</td>
<td>5</td>
<td>15</td>
<td>33.3%</td>
</tr>
<tr>
<td>WADOH ECS Level III</td>
<td>2011</td>
<td>6</td>
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<td>21.4%</td>
</tr>
<tr>
<td>WADOH ECS Level III</td>
<td>2012</td>
<td>11</td>
<td>20</td>
<td>55.0%</td>
</tr>
<tr>
<td>WADOH ECS Level III</td>
<td>2013</td>
<td>21</td>
<td>41</td>
<td>51.2%</td>
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</tbody>
</table>

Date of report: 07/29/2014 10:40:45 GMT 07:00 run by User: Matt Nelson (mpnelson) at Site: WA State DOH (70145)
Please note: GWTG aggregate comparative data is intended for internal quality improvement. Permission is required from the American Heart Association and Outcome Sciences, Inc. d/b/a Outcome for external presentation or publication of benchmark data.
Limitations

• Not all hospitals in WA are using Get With The Guidelines
• Small N size of Level III hospitals
• Larger facilities may be sampling
Let’s Hear from YOU!

- Best Practices & Processes
- Innovations
- Education
- Communication
- Successes
- Challenges
- Next Steps…