# AHA/ASA Ischemic Stroke Performance Measures

## 2. Discharged on antithrombotic therapy

Percentage of patients with ischemic stroke who are discharged on antithrombotic therapy

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Ischemic stroke patients prescribed antithrombotic therapy(^1) at hospital discharge.</th>
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</thead>
<tbody>
<tr>
<td>Denominator</td>
<td><strong>Included patients</strong>&lt;br&gt;• All patients with ischemic stroke</td>
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<tr>
<td></td>
<td><strong>Excluded patients</strong>&lt;br&gt;• Less than 18 years of age&lt;br&gt;• Length of stay ≥120 days&lt;br&gt;• ‘Comfort Measures Only’ documented&lt;br&gt;• Enrolled in clinical trials related to stroke&lt;br&gt;• Admitted for ‘Elective Carotid Intervention’&lt;br&gt;• Discharged to another hospital&lt;br&gt;• Left against medical advice&lt;br&gt;• Died&lt;br&gt;• Discharged to home for hospice care&lt;br&gt;• Discharged to a health care facility for hospice care&lt;br&gt;• With a documented reason for not prescribing antithrombotic therapy at discharge</td>
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<th>Period of Assessment</th>
<th>Hospital discharge</th>
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**Sources of Data**<br>Prospective flow sheet, retrospective medical record review, electronic medical record

**Rationale**

Antithrombotic medications have been shown to reduce morbidity, mortality, and stroke recurrence rates in ischemic stroke patients. Data from large studies suggest that antithrombotic medications should be prescribed at hospital discharge unless contraindicated.

**Source for Recommendation**


1. For patients with noncardioembolic ischemic stroke or TIA, the use of antiplatelet agents rather than oral anticoagulation is recommended to reduce the risk of recurrent stroke and other cardiovascular events (*Class I; Level of Evidence A*).
2. Aspirin (50 mg/d to 325 mg/d) monotherapy (*Class I; Level of Evidence A*), the combination of aspirin 25 mg and extended-release dipyridamole 200 mg twice daily (*Class I; Level of Evidence B*), and clopidogrel 75 mg monotherapy (*Class IIA; Level of Evidence B*) are all acceptable options for initial therapy. The selection of an antiplatelet agent should be individualized on the basis of patient risk factor profiles, cost, tolerance, and other clinical characteristics.
3. For patients with ischemic stroke or TIA with paroxysmal (intermittent) or permanent AF, anticoagulation with a vitamin K antagonist (target INR 2.5; range, 2.0 to 3.0) is recommended (*Class I; Level of Evidence A*). For patients unable to take oral anticoagulants, aspirin alone (*Class I; Level of Evidence A*) is recommended. The combination of clopidogrel plus aspirin carries a risk of bleeding similar to that of warfarin and therefore is not recommended for patients with a hemorrhagic contraindication to warfarin (*Class III; Level of Evidence A*).
Method of Reporting

- Per patient: Documentation of whether antithrombotics were prescribed at discharge.
- Per patient population: Percentage of patients prescribed antithrombotics at discharge.

Challenges to Implementation

- Expanding numbers of antithrombotics and anticoagulants will necessitate frequent updates to the measure.

Analogous Measures Endorsed by Other Organizations

- Analogous measures endorsed or used by: NQF (STK-02, NQF #0435), TJC, AHA GWTG-Stroke, CDC PCNASR, AMA PCPI, and CMS Hospital IQR

1Antithrombotics may include aspirin (acetylsalicylic acid), clopidogrel, combination aspirin+dipyridamole, warfarin, heparin, low molecular weight heparins, dabigatran, rivaroxaban, apixaban or others, prescribed at doses intended to prevent arterial thrombosis or embolism. The numerator should not include patients prescribed only lower doses of these drugs intended to prevent deep vein thrombosis, rather than recurrent ischemic stroke.